



# 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

November 4, 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: Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes**

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) proposed rule, “Streamlining the Medicaid, Children’s Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes” (CMS-2421-P). The TTAG strongly supports improvements to these processes that remove barriers to care, and we look forward to seeing how these changes promote enrollment and retention within Medicaid, the Children’s Health Insurance Program (CHIP), and the Basic Health Program (BHP).

**Preamble to Comments:**

Before commenting specifically on this proposal, 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.

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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 schools caused an “intergenerational pattern of cultural and familial disruption”<sup>1</sup> 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.”<sup>2</sup> 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.<sup>3</sup> 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.<sup>4</sup>

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.

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**Comments:**

We commend the Administration's efforts to streamline the Medicaid, CHIP, and BHP eligibility and enrollment processes. People of this nation should have access to affordable, high-quality health care, regardless of their ability to navigate the administrative burdens and enrollment barriers many encounter when seeking coverage. It is essential to the health and well-being of all people, but especially our American Indian and Alaska Native communities, to make it easier to enroll and maintain coverage in the health care programs in which people are eligible. The TTAG supports many of these proposals, which aim to increase the automation of the renewal determination process and reduce the likelihood that eligible individuals lose their health coverage during the Medicaid unwinding process we are entering into soon.

The TTAG supports the use of information collected and determinations made by other agencies throughout the federal government in the determinations of coverage in Medicaid, CHIP, and the BHP. Automating the enrollment and renewal processes – and utilizing the work that other agencies have already done – will decrease the burden for both states and beneficiaries alike. Any time a reliable secondary source can be utilized to expedite these processes, CMS should support its use. The burden placed on applicants to provide information that is readily available from other sources is an unnecessary barrier to care, and we are encouraged to see that the agency has recognized this and proposed a solution. Navigating the enrollment and renewal process is not easy, especially when it comes to more vulnerable populations that these programs service, like the elderly, the disabled, and those with low incomes, and we support efforts to streamline and facilitate these processes.

The TTAG supports the proposal to require states to auto-enroll most Social Security Income (SSI) beneficiaries into the Qualified Medicare Beneficiary Group. Further, the TTAG supports the determination of eligibility to be done through various state applications, including the use of the Supplemental Nutrition Assistance Program (SNAP) benefits assessment to automatically supplant the renewal process and use that data to determine eligibility renewals. We encourage CMS to continue to be creative as it looks for ways to accurately crossmatch eligibility and renewal processes to save time and effort on all fronts – from the beneficiary to the state Medicaid agency, and CMS itself.

The TTAG supports and recommends the proposal that CMS require states take proactive steps when unanswered mail is returned to them. Oftentimes, as you know, returned mail indicates a potential address change. We recommend that states leverage data sources outside of its own Medicaid agency to obtain updated and accurate contact information for enrollees to ensure that information is being provided to enrollees regarding their coverage, and that no disenrollment action is taken due to return mail or a lack of response via mail from an enrollee. Further, we recommend that outreach be conducted via alternative modalities to ensure accurate information, like by phone when available. This would help ensure that information is properly provided,

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and it is a good two-step verification process to ensure that mail is in fact delivered to the beneficiary.

The TTAG supports the proposal to streamline and facilitate transitions between the Medicaid and CHIP programs, for example, by issuing a combined notice of eligibility or by accepting the eligibility determination made by the other agency and allowing that eligible individual to transition from one program to the other. This would eliminate some of the burden of the application process and enrollment requirements, which can delay or restrict access to much needed care for children. In addition, the TTAG supports the proposals to maximize CHIP enrollment by eliminating waiting periods and removing premium lockouts that are incurred due to unpaid premiums or enrollment fees. The TTAG further supports the proposal to prohibit annual and lifetime limits on *any* CHIP benefits. As a program serving children in need of coverage, we encourage the elimination of all barriers to care in the CHIP program.

**Conclusion:**

We appreciate your consideration of the above comments and recommendations and look forward to engaging with the agency further on ways to remove barriers to care and to promote the health and well-being of our people.

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