Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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November 17, 2008

MEMORANDUM

To: Rodger Goodacre, Acting Director
Tribal Affairs Group, CMS

From: Mickey Peercy, Chair
TTAG Tribal Consultation Policy Subcommittee

Re: Feedback on CMS Revisions to TTAG Proposed Tribal Consultation Policy

Thank you very much for sharing with me the September, 2008, CMS revisions to the tribal consultation policy on which we have all been working over the past four years. We were pleased to see that in a number of provisions CMS restored language or concepts proposed by the TTAG in its December, 2005 draft; please convey our appreciation to your CMS colleagues for these restorations.

Some issues still remain, however. I feel that many of them could be resolved expeditiously if TTAG and CMS personnel could have a face-to-face discussion, but my Subcommittee members and I recognize that it not feasible to convene a CMS "team" for such a conversation since so many CMS offices have a role in review of the consultation policy.

Thus, we are taking the next-best step by explaining here why we want to retain some important concepts in the TTAG proposal which have either been changed or eliminated in CMS's March, 2008, and September, 2008 revisions. We are hopeful that knowing our reasons may persuade CMS to agree to TTAG's requests. We also propose some compromise ideas for CMS to consider.

A. Level of CMS Commitment to Tribal Consultation

It seems to us that CMS is reluctant to make a commitment to go beyond the level of consultation required by the HHS tribal consultation policy. Since CMS policies are complex and have significant impact on whether AI/ANs have access to CMS programs, we believe CMS should view the HHS consultation policy requirements as a floor rather than a ceiling. We find the reluctance to go beyond the HHS policy reflected in CMS revisions to the following sections:

- Sec. 9 – Consultation Process: CMS revisions here focus consultation efforts largely on the annual HHS regional consultation sessions and paper or electronic-based methods of consultation; they seem to limit the possibility of other tribal, state or national Indian-specific consultation sessions. We seek greater flexibility for the agency and for tribes in the timing, manner and subject matter of consultation. Also see our comments about Sec. 9 revisions regarding consultation with States.
- Sec. 11 – Budget Formulation: Here CMS has eliminated several steps designed to obtain information on the budget priorities of tribes and the TTAG. It is vital that the TTAG have a substantive role in setting the CMS/TTAG annual work plan and in prioritizing the action items for which financial resources will be supplied.

- Sec. 13 – Meeting Records and Additional Reporting: CMS revisions here would limit its reporting on consultation to the Department's Annual Report on regional consultation sessions. This is insufficient, as most significant consultation events will occur apart from the Department's annual sessions.

We believe CMS would agree that issues involving individual Indian and Indian health program participation in CMS-administered programs are often very complex and require special expertise to fully appreciate how Indians will be affected by new or changed policies. It is for this reason that we hoped the agency would commit to an enhanced level of interaction and not limit itself only to the procedures in the Departmental policy.

We note that throughout the agency's revision, the TTAG's suggested wording of "not prohibited by law" has been changed to "permitted by law". The TTAG developed its wording in recognition that often the Social Security Act and other relevant laws do not *expressly* address many potential actions – such as tribal consultation with States on Medicaid and SCHIP matters. In such cases, tribal requests should not be denied because there is no express "permission" or direction in the law. What we seek to achieve here is greater flexibility on the part of CMS officials to "think outside the box" when it comes to implementing SSA programs in the unique system for delivering health care in Indian Country, as that system differs in major respects from the mainstream health care system. Of course, the final decision whether to take a requested action rests with CMS, but we believe the agency should not truncate its consideration of implementation options merely because there is no *express* "permission" or requirement for it in the law.

We, therefore, ask CMS to re-consider its revisions/deletions in these portions of the policy.

B. How to Measure the Success of the Consultation Policy

We seem to have a fundamental difference of opinion with CMS on how to measure the success of a consultation policy. For example, in Sec. 12.1.2, the TTAG proposed that success should be measured by the extent to which it "results in improvements in access to and quality of care provided to AI/ANs and ultimately in improvements in health status of AI/ANs." To us, achieving greater program participation and improved health status is the whole purpose for consultation. CMS replaced this success standard with one that states the goal of consultation is "to provide meaningful access to the CMS policy development process on issues with Tribal implications." While we agree that is a desirable goal, it focuses on *process* only, rather than on the overarching objective of tribes – to improve the health of Indian people by increasing their access to care.

We think that the TTAG's success measurement standard in Sec. 12.1.2 better reflects the goals statement in Sec. 1 – Introduction – about which TTAG and CMS agree:

> "The Centers for Medicare & Medicaid Services and Indian Tribes share the goals of *eliminating health disparities* of American Indians and Alaska (AI/AN) and ensuring that *access* to Medicare, Medicaid, and State Children's Health Insurance programs (SCHIP) is maximized." (emphasis added)

Similarly CMS's revisions to Sec. 5 – CMS Core Values – deleted the TTAG's statement that "federal delivery of health services and funding of programs *to maintain and improve the health of AI/ANs* are consonant with and required by the Federal Government's historical and unique legal relationship between Indian tribes and the United States." The agency changed this provision to focus on "up-to-date health care coverage and to promote quality care for beneficiaries." We certainly agree with these concepts, and would support revising the TTAG-drafted provision to incorporate them. At the same time, however, we ask CMS to restore the TTAG's reference to maintaining and improving the health of

AI/ANs. Such a combination provision would resolve this issue and properly reflect the goals stated in Sec. 1.

C. Tribal-State Consultation

In Secs. 9.2 – 9.2.9, the TTAG sought CMS's support for assuring greater tribal consultation with States regarding Medicaid and SCHIP proposals. We appreciate CMS's commitment to "encourage", "facilitate" and "assist" States in developing meaningful tribal consultation processes, but were disappointed CMS stopped short of requiring States to consult with tribe on program changes that affect AI/ANs (Sec. 9.2).

We recognize that the SSA does not *require* States to consult with tribes on State Plan Amendments or waiver proposals which affect tribes, but neither does that law deny CMS the authority to impose such a requirement. For this reason, we suggested that "to the extent not prohibited by law", CMS should require that States consult when a proposal would affect AI/ANs. In fact, CMSO did just that in its July 17, 2001, letter to State Medicaid Directors which *requires* States to consult with tribes prior to submitting waiver requests/renewals. In the consultation policy, however, CMS rejected the requirement that States consult with tribes – even on waiver requests which CMSO already requires. At a minimum, the consultation policy should accurately reflect this CMSO waiver policy.

We seek a State consultation requirement because in our view, prudent policymaking is well-served by evaluating all impacts of a proposal, including Indian health impacts. Those states that willingly consult with tribes provide benefit to all concerned – tribes, the State, CMS reviewers and sound policy. But since some States do not consult with tribes, it is incumbent on the agency to either require them to do so or to establish another mechanism for full tribal vetting.

If CMS is reluctance to direct States to consult with tribes, we ask the agency to support another mechanism in order to achieve the benefits voluntary consultation produce. The TTAG proposed such a mechanism in Sec. 9.2.6 – which calls for CMS to notify tribes of SPAs and waiver requests with tribal impacts – but this, too, was rejected by the agency. We doubt that this provision was rejected because CMS does not want tribes to learn of such State proposals; more likely it was rejected because agency personnel believe it would be too cumbersome to supply copies of all SPAs and waiver requests to all tribes in the proposing State. We assure you that the TTAG does not want tribes to be overwhelmed by such a flood of paperwork, either. All we seek is notice of such requests (as the wording of Sec. 9.2.6 indicates) so that affected tribes can evaluate a proposal and voice their views.

Perhaps both agency and tribal concerns can be accommodated by re-wording Sec. 9.2.6 to embrace the following concepts:

- Where a proposed SPA or waiver request which has tribal implications does not describe the extent to which tribes were consulted, CMS will provide a notice that summarizes the request to tribes and IHS programs in the State and to the TTAG. We presume that internal procedures already require such a summary to be distributed within the agency in order for a proposal to be fully evaluated.

- Where a proposed SPA or waiver request certifies that IHS and tribes were consulted prior to submission, and describes the nature of the views expressed (and with regard to waiver requests/renewals, complies with the July 17, 2001 SMD), no further action by the agency would be needed unless, of course, CMS desire more input from the IHS or tribes as part of its internal evaluation process.

- Require States to describe the extent of tribal consultation when submitting SPAs or waiver requests.

We ask CMS to revise its position on Sec. 9.2.6 in light of these considerations.

D. References to Applicable Laws

Sec. 2 – Background – lists several laws which affirm the "special relationship" between tribes and the United States. In its September, 2008, revisions, CMS deleted the Snyder Act and to the Social Security Act from this list, perhaps because neither was referenced in the comparable section of the Departmental policy and because inaccurate SSA titles were listed. Since CMS's entire relationship with tribes involves interaction on the SSA – particularly Titles XVIII, XIX and XXI – the TTAG believe it is vital to reference the SSA in the consultation policy. This should be done by restoring the SSA to the list of laws in Sec. 2, or by developing a separate paragraph to refer to the eligibility of Indian people and Indian health programs for participation in the programs authorized by these SSA titles.

The September, 2008, draft also revised Sec. 7.1.2 which describes the authority of tribal organizations to operate programs pursuant to the Indian Self-Determination and Education Assistance Act. We suspect that the agency revised the first sentence solely to improve its syntax. But in so doing, an important ISDEAA concept was omitted – that is, that tribal organizations must receive authorization from one/more tribes to carry out programs under the ISDEAA. In the interests of accuracy, we ask that the TTAG-drafted sentence be restored.

Conclusion

We hope that CMS, in a spirit of partnership and shared interest in improving AI/AN access to the programs it administers, will work with the TTAG to overcome these remaining obstacles so we can finalize a tribal consultation policy which achieves the shared goals expressed in Section 1. Please accept our sincere thanks to you and all CMS personnel who have helped develop this consultation policy.