

National Indian Health Board



Submitted via Medicaid.gov

September 15, 2019

Administrator Seema Verma
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20101

RE: Utah Per Capita Cap 1115 Demonstration

Dear Administrator Verma,

On behalf of the National Indian Health Board (NIHB),¹ I write to comment on the Utah Section 1115 Demonstration waiver application seeking to implement Per Capita Caps, community engagement requirements, and mandatory Managed Care enrollment for Medicaid beneficiaries. This waiver as written is concerning to American Indians and Alaska Natives (AI/ANs) and would set a dangerous precedent for Indian health for the reasons we highlight below.

NIHB stands in support of the Tribes in Utah, that have worked with the state to preserve protections for American Indians and Alaska Natives who meet the Utah Medicaid eligibility for cost sharing exemptions. In submitting our letter of support, we remind you that AI/ANs are among the nation's most vulnerable populations and that Medicaid plays a critically important role in extending valuable resources to the chronically underfunded Indian health system, which serves Indian Health Service (IHS) beneficiaries.

Federal Trust Responsibility

Medicaid is one of the major programs the government provides access to pursuant to its trust obligation to AI/ANs. Congress has declared that "it is the policy of [the U.S.], in fulfillment of its special trust responsibilities and legal obligations to Indians . . . to ensure the highest possible

¹ Established in 1972, the National Indian Health Board (NIHB) is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

health status for Indians and urban Indians and to provide all resources necessary to effect that policy; [and to render health care services] more responsive to the needs and desires of Indian communities.”²

The Department of Health and Human Services (HHS) and CMS have a legal responsibility to advance these objectives when administering the federal health care programs they oversee, for all Tribal members. This trust responsibility and the federal laws designed to implement it not only permit CMS to treat those served by the Indian health system as unique Medicaid enrollees entitled to special accommodation and treatment, they *require* it.

Per Capita Caps

“The State requests that individuals with verified membership in a federally recognized tribe be excluded from the per capita cap calculations.”

Under a per-capita cap program, a state receives a capped amount per Medicaid enrollee from the federal government. Caps would be estimated from previous costs, although the federal government would only be responsible for funding up to the cap; individual states would have to pay the excess costs, if any. For Utah, the state’s demonstration waiver is ambiguous as to how the per capita caps per waiver/per month would work. The waiver says that due to the current and potential budget conditions that may arise in the state of Utah, the proposal includes a request that the state can cap enrollment based on available state appropriations. Verified members of federally recognized Tribes would be included in budget neutrality calculations, but excluded from per capita cap calculations. The impact this would have on reimbursement rates and continued access to Medicaid for AI/ANs is unclear. Any AI/AN exclusion must be applied not just to the per capita cap calculations, but to the caps themselves.

Any cap on Medicaid will significantly impact Tribal governments, AI/AN Medicaid beneficiaries, and Indian health providers. As you know, Congress authorized 100 percent FMAP for services received through IHS and Tribal facilities. Specifically, Congress observed that since the United States already had an obligation to pay for health services to Indians as Indian Health Service (IHS) beneficiaries, it was appropriate for the United States to pay the full cost of their care as Medicaid beneficiaries. The Committee noted that because the 100% FMAP provision was limited to services received through the Indian health system, it was being provided for IHS eligible AI/ANs for whom the United States has an obligation and who are already eligible for “full Federal funding of their services.”³ This key provision ensures that the responsibility to pay for Medicaid services to AI/ANs remains with the federal government, and is not shifted onto the States. This was a principle reason why Congress included an exemption on services received through an IHS facility from the statewide caps or block grants in the American Health Care Act.⁴

Medicaid reimbursements are critically important in filling the gap created by chronic underfunding of IHS, and are a critical source of funding for Tribes seeking to take over IHS

² 25 U.S.C. § 1602.

³ H.R. REP. No. 94-1026, pt. III, at 21 (1976), as reprinted in 1976 U.S.C.C.A.N. 2782, 2796.

⁴ American Health Care Act (AHCA, H.R. 1628).

hospital systems through self-governance agreements. In 2017 for example, the per capita spending for IHS patient services was \$4,078 as compared to \$9,726 per person nationally.⁵ Medicaid is a critically needed resource for IHS, tribally operated and Urban Indian health programs across the country.

As important as Medicaid is to the overall funding for the Indian health system, Medicaid payments to the Indian health system represent less than one percent of total spending in the Medicaid program. As a result, because of this small amount and 100% FMAP, preserving full federal funding for Medicaid services received through the Indian health system will not adversely affect Utah's overall effort to cap and control federal Medicaid spending.

It is not enough to exempt members of federally recognized tribes from state proposed Medicaid cap calculations, instead to ensure the state fully receives 100% FMAP for services received in and through I/T/U's, we request Medicaid reimbursement to IHS, Tribal and urban Indian programs be fully exempt from any per capita caps which would otherwise limit such reimbursement. Devoting resources to our health system is a federal responsibility and cannot be shifted to the states. This policy position has previously been supported by the National Governor's Association during past Medicaid reform efforts⁶ and is consistent with the United States trust and legal responsibilities to Tribes.

Work Requirements

“Therefore, the State will exempt certain individuals from the requirement, as approved under the State's 1115 PCN waiver. The exemptions are largely aligned with federal SNAP exemptions. The exemptions are: ... A member of a federally recognized Tribe.”

Utah proposes an exemption from community engagement requirements for members of federally recognized Tribes. NIHB recommends the exemption, however, should apply to all AI/AN persons that are eligible to receive health care from IHS, Tribally-operated and urban Indian health programs. AI/AN Medicaid beneficiaries are unique among Medicaid enrollees in that they also have access to IHS. As a result, the employment incentive structures created by Medicaid work requirements do not operate in the same way for AI/AN Medicaid beneficiaries who may forgo Medicaid coverage and rely instead on IHS coverage. This, in turn, will strain the underfunded IHS system. As a practical matter, many AI/AN Medicaid beneficiaries may not be able to meet Medicaid work requirements due to high on-reservation unemployment and/or lack of connection to State employment programs. Many AI/ANs look to their Tribal governments for employment assistance rather than their state and as a result will not be able to demonstrate they are participating in State employment assistance programs. Finally, imposing work requirements on AI/AN Medicaid beneficiaries is inconsistent with the federal trust responsibility and congressional intent to increase Indian health system access to Medicaid resources.

Managed Care

⁵ IHS profile, <https://www.ihs.gov/newsroom/factsheets/ihsprofile/>

⁶ National Governors Association, Resolution HHS-18, “Indian Health Services,” March 1, 2006.

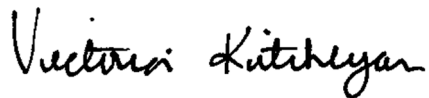
“The State proposes to exempt individuals with verified membership in a federally recognized tribe from the enrollment limit for the Adult Expansion and Targeted Adult Populations. Enrollment for these populations will continually remain open for individuals who meet this exception.”

Utah’s proposal to require managed care for the entirety of the state’s Medicaid eligible population by January 2020 is problematic for AI/ANs. Mandatory managed care limits Indian health programs’ access to Medicaid resources, and poses a barrier to AI/AN participation in the Medicaid program. Simply put, Medicaid managed care has not succeeded in Indian country. Medicaid managed care providers often have little to no familiarity with the Indian health system and routinely disregard the rights of AI/ANs and Indian health providers under the Medicaid statute, the Indian Health Care Improvement Act, and other federal law. AI/ANs continue to find it difficult to access Indian health care providers (IHCPs) in managed care, and IHCPs continue to have difficulties being reimbursed by the Medicaid program from managed care entities. These issues and others pose insurmountable barriers for AI/ANs in accessing the Medicaid program. We recommend that AI/AN’s remain in the traditional Medicaid program and not be auto-assigned into managed care, but may opt-in to a managed care plan, if they so choose. This is in compliance with the attached CMS Information Bulletin..... We further recommend that a self-attestation process be instituted and that descendants of Tribal members, including children, grandchildren, and adopted and foster care children be included in this exempted group so that barriers to accessing health care are not created among tribal families.

Conclusion

We are grateful for the opportunity to provide comments and recommendations and look forward to further engagement with CMS. Should you have any questions regarding NIHB’s comments, or for more information, please contact NIHB’s Director of Policy, Devin Delrow, at ddelrow@nihb.org.

Sincerely,



Victoria Kitcheyan, Chair
National Indian Health Board

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