October 12, 2019

The Honorable Alex Azar II
U.S. Department of Health and Human Services
200 Independence Avenue SW, Sixth Floor
Washington, DC 20201

Re: Montana Health and Economic Livelihood Partnership (HELP) Demonstration Program - Extension Request (Project Number 11-W-00300/8)

Dear Secretary Azar:

On behalf of the National Council of Urban Indian Health[1] and National Indian Health Board[2] (collectively, National Organizations),[3] we submit the following comments to the Centers for Medicare & Medicaid Services (CMS) on the Montana Health and Economic Livelihood Partnership (HELP) Program section 1115 demonstration (HELP Program Amendment) pending extension and amendment application. As elected leaders of National Organizations, we serve as the collective voice for the health care interests of American Indians and Alaska Natives (AI/ANs), including on issues related to access to care and the Medicaid program. The Medicaid program is of vital importance to AI/AN health care and any restriction of eligibility for AI/AN people would have detrimental impacts on the Indian health system. For the reasons contained herein, we

[1] The National Council of Urban Indian Health (NCUIH) is the national representative of Urban Indian Organizations receiving grants under Title V of the Indian Health Care Improvement Act and the AI/ANs they serve. Founded in 1998, NCUIH is a 501(c)(3) organization created to support the development of quality, accessible, and culturally sensitive health care programs for AI/ANs living in urban areas. NCUIH provides advocacy, education, training, and leadership for Urban Indian health care providers. NCUIH strives to improve the health of approximately 70 percent of the AI/AN population that reside in urban areas, supported by quality, accessible health care centers and governed by leaders in AI/AN communities.

[2] 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 or regional Tribal organization elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board or regional Tribal organization, 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 rely on IHS for delivery of some, or most, of their health care, the NIHB is their advocate.

[3] National Organizations represent the interests of the Indian health care delivery system, which is comprised of Indian Health Service, Tribally-owned or –operated, and urban Indian organization facilities (I/T/U system) and the AI/ANs they serve.

strongly support the aspect of the HELP Program Amendment that exempts AI/ANs from proposed work and community engagement requirements as a condition of eligibility for the Medicaid.

Waiver Background

On August 30, 2019, the State of Montana submitted an extension and amendment request to CMS for its HELP Program. The pertinent proposed changes include a proposal to allow the state to establish work/community engagement requirements for non-exempt expansion adults as a condition for Medicaid coverage, as well as to revise the premium structure to include gradual increases to monthly premiums based on the length of time an individual is enrolled in coverage under the demonstration.

When touting the key milestones and accomplishments[4] surrounding the expansion of Medicaid in Montana, the State acknowledged that expansion had been an opportunity to dramatically improve the health of the state by incentivizing primary and preventive care. "To promote use of high value health services, the state did not apply copayments for preventive health care services." It is unclear how requiring copayments, increased premiums, and work requirements from its Medicaid beneficiaries now promotes continued use of high value health services.

Work/Community Engagement Requirements

National Organizations remind CMS that many families would like to be employed or have access to better-paying jobs, yet jobs and volunteer opportunities can be hard to find in every community in Montana, including AI/AN communities. The State provides a list of qualifying activities and exemptions under the new work requirements. Nevertheless, National Organizations remain concerned that many Montanans will be at risk of losing Medicaid coverage due to the inability to find work or volunteer activities that satisfy the work requirements, or the difficulty of demonstrating to the state how they should qualify under a standard, hardship, or good cause exemption.

The State acknowledges that because work requirements are a new policy with little precedent nationally, "it is impossible to predict future enrollment effects with certainty, and [that] coverage losses could be greater" than the State's current estimate of between 4% and 12% of enrollees that will fail to meet or report the work engagement requirement.[5]

As a general matter, National Organizations are concerned that work / community engagement requirements have the potential to significantly limit access to healthcare for America's most vulnerable populations. This is especially concerning with respect to

[4] See Montana's Section 1115 Waiver Annual Report submitted to CMS on August 8, 2018, which includes a federal evaluation design and timeline by the Urban Institute and Social & Scientific Systems, Inc.

[5] Montana Department of Public Health and Human Services Section 1115 Demonstration Amendment and Extension Application, page 18.

AI/ANs because limiting AI/AN access to health care is inconsistent with the federal government's trust responsibility for the provision of health care to AI/ANs.

Federal Government's Trust Responsibility for the Provision of Health Care to AI/ANs

It is longstanding and settled law that the United States has a trust responsibility to provide access to health care for AI/ANs.[6] The government's trust responsibility applies to all federal agencies and extends to all AI/ANs regardless of their current place of residence. Medicaid is one of the major programs the federal government utilizes in its implementation of this responsibility – and any barrier to access of health care, including the imposition of additional restrictions for Medicaid eligibility, for AI/ANs is contrary to the government's trust obligation.

Medicaid is a critical resource to the communities that we represent. [7] Restricting participation in Medicaid for AI/ANs would impose a significant financial burden on the Indian health system, which already suffers from chronic underfunding. Congress recognized the importance of Medicaid to the Indian health system in 1976, when it authorized the billing of Medicaid so that Medicaid funds could "flow into" a health system that had for too long been underfunded.[8] The Medicaid program continues to be essential to I/T/U facilities. For example, a recent report by the Government Accountability Office highlighted the benefits Medicaid confers to Indian Health Service (IHS) health facilities through the collection of third-party revenue and to AI/ANs through increased access to care.[9] This funding enables Indian Health Care Providers to provide more services to more patients. Tribally-owned and –operated and urban Indian organization facilities similarly rely on Medicaid revenues to provide high quality, culturally-competent services to their AI/AN patients. Essentially, Medicaid is a critical resource for I/T/U facilities – bringing in $729 million to IHS facilities alone in fiscal year 2018.[10]

National Organizations caution CMS that the imposition of any barriers to AI/AN access to health care, like mandatory work and community engagement requirements as a prerequisite for Medicaid eligibility, is a violation of longstanding U.S. policy and the Federal trust obligation to AI/ANs. Reducing eligibility limits access to care for AI/ANs and significantly reduces essential funding at I/T/U facilities, causing reduced services and ultimately decreasing the level of quality care that is provided. We strongly support

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[6] 25 U.S.C. § 1602(a)(1)

[7] Recent figures suggest that 27% of nonelderly AI/AN adults and half of AI/AN children are enrolled in the Medicaid program. Henry J. Kaiser Family Foundation, Medicaid and American Indians and Alaska Natives (Sept. 2017). Another recent figure finds around 40% of UIO patients are Medicaid enrollees. *See* Indian Health Service, Office of Urban Indian Health Programs, UDS Summary Report Final – FY2016.

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

[9] See *Indian Health Service: Facilities Reported Expanding Services Following Increases in Health Insurance Coverage and Collections.* GAO-19-612: Published: Sep 3, 2019. Publicly Released: Oct 1, 2019.

[10] *Id.* at 16

the exemption for AI/AN people[11] from community engagement requirements in the HELP Program Amendment and respectfully request CMS to take action in accordance with the recommendations contained herein.

Tribal Consultation and Seeking Advice from Indian Health Providers and Urban Indian Organizations

National Organizations appreciate that as part of its demonstration extension request, the State of Montana complied with the tribal consultation requirements in section 1902(a)(73) of the Social Security Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408[12], and the state's tribal consultation requirements.

In seeking comments from the public, tribes, Indian health providers and UIOs, multiple commenters[13] requested that IHS beneficiaries be exempt from work requirements. Commenters cited the importance of Medicaid to Montana's AI/AN population and health care service delivery. Commenters also noted that many IHS beneficiaries live in areas of chronic unemployment and devoid of any form of coverage other than Medicare or Medicaid, and that AI/ANs are among the most vulnerable with respect to poverty, health disparities, and mental and behavioral health disorders. The written response of the State reads:

> The Department will seek to exempt American Indians/Alaskan Natives from work/community engagement requirements to the maximum extent permissible under federal law. The Department looks forward to continuing its partnership with IHS and Tribal Health organizations to further design the HELP program to ensure IHS beneficiaries have access to high quality healthcare.

Although the National Organizations applaud the State for confirming it will seek to exempt AI/ANs from work requirements, all Medicaid beneficiaries derive their eligibility through individual Medicaid state plans, and are subject to all applicable Medicaid laws and regulations in accordance with those Medicaid state plan, except as

[11] Persons eligible for IHS health care services in accordance with 25 U.S.C. § 1680c, 42 C.F.R. §§136.12, 136.1442, 136.23.

[12] In states with Urban Indian Organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any renewal of a demonstration (42 CFR Section 431.408(b)(3)).

[13] Montana Department of Public Health and Human Services Section 1115 Demonstration Amendment and Extension Application, pages 73-74.

expressly listed as waived in a demonstration, subject to the operational limits as described in the special terms and conditions (STC). The State fails to specify the AI/AN work requirements exemption in the STC. In response to operational questions it received from tribes, the State responded that "implementation details will be finalized after the approval of the amendment and extension application."[14] Furthermore, the State failed to include the entirety of the Indian health care delivery system in its assurance – omitting a commitment to continue partnering with Indian health care providers, including UIOs.

National Organizations strongly request that once Montana receives approval of its pending application, that the State inserts language that exempts AI/AN from work and community engagement requirements. The exemption must be consistent with the definition of AI/AN for purposes of the Medicaid program, which includes the I/T/U system.[15].

Post-Award Public Input Process

We appreciate the State of Montana's efforts to work with Tribal leaders and UIOs on this matter as part of the trust obligation and look forward to further engagement with the State and CMS throughout the approval and implementation process. However, there is inadequate information on how the State of Montana will comply with the post-award public input process.

Following the original approval of the HELP Demonstration Program waiver, the State held an initial post-award public forum within 6 months of the implementation date of the waiver and then annually thereafter, using the Medical Care Advisory Committee. National Organizations request that the State implement a Post-Award Public Input Process for the HELP Program Amendment that is as inclusive of AI/AN beneficiaries and members of the public, tribes, Tribal Health Programs, and UIOs, consistent with what is otherwise required when submitting a demonstration waiver or extension request.

Copayments and Premiums

Under a section entitled "Individuals Not Responsible For Copayment", the list includes AI/ANs who are eligible for, currently receiving, or have ever received an item or service furnished by an IHS provider, Tribal Health Program, UIO provider, or through referral under contract health services (now Purchased/Referred Care). In other

[14] Montana Department of Public Health and Human Services Section 1115 Demonstration Amendment and Extension Application, page 28.

[15] See Centers for Medicare & Medicaid Services Tribal Affairs, Tribal Glossary at 2, https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/Tribal-Glossary-Brochure.pdf (providing the definition of AI/AN for the Medicaid and CHIP programs as "[a]n American Indian or Alaska Native or other individual who is eligible for health services through the Indian Health Service, tribes and tribal organizations, or urban Indian organizations (I/T/U)").

application materials, the following statement appears next to "Indian Health Services (IHS) and Tribal Health Services":

> The HELP Plan partners with IHS, Tribally Operated Health Care Clinics, and Urban Indian Health Centers. These clinics provide medically necessary services for some enrolled participants. American Indian participants never have a copayment.[16,17]

The State should clarify that in addition to exemption from copayments, AI/AN Medicaid beneficiaries are also exempt from premiums, enrollment fees, deductibles, and coinsurance, and AI/AN children are exempt from all cost-sharing in the Children's Health Insurance Program (CHIP).

Conclusion

For the aforementioned reasons, the National Organizations strongly oppose the imposition of mandatory work requirements, copayments, or premiums on AI/ANs and respectfully request CMS take action in accordance with these comments in its decision on Montana's HELP Program Amendment.

The National Organizations support the exemption for AI/ANs from the proposed HELP Program work requirements, which must be included in the STC, and note that this should be interpreted inclusively, consistent with the definition of AI/AN for purposes of the Medicaid program, which includes the I/T/U system.[18] Imposing this work requirement on the AI/AN population would be a violation of the trust responsibility and this exemption is therefore necessary for compliance with legal obligations. We thus request that if CMS seeks to approve the community engagement requirement in the HELP Program Amendment, it must approve it with an exemption for AI/ANs.

[16] See *Montana HELP Plan Participant Guide*, page 23.

[17] Beneficiaries described in 42 CFR 447.56(a) (including AI/ANs) must be exempt from all copayments and premium contribution requirements.

[18] See Centers for Medicare & Medicaid Services Tribal Affairs, Tribal Glossary at 2, https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/Tribal-Glossary-Brochure.pdf (providing the definition of AI/AN for the Medicaid and CHIP programs as "[a]n American Indian or Alaska Native or other individual who is eligible for health services through the Indian Health Service, tribes and tribal organizations, or urban Indian organizations (I/T/U)").

Thank you for your consideration of the comments contained herein.

Sincerely,

Francys Crevier
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National Council of Urban Indian Health

Stacy A. Bohlen
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National Indian Health Board