Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board 926 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

April 27, 2009

Charlene Frizzera, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2244-F3
P.O. Box 8010
Baltimore, MD 21244-8010

Subject: Final Rule; delay of effective date and reopening of comment period: Medicaid Program; Premiums and Cost Sharing; 74 FED. REG. 13348 (Mar. 27, 2009)

Dear Ms. Frizzera:

As Chair and on behalf of the Centers for Medicare & Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG), I write to submit the following comments for your consideration regarding the Centers for Medicare & Medicaid Services (CMS) final rule on premiums and cost-sharing in the Medicaid program, CMS-2244-F and CMS-2244-F3, as published on November 25, 2008 and re-opened on March 27, 2009 for delay of implementation until December 31, 2009 and requesting new comments.

The CMS TTAG was established in October 2004 to provide advice and input to the CMS on policy and program issues affecting delivery of health services to AI/ANs served by CMS-funded programs, including Medicaid. Most recently, the American Recovery and Reinvestment Act of 2009 (ARRA) section 5006(e)(1) mandates that the TTAG be maintained within CMS. For the past several years, the TTAG has carried out its responsibilities as an advisory group by holding monthly conference calls and three face-to-face meetings each year.

ARRA Sec. 5006(a). This provision of law, which becomes effective July 1, 2009[1], amends Secs. 1916 and 1916A of the Social Security Act to prohibit the imposition of any cost-sharing on AI/ANs who are enrolled in Medicaid and CHIP for services furnished directly by the Indian Health Service, an Indian Tribe or tribal organization or an urban Indian organization (collectively "I/T/Us"), or through referrals under contract health services programs.

Implementation mechanisms needed at State level. With the effective date of this new prohibition fast approaching, it is important that CMS assure that mechanisms are timely put in place at the State level to assure compliance with this new provision on and after July 1, 2009. Specifically, those mechanisms should assure:

[1] The FEDERAL REGISTER notice (74 FED.REG.13346, 13347; Mar. 27, 2009) incorrectly stated that Sec. 5006(a) becomes effective December 1, 2009. The correct date is July 1, 2009, the date on which all amendments made by Sec. 5006 become effective. *See* Pub. L. 111-5, §5006(f), 123 STAT 511.

- That States impose no prohibited assessments on AI/ANs covered by this new law.

- That State Medicaid and CHIP payments to I/T/U providers are not reduced by the amount of any cost-sharing that would otherwise be due from a covered AI/AN but for the amendment made by Sec. 5006(a). Achieving this outcome will require the States to establish reliable methods for identifying claims from I/T/Us to assure that no prohibited reduction in payment occurs.

- That State Medicaid and CHIP payments to contract health services providers to which covered AI/ANs are referred under contract health services programs for covered services are not reduced by the amount of any cost-sharing that would otherwise be due from such individual but for the amendment made by Sec. 5006(a). This will also require the States to establish reliable methods for identifying claims for services provided to AI/ANs by such providers in order to assure that prohibited reductions in payments do not occur.

- That State Medicaid and CHIP programs timely inform all providers of the prohibitions in the new law so that should a covered AI/AN be referred to such a provider for covered services, the provider does not impose any prohibited assessment on such a patient.

Enforcement. In addition, CMS must establish effective procedures to properly enforce Sec. 5006(a). We expect that such procedures would include the addition of a new audit element capable of quickly detecting any violations of the Sec. 5006(a) by a State Plan; a requirement that the State Plan make immediate disclosure upon discovery of any prohibited reductions in payment; and a requirement that the State Plan make supplemental payment to I/T/U and contract health services providers for any prohibited reductions in payment.

July 1, 2009 implementation. To the extent that CMS is unable to issue a complete revised final rule in the "Medicaid Program: Premiums and Cost Sharing" proceeding to be effective July 1, 2009, the TTAG urges the agency to issue at least an interim rule to implement Sec. 5006(a) by that date. Without such action, violations of the new provision could occur and potentially go undetected.

Finally, of course, the final rule that is now being re-examined should be revised wherever necessary to reflect the new policy dictated by ARRA Sec. 5006(a).

Tribal Consultation. In our March 24, 2008, comments in this rulemaking proceeding, the TTAG noted with great disappointment that CMS failed to comply with Departmental policy which required consultation with Indian Tribes about the premiums and cost sharing regulations before they were issued for public comment; Departmental policy requires such consultation whenever, as here, the proposed regulations would have significant impact on AI/ANs eligible for Medicaid and on I/T/U programs. Furthermore, the agency did not even seek advance input from the TTAG which was created by CMS expressly to provide advice on policy and program issues affecting delivery of health services to AI/ANs covered by CMS-administered programs.

Offering tribes and the TTAG only the opportunity to comment on already-fashioned proposed regulations does not comply with the agency's consultation obligation.

Through Sec. 5006(a), Congress subsequently amended the law to relieve the financial burdens on Indian health programs and to remove the disincentive for AI/ANs to enroll in Medicaid, as described by the TTAG in its 2008 comments. The TTAG is grateful for this legislative action, but our dismay remains acute over the agency's failure to comply with the Departmental policy requiring tribal consultation, and its failure to seek advance advice from the TTAG.

With new leadership taking over policymaking and management at the Departmental and CMS levels, the TTAG urges the new leaders to be vigilant in fulfilling their responsibilities for early tribal consultation as required by the letter and spirit of the HHS Department's Tribal Consultation Policy.

Thank you for the opportunity to submit these comments.

Sincerely yours,

/s/

Valerie Davidson
Chair