



Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services



c/o National Indian Health Board | 910 Pennsylvania Avenue, SE | Washington, DC 20003 | (202) 507-4070 | (202) 507-4071 fax

October 27, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via regulations.gov

Re: Medicaid Program; Temporary Increase in Federal Medical Assistance Percentage (FMAP) in Response to the COVID-19 Public Health Emergency (PHE); Reopening of Public Comment Period

Dear Dr. Brooks-LaSure:

On behalf of the CMS Tribal Technical Advisory Group (TTAG), I write to provide a response to the Centers for Medicare and Medicaid Services (CMS) reopened Interim Final Rule (IFR) with comment period, “Medicaid Program; Temporary Increase in Federal Medical Assistance Percentage (FMAP) in Response to the COVID-19 Public Health Emergency (PHE); Reopening of Public Comment Period” (CMS-9912-N).

Preamble to Comments:

Before commenting specifically on this interim final rule, we highlight the important context in which TTAG’s comments are offered, and which should inform CMS’s consideration of them: the deep inequities in this nation’s health care delivery system, and the Biden administration’s commitment and urgent effort to eliminate them. Over the last year the entire federal government, including CMS, has been working to respond to the President’s Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (EO 13985).

For the first time, the federal government is taking a systematic approach to address equity issues. CMS has responded by first issuing its CMS Strategic Plan, “Pillar: Health Equity” that laid out CMS’ definition of health equity and a broad strategy to advance equity through its programs. More recently, CMS has published its Framework for Health Equity 2022-2032, which is a more detailed ten-year plan intended to address equity and health disparity issues across Medicare, Medicaid, CHIP, and the Health Insurance Marketplaces.

Important to understand about health disparities is that American Indian and Alaska Native (AI/AN) people were once one of the healthiest people on this continent, before colonialism and the United States policies of termination, assimilation, and boarding

CMS TTAG Letter to CMS Administrator Brooks-LaSure

Re: CMS-9912-N

October 27, 2022

Page 2 of 4

schools caused an “intergenerational pattern of cultural and familial disruption”¹ that drive health disparities to this day. These drivers have manifested in some of the worst health disparities for AI/AN people, including extraordinarily high and disproportionate rates of infant and maternal mortality, cancer, cardiovascular disease, depression and other behavioral health conditions, among other ailments. The recent Department of Interior Boarding School Report explains that “Native Americans continue to rank near the bottom of all Americans in terms of health, education, and employment. Many AI/ANs face unique challenges and harsh living conditions resulting from the United States having removed their tribes to locations without access to adequate resources and basic infrastructure upon which their tribal governments can foster thriving communities.”² It is important to acknowledge that efforts to address these disparities are often complicated by culturally inappropriate interventions and an inadequate understanding of the historical effects of United States policies and ongoing trauma of AI/AN people.³ It is this history that is the root cause of the significant health disparities that affect AI/AN populations.

The TTAG is deeply appreciative that the President’s EO 13985 and the CMS Framework for Health Equity provide an opportunity to focus on these concerns, and that the CMS Framework provides an opportunity to design, implement, and operationalize policies and programs to address health equity issues. The TTAG has always taken the position that CMS has ample legal authority to undertake distinct policies and programs specifically focused on AI/AN beneficiaries and the IHS programs that provide their care, because of their unique legal status under the U.S. Constitution and the duties owed by the federal government under its treaty and trust responsibilities to AI/ANs.⁴

Under established principles of Indian law, programs and policies that are specifically established for Indigenous people and organizations do not constitute prohibited race-based classifications; rather, they are based on the unique political relationship between the federal government and Indian Tribes. This unique legal relationship, taken together with EO 13985 and CMS’ Framework for Health Equity, provides a sound basis for CMS to adopt the TTAG recommendations on the Proposed Rule. We trust you will agree that the TTAG recommendations are directly related to CMS’ Framework discussed in “Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps.” These TTAG’s recommendations fit clearly in the intended outcomes of this chapter of the Framework as well as other priority areas of the Framework.

Comments:

To receive the temporary FMAP increase, a state was required to keep beneficiaries enrolled in Medicaid, if they were enrolled on or after March 18, 2020. As you know, however, the original interpretation of Section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA) required that states keep beneficiaries enrolled with the same amount, duration, and scope of benefits, through the end of the month in which the COVID-19 PHE ends. Additionally, states could not subject these

CMS TTAG Letter to CMS Administrator Brooks-LaSure

Re: CMS-9912-N

October 27, 2022

Page 3 of 4

beneficiaries to any increase in cost sharing or beneficiary liability for institutional services or other long-term services and supports during this time period. This change in interpretation saw Medicaid beneficiaries experience loss of benefits that were even more precious to them during the struggles they faced during the most trying times of the PHE.

The overarching goal of this IFR was to keep beneficiaries on the rolls in order to maintain continuous enrollment in the Medicaid program through the incentive of increased FMAP for states. However, the change in the interpretation noted above shows that state concern of the fiscal impact of continuous enrollment on their bottom line mattered more than ensuring that beneficiaries continue to receive health care throughout the COVID-19 pandemic.

Therefore, we recommend CMS return to its original interpretation of section 6008(b)(3) of the FFCRA described in the FAQs from April 13, 2020, May 5, 2020, and June 30, 2020. Under this proposed interpretation, to be eligible for the temporary FMAP increase, a state would not only be required to keep its beneficiaries enrolled in Medicaid, but it would not be permitted to reduce the amount, duration, or scope of their benefits or modify their cost sharing after the effective date of the final rule. We agree with the Agency that this interpretation is a reasonable approach to implementing section 6008(b)(3) of the FFCRA.

We recommend that CMS rescind § 433.400 and replace that provision with a Final Rule that implements its original interpretation of section 6008(b)(3). We recommend CMS require states to offer Medicaid beneficiaries whose coverage was changed in a manner consistent with § 433.400 an opportunity to re-enroll in – or to have their enrollment changed back to – their prior coverage.

Throughout the PHE, states implemented cuts and reductions to Medicaid services and eligibility following the issuance of the IFR. Individuals inconsistently lost benefits and access to crucial health care, including access to home and community-based services that many depended on in order to remain in their homes during the pandemic. This must be put to a stop before others lose necessary coverage. Beneficiaries should continue to at least receive the status quo care they received prior to the PHE. Any move to the contrary – and any move that reduces access to care – is contrary to the intent of the FFCRA. The IFR as it currently stands, permits states to reduce the amount, duration, and scope of benefits for groups of enrollees, including individuals who become eligible for Medicare and qualify for a Medicare Savings Program and individuals who are lawfully residing immigrants that reach adulthood. Under the current interpretation of the IFR, states may eliminate optional benefits or even change the scope of benefits or increase cost-sharing, all while the state continues to receive the bump in FMAP. This is a gross misinterpretation of a statute aimed at putting “Families First” in the fight against COVID-19.

If a beneficiary experienced changes to their coverage, we recommend CMS permit those beneficiaries to re-enroll in, or to have their enrollment changed back to, their

CMS TTAG Letter to CMS Administrator Brooks-LaSure

Re: CMS-9912-N

October 27, 2022

Page 4 of 4

prior coverage. This is required in order to make the beneficiary whole as a result of the misaligned interpretation that states have been operating under for the past couple years. Throughout the PHE, Indian Country has seen a decrease in coverage as well as the more extreme disenrollment from coverage altogether. For example, AI/AN individuals enrolled in Medicaid in Idaho were dropped from Medicaid while the state was collecting the increased FMAP. We ask that CMS do everything in its power to ensure that states abide by the continuous enrollment provisions and do not drop beneficiaries from Medicaid rolls. In addition, we recommend the Agency do all it can to mandate and to encourage states to review disenrollment decisions and re-enroll those who are eligible. We understand this is a big lift for states, so we recommend CMS provide the appropriate support to states to ensure that people continue to receive the care they need during this PHE.

Conclusion

Again, we urge that CMS rescind § 433.400 and replace that provision with a Final Rule that implements its original interpretation of section 6008(b)(3), which would prohibit states from reducing the amount, duration, and scope of enrollees' Medicaid benefits until the end of the month in which the public health emergency ends. We appreciate your consideration of the above comments and recommendations and look forward to engaging with the agency further.

Sincerely,

A handwritten signature in black ink that reads "W. Ron Allen". The signature is written in a cursive, flowing style.

W. Ron Allen, CMS/TTAG Chair
Jamestown S'Klallam Tribe, Chairman/CEO