December 8, 2019

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: State of Colorado Proposed Section 1115 SUD Demonstration

Dear Administrator Verma:

On behalf of the National Council of Urban Indian Health[1] and the National Indian Health Board[2] (collectively, National Organizations),[3] we submit the following comments to the Centers for Medicare & Medicaid Services (CMS) on the state of Colorado's Section 1115 waiver, Expanding the Substance Use Disorder Continuum of Care (waiver). As national representatives of the health care interests of American Indians and Alaska Natives (AI/ANs), we support the expansion of Substance Use Disorder (SUD) services covered under the Medicaid program – which is vital to AI/AN health care. However, we are concerned with how the waiver would impact Indian Health Care Providers[4] and

[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 the Indian Health Service, Tribally-owned or operated, and urban Indian organization facilities (I/T/U system) and the AI/ANs they serve.

[4] The AI/AN health care delivery system consists of Indian Health Service-operated facilities, Tribally-owned or operated facilities, and urban Indian organizations. As referenced herein, the term "Indian Health Care Provider" refers to these facilities.

with the lack of sufficient consultation conducted on this waiver. Any restriction of Medicaid covered services would have detrimental impacts on Indian Health Care Providers.

Waiver Background

On November 7, 2019, the Centers for Medicare & Medicaid Services posted on its website an 1115 waiver from the state of Colorado – expanding the Substance Use Disorder Continuum of Care. Through the waiver, the state seeks to improve health outcomes, promote long-term recovery, and reduce overdose deaths. To do this, the state notes that it seeks to:

- Increase access to necessary levels of care by adding Medicaid coverage for inpatient and residential SUD treatment, including withdrawal management (WM) services;
- Ensure that members receive a comprehensive assessment and are placed in an appropriate level of care;
- Further align the state's SUD treatment system with a nationally recognized SUD-specific standard;
- Increase provider capacity where needed; and
- Improve the availability of Medication Assisted Treatment (MAT) to promote long-term recovery.

The state's current Medicaid plan covers outpatient therapy, clinically managed residential WM, and inpatient detoxification for adult members with an acute medical diagnosis. The waiver proposes to add Medicaid coverage for clinically managed low-intensity residential services, clinically managed high-intensity residential services, clinically managed population-specific high-intensity residential services, medically monitored intensive inpatient services, and medically managed inpatient WM services.

The waiver does not propose to change Medicaid eligibility criteria and notes that there will not be cost sharing for services provided under this program. The Colorado Medicaid SUD delivery system is currently operated under a capitated managed care structure, which is administered by seven Regional Accountable Entities. The services added under this waiver will be covered under the same delivery system.

Comments

The Trust Responsibility

It is longstanding and settled law that the United States has a trust responsibility to provide access to health care for AI/ANs.[5] 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

[5] 25 U.S.C. § 1602(a)(1).

its implementation of this responsibility – and any barrier to access of health care, including the limitation of coverage for services provided by Indian Health Care Providers, is contrary to the federal government's trust obligation.

Notwithstanding the government's trust obligation to preserve the Indian health system and raise the overall health status of our Peoples, health outcomes among AI/ANs have either remained stagnant or become worse in recent years. AI/AN communities continually encounter higher rates of poverty, lower rates of health care coverage, and less socioeconomic mobility than the general population. In 2014, 9% of AI/ANs over the age of 18 had a co-occurring mental health and substance use disorder – more than 3 times the rate of the general population.[6] Studies have also demonstrated that AI/ANs have a younger age of initiation of drug and alcohol use than the general population.[7]

The Importance of Medicaid to Tribes and urban Indians

These dire statistics make the administration of Medicaid a critical component to maintaining the health statuses of the communities that we represent.[8] Medicaid is essential to Indian Health Care Providers because it allows Indian Health Care Providers to provide *more* services to *more* patients. Congress made this so when, in 1976, it authorized the Indian Health Service (IHS) to bill Medicaid so that Medicaid funds could "flow into" a health system that had for too long been underfunded.[9] Today, Medicaid funding brings in up to $729 million to IHS facilities in one fiscal year.[10] This is possible through IHS facilities' collection of third-party revenue.[11] It cannot be overstated how much Tribally-owned and operated and urban Indian organization facilities rely on Medicaid revenues to provide high quality, culturally-competent services to their AI/AN patients, and to increase access to care.

Tribal Consultation

Despite the importance of Medicaid to Indian Health Care Providers and the crucial nature of making SUD services available to AI/ANs, the waiver submitted to CMS makes no mention of the state's AI/AN Medicaid population or of Indian Health Care

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[6] Whitesell NR, Beals J, Crow CB, Mitchell CM, Novins DK. Epidemiology and etiology of substance use among American Indians and Alaska Natives: risk, protection, and implications for prevention. Am J Drug Alcohol Abuse. 2012;38(5):376-82. doi: 10.3109/00952990.2012.694527. PubMed PMID: 22931069; PubMed Central PMCID: PMCPMC4436971.

[7] Heart MY, Chase J, Elkins J, Altschul DB. Historical trauma among Indigenous Peoples of the Americas: concepts, research, and clinical considerations. J Psychoactive Drugs. 2011;43(4):282-90. doi: 10.1080/02791072.2011.628913. PubMed PMID: 22400458.

[8] 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.

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

[10] FY 2018. See *Indian Health Service: Facilities Reported Expanding Services Following Increases in Health Insurance Coverage and Collections* at 15. GAO-19-612: Published: Sep 3, 2019. Publicly Released: Oct 1, 2019.

[11] 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.

Providers. In fact, the only portions of the waiver related to these facilities are on pages 23 and 24, where the state indicates it conducted consultation with Tribal populations on the proposed waiver.[12]

CMS requires states to conduct meaningful consultation with Tribes, and seek advice from urban Indian health organizations, in advance of proposing a demonstration waiver that has or would have a direct effect on Indian health providers.[13] Further, Colorado's Tribal consultation agreement shows that the state must keep consistent communication with Tribes and Urban Indian Health Organizations. It says:

> [E]ach State Agency, the Department of Public Health and Environment, and the Department of Health Care Policy and Financing shall distribute to the Tribes and the UIHO Urban Indian Health Organization a Programmatic Action Log Update . . . of Programmatic Actions being developed and or initiated by each State Agency . . . [and] a short description of each Programmatic Action, any clearly foreseeable Tribal Implications, important dates or implementation timeframes, and if the Programmatic Action is considered an Actionable Item . . . .[14]

Colorado indicates that it conducted Tribal consultation on August 8, 2019, and that it "did not receive any comments or questions." National Organizations are aware that Denver Indian Health & Family Services was unable to attend this one session. At this time, National Organizations are not aware of any dialogue taking place between the two federally recognized Tribes and the state, since a record of Tribal outreach or consultation is not available on Colorado's public website, as it is for stakeholders.

We note the state's recognition of Tribal treatment issues as summarized in the June 2019 Stakeholder Engagement Summary.[15] There, in response to whether the proposed SUD benefit would "allow for services to be provided out of Colorado," the Department of Health Care Policy and Financing (HCPF) stated, "It is unclear at this moment, but we have talked about it *for* Tribal populations because of their locations or having access to services that are more culturally responsive."[16] Although we are pleased

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[12] State of Colorado Proposed Section 1115 Waiver Demonstration (Oct. 31, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/co/co-continuum-care-pa.pdf

[13] 42 C.F.R. 431.408(b).

[14] Colorado Tribal Consultation Agreement (Jan. 1, 2011), https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Downloads/CO/CO-11-001-179.pdf

[15] Substance Use Disorder (SUD) Inpatient and Residential Treatment Waiver Development Stakeholder Engagement Meetings Summary
June 2019, https://www.colorado.gov/pacific/sites/default/files/June%202019%20Stakeholder%20Engagement%20Meetings%20Summary.pdf

[16] Substance Use Disorder (SUD) Inpatient and Residential Treatment Waiver Development Stakeholder Engagement Meetings Summary.

that the state recognized that Tribes live in cross-border areas, and have unique health circumstances, we ask whether the state has spoken *with* Tribes on out-of-state treatment specifically.

Because the state demonstration waiver seeks to expand services for SUDs that are covered under the Medicaid program, it is imperative that the state conduct meaningful consultation with the Indian Health Care Providers – especially since the state has already considered out-of-state treatment scenarios for "Tribal populations." Our health statistics support our stance that the state's SUD waiver has *clearly foreseeable* Tribal implications. This is congruent with the federal recognition of Tribes as Sovereign Nations and with the state's Tribal consultation agreement, which commits to regular communication with Tribes and Urban Indian Health Organizations in advance of programmatic action with Tribal implications.

Meaningful consultation is especially important in this instance because of the fact that the additional services will be covered under a system of capitated managed care, which is administered by Regional Accountable Entities. National Organizations note that AI/ANs cannot be mandated into managed care and that AI/AN people must be allowed to seek high-quality, culturally-competent Medicaid services with Indian Health Care Providers. Any proposed restriction to coverage of Medicaid services by Indian Health Care Providers would impose a significant financial burden on the Indian health system, which already suffers from chronic underfunding. **National Organizations thus request that this waiver include assurances that Indian Health Care Providers will be included in the continuum of care**.

In a similar vein, **National Organizations request that the state collaborate with Indian Health Care Providers for planning and implementation related to the expanded SUD continuum of care.** We are aware that the state plans to hold listening sessions as part of the waiver implementation and appreciate that it has outlined some of its planned activities to support successful implementation, including regional meetings. **We respectfully request that the state conduct Indian Health Care Provider-specific listening sessions and conduct meaningful consultation with those providers during the implementation stage to ensure the state fully accounts for the AI/AN beneficiaries of Medicaid under this expanded SUD program.**

Conclusion

For the reasons contained herein, National Organizations support the state of Colorado's efforts to increase coverage for SUD treatment and services. We encourage CMS and the state to include assurances that Indian Health Care Providers will be a

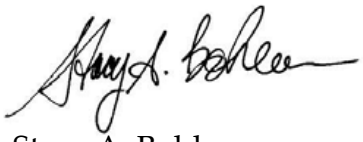
June 2019 at 5, https://www.colorado.gov/pacific/sites/default/files/June%202019%20Stakeholder%20Engagement%20Meetings%20Summary.pdf

component of the Colorado Medicaid SUD delivery system and be included as an integral partner in all implementation efforts.

Thank you for your consideration of our comments and recommendations.

Sincerely,

Francys Crevier
Executive Director
National Council of Urban Indian Health



Stacy A. Bohlen
Chief Executive Officer
National Indian Health Board