National Indian
Health Board

Submitted via email

February 3, 2021

Anne Marie Costello
Acting Deputy Administrator & Director
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Arizona Section 1115 Demonstration Renewal Proposal

Dear Administrator Costello:

On behalf of the National Indian Health Board (NIHB),[1] I write to you regarding the renewal of Arizona's Section 1115 Medicaid Demonstration Project. We support the addition of the Tribally focused provisions, specifically those allowing of billing for traditional healing practices and the addition of the Tribal Dental Benefit, both of which we feel will enhance the ability of Arizona's IHS and Tribal facilities to deliver health care that is culturally appropriate and responsive to the needs of their communities. These provisions represent the state's recognition of the unique needs of Tribal communities and we are proud to support their approval.

Trust Responsibility

CMS's approval of these beneficial provisions would help fulfill the federal trust responsibility for Indian health. The 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 have been repeatedly re-affirmed by the Supreme Court, legislation, executive orders and regulations.[2] 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

[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] 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).

highlighted recently in the Department of Health and Human Services (HHS) Strategic Plan for 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.[3]

The trust responsibility establishes a clear relationship between the Tribes and the federal government.[4] The Constitution's Indian Commerce clause, Treaty Clause and Supremacy clause, among others provide the legal authority and foundation for distinct health policy and regulatory decision making by the United States when carrying out its unique trust responsibility to provide for the health and welfare of AI/ANs and support for the Indian health system that provides their care.

Tribal Dental Benefit

We support the creation of the Tribal Dental Benefit, which allows IHS and Tribal facilities to bill for dental services, in excess of $1,000 per person cap that is the standard for Arizona's Medicaid program. Lifting this cap will result in increased access to care for patients and revenue that the IHS and Tribal facilities can use to address the pressing oral health needs of their patients. As the state describes in its waiver application, AI/ANs are more likely to have poorer oral health due to untreated oral health issues, a condition which is exacerbated by the labor shortages that the Indian health care system faces. As the state also notes, dental vacancies in areas where IHS provides direct services varies from 14% in the Phoenix area to 34% in the Navajo area. Many of our providers are in rural communities, where it can be difficult to attract and retain providers. We support the state's position that additional funding will be instrumental in providing IHS and Tribal facilities with the resources needed to fill these vacancies. We also believe that by increasing third-party revenue, IHS and Tribal facilities have a better likelihood of staying up to date and equipped to address the issues that their patients face.

This issue is especially important due to the recent COVID-19 pandemic, which significantly reduced third-party revenues across the Indian health system. Part of the trust responsibility for Indian health involves ensuring that Tribes have the resources that they need to address the health concerns in their community. However, the federal government has fallen significantly short of meeting that responsibility. The disparities noted by the state in its application are examples of how this expresses itself in the health outcomes of our people. The approval of this provision would represent progress towards ensuring that IHS and Tribal providers in Arizona are able to access additional resources and **we urge the agency to approve it**.

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

[4] 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.

Traditional Healing Practices

We also support Arizona's request to cover traditional health practices furnished through IHS and Tribal facilities. We also support the state's decision to respect Tribal sovereignty which provides a process for each entity to determine the traditional healing practices of the Tribe(s) served which endorses the practices of traditional healers in a coordinated and complementary fashion with medical staff. We believe that this is a tremendous step forward in recognizing the role of traditional medicine in improving health outcomes. It is also a recognition of the centrality of traditional practices in the culture of Arizona's Tribal communities. Trusting Tribes to know how to best treat their people is a way to recognize Tribal sovereignty. In 2015, Arizona established a Traditional Healing workgroup, in which federal, state, and Tribal officials came together to discuss the prospect for approving traditional healing services under Medicaid. After years of advocacy, this provision was included in the state's 1115 demonstration – another example of the state's recognition of Tribal sovereignty. We are happy to see this included in Arizona's renewal application and we support the work that was done in order to get to this point.

We also remind CMS of the 100% FMAP and the important role it plays in fulfilling the trust responsibility. Reimbursing for traditional medical practices alongside Western medicine is an important recognition of the equality of traditional medicine and how it is used by Tribal communities. It also allows Tribes to use the additional third-party revenue to expand traditional healing services, coordinate the services within the facility, hire additional healers as appropriate and create a space for ceremonial practices, which expands their capacity to provide culturally competent care to their patients. We believe that these objectives are important to fulfilling the trust responsibility and ensuring that Tribes have the resources needed to provide for their people.

By including this in its application, Arizona is committing to using its Medicaid program to reimburse Tribes for practices whose existence predates much of Western medicine and whose effectiveness can be attested to by generations of people who have long occupied the land now included within the boundaries of the state. The sovereignty and traditional practices of our Tribal Nations predate the United States, and we support any recognition of this by the states. Already the Indian Health Care Improvement Act (IHCIA) (§ 1680u) makes it clear that the IHS may promote traditional health care practices, consistent with the Service standards for the provision of healthcare, health promotion, and disease prevention. We believe that this is an important recognition of Tribal sovereignty and **we urge the agency to approve it.**

Community Engagement Requirements

We acknowledge and thank Arizona for its proposed exemption of members of federally recognized Tribes, as well as their children and grandchildren from the community engagement requirements. We also acknowledge, however, that the state previously sought a broader exemption for AI/ANs who are eligible for services through the IHS, a Tribal or a Urban Indian health program; however, CMS, under the prior Administration narrowed the application of the exemption. As we have stated in prior communications, we believe that exempting AI/ANs, particularly IHS beneficiaries, from community engagement requirements honors the trust responsibility to provide health care to AI/AN people. Community engagement requirements are

deeply problematic for IHS beneficiaries AI/ANs. As a practical matter, many AI/AN Medicaid beneficiaries may not be able to meet these requirements due to high on-reservation unemployment and/or lack of connection to State employment programs. We believe that imposition of any state level restrictions onto AI/ANs is a violation of the trust responsibility and **we urge the agency to once again approve Arizona's AI/AN exemption.**

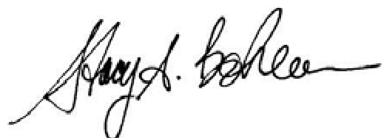
Uncompensated Care Payments

We appreciate the state's decision to continue providing supplemental payments to IHS and Tribal facilities in order to alleviate the financial burden of providing uncompensated care to Medicaid-eligible adults. As the state acknowledges in its waiver request, these payments are important for helping IHS and Tribal facilities supplement their existing funding, specifically the state cites the ability to maintain current staffing levels and increase their capacity to provide care to patients. These payments are also important because they help insulate the Indian health system from cuts to optional benefits that may affect reimbursement for services provided through IHS and Tribal facilities. **We support the continuation of these payments and urge the agency to once again approve them.**

Conclusion

We support the advocacy efforts of Tribes in Arizona and the provisions that have been included because of their hard work. We believe that both the Tribal Dental Benefit and the new reimbursements for traditional healing will directly result in better health outcomes for patients; by increasing third-party revenue to IHS and Tribal programs, it will also help ensure that Tribal programs keep their facilities up to date and attract and retain providers. We also believe that the ability to be reimbursed for traditional healing practices is an important recognition of Tribal sovereignty and the centrality of traditional medicine to Tribal cultures. **We wholeheartedly encourage CMS to approve these named provisions**. Thank you in advance for your consideration.

Sincerely,



Stacy A. Bohlen, CEO

National Indian Health Board