Tribal Technical Advisory Group
To the Centers for Medicare & Medicaid Services
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Submitted electronically via: http://www.regulations.gov

September 13, 2019

Ms. Seema Verma, Administrator
Centers for Medicare and Medicaid Services
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS-2406-P2: Methods for Assuring Access to Covered Medicaid Services-Rescission (CMS-2406-P2)

Dear Administrator Verma:

The Tribal Technical Advisory Group (TTAG) appreciates this opportunity to share our concerns regarding the proposed repeal of existing regulations on equal access to Medicaid services, a proposal we strongly urge you to withdraw and reconsider for the reasons explained below.[1] We also request that, consistent with CMS's Tribal Consultation Policy, Tribal representatives be included as partners with States and other stakeholders in CMS's effort to develop a more uniform, data-driven Medicaid access methodology and strategy, which was announced in a July 11, 2019 CMCS Informational Bulletin and in the preamble to the proposed rule.[2] Finally, we urge CMS to formally withdraw SMD 17-004[3] since, according to the proposed rule's preamble, CMS has decided not to adopt the "nominal" rate reduction approach described there.[4]

Interest of the Indian Health System.

The Indian health system is comprised of programs managed directly by the Indian Health Service (IHS), tribally-operated programs under the Indian Self-Determination and Education Assistance Act (P.L. 93-638), and urban Indian health programs operated under the Indian Health Care Improvement Act (P.L. 94-437). The Indian health system and the American Indians and Alaska Natives (AI/ANs) it serves are significantly affected by State Medicaid fee-

[1] The TTAG advises the Centers for Medicare and Medicaid Services (CMS) on Indian health policy issues involving Medicaid, CHIP, Medicare, and any other health care programs funded in whole or part by CMS. In particular, the TTAG focuses on providing policy advice designed to improve the availability of health care services to American Indians and Alaska Natives under these programs, primarily those furnished through providers operating under the health programs of the Indian Health Service, Indian Tribes, Tribal Organizations, and urban Indian organizations.
[2] CMCS Informational Bulletin, *Comprehensive Strategy for Monitoring Access in Medicaid*, July 11, 2019, https://www.medicaid.gov/federal-policy-guidance/downloads/cib071119.pdf
[3] CMS, SMD # 17-004, *Medicaid Access to Care Implementation Guidance* (Nov. 16, 2017). https://www.medicaid.gov/federal-policy-guidance/downloads/smd17004.pdf
[4] Preamble to the proposed rule, 84 Fed. Reg. 33722 (July 15, 2019) at 33723.

for-services rates (FFS), and they are harmed when States cut those rates. At first blush this may seem surprising, since State Medicaid programs typically pay for Indian health system services using encounter rates established by the IHS and approved by the Office of Management and Budget (OMB). But the IHS encounter rates apply only to *some* services, and a large and growing percentage of Medicaid-covered Tribal services are paid outside those rates, typically under the same fee schedules that apply to non-Tribal providers.[5] That includes three of the highest-cost services furnished by Tribal programs: outpatient surgeries, which most States pay for under Ambulatory Surgical Center (ASC) rates; physician and other professional services furnished to Tribal hospital inpatients, since the IHS inpatient encounter rate is limited to the hospital's own facility services;[6] and skilled nursing facility services, which are not included in the IHS encounter rates. FFS cuts of even a few percentage points can have a devastating impact on financing for Indian health programs. In Alaska, for example, the Alaska Native Medical Center anticipates it will lose $2.5 million in one year under that State's proposed plan to cut ASC and specialty physician rates 5% and to withhold inflation increases. This would result in significant loss in Medicaid reimbursement to a Tribal provider, while saving the State only one one-hundredth of that amount—approximately $25,000.[7] Other important and growing Tribal services paid outside the encounter rates include Home and Community-Based Services, Waiver Services, and Community Health Aide Services, all of which are cost-effective and reduce the need for expensive institutional care and travel.

Medicaid reimbursement is also particularly important to Tribal programs and their AI/AN patients. We remind you that AI/ANs are among the nation's most vulnerable populations, and their health status is dramatically lower than national averages. The average life expectancy for AI/ANs is 5.5 years shorter than the general population; their mortality rates are more than 3 times the national average for diabetes, nearly 5 times the national average from cirrhosis, 6 times the national average from alcohol-induced causes, and AI/ANs die from suicide, assault, and drug-induced causes at nearly twice the national averages as of 2010.[8] The Department of Health and Human Services, Centers for Disease Control and Prevention determined that in 2017, 12.4% of AI/ANs were in "fair" health and 5.1% were in "poor health," compared to 7.1% and 2.0% of the country's population as a whole, respectively.[9] AI/AN people are also heavily reliant on the IHS for their health care services and – because of chronic and severe IHS underfunding – on Medicaid. The IHS is currently funded at only about 56% of

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[5] The IHS encounter rates are used principally for services of hospitals and other health care facilities. While the rates were initially developed to address limited hospital cost information and administrative billing capabilities at IHS hospitals, they continue to be recognized as a fair and "very efficient" reimbursement methodology.

[6] See 84 Fed. Reg. 2241 (Feb. 6, 2019), IHS Reimbursement Rates for Calendar Year 2019 ("Since the inpatient per diem rates set forth below do not include all physician services and practitioner services, additional payment shall be available to the extent that those services are provided.").

[7] The very small savings to the State is because the vast majority of ANMC patients are AI/ANs and the services thus qualify for 100% FMAP. The professional fee rate cuts have a particularly large impact on the Alaska Native Medical Center, which unlike other Tribal hospitals is also paid FFS for physician and practitioner services furnished to outpatients, plus a reduced encounter rate.

[8] Indian Health Service, Disparities, https://www.ihs.gov/newsroom/factsheets/disparities/

[9] Centers for Disease Control and Prevention, Summary Health Statistics: National Health Interview Survey, 2017, https://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2017_SHS_Table_P-1.pdf.

need,[10] and despite the extensive health care needs of AI/ANs, average per capita spending on IHS patients is barely one-third of the average American's health care costs and one-quarter of the amount spent on the average Medicare beneficiary.[11] It was in order to partly address these problems that Congress first authorized IHS and Tribal programs to bill the Medicaid program 43 years ago. It did so explicitly to provide supplemental federal funding to the Indian Health system and to ensure that Medicaid funds would "flow into IHS institutions."[12] Since then, Medicaid resources have become a critically important component of the Indian health funding stream, and have allowed many IHS and Tribal facilities to begin to address some of the chronic health disparities faced by Indian people in the United States. Without meaningful access to Medicaid resources and adequate reimbursement rates, many Indian health programs would be unable to maintain current levels of service, let alone expand to better address the long-standing health disparities.

The Proposed Changes Should Be Withdrawn at This Time.

CMS has an obligation to ensure compliance with Section 1902(a)(30)(A) of the Medicaid statute, which requires that States ensure payments under their State plans are sufficient "to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." The current regulations were adopted in 2015 to implement a data-driven process for fulfilling this statutory obligation. We applaud CMS for withdrawing its March 2018 proposal, which was broadly opposed by providers and public health experts. But the new proposal is at least as alarming and in some ways more so. The sweeping changes now proposed are premature, unnecessary, and frankly dangerous, and we urge CMS to withdraw them at this time. The current requirements should be retained until they can be more fully evaluated after a longer track record, or until they can be replaced by the new data-driven approach CMS says it is actively pursuing in partnership with States and other stakeholders.

The proposed changes would compromise CMS's ability and duty to ensure States rates meet Medicaid access requirements.

To at least the same extent as the 2018 proposed changes, these proposed changes would significantly weaken CMS's ability to monitor and enforce access to covered services in Medicaid programs. While the 2018 proposal would have exempted "nominal" rate changes from certain requirements, the new proposal would apply to *all* FFS changes, and it would repeal essentially all requirements State Medicaid programs must follow to ensure and demonstrate that their rates satisfy Medicaid access requirements. Under the new proposal, the requirements that

[10] National Indian Health Board, Public Health in Indian Country, https://www.nihb.org/docs/05132014/Public%20Health%20in%20Indian%20Country%20Fact%20Sheet.pdf

[11] Indian Health Service, IHS 2016 Profile, https://www.ihs.gov/newsroom/factsheets/ihsprofile/; National Congress of American Indians, Reducing Disparities in the Federal Health Care Budget, http://www.ncai.org/resources/ncai-publications/08_FY2017_health_care.pdf

[12] Section 1911(d) of the Social Security Act, 25 U.S.C. 1641(d); H.R. Rep. No. 94-1026, at pt. III, 20 (1976).

States must develop and maintain an Access Monitoring Review Plan (AMRP),[13] have mechanisms for receiving and responding to beneficiary and provider input on access to care,[14] and consider input from providers and beneficiaries before adopting rate reductions or restructuring,[15] are all slated for elimination. Literally all that would remain are a verbatim and unnecessary restatement of the statutory access to care requirement[16] and a requirement that States "maintain documentation of payment rates and make it available to HHS on request." [17] Although the preamble asserts that "States would still be required to submit information and analysis to demonstrate compliance with section 1902(a)(30)(A) when submitting payment SPAs," the proposal itself would actually repeal the only language stating that requirement.[18]

In lieu of the current, relatively modest requirements, CMS proposes allowing States to submit with their rate-cut SPAs whatever data they deem appropriate to support them, in accordance with future non-binding guidance that CMS describes only generally and says it will issue when it finalizes the regulation changes. CMS evidently does not plan to solicit public comment on this critical future guidance, which we find very concerning. Nor does CMS explain why it expects that, under this "flexible" approach, States will actually engage in a robust analysis of their rates and their impact on access, when many have made little effort to comply even with the current mandatory requirements,[19] studies demonstrate that many Medicaid services are already chronically underfunded,[20] States generally have a strong financial incentive to lower rates and Medicaid spending, and FFS patients and providers become increasingly marginalized as States move more services and beneficiaries to managed care.

It is imperative for CMS to recognize and embrace its vital role in ensuring that State FFS rates remain at levels sufficient to ensure access under the federal standard. CMS's role is especially important in the wake of the Supreme Court's decision in *Armstrong v. Exceptional Child Center, Inc.*,[21] which held that providers and beneficiaries have no private right of action against a State to contest payment rate changes and left CMS as the only effective bulwark against heedless or ill-considered State rate cuts.[22] For this reason, changes to the equal access regulations must be made with particular care. The government has a heightened responsibility

[13] Proposed repeal of 42 CFR 447.203(b).
[14] Proposed repeal of 42 CFR 447.203(b)(7)
[15] Proposed repeal of 42 CFR 447.204(a)(2) and (b)(3).
[16] Proposed 42 CFR 447.204.
[17] Proposed 42 CFR 447.203(a). (The proposal would remove and reserve paragraph (c) of §447.203.)
[18] The proposal would repeal 42 CFR 447.204(b) in its entirety, including the requirement that "the state must submit to CMS with any proposed state plan amendment affecting payment rates … (2) an analysis of the effect of the change in payment rates on access."
[19] See the data collected by the Center on Budget and Policy Priorities, in its May 22, 2018 public comment on CMS's March 2018 proposal, p. 3.
[20] The American Hospital Association has determined that, on a national level, the Medicaid payment shortfall for hospitals in 2016 was $20 billion, a shortfall that is in addition to the $38.3 billion of uncompensated care hospitals provided that year to patients without insurance. American Hospital Association, Underpayment by Medicare and Medicaid, Fact Sheet, January 2018; American Hospital Association, Undercompensated Hospital Care Cost Fact Sheet, January 2018.
[21] *Armstrong v. Exceptional Child Center, Inc*., 135 S. Ct. 1378 (2015).
[22] After *Armstrong*, Medicaid providers and beneficiaries may challenge rate cuts after CMS approves them under the Administrative Procedure Act.

to monitor access and provide redress for provider and beneficiary complaints given there is no other avenue for stakeholders to seek corrective action. Further, CMS's Medicaid FFS recipients include some of the program's most vulnerable and high-needs patients, on whose behalf CMS should be especially vigilant. In addition to AI/ANs, the populations most likely to be carved out of States' managed care programs and remain in FFS Medicaid are individuals with disabilities, those in need of behavioral health services, and those requiring long-term services and supports.[23] It is for these reasons that the non-partisan Medicaid and CHIP Payment and Access Commission (MACPAC) considers CMS enforcement of the equal access provision to be "the primary mechanism for ensuring that Medicaid beneficiaries have sufficient access to care when services are delivered under FFS arrangements," and why it emphasizes that "State activities to collect and report data [are] necessary for the federal government to carry out this role."[24]

The proposed changes are premature.

We believe CMS's proposed rescission of current requirements is arbitrary and capricious and contrary to law. The current regulations were CMS's method of ensuring that States comply with the statutory mandate to ensure equal access to care. It is premature to rescind those regulations before they have been given a chance to work and without a comprehensive alternative in place. It is simply too soon to fully evaluate the impact of the current rules, which are still in their infancy – let alone to jettison most of them entirely. States' initial AMRPs were due less than three years ago, on October 1, 2016, and some States have still not met that requirement. As of August 29, 2019, two States and three territories still do not have review plans posted on CMS's public website at all.[25] Others submitted plans that are clearly deficient, according to a review conducted jointly by four highly-regarded institutions: Georgetown University's Center for Children and Families, the American Academy of Pediatrics, the Center on Budget and Policy Priorities, and the National Health Law Program.[26] Further, to the best of our knowledge CMS has issued no analysis of the AMRPs it has received. And importantly, States that did comply are still in the *first cycle* of tracking access issues and analyzing the impact of rate changes implemented after submitting their initial plans.[27] Before concluding that the current requirements are ineffective, unnecessary, or unduly burdensome, CMS should wait for the completion of at least the first three-year AMRP cycle, see that all States and territories come into full compliance, fully assess and respond to the submitted plans, determine through a transparent process how effective the current process has been, and fully analyze the connection between FFS rate monitoring and access to care.

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[23] MACPAC May 21, 2018 public comment on the March 2018 proposal, CMS-2406-P, p. 2.
[24] MACPAC May 21, 2018 public comment on the March 2018 proposal, CMS-2406-P, p. 2.
[25] These are Vermont, Tennessee, American Samoa, the Northern Mariana Islands, and Puerto Rico. Centers for Medicare and Medicaid Services, *Access Monitoring Review Plans,* https://www.medicaid.gov/medicaid/access-to-care/review-plans/index.html (last visited Aug. 29, 2019).
[26] See the public comments submitted on the March 2018 proposal by the Center on Budget and Policy Priorities, p. 3.
[27] For example, the State of Alaska is still analyzing the effect of rate cuts it adopted in 2018, which it plans to monitor through 2021. Alaska Medicaid Access Monitoring Review Plan 2017 Report, http://dhss.alaska.gov/Commissioner/Documents/AMRP_SFY2017.pdfhttp://dhss.alaska.gov/Commissioner/Documents/AMRP_SFY2017.pdf

We are intrigued by CMS's plan to develop an alternative approach to evaluating and ensuring access to care in consultation with States and other stakeholders – an effort that should include Tribes, as we discuss more fully below. But that effort has only just begun, and no alternative strategy has yet been developed. CMS should forgo making major changes to the existing regulations on equal access until it has a justifiable alternative to replace it.

The proposed changes would not significantly lower State costs or ease their administrative burdens.

CMS explains that its intention is to give States more flexibility and lighten their administrative burden. But CMS estimates only miniscule cost-savings to States stemming from these changes: less than $24,000 annually per State.[28] Actual State savings will be lower – or should be – since CMS's estimate does not consider the costs States will have to incur to ensure adequate rates under the proposed new "flexible" approach. These savings are insignificant, especially when weighed against the very real risk that States, regularly beset by budget pressures, will cut FFS rates to levels that violate Medicaid's equal access provision.

Further, while regulatory relief is a worthy policy goal, it needs to be undertaken thoughtfully. CMS should selectively target only requirements that are duplicative, provide no value, or do harm. The current regulatory requirements, which protect beneficiary access to care, do not meet those criteria. Rather, they provide CMS the tools it legitimately needs to fulfill its statutory obligations and oversight functions. They should be retained until an equally effective alternative, such as the new strategy CMS reports it is actively pursuing, is identified and implemented.

More conservative ways to reduce State burdens and costs.

Instead of tossing out the current requirements, there are modest steps CMS could take that would both make it easier for States to comply with the requirements and facilitate CMS's analysis of State review plans and access. By adopting a standard reporting template and metrics for AMRPs, CMS would take a lot of the guesswork out of the process for States. The greater reporting uniformity would also make it much easier and more efficient for CMS to monitor States' efforts and enforce compliance. CMS could further ease the administrative burden on States by offering them more technical and financial assistance.

Tribal Representatives Should be Included as Partners with CMS and States in Developing the Comprehensive Strategy for Monitoring Access in Medicaid.

CMS announced in the proposed rule's preamble and in a July 11, 2019 Informational Bulletin that it "is initiating a strategy to measure and monitor beneficiary access to care across Medicaid," including services furnished through both FFS and managed care delivery systems

[28] Proposed rule preamble at III.B.1, 84 Fed. Reg. 33725.

and in home and community-based waiver services.[29] It announced that it will lead the effort working "in partnership with States and other stakeholders."[30] We are intrigued by and support that initiative. But it is extremely important that Tribes be involved in the effort along with CMS, States, and other stakeholders.

Tribal participation is not only appropriate, it is explicitly called for under CMS's Tribal Consultation Policy, which formalizes CMS's policy to "seek consultation and the participation of Indian Tribes in the development of policies and program activities that impact Indian Tribes."[31] The Policy recognizes that "[t]he involvement of Indian Tribes in the development of CMS policy is crucial for mutual understanding and development of culturally appropriate approaches to improve greater access to CMS programs for AI/ANs, to enhance health care resources to IHS and Tribal health programs, and to contribute to overall improved outcomes for American Indians."[32] Under the Policy, Tribal consultation is triggered "by any policy that will significantly impact Indian Tribes," which may "arise in any policy area for which CMS has responsibility, such as … changes in provider payment and reimbursement methodologies."[33]

Including Tribal representatives in developing the new strategy would be a crucial and immensely valuable first step in the required Tribal consultation process.[34] Taking account of Tribal considerations and drawing on Tribal expertise and experience at the outset will help ensure the new strategy reflects the needs and concerns of Indian country, and that Tribal input is both "meaningful and timely."[35]

Specifically, we request that at least three Tribal leaders and technical experts be included as partners with CMS and States on each work group and technical expert panel. Once CMS has identified what groups and panels will be established, we would be pleased to recommend Tribal representatives for each.

SMD 2017-004 Should be Withdrawn Now that CMS has Decided Against Formally Adopting its Approach.

Finally, we urge CMS to formally withdraw SMD 2017-004. That guidance anticipated and is similar to CMS's March 2018 proposed rule changes, which would have exempted from current requirements States having 85% or higher managed care penetration and so-called "nominal" FFS rate cuts, and which CMS has now decided not to adopt, noting that an "overwhelming number of commenters raised concerns that the exemption thresholds were

[29] CMS CIB July 11, 2019, *Comprehensive Strategy for Monitoring Access in Medicaid*, https://www.medicaid.gov/federal-policy-guidance/downloads/cib071119.pdf
[30] Proposed rule preamble, 84 Fed. Reg. 84 at 33724; Id.
[31] CMS Tribal Consultation Policy (Dec. 10, 2015), https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSTribalConsultationPolicy2015.pdf § 4.1.
[32] §5.4.
[33] §5.5.
[34] Once the strategy is developed, more inclusive and formal Tribal consultation will also be required.
[35] §5.3.

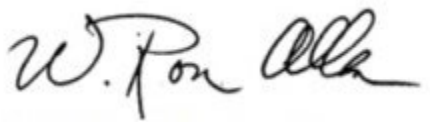
arbitrarily set without data to support them."[36] Since CMS has now abandoned that approach, it should withdraw the prior guidance that seems to support it. States should not be misled into believing they can adopt "nominal" changes without analysis or CMS scrutiny,[37] and CMS should protect providers and beneficiaries from such arbitrary cuts.

Conclusion:

Tribal health programs and AI/AN beneficiaries are directly and disproportionately impacted when States reduce FFS reimbursement rates. CMS has a primary and vital role to play in ensuring that States maintain rates sufficient to ensure that Medicaid provides full and appropriate access to covered services. It is premature, unnecessary, and dangerous to toss out the existing regulatory framework, which does not impose undue costs or burdens on States and which is too new to fully evaluate, and we therefore urge you to withdraw the proposed changes. We applaud CMS's decision to abandon the 2018 proposal to exempt certain States and rate changes from the current requirements, and we urge CMS to withdraw its similar 2017 guidance to States. Finally, Tribal leaders and technical experts should be included at the outset in CMS's recently-announced effort to develop a comprehensive new strategy for monitoring Medicaid access across all delivery systems, and the TTAG stands ready to recommend Tribal representatives to work on that initiative.

Should you have any questions about TTAG's comments as set forth in this letter, please contact Devin Delrow, Director of Policy at the National Indian Health Board, ddelrow@nihb.org.

Sincerely,



W. Ron Allen, Chair
Tribal Technical Advisory Group

cc: Kitty Marx
Director, Division of Tribal Affairs
Centers for Medicare & Medicaid Services

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[36] Preamble to the proposed rule, 84 Fed. Reg. at 33723 (July 15, 2019).
[37] Alaska recently proposed broad-based rate cuts of 5%, partly in reliance on SMD 2017-004. A lawsuit challenging the cuts on numerous grounds is pending in State superior court.