National Indian Health Board

Submitted via Email

June 26, 2020

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

Re: Oklahoma SoonerCare 2.0 Healthy Adult Opportunity Demonstration

Dear Administrator Verma:

On behalf of the National Indian Health Board (NIHB),[1] I write to comment on Oklahoma's Medicaid section 1115 demonstration waiver, SoonerCare 2.0, which seeks to reform the delivery of Medicaid in Oklahoma utilizing the "Healthy Adult Opportunity" (HAO) funding cap program that CMS announced earlier this year. As a national Tribal organization working to improve 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 AI/AN people, with around one in four of our population utilizing the program.

We write today to make it clear that we do not support approval of this waiver. We feel that a capped structure represents an unacceptable departure from the intended purpose of the Medicaid program, which was to make health care accessible to low-income and vulnerable populations. As constructed, we do not feel that the Healthy Adult Opportunity is compatible with the goals of the program. At the same time, if CMS determines that it will accept the waiver, we want to demonstrate our full support for all of the Tribal recommendations that the Oklahoma Tribes shared with the state in the course of developing the waiver. While not all of these recommendations were included, we believe that the design of the waiver better serves the purpose of the Medicaid program with the Tribal recommendations incorporated into the waiver, and incorporated fully.

Background

On January 30, 2020, CMS Administrator Seema Verma announced that states would be able to take advantage of an optional demonstration initiative, the "Healthy Adult Opportunity," (HAO)

[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.

as a mechanism for delivering services to their Medicaid expansion population[2]. Oklahoma quickly indicated their interest in becoming the first state to apply for an HAO waiver and launching SoonerCare 2.0, a new version of their current "SoonerCare" Medicaid program. After a period of consultation with Tribes and local stakeholders, the Oklahoma Health Care Authority (OHCA) submitted the HAO waiver for CMS's consideration.

Tribal Population in Oklahoma

Oklahoma is home to 39 federally-recognized Tribal nations[3] and, with 17.4 percent of their population identifying as AI/AN[4], has the second highest percentage of AI/ANs in the country. What happens in Oklahoma has a substantial impact on Indian Country generally, and the AI/ANs specific provisions that are approved may provide a model that other states will seek to use. Given the novel nature of this waiver request, we feel that special attention should be paid to the AI/AN specific provisions and the potential example that may be shared if CMS approves the waiver.

Trust Responsibility

United States owes a special duty of care to Tribal Nations, which animates and shapes every aspect of the federal government's trust responsibility to Tribes. Rooted in treaties and authorized by the United States Constitution, the federal government's unique responsibilities to Tribal Nations has been repeatedly re-affirmed by the Supreme Court, legislation, executive orders and regulations.[5] 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 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.[6]

Congress recognized this unique relationship and duty when it authorized, and CMS implemented the 100% FMAP rule for services received through IHS and tribal providers.[7] It provides that the federal government is solely responsible for paying for the care of AI/ANs Medicaid beneficiaries receiving services at Indian Health Service (IHS) and Tribal clinics.

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[2] "Trump Administration Announces Transformative Medicaid Healthy Adult Opportunity," Centers for Medicare & Medicaid Services, Jan 30, 2020 https://www.cms.gov/newsroom/press-releases/trump-administration-announces-transformative-medicaid-healthy-adult-opportunity

[3] "39 tribes call state home," *The Oklahoman*, https://oklahoman.com/article/1914848/39-tribes-call-state-home

[4] www.ncai.org/about-tribes/demographics, Feb 16, 2003

[5] 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).

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

[7] The FMAP refers to the share of the payment to the state by the federal government.

The trust responsibility establishes a clear relationship between the Tribes and the federal government that does not exist with the states[8]. CMS should be vigilant about any potential encroachments on this responsibility.

Terms of the HAO Waiver

AI/AN Exemptions

We want to recognize the protections that OHCA asked for in this waiver request. We acknowledge the continued exemption for AI/ANs from the state's community engagement requirement, which is consistent with the previous iteration of their SoonerCare 1115 waiver[9], the approval of Arizona's community engagement exemption for Indians, and CMS's new framework. We also acknowledge that OHCA requested that services provided through IHS and Tribal facilities eligible for 100% FMAP reimbursement be exempt from any future benefits or prescription drug formulary changes and that they recognized that the statutory requirements that AI/ANs be exempt from premiums and cost shares under this waiver. We feel that these protections are in line with the trust responsibility and the need to avoid state interference in the ability of AI/ANs to access health care.

Automatic Enrollment in Managed Care

We have grave concerns about automatic enrollment of AI/ANs into managed care under this waiver. Under 42 U.S.C. § 1396u-2(a)(2)(C), Congress indicated its intent that a State may not require an Indian (as defined in section 4(c) of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)) to enroll in a managed care organization plan, unless the entity is an Indian Health Service, urban Indian health, or an Indian health (Tribally operated) program. While we acknowledge that AI/ANs are not *mandated* into managed care in this waiver (there is an opt out provision), we are deeply concerned that the proposed demonstration seeks automatic enrollment of AI/ANs in managed care, contrary to the purpose of the Indian exemption.

We note that while OHCA currently administers their managed care program, there are imminent plans to change this delivery. On June 18th, Governor Kevin Stitt announced plans to solicit proposals from private managed care organizations. Once the private managed care organizations control, automatic enrollment into managed care will very likely bring AI/ANs into contact with providers who have had little contact or understanding of the Indian health system. The purpose of the Indian exemption was to make interactions between AI/ANs and managed care a voluntary endeavor. We are also concerned about the usage of an 1115 waiver as a mechanism to bypass Congress's intent.

[8] 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.

[9] NIHB commented on this waiver on January 18, 2019, that comment is available at: https://www.nihb.org/tribalhealthreform/wp-content/uploads/2019/01/NIHB_Comment_on_SoonerCare_Amendment-1.pdf

Exclusion from the Cap

We acknowledge the request for explicit protection from changes to benefits mentioned in the waiver. However, in order to ensure all legally required Indian benefits and protections remain, CMS should clarify that services received through IHS and Tribal providers eligible for the 100% FMAP will not be counted towards Oklahoma's allowable cap. We also want confirmation that reimbursements to Indian health entities would continue at the current rates once Oklahoma reaches the cap and will not be adjusted as a result. To this end, we would also like confirmation that care provided by the Indian health system at 100% FMAP is not included in the calculations of the cap. In fact, we recommend that CMS make it explicitly clear that the Indian Health system is completely separate from the capped portions of this waiver. This would ensure that care for AI/ANs is not capped or rationed once state spending reaches the maximum federal funding level, and it would also ensure that the costs for Indian beneficiaries receiving care in the Indian health system come from the federal government.

Tribal Recommendations

If CMS decides to approve this waiver, we recommend that they retain the exemptions that have been provided for AI/ANs and the Indian Health System. We believe that exempting AI/ANs from community engagement requirements honors the trust responsibility to provide health care to AI/AN people.

As noted above, we are concerned about the implementation of automatic enrollment in managed care, a system that is not compatible with the Indian health system. We also want clarification regarding the relationship between services provided at 100% FMAP and the cap that the state will use. We hope that you will consider and address both of these concerns.

Conclusion

While we ultimately recommend that this waiver not be approved, we are deeply interested in the ramifications of this demonstration on AI/ANs and the Medicaid program as a whole. We are grateful for the opportunity to provide comments and recommendations and look forward to further engagement with CMS.

Sincerely,

William Smith
Acting Chairman
National Indian Health Board

Cc: Kitty Marx, Director, Division of Tribal Affairs