National Indian Health Board

January 17, 2020

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

Re: Nebraska Medicaid Section 1115 Heritage Health Adult Expansion Demonstration

Dear Administrator Verma:

On behalf of the National Indian Health Board (NIHB),[1] I write to comment on Nebraska's Medicaid section 1115 demonstration waiver, the "Heritage Health Adult" expansion program (HHA or the waiver), which seeks to implement Nebraska's Medicaid expansion as a two-tier system.[2] As a national Tribal organization working to increase the health status of the American Indian and Alaska Native (AI/AN) populations in the U.S., we must vigilantly track policy changes that impact access to Medicaid – a critical lifeline to our peoples, with around one in four AI/ANs utilizing the program. We are concerned that approval of Nebraska's waiver, as currently proposed, would set a damaging precedent for future Medicaid waiver applications in other states, and diminish the ability of the program to help fulfill the trust responsibility to the AI/AN individuals in the state. We urge you to consider these implications for AI/AN, as outlined below.

Background

In November 2018, Nebraska voters voted for Initiative 427, which expanded Medicaid coverage to otherwise ineligible adults up to 138% of the federal poverty level under the provisions of the Affordable Care Act. With this section 1115 demonstration, Nebraska seeks to implement the expansion through a tiered Medicaid structure that will only apply to those who receive Medicaid through the expansion.

Tribal Population in Nebraska

[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.

[2] CMS, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ne/ne-hha-pa.pdf

There are four federally recognized Tribes with headquarters in Nebraska[3] and approximately 10,000 people live on reservations in the state. In addition, Tribal members from neighboring states, particularly from Tribes whose traditional homelands cross state lines, live in Nebraska. There is a substantial interest in this proposal from Tribes in the state. There is also a belief that its approval, as currently drafted, could have a negative impact on Indian Health Services (IHS) and Tribal health providers in the state.

Terms of the Heritage Health Adult (HHA) expansion program

Two-Tiered Medicaid System

The Section 1115 demonstration consists of "Basic" and "Prime" Medicaid plans. Nebraska proposes to enroll everyone who receives Medicaid through this expansion into a "Basic" plan, which includes comprehensive medical, behavioral health, and prescription drug coverage. In order to be eligible for a "Prime" package, which gives the beneficiary access to vision, dental, and over the counter medication coverage, beneficiaries must complete community engagement requirements and engage in "wellness initiatives and personal responsibility activities."

In order to satisfy the personal responsibility requirements, non-exempt beneficiaries must: avoid missing three or more scheduled provider appointments in a benefit period; maintain employer sponsored health coverage if it is available to him or her; and notify the state of any change in status that will impact the beneficiary's Medicaid eligibility or benefit tier. In order to satisfy the wellness initiative requirements, non-exempt beneficiaries must: actively participate in case and care management with managed care organizations; attend an annual health visit; and choose a primary care provider.

The only beneficiaries who would be automatically enrolled in a Prime benefits package are people who are medically frail, 19 and 20 year olds, and pregnant women who become eligible under the expansion. American Indians and Alaska Natives (AI/ANs) individuals enrolled in a federally recognized tribe would be exempt from community engagement requirements but not the wellness initiatives and personal responsibility activities.

Tribal Response

i. The Trust Responsibility

We are concerned that AI/ANs are not fully exempt from the terms of this waiver (which would ensure they would receive the Prime benefits package). The United States owes a trust responsibility to Tribes as sovereign nations; a trust responsibility which has been codified by treaties and reinforced through affirmation by the United States Supreme Court.[4] In 1977, the Senate report of the American Indian Policy Review Commission stated that, "[t]he purpose behind the trust doctrine is and always has been to ensure the survival and welfare of Indian tribes

[3] The Santee Sioux, Omaha, Ponca, and Winnebago Tribes all have their headquarters in Nebraska.

[4] The Court has consistently held that the federal government has a trust responsibility to Tribes, which has formed the foundation for federal/Tribal relations. *See* Seminole Nation v. United States, 316 U.S. 286 (1942), United States v. Mitchell, 463 U.S. 206, 225 (1983), and United States v. Navajo Nation, 537 U.S. 488 (2003).

and people." This trust responsibility is highlighted most recently in the Department of Health and Human Services (HHS) Strategic Plan FY 2018–2022:

> Importantly, the Federal Government has a unique legal and political government to-government relationship with Tribal governments and a special obligation to provide services for American Indians and Alaska Natives based on these individuals' relationship to Tribal governments[5].

This creates a unique relationship between Tribes and the federal government, which has been recognized by Congress through the implementation of the 100% Federal Medical Assistance Percentage,[6] which provides that the federal government is solely responsible for paying for the care of AI/ANs who visit IHS and Tribal clinics.

The trust responsibility establishes a clear relationship between the Tribes and the federal government that does not exist with the states and we believe that the proposed two-tiered system, even if it does not result in the complete suspension of benefits, improperly diminishes this government –to-government relationship. The imposition of additional barriers to enrollment in a full slate of benefits by the state interferes with a relationship that exclusively exists between the Tribes and the federal government.[7]

ii. Personal Responsibility and Wellness Initiative Requirements

While we acknowledge and appreciate the state's exemption for members of federally recognized Tribes from compliance with the waiver's Community Engagement requirement, we note that an AI/ AN exemption is not in place for the Personal Responsibility and Wellness requirements. We are concerned about this omission and the impact that noncompliance may have on AI/ANs and the health facilities that they visit. For example, the Personal Responsibility requirement places an affirmative duty on the beneficiary to report changes that may impact their benefit tier. Many of Nebraska's Tribal residents live in remote rural communities where access to technology is limited and the ability to report may be severely impaired as a result. This concern is not a theoretical abstraction and we can look to other states to see where this has happened. In Arkansas, over 18,000 people lost access to Medicaid for failure to comply with the work requirement.[8] In New Hampshire, a similar fate awaited Medicaid recipients but the state intervened to delay the penalties.[9] Both requirements were subsequently stricken down by the United States District Court

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[5] Introduction, "Cross-Agency Collaborations", https://www.hhs.gov/about/strategic-plan/introduction/index.html

[6] The FMAP refers to the share of the payment to the provider that the federal government pays when services are rendered.

[7] In Worcester v. Georgia, 31 U.S. 515 (1832), the Supreme Court explicitly outlined that the relationship between the federal government and the Tribes is a relationship between sovereign nations and that the states are essentially third party actors.

[8] More detailed information about Arkansas's enrollment difficulties can be found here: https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/

[9] *See* Letter from Jeffrey A. Meyers, Commissioner of the New Hampshire Department of Health and Human Services to Governor Christopher T. Sununu, among others. "Re: Determination and Findings Relative to the Granite Advantage Community Engagement Requirement" July 8, 2019 https://www.nhpr.org/sites/nhpr/files/MedicaidExpWorkHHS_letterJuly2019.pdf

in Washington, DC. In both cases, plaintiffs cited access to technology as a barrier to updating their status.

iii. "Avoid missing three or more scheduled provider appointments in a benefit period"

We are also concerned about the requirement that a beneficiary not miss three appointments during the benefit period, and the corresponding administrative burden it would place on IHS and Tribal clinics to maintain and report this information. It is unclear as to whether the medical provider or the patient has the duty to report a missed appointment. If the clinics are required to report, this would imposed an additional administrative burden. IHS and Tribal clinics operate within a system that is chronically underfunded. In 2017, for example, the per capita spending was $4,078 for IHS patients, as compared to $9,726 per person nationally.[10] The addition of what is essentially an unfunded mandate, by way of this waiver, will further exacerbate these issues.

iv. Impacts to Funding for IHS and Tribal Clinics

Noncompliance could also put clinics in an untenable situation. Many IHS and Tribal clinics rely on Medicaid to fill funding gaps.[11] They also serve patients who face barriers that are common among low-income residents of other rural environments. For example, transportation is a major barrier in rural communities. A transportation insecure person may face difficulty keeping appointments because they do not have a reliable means of getting to those appointments. Unlike in urban areas, public transportation does not exist as a seamless apparatus that could help get AI/AN patients to appointments. If a person misses three appointments because of these difficulties, they face the possibility of losing access to Prime level Medicaid benefits. If the beneficiary is receiving services that they obtained through Prime at an IHS or Tribal facility then IHS becomes responsible for paying for their care, further diluting their already limited budget. The impacts of failing to comply with these requirements, whether it is through failure to actually comply or failure to report, can have substantial negative impacts on clinics.

v. Retroactive Medicaid Billing

We are concerned about the elimination of retroactive Medicaid billing for new enrollees under this proposed waiver. If retroactive Medicaid billing is eliminated, it could mean that IHS will have to pay for the expenses incurred by beneficiaries before they are able to apply for Medicaid. Unlike a private sector clinic, IHS and Tribal clinics would have to absorb those costs and cannot bill the patient to attempt to recoup them. Given that many of these facilities are dependent on Medicaid to fill their budget gaps, elimination of retroactive billing will represent a financial setback.

vi. Mandatory Managed Care

Under 42 U.S.C. § 1396u-2(a)(2)(C), a State may not require an Indian (as defined in section 4(c) [1] of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)) to enroll in a managed care organizations, such as Heritage Health's contracting organizations

[10] IHS profile, https://www.ihs.gov/newsroom/factsheets/ihsprofile/
[11] IHS is the payor of last resort, see 42 CFR § 136.61

(UnitedHealthcare of Midlands, Inc., WellCare of Nebraska, Inc., and Nebraska Total Care), unless the entity is an Indian Health Service, urban Indian health, or an Indian health (Tribally operated) program and only if such entity is participating under the State plan. We are deeply concerned that the proposed demonstration seeks mandatory enrollment of AI/ANs in Managed Care, counter to the language and purpose of the Indian exemption.

Tribal Recommendations

Given what we have stated above, we are requesting a full exemption of AI/ANs in Nebraska from the extra requirements needed to enroll in the Prime benefit package. In light of the federal trust responsibility, we believe that AI/ANs should be automatically enrolled in the Prime benefit package. Given that the state already automatically enrolls people who are medically frail, 19 and 20 year olds, and pregnant women who become eligible under the expansion in Prime benefits, we know that a mechanism exists (in the proposal) that could be used to automatically enroll AI/ANs in the prime benefits package.

We urge you to uphold the unique relationship between the Tribes and federal government, as well as acknowledge the unique funding structure of the Indian Health System, and exempt AI/ANs from the elimination of retroactive Medicaid billing. To do otherwise would expose IHS and Tribal facilities to increased financial strain and difficulty.

Given the 100% FMAP, we know that this can be done with minimal burden on the State of Nebraska. The federal government has a trust responsibility to AI/AN people and we feel that this waiver represents an unnecessary intrusion by the state.

Conclusion

We are deeply concerned about the ramifications of this demonstration on AI/ANs and the precedent that it may set for other states going forward. We are grateful for the opportunity to provide comments and recommendations and look forward to further engagement with CMS.

Sincerely,

Stacy A. Bohlen
CEO
National Indian Health Board