Tribal Comment Summary

The Michigan Department of Health and Human Services (MDHHS) sent written notification to the Tribal Chairs and Health Directors on July 9, 2018 informing them of the proposed Healthy Michigan Plan (HMP) Section 1115 Demonstration extension application amendment and offered to have a consultation conference call on August 6, 2018. MDHHS posted the HMP Section 1115 Demonstration extension application amendment and supporting documents on the MDHHS web page and published a notice in newspapers across the state. The initial in-person tribal consultation took place on July 11, 2018 during the Quarterly Tribal Health Director's Association meeting in Watersmeet, Michigan, where the details of the waiver extension amendment application were discussed. A tribal consultation conference call was held on August 6, 2018 that provided detailed information about the proposed HMP changes and how these changes will impact Native Americans. During this call, several tribes requested a follow-up in-person consultation meeting to further discuss the issues.

The follow-up in-person tribal consultation meeting was held in Lansing, MI on August 27, 2018 from 3:00 to 5:00 pm. This meeting included members from various tribes throughout Michigan, MDHHS leadership, and senior members from Governor Snyder's staff. All comments were reviewed and considered by MDHHS in the development of the final waiver amendment. Below is a summary of the comments received. Copies of all written tribal comments are included in this attachment.

Many of the commenters expressed concern regarding the impact of implementation on tribal members, leading to a loss of coverage and increasing the administrative burden on beneficiaries. In general, the comments reflected the following themes:

1. Native Americans should be exempt from the workforce engagement requirements;
2. If workforce engagement requirements are implemented, allow an additional 3 months of non-compliance in counties of high rates of seasonal unemployment;
3. Suggestions to expand the Medically Frail list of diagnosis codes;
4. The comment period should be extended because the tribal consultation requirements were not met;
5. Work requirements will cause a financial burden on the Indian Health System (IHS); and
6. Request for exemption from the healthy behavior 48 months of cumulative eligibility requirement.

1. Native Americans should be exempt from the workforce engagement requirements

Comments: Tribal representatives disagreed with CMS' view that exempting Native Americans from workforce engagement requirements would present civil rights concerns and believe an exemption would be permissible.

MDHHS Response: MDHHS is required to submit the waiver amendment to CMS in compliance with PA 208 of 2018, which does not include an exemption for Native Americans. However, MDHHS intends to continue consultation with the tribes throughout the waiver submission and implementation process and anticipates additional comment from CMS on these issues.

2. If workforce engagement requirements are implemented, allow an additional three months of non-compliance in geographically isolated areas with high rates of seasonal unemployment

Comments: Tribal members voiced concerns during the consultation that they are disproportionally impacted by seasonal unemployment rates in geographically isolated areas and they should be exempt from the workforce engagement requirement. Other tribal members commented that if they are required to participate, they should be allowed to claim an additional three months of non-compliance. Tribal members further noted that the mandatory workforce engagement requirements will create a barrier to Medicaid access that is unique to tribal members as well as those individuals located in the most geographically isolated areas of the State where employment opportunities are limited or seasonal at best. Additionally, tribal members commented that Native American beneficiaries may not be able to meet the work requirements due to lack of connection to State employment programs.

MDHHS Response: During the legislative process, PA 208 of 2018 was revised to grant individuals three months of noncompliance in a 12-month period, which would account for seasonal fluctuations in unemployment. In addition, state law recognizes participation in Tribal Employment Programs as a qualifying activity for the workforce engagement requirements. Finally, as noted above, MDHHS intends to work collaboratively with the tribal community throughout the waiver implementation process to assure that the concerns of tribal members are addressed, whenever possible, in accordance with state law.

3. Suggestions to expand the Medically Frail list of diagnosis codes

Comments: Commenters suggested MDHHS add additional behavioral health diagnosis codes to the medically frail list.

MDHHS Response: MDHHS reviewed the suggested diagnosis codes and has revised the list to incorporate many of the codes. The medically frail process and a complete list of the diagnosis codes can be found on the MDHHS website.

4. The comment period should be extended because the tribal consultation requirements were not met in accordance with the State of Michigan or Michigan Tribal-State Accord

Comments: Tribal representatives asked MDHHS to extend the comment period because they did not believe the conference call on August 6, 2018 satisfied the tribal consultation requirements.

MDHHS Response: Although MDHHS believes that the August 6, 2018 conference call met Medicaid State Plan tribal consultation requirements, per the request of tribal members, MDHHS held an in-person consultation meeting on August 27, 2018 to allow for additional testimony and extended the tribal comment period to August 31, 2018. Any comments received from tribal members by August 31, 2018 are included in waiver documents submitted to CMS.

MDHHS welcomes additional comments from tribal members and is open to further stakeholder input after waiver submission.

5. Work requirements will cause a financial burden on the Indian health system

Comments: Several comments indicated that the imposition of work requirements on Native Americans will cause a financial burden on the IHS system, by shifting funding responsibility from Medicaid to IHS as beneficiaries lose Medicaid coverage due to the work requirements. Furthermore, commenters believe this undermines the federal trust responsibility to provide healthcare to Native Americans.

MDHHS Response: As MDHHS implements the workforce engagement requirements, it will undertake active outreach efforts to beneficiaries and partner with community stakeholders to ensure that beneficiaries understand program requirements and do not lose coverage as a result of noncompliance. MDHHS will include the tribes in subsequent workgroups to implement the proposal as applicable.

6. Request for exemption from the healthy behavior 48 months of cumulative eligibility requirement

Comments: While the tribes do encourage healthy behaviors through their own government programs and traditional practices, a request was made to exempt Native Americans from the 48-month cumulative enrollment requiring the completion of healthy behavior to maintain healthcare coverage.

MDHHS Response: MDHHS did clarify in the waiver extension amendment that Native Americans who are receiving services through a Medicaid health plan are not exempt from this requirement. Native Americans are a voluntary Medicaid health plan population.

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Consultation Testimony
Michigan Department of Health and Human Services
August 27, 2018

Ahneen, BiiWaagajiig, n'dizhnikaaz. Mukwa Megizi Ndodem. Bahweting n'donjaba. My name is Aaron Payment. As the elected Tribal Chairperson of the Sault Ste. Marie Tribe of Chippewa Indians, I am speaking on behalf of the Tribe. As always, my Tribe and I want to work in partnership with you.

Today I am here to explain why Medicaid beneficiary work requirements cannot be applied to Tribal Nations. This is not just a Michigan issue, but one that is national in scope. I'll begin by providing a context for the federal government and any entity carrying out the duty of the federal government to provide "health" care to tribes pursuant to treaties and the supreme law of the land ~ United States Constitution. I will then summarize how the national controversy spread to our state. I'll explain the issues and ramifications the new policy has in regard to the federally recognized Tribes. Then, I will explain how several states have successfully dealt with it and suggest how Michigan should proceed.

The United States has a trust and treaty based responsibility to provide access to health care for American Indians and Alaska Natives, and that responsibility includes ensuring access to federal health programs like Medicaid. Congress has declared that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians ... to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."

I serve on the HHS Secretary Tribal Advisory Council and attest that this trust responsibility is highlighted 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.

National Controversy Spreads to States:

In January 2018, the Centers for Medicare and Medicaid Services (CMS) announced its new policy to incentivize employment and community engagement among Medicaid beneficiaries.[1] The policy was designed to encourage states to implement work requirements

[1] See copy of the Dear State Medicaid Director Letter, January 11, 2018: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf

as a condition of Medicaid eligibility, should a state choose to do that through a 115 Demonstration Waiver.

CMS noted that Tribes would not be exempt from these requirements because of "civil rights issues"[2] and directed states to be open to including Tribal work programs as meeting the state community engagement requirements[3]. Additionally, CMS encouraged states to consult with Tribes prior to submission of a Waiver.[4]

Immediately, Tribes noted 4 major issues:

1. The policy will likely weaken Tribal health care services.
2. The policy undermines Congressional intent regarding Indian Health Service (IHS) funding mechanisms.
3. The policy attempts to delegate the federal trust responsibility to state governments, which cannot happen as it is inconsistent with treaties and the supreme law, the U.S. Constitution.
4. By categorizing Tribes "racially," the policy fails to recognize Tribal governments politically.

At the federal level, Congress reacted. On April 27, 2018, ten members of the United States Senate sent a letter to Department of Health and Human Services Secretary Azar to express "growing concerns" regarding the CMS policy.[5] The Senate letter noted that including Tribes in work requirements is contrary to federal law, the U.S. Constitution, treaties, and the federal trust responsibility. The Senate letter explained that the new policy violates the U.S. Supreme Court ruling *Morton v. Mancari*.[6] The Senate letter also noted that the policy violates legislative intent regarding to the Congressional changes to Sections 1905(b) and 1911 of the *Social Security Act*.

On April 30, 2018, Representative Tom Cole (R OK 4) wrote Secretary Azar and CMS Administrator Verma[7]. He noted his strong opposition to the classification of Native Americans as a "racial group" and noted that the new CMS policy undermines Tribal sovereignty. Congressman Cole argued that the policy goes against specific Congressional intent to ensure stable funding for the Indian Health Service via the changes made to the *Social Security Act*.

On May 15, 2018, fifty-six Congressional members from the House (including three members from the Michigan Delegation) reacted to the CMS policy announcement, expressing "profound concern" and "strong opposition" to Secretary Azar and Administrator

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[2] See copy of the Dear Tribal Leader Letter, January 17, 2018: https://www.indianz.com/News/2018/04/23/dttl011718.pdf

[3] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf See page 7.

[4] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf See page 8.

[5] A copy of this letter has been provided to Mike McCoy. See August 21, 2018 email from Meghan Starling. The April 27, 2018 letter to Secretary Azar is signed by Senators Chuck Schumer, Lisa Murkowski, Tom Udall, Maria Cantwell, Jeffrey A. Merkley, Heidi Heitkamp, Catherine Cortez-Masto, Martin Heinrich, Tina Smith, and Elizabeth Warren.

[6] *Morton v. Mancari* sets forward the rule of law that federal classifications fulfilling federal obligations to Indian Tribes are not based on race but on the political relationship between the Tribes and the federal government.

[7] A copy of this letter has been provided to Mike McCoy. See August 21, 2018.

Verma. [8] The letter states, "[b]eyond the question of legality of the underlying authority of CMS to allow Medicaid work requirements under Section 1115 of the *Social Security Act*, we strongly oppose CMS's guidance that would deny any exemption of tribal citizens from state Medicaid waiver requests." The letter reaffirms that the United States and Tribal governments interact on a government-to-government basis and that the programs enacted by Congress to benefit Native Americans, such as Medicaid, are provided as a function of that political relationship. Perhaps most importantly, the letter urges the rescission of the "misguided" policy decisions.

At the same time, state government programs were being set up to meet new national policy standards. Here at home, the Michigan state legislature passed Senate bill 897. On June 22, Governor Synder signed it into law. Now known as "Public Act 208 of 2018" the law amends the Social Welfare Act of Michigan by including work requirements for beneficiary recipients. Unfortunately, and just like the national policy, the Michigan law fails to recognize Tribes as sovereigns, it undermines Congressional intent regarding the federal funding of the Indian Health Service, and will likely weaken Tribal health care programs.

Flexibility exists:

Administrator Verma gave a speech to the American Hospital Association Annual Membership meeting on May 7, 2018, and appeared to ease up on the issue of community engagement requirements forced upon Tribal governments. She stated, "*We believe we can give states flexibility and discretion to implement the community engagement requirements with respect to Tribal members. We look forward to working with states and Tribes to try to help them achieve their goals and determine how to best apply community engagement to serve their populations.*"[9]

States Exempting Tribes:

At least three states have exempted Tribes from Medicaid work requirement programs. Arkansas does not require Tribes to meet work requirements.[10] Additionally, the Arkansas plan, submitted March 5, 2018, notes that "[*u]nder the Indian Health Care Improvement Act (IHCAI), I/T/U facilities are entitled to payment notwithstanding network restrictions.*"[11] As another example of a state exempting Tribes from the community

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[8] A copy of this letter has been provided to Mike McCoy. See August 21, 2018 email from Meghan Starling. The letter is signed by: Representatives Tom Cole, Mike Simpson, Walter B. Jones, Don Young, Juan Vargas Steve Pearce, Collin Peterson, Coleen Hanabusa, John B. Larson, Joe Courtney, Duncan Hunter, Tony Cardenas, Debbie Wasserman Schultz, Keith Ellison, Mike Thompson, Ruben Gallego, Raul Ruiz, John Moolenaar, Mark Pocan, Dina Titus, Denny Heck, Ted Deutch, Norma J. Torres, Gregg Harper, Greg Walden, Mark Takano, Jacky Rosen, Paul Mitchell, Betty McCollum, Ken Calvert, Derek Kilmer, Michelle Lujan Grisham, Tim Walz, Grace Napolitano, Elise Stefanik, Peter DeFazio, Jared Huffman, Mario Diaz-Balart, Ben Ray Lujan, Alcee L. Hastings, Erik Paulsen, Kyrsten Sinema, Paul M. Grijalva, Rick Nolan, Pramila Jayapal, Jack Bergman, Charlie Crist, Donald S. Beyer Jr., Martha McSally, Jackie Walorski, Scott Tipton, Daniel T. Kildee, Pete Sessions, Trent Kelly, and Sean Duffy.

[9] For a copy of the speech, go to: https://www.cms.gov/newsroom/fact-sheets/speech-remarks-cms-administrator-seema-verma-american-hospital-association-annual-membership-meeting

[10] See https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-ca.pdf

[11] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-ca.pdf See page 13 of 48.

engagement requirements, see Arizona's plan.[12] The plan, put into effect on August 3, 2018, exempts American Indians from work requirements.

Perhaps most interesting is Utah's treatment of Medicaid work requirements: On August 15, 2017 Utah provided an interesting model that exempts Tribes from work requirements. [13] Within the "Tribal Consultation" section of its plan, it states:

> ***Tribal representatives stated there is a concern with applying the work requirement to American Indian/Alaska Native (AI/AN) population. They felt this requirement would prohibit individuals from completing the application. They added that unemployment rates are high in these areas.***
>
> ***They also felt it would have a direct and negative impact on the 3rd party resources available to the IHS and tribal health programs. In addition, they believe requiring an AI/AN to work in order to access health care is not compliant with federal policy.***
>
> ***In response to these concerns, American Indian/Alaska Natives will be enrolled in the work requirement program but will not have their medical benefits terminated if they fail to complete all required work activities.*** [14]

Next Steps:

On behalf of my Tribe, I urge the State of Michigan to follow the example of Arizona, Arkansas, and Utah. Each of these states have Medicaid work requirements. At the same time, they show respect to Tribal sovereignty, support federal legislative intent regarding Medicaid, and allow Tribal health care facilities to operate as best they can.

Similar to Utah's plan, Michigan Public Act 208 of 2018 includes specific language referring to a "tribal employment program." Sault Ste. Marie Tribe of Chippewa Indians recommends that Michigan include in its Waiver Amendment to CMS, a section regarding Tribal consultation, just as Utah does. The section should include that, "In response to concerns identified by Tribal governments, American Indians and Alaska Natives can be enrolled in their own Tribe's "Tribal Employment Program" but will not have their medical benefits terminated if they fail to complete all required work activities."

Through the ebbs and flows of federal health care policy, it can be confusing and frustrating to States and partners in fulfilling the federal health responsibility, as well as, providing for the promises of the ACA to benefit Michigan citizens. Michigan was not one of the first states to join the Medicaid expansion but once it did, Michigan citizens shared in this promise. I am mindful that through elections, policies shift such that full implementation of the work requirement or any efforts to undermine the ACA (when a full repeal was not tenable in the Senate) may simply be undone. I am also cognizant that

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[12] See https://www.azahcccs.gov/shared/Downloads/News/AHCCCSWorks1115WaiverAmendmentRequest.pdf

[13] Please see: https://health.utah.gov/MedicaidExpansion/pdfs/Utah%201115%20PCN%20Waiver%20Revisions%2015%20Aug%2017.pdf

[14] https://health.utah.gov/MedicaidExpansion/pdfs/Utah%201115%20PCN%20Waiver%20Revisions%2015%20Aug%2017.pdf See page 8.

elections this fall may shift policy once again, such that it would behoove the State of Michigan to not implement unnecessarily drastic changes only to find these undone come January 2019.

Finally, to be clear, the Sault Tribe is opposed to the implementation of work requirements for Native American; especially those residing in desolate or geographically isolated areas of the State. I echo other tribes' testimony and request that the Michigan Department of the Health and Human Services:

1. Consider the addition of a specific exemption from the workforce engagement requirements for Native Americans as well as those who reside in desolate or geographically isolated areas of the State like Michigan's Upper Peninsula.

2. Include the Tribe as a partner at the table during the revision process before submission to CMS in order to ensure the goals of the State/Tribal Accord are met.

3. Include the Tribe in subsequent workgroups developed to implement the Proposal, if applicable.

Thank you for this opportunity to consult. I hope that you will wish to work with us.

If you have any questions, please ask. I stand ready to answer any of your questions.

Sincerely,

Aaron A. Payment

Aaron A. Payment

Lac Vieux Desert Band Of Lake Superior Chippewa Indians
Tribal Government

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Executive Officers:
James Williams, Jr., Tribal Chairman
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Susan McGeshick, Treasurer
Gertrude McGeshick, Tribal Secretary

Council Members:
Michael Hazen, Jr.
Michelle Hazen
Mitchell McGeshick
Tyrone McGeshick
Henry Smith

August 27, 2018

MDHHS
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
Attention: Medicaid Policy
P.O. Box 30479
Lansing, Michigan 48909-7979

Re: Lac Vieux Desert Band of Lake Superior Chippewa Indians
Comments Re: Healthy Michigan Plan §1115 Demonstration Waiver Extension Application Amendment

Dear Mr. Wise:

The Lac Vieux Desert Band of Lake Superior Chippewa Indians ("Tribe") appreciates the opportunity to respond to the State of Michigan's ("State") request to amend the Healthy Michigan Plan §1155 Demonstration Waiver Extension Application ("the Proposal"). Like many tribes across the nation, the Tribe runs its own tribal health care facility ("LVD Health Center"), providing health care services to both Native and non-Native patients. The LVD Health Center is a full-service health clinic, offering primary care, walk-in services, dental services, lab and imaging, chiropractic and physical therapy, optical care, acupuncture, behavior health and family services, and pharmacy services. The LVD Health Center has 12 exam rooms with 2 procedure rooms and a care team area, a 9-chair dental suite with lab services, retail pharmacy, an imaging suite, a clinical lab, chiropractic and physical therapy department, an optical department with sales area and two patient exam rooms, behavior health and family services, an administrative suite, and a community gathering room. The LVD Health Center is unique in that it provides services to both Native and non-Native patients and is only one of three providers accepting Medicaid in a four (4) county service area consisting of Dickinson, Gogebic, Ontonagon and Iron counties, making it a valuable resource in the rural and geographically isolated area on the western end of Michigan's Upper Peninsula.

As the Tribe understands it, the State, pursuant to Public Act 208 of 2018 is requesting authority from the Centers for Medicare and Medicaid Services ("CMS") through the Proposal[1] to

[1] It is worth noting that the Proposal was not developed in accordance with the State-Tribal Accord (per Executive Directive 2001-2) entered into between Governor Engler (2002) and extended by both Governors Granholm and

implement changes in cost-sharing requirements for beneficiaries of the Healthy Michigan Plan ("HMP") for individuals with income between 100% and 133% of the federal poverty level as well as implement certain workforce engagement requirements to maintain eligibility.[2] After being presented with notice of the HMP Application Amendment in December 2017 that did not include information as to how the HMP Application would be amended, the Tribe received another notice with more information in July 2018 - the same date the Proposal was made available for public comment. A conference call with the tribes was held on August 6, 2018 but little was dedicated to allowing tribes to address concerns or voice any suggestions, revisions or objections as indicated by the notice. A Tribal/State consultation is scheduled for August 27, 2018.

While the Tribe appreciates that the Proposal recognizes that Native Americans are exempt from the cost-sharing requirements as required by federal law[3], it must be noted that no such exemption has been recognized for Native Americans regarding the work requirements further, it fails to recognize Congress's intent that Medicaid be administered in a manner that supports Indian Health Services ("IHS"'s) provision of health care to Native Americans. Indeed, based on the Tribe's experience and data, three things about the Proposal are abundantly clear, (1) mandatory work requirements will create a barrier to access to Medicaid that is unique to IHS beneficiaries as well as those individuals located in the most geographically isolated areas of the State where employment opportunities are limited or seasonal at best[4]; (2) the Proposal's imposition of additional qualifying requirements for both Native Americans and non-Native Americans served by the LVD

Snyder, which calls for a respectfully government to government relationship when dealing with Michigan Federally Recognized Tribes of which Section V. Implementation, reads:

> For purposes of this accord, "state action significantly affecting tribal interests" is defined as regulations or legislation proposed by executive departments, and other policy statements or actions of executive departments, that have or may have substantial direct effects on one or more tribes, on the relationship between the state and tribes, or on the distribution of power and responsibilities between the state and tribes. State action includes the development of state policies under which the tribe must take voluntary action to trigger application of the policy.

Consultation occurs before or in conjunction with policy, legislative, regulation development, not at the same time it is made available to the public

[2] While the Tribe has been assured that the Proposal affects only those individuals who fall between 100%-133% of the federal poverty level, what happens to those individuals who are unable to become gainfully employed or lose their employment? Notwithstanding the fact that in the Western Upper Peninsula, there are more residents than jobs, where is the line between Medicaid eligibility and Upper Peninsula Health Plan ("UPHP") coverage? And if there is a line, while an individual is in an unemployed situation, don't the additional requirements actually discourage an individual with a chronic health condition who needs medical care not to work in order not to become eligible for the UPHP?

[3] See 42 CFR 447.56

[4] While tribal governments support full employment for their citizens, mandating work requirements through the Medicaid program will not increase employment in Indian Country where unemployment rates remain the highest in the United States. U.S. Census Bureau numbers reflect the unemployment rate among Native Americans nationwide is at least 12% (in some places they are as high at 40% or much higher) well over twice the national average of 4.9%. Moreover, many tribal citizens provide for their families through traditional work outside the formal economy, such as through subsistence fishing, hunting, gathering, offering spiritual support, traditional healing services, and other culturally significant activities in which the exchange of gifts for services is traditionally recognized. How are these activities to be counted to meet workforce engagement requirements? While reference in the Proposal has been made to "tribal employment programs" which may encompass content designed to track such "employment", the existence of such a program assumes the Tribe has the resources available to develop, operate and sustain such a program. That is simply not the case for many tribes.

Health Center will preclude Medicaid reimbursement for the Tribe; and (3) the Proposal lacks a comprehensive list of exemptions to identify an individual as medically frail recognizing the broad spectrum of behavioral health diagnosis encompassed by ICD-10.

It is important to note that Section 1911 of the Social Security Act, enacted over 40 years ago, authorizes IHS and tribally operated programs like the LVD Health Center to bill the Medicaid program and receive reimbursement. Section 1911 was enacted to provide supplemental funding to the Indian health systems and designed to ensure that Medicaid funds would "flow into IHS institutions." Unlike other Medicaid enrollees, IHS beneficiaries have access to the IHS system at no cost to them. Faced with mandatory work requirements, Native American enrollees will simply choose to no longer participate in the Medicaid program. That, in turn, will deprive the LVD Health Center of Medicaid resources that is contrary to the Congressional intent of §1911 of the Social Security Act and thwart the objectives of the Medicaid statute for purposes of Indian health.[5]

Indeed, the Proposal in its current form amounts to nothing more than a condition to the Tribe's access to Medicaid reimbursement funding based on the contingency of an individual Indian's compliance with a State-created "experimental, pilot or demonstration project." Given that an individual Indian would receive the same health care at the Tribe's health clinic or any other IHS facility regardless of his or her qualification under the State's Medicaid plan, it is a certainty the number of such persons who would participate in the State plan that imposed additional qualifying requirements would decline, thus precluding Medicaid reimbursement for the Tribe. This interposition of extra statutory State requirements would therefore result in a decrease in funding to support the LVD Health Center; and importantly, as a matter of law, such decrease would be accomplished through an exercise of administrative discretion (i.e., CMS's approval of a State Medicaid plan waiver applications), not statutory directive or authorization. Moreover, this exercise of discretion would undermine Congress's manifest intent that CMS administer Medicaid in a manner that supports IHS. In fact, Congress has provided that IHS reimbursements from Medicaid be borne entirely by CMS, with no portion paid by any state.[6] Nothing in Congress's provision for IHS reimbursements—a framework that narrowly focuses on "services provided" and the facility providing those services—leaves room for CMS to impose additional requirements on program beneficiaries as a prerequisite to IHS's obtaining Medicaid reimbursements.

It is also important to note that mandatory work requirements for Native Americans is inconsistent with federal treaty and trust obligations. In fact, Congress declared in the Indian Health Care Improvement Act (P.L. 94-437), "that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians…to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."[7] Despite this commitment, Native Americans still face enormous health disparities and continue to have a lower life expectancy than the overall population. Native Americans are more likely to die of diabetes, unintentional injury, intentional self-harm or suicide, chronic lower respiratory diseases, liver

[5] Between August 1, 2017 and August 1, 2018, Upper Peninsula Health Plan enrollees represented approximately 13% of the total billable medical patient encounters at LVD Health Center. These medical patient encounters constituted over 30% of LVD Health Center revenue during that same period. In addition, these percentages for both patient encounters and revenue are significantly higher when adding in dental and other services currently offered at the LVD Health Center. That information was unavailable at the time of submission of these comments.
[6] 42 U.S.C. § 1396d(b) ("the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization").
[7] 25 U.S.C. § 1602(1).

disease, influenza and pneumonia.[8] Yet, the IHS is currently only funded at around 60% of need.[9] Congress intended for Medicaid to help address this funding shortfall when it authorized IHS to bill Medicaid.[10] This is made clear by the legislative history surrounding such authorization which states that "[t]hese Medicaid payments are viewed as a much-needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian."[11] To ensure that Indian health care remained a federal responsibility that was not shifted to the states, Congress also enacted legislation to provide for a 100% federal medical assistance percentage for Medicaid services received through and HIS or tribal facility, like the LVD Health Center.[12] Congress has also amended Medicaid numerous times to accommodate the unique nature of the Indian health system.[13] To be sure, Medicaid has become a critical component of the United States' fulfillment of its trust responsibilities to provide for Native American health care. Additional State mandated requirements on Native Americans which serve as a barrier to Medicaid are fundamentally at odds with the Federal governments treaty and trust responsibilities to the Indian tribes.

Furthermore, failure to include an exemption for desolate and geographical isolated areas undermines the overall purpose of the Social Security Act as it related to the Medicaid program and could prove detrimental to the State as an argument could be made that the State has failed to adequately consider the basic question of whether the Proposal would harm the core Medicaid goal of providing health coverage.[14] The rapid rate at which the Proposal is moving through the Michigan Department of Health and Human Services for submission to CMS[15] and the depressed economic conditions of Michigan's Upper Peninsula reinforces a lack of adequate reflection on the part of the State.[16]

Finally, with over 68,000 ICD-10 codes that identify medical conditions that could lead to a diagnosis that result in an enrollee being diagnosed as medically frail, only 500 codes are specified.

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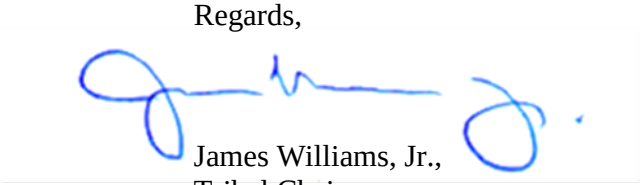
[8] See Indian Health Service, Factsheets: Disparities, https://www.ihs.goc/newsrooms/factsheets/disparities/.
[9] See Indian Health Service, Frequently Asked Questions.
[10] 42 U.S.C. §§ 1395qq, 1396j.
[11] H.R. Rep. No. 94-1026-Part III at 21 (May 21, 1976, reprinted in 1976 U.S.C.C.A.N. 2796).
[12] 42 U.S.C. § 1396(d).
[13] Balanced Budget Act of 1997 (P.L. 105-33)(providing an exception for American Indians/Alaskan Natives and others when allowing states new flexibility to mandate enrollment into managed care systems); 42 U.S.C. §§ 1396o(j), 1396o-1(b)(3)(A)(vii)(prohibited states from imposing premiums or cost sharing on American Indians/Alaskan Natives receiving covered services through HIS or a tribal facility); 42 U.S.C. §§1396a(ff), 1397gg€(1)(H)(ensured that certain trust-related property would be excluded from ineligibility determinations); 42 U.S.C. § 1396p(b)(3)(B)(imposed Medicaid estate recovery protections for American Indians/Alaskan Natives); 42 U.S.C. § 1396u-2(h)(established special rules to ensure Indian health care providers are reimbursed by states using managed care systems).
[14] Cf. Stewart, et. al. v. Azar, Civ. Action No. 1:18-cv-152 (D.C. 2018) (finding the Secretary's approval Kentucky's HEALTH program arbitrary and capricious prohibiting Kentucky from implementing it until HHS makes an assessment of whether the program in fact will help the state furnish medical assistance to its citizens).
[15] P.A.208 of 2018 was signed into law on June 22, 2018. The Proposal was released on July 9, 2018. MDHHS is mandated to submit the Proposal by October 1, 2018. Little more than 90 days will pass between development and submission of the Proposal that could affect hundreds of thousands of Michigan residents.
[16] In March 2018, the Bureau of Labor Statistics report a 6% unemployment rate in Gogebic County and a 10.3% unemployment rate in Ontonagon County. With the recent announcement of the closing of the Ojibway Correctional Facility, the largest and highest paying employer in Gogebic County, those numbers are sure to rise. https://www.mlive.com/news/index.ssf/2018/08/plan_to_close_prison_rocks_up.html. Coupled with transportation issues and inclement weather, workforce engagement requirements are simply out of tune with the State's most geographically isolated areas.

The current list lacks significant behavioral health diagnoses that are likely to affect an enrollee's ability to meet the work requirements. Specifically, the current list of ICD-10 codes fails to include F31-F68.10, all of which may represent significant impairments to an individual's ability to be active 20 hours each week, let alone attain gainful employment. These ICD-10 codes include diagnoses such as severe bi-polar disorder, sever manic depressive disorder, certain adjustment disorders and other significant diagnoses which could very well lead to an individual being determined medically frail. In addition, the language used to describe a medically frail diagnosis seems to require that an individual self-report, a claims analysis, and a health care provider referral. The Tribe submits that the "and" should be revised to an "or" as both would provide adequate evidence of such a determination by a health care professional.

For all the reasons explained herein, the Tribe is opposed to the implementation of work requirements for Native American HMP enrollees and HMP enrollees residing in desolate or geographically isolated areas of the State, and respectfully requests that the Michigan Department of the Health and Human Services:

1. Consider the addition of a specific exemption from the workforce engagement requirements for Native Americans as well as those who reside in desolate or geographically isolated areas of the State like Michigan's Upper Peninsula.
2. Revisit and revise the Proposal to include a more comprehensive list of behavioral health diagnosis when determining whether an individual is medically frail as well as clarify language regarding how such a determination is required to be made.
3. Include the Tribe as a partner at the table during the revision process before submission to CMS in order to ensure the goals of the State/Tribal Accord are met.
4. Include the Tribe in subsequent workgroups developed to implement the Proposal, if applicable.

Regards,



James Williams, Jr.,
Tribal Chairman

Pokégnek Bodéwadmik · Pokagon Band of Potawatomi
Tribal Council

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August 21, 2018

Michigan Department of Health and Human Services
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
Attention: Medicaid Policy
P.O. Box 30479
Lansing, Michigan 48909-7979
Attn: Kathy Stiffler, Acting Director

Re. Tribal Comments on Healthy Michigan Plan Demonstration Waiver Amendment

Dear Ms. Stiffler,

The Pokagon Band of Potawatomi Indians (the Tribe) is pleased to provide comments on the State of Michigan's proposed Healthy Michigan Plan §1115 Demonstration Extension Waiver (Amended Waiver). The Tribe is pleased that the State has afforded it the opportunity to submit comments on the Waiver, and appreciates the State's commitment to further tribal consultation. We look forward to working with your staff throughout the consultation process on the waiver proposal.

As discussed below, the Tribe has concerns with parts of the Amended Waiver as they apply to Native Americans. While the Tribe appreciates the Amended Waiver's clear exemption of Native Americans from the cost-sharing provisions, and including other exemptions, overall the Tribe requests MDHHS to include more clear language on exemptions, and to broaden the exemptions for Native Americans. The Amended Waiver, and its actual implementation, may conflict with federal law exempting Native Americans from general Medicaid requirements, including work engagement requirements, healthy behavior incentives, and managed care requirements. Our specific comments, discussed in detail below, can be summarized as follows:

1. We support the exemption from cost-sharing for Native Americans.

2. Native Americans should also be exempt from the healthy behaviors requirement. This appears to be the intent but the application is not clear on this point and should be amended accordingly.

3. Native Americans should be exempted from the work requirements. While the intent behind the requirement is understandable, because Native Americans have access to medical care at no cost through our tribal clinic and other federally-funded clinics, the employment incentive structures created by Medicaid work requirements do not operate in the same way for Native American Medicaid beneficiaries, who may

simply forgo Medicaid coverage and rely instead on the free care offered at federally-funded clinics, which in turn adds significant financial strain on the those clinics.

4. The Application should be amended to clarify that Native Americans are exempt from mandatory enrollment in managed care, which appears to be your intent as stated in your recent letter to tribes.

5. We request consultation on the waiver application, as required by law and CMS policy.

Background

The Tribe is based in Dowagiac, Michigan, and has approximately 5,600 citizens, the majority of whom live in Michigan, and many on the Tribe's reservation. The Tribe provides housing, education and health services to its citizens, both those living on and off the reservation.

The Pokagon Band Department of Health Services serves as a primary care provider for its citizens in Allegan, Van Buren, Berrien and Cass counties in Michigan, and La Porte, St. Joseph, Elkhart, Stake, Marshall and Kosciusko counties in Indiana. Its Contract Health Service Delivery Area (CHSDA) encompasses all of those counties.

The Pokagon Band Department of Health Services is an ambulatory clinic which provides direct patient care in the areas of diagnosis, prevention and treatment of acute and chronic illness, with an emphasis on health and wellness. The Health Department serves Pokagon citizens who live in Michigan and Indiana, providing services including management of acute and chronic illness, routine medical care, laboratory services, minor procedures, immunizations, wellness visits for adults and children, health and medical education, including illness prevention, and conducting periodic health fairs and educational events.

The United States has a federal trust responsibility to provide health care to American Indians and Alaska Natives, which is implemented by federal agencies like CMS. Both the HHS and CMS tribal consultation policies recognize "the unique government to government" relationship between the United States and Tribes, as well as the trust responsibility "defined and established" by "the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations and executive orders."[1] One manifestation of this trust responsibility is that "CMS and Indian Tribes share the goals of eliminating health disparities for American Indians and Alaska Natives (AI/AN) and of ensuring that access to Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and Exchanges is maximized."[2]

Tribal Medicaid Protections

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[1] Centers for Medicare & Medicaid Services Tribal Consultation Policy (Nov. 17, 2011), at 1; U.S. Dep't of Health and Human Services Tribal Consultation Policy (Dec. 14, 2010), at 1.

[2] Centers for Medicare & Medicaid Services Tribal Consultation Policy (Nov. 17, 2011), at 2.

In furtherance of the federal trust responsibility, Congress has enacted a number of provisions in the Medicaid statute that are designed to reduce barriers for Native Americans people to access Medicaid benefits. The Indian health system is unique and has a unique relationship to the Medicaid program. The Indian health system relies primarily on funding provided through appropriations to the Indian Health Service (IHS), but these appropriations are insufficient to fully fund the system. Recognizing this, Congress enacted legislation over 40 years ago to authorize the IHS and tribal health programs to bill the Medicare and Medicaid programs as a way to supplement inadequate IHS funding.[3] The House Committee on Interstate and Foreign Commerce justified its action by stating that "[t]hese Medicaid payments are viewed as a much-needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian."[4] Other Medicaid statute amendments relating to Indians include the following:

- **100 percent FMAP**. An amendment to Section 1905(b) of the Social Security Act, 42 U.S.C. §1396d(b), applied a 100 percent federal medical assistance percentage (FMAP) to Medicaid services provided to an Indian by an IHS or tribally-operated facility. As a result of Section 1905(b), the State is reimbursed at 100 percent FMAP for services provided to Medicaid eligible individuals who receive services at an IHS or tribal facility, resulting in **no cost to the State** for Indian participation in the Medicaid program.[5]

- **No Mandated Managed Care**. An amendment to Section 1932 of the Social Security Act, 42 U.S.C. § 1932(a)(2)(C), provides that States may not require Indians to enroll in managed care entities as a condition of participating in its Medicaid program.

- **No Premiums or Cost Sharing**. Section 5006 of the American Recovery and Reinvestment Act of 2009 (ARRA) added a number of Indian-specific Medicaid

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[3] 42 U.S.C. §1395qq and 42 U.S.C. §1396j.

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

[5] The application of 100 percent FMAP to the Medicaid-covered services provided by these facilities was made in express recognition of the federal government's treaty obligations for Indian health. The House Committee Report stated that since the United States already had an obligation to pay for health services to Indians as *IHS beneficiaries*, it was appropriate for the United States to pay the full cost of their care as *Medicaid beneficiaries:*

> (1) the Federal government has treaty obligations to provide services to Indians; it has not been a State responsibility;
>
> (2) since the 100 percent matching is limited to services in IHS facilities, it is clearly being paid for Indians who are already IHS eligible (and therefore clearly part of the population to which the U.S. Government has an obligation) and who are already eligible for full Federal funding of their services, and
>
> (3) States with a large IHS eligible Indian population have a limited tax base because so much of the land is public and not taxable; the higher matching rate under Medicaid simply recognizes this. H.R. REP. No. 94-1026, pt. III, at 21 (1976), as reprinted in 1976 U.S.C.C.A.N. 2782, 2796.

protections, including a provision that provides that States are prohibited from imposing any premium or cost-sharing on an Indian for a covered service provided by the IHS, a health program operated by an Indian tribe, tribal organization or urban Indian organization, or through referral under contract health services. 42 U.S.C. §§1396o(j) and 1396o-1(b)(3)(vii).[6]

- **Disregard of Certain Indian Property from Resources for Medicaid and CHIP Eligibility.** Section 5006(b) of ARRA exempts certain types of Indian property from the resources calculation for Medicaid eligibility. 42 U.S.C. §§1396a(ff) and 1397gg(e)(1)(H).

- **Medicaid Estate Recovery Protections.** Section 5006(c) of ARRA provides an exemption for certain Indian-related income, resources and property held by a deceased Indian from the Medicaid estate recovery requirement. 42 U.S.C. §1396p(b)(3)(B).

- **Special Indian-specific Rules for Medicaid Managed Care.** Section 5006(d) of ARRA provides protections for Indian people and Indian health providers when Indians voluntarily choose to participate in managed care systems. It provides that Indian enrollees have the right choose their Indian health program as their primary care provider, that Indian health providers (IHS, tribal and urban Indian organization programs) have a right to prompt payment from managed care entities, and directs the States to make up the difference in payment to tribal health facilities by a managed care entity that was not what Medicaid would otherwise pay for the service. 42 U.S.C. §1396u-2(h).

Tribal Concerns with Healthy Michigan Plan Extension Waiver

We have reviewed the Tribal Notice sent July 9, 2018, containing information on how the Healthy Michigan Plan §1115 Demonstration Extension Waiver ("Amended Waiver Extension Application" or "Application")), the Section 1115 Demonstration Extension Application amended July 9, 2018,[7] and Public Act 208. We are concerned that the draft waiver application includes detrimental aspects the State should change before submission to CMS.

1. Exemption of Native Americans From Cost-Sharing

The Amended Waiver Extension Application makes clear that Native Americans are not subject to the cost-sharing and premium provisions of the proposed waiver.[8] As discussed above, the Social Security Act specifically exempts American Indians and Alaska Natives from premiums, co-payments, or cost-sharing of any kind in the Medicaid program. 42 U.S.C. 1396o(j). The Tribe supports including the exemption in the waiver application. Additionally, in

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[6] In recognition of the trust responsibility, Indian children have been exempt from cost-sharing in the CHIP program pursuant to regulation at 42 C.F.R. §457.535.

[7] Available online at https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_66797-472387--,00.html.

[8] Amended Waiver Extension Application, 8, 9, and Exhibit C at 1.

any discussions with CMS concerning the application, you should insist that this exemption be included in any final waiver that may be granted.

2. Healthy Behavior Requirements

The Amended Waiver Extension Application is not clear as to whether Native Americans are exempted from the healthy behaviors requirement. The Application states that beneficiaries with an income between 100% and 133% of the FPL must complete a healthy behavior to remain eligible after 48 months of eligibility. Application at 7. It further states that Native Americans are exempt from the cost-sharing requirement, Application at 8, 9, but does not expressly state that they are exempt from the healthy behaviors requirement. The July 9 Tribal Notice states, on the other hand, that "Native American enrollees … will not be subject to the eligibility suspension provisions outlined above," (at p. 2), referring to both the cost-sharing and healthy behavior requirements. If it is your intent to exempt Indians from the healthy behavior requirement—as it appears to be—then the Application should be amended to say so expressly.

We encourage healthy behaviors through our own government programs and traditional practices, and encourage an open dialogue with the State to develop healthy behavior incentives within the Tribe and to share our traditional knowledge and practices to help improve healthy behaviors throughout Michigan. However, without a clear exemption of Native Americans from the healthy behavior requirements in the Waiver, the risk of lost health coverage through unforeseen consequences, inaccurate implementation or administrative errors is too great.

While imposing healthy behaviors and other eligibility conditions may be appropriate for Michigan's non-Indian population, they will not work as intended in Indian country because the incentives are not the same. Faced with meeting these requirements as a condition of Medicaid eligibility, American Indians and Alaska Natives will simply elect not to enroll in Medicaid and rely on IHS instead. This will lead to more uncompensated care provided to otherwise Medicaid eligible individuals by the IHS, tribes and non-Indian healthcare providers. Instead of incentivizing healthy behaviors and employment, such requirements will lead to decreased Indian access to the Medicaid program, a result at odds with congressional intent.

3. Work Requirements

Although the Tribe fully supports the goal of increasing employment for its tribal citizens and others, work requirements simply will not accomplish their goal when they are applied to Michigan's Native American population. Native Americans are unique among Medicaid enrollees because they also have access to the IHS, and therefore the employment incentive structures created by Medicaid work requirements do not operate in the same way for Native American Medicaid beneficiaries. Because Native American beneficiaries may simply forgo Medicaid coverage and rely instead on IHS coverage, which in turn adds significant financial strain on the perennially underfunded IHS system.

Additionally, as a practical matter, many Native American Medicaid beneficiaries may not be able to meet Medicaid work requirements due to high on-reservation unemployment and/or lack of connection to State employment programs.

4. Managed Care Requirements

The Tribe requests an explicit exemption in the Application from the Healthy Michigan Plan's (HMP) managed care requirements. Although MDHHS stated in the July 9, 2018 Tribal Notice that that Native Americans may "voluntarily enroll in the managed care delivery system," (p. 2, emphasis added)—making clear that they cannot be required to enroll in managed care—the Application does not expressly exempt them from any requirements to enroll, or to be automatically enrolled into such a system. Express exemption language is essential because the Amended Waiver Extension states "services for HMP beneficiaries are provided through a managed care delivery system, and that "[a]ll HMP eligible beneficiaries are initially mandatorily enrolled in a Medicaid Health Plan (MHP), with the exception of those few beneficiaries who meet the MHP enrollment exemption criteria or those beneficiaries who meet the voluntary enrollment criteria." (p. 9, emphasis added)." The language in the Application is at best unclear. It should be revised to clearly state that Indians are not subject to mandatory enrollment in managed care.[9]

Without this clear exemption language, even with the clear intent to exempt Native Americans from the various additional programs the Amended Waiver creates, the State's proposal would likely result in additional administrative burdens to the State, to the Tribe, and to the Managed Care Entities that are unnecessary and can be easily avoided. By simply adding clear and concise language directly into these Amended Waiver initiatives, then the implementation of the Amended Waiver initiatives will go much more smoothly and without costly errors or misunderstandings of the scope of the exemptions.

5. Request for Tribal Consultation

We appreciate the efforts the State has made in consulting with tribes through its conference call on August 6, 2018, as communicated in the June 9 Tribal Notice letter, and the extended comment deadline of August 23, 2018. However, under federal law and policy, tribal consultation requires more than simply public comment participation and one brief pre-schedule phone call. As CMS's Tribal Consultation Policy explains, Section 5006(e) of the American Recovery and Reinvestment Act (ARRA) requires any State with one or more Indian health providers to obtain advice and input on a regular, ongoing basis prior to submitting a waiver

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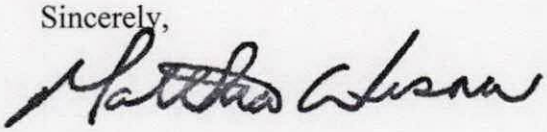
[9] Requiring Indians to enroll in managed care plans would result in additional administrative burdens to the State, to the Tribe, and to the managed care entities that are unnecessary and can be easily avoided. Managed care entities would be in a position of having to administer the program in a manner that allowed Indian enrollees to choose the Pokagon Health Department as their primary health care provider of choice, 42 U.S.C. § 1396u-2(h)(1), to make payments to the Pokagon Health Department whether they were an in-network provider or not, 42 U.S.C. § 1396u-2(h)(2) and 25 U.S.C. § 1621e, and would require the State to make supplemental payments to the Pokagon Health Department to the extent the managed care entities paid less than the rate that applies to the provision of such services under the State plan. 42 U.S.C. § 1396u-2(h)(2)(C)(ii). In addition, the managed care entities (and the State, in its oversight capacity) would have to design Indian-specific plans in order to ensure that Pokagon Band citizens did not have to make any payments or cost-sharing. 42 U.S.C. §§ 1396o(j), 13960-1(b)(3)(A)(vii) and (b)(3)(B)(x).

request or proposal for a demonstration project likely to have a direct effect on Indians and Indian health providers. 42 U.S.C. § 1396a(a)(73).[10] Because of the unique issues arising from the interactions of Medicaid and tribal healthcare, we request further consultation to more sufficiently discuss the health impacts of the waiver and necessary clarifications to ensure a smooth transition for Native Americans. We will follow-up with MDHHS Liaison to the Michigan Tribes, Lorna Elliott-Egan, in order to resolve the ambiguities and ensure the necessary exemptions are included in the finalized demonstration waiver.

Conclusion

We understand the State is eager to move forward with the submission of these waivers and to have CMS begin assessing them. We appreciate the consultation processes already completed, and the changes already made to ensure Native American exemptions from cost-sharing. We believe further progress can be made, and better policy outcomes achieved, by ensuring all aspects of the Amended Waiver programs include sufficient and clear exemptions for Native Americans. This approach will not only expedite this process, but also ensure that the waiver can be implemented in the most efficient and least complicated and burdensome fashion possible.

Sincerely,



Matthew Wesaw
Tribal Council Chairman
Pokagon Band of Potawatomi Indians

Cc: Matt Clay, Director, Pokagon Band Department of Health Services
Elliott Milhollin, Esq., Hobbs, Straus, Dean & Walker, LLP

[10] Federal regulations also require the continued consultation through the submittal of the waiver to CMS when the waiver will have a direct effect on the Tribe. CMS's Tribal Consultation Policy, citing Section 1115 Transparency Regulations at 42 C.F.R. § 431.408(b). Documentation of the State's consultation activities must be included in the demonstration application. 42 C.F.R. § 431.408(b)(3).

Pokégnek Bodéwadmik · Pokagon Band of Potawatomi
Tribal Council

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August 31, 2018

Michigan Department of Health and Human Services
Medical Services Administration
Bureau of Medicaid Policy and Health System Innovation
Attention: Medicaid Policy
P.O. Box 30479
Lansing, Michigan 48909-7979
Attn: Kathy Stiffler, Acting Director

Re. Additional Comments on Healthy Michigan Plan Demonstration Waiver Work Requirements

Dear Ms. Stiffler,

The Pokagon Band of Potawatomi Indians (the Tribe) is writing to follow up on the August 21, 2018 comments we provided to you on the State of Michigan's proposed Healthy Michigan Plan §1115 Demonstration Extension Waiver (Amended Waiver). Tribes are universally opposed to the Amended Waiver's proposal to include work and community engagement requirements as a condition of Medicaid eligibility. As discussed below, CMS lacks the legal authority to approve such requirements, and cannot approve any waiver that would impose such requirements on American Indians and Alaska Natives (AI/ANs).

We understand CMS has expressed concern regarding the approval of a waiver that contains an exemption for AI/ANs from work and community engagement requirements, but CMS's concerns are misplaced and lack any legal basis. As a result, we request that to the extent the State decides to maintain its proposal to impose work and community engagement requirements, it exempt AI/ANs from those requirements. As discussed below, as an alternative, the State should exempt individuals who are not required to enroll in managed care, and/or individuals who are exempt from cost-sharing in the Medicaid program.

Work requirements will not work in Indian country

The Tribe fully supports programs designed to increase employment, and has developed significant economic development, education, and workforce training programs for our citizens. We are concerned, however, that the Amended Waiver's work requirements will not work for AI/ANs. Unlike other Medicaid enrollees, American Indians have a right to access care at IHS and tribal facilities at no cost to them. As a result, they have no incentive to participate in the Medicaid program if meeting the State's work requirements is too burdensome. Imposing work requirements on our citizens will result in many of the patients we serve dropping off of Medicaid or not enrolling in the first place. That, in turn, would deprive the Indian health system of a stream of supplemental funding it needs to survive, and which Congress intended it receive.

CMS may not lawfully approve a waiver that imposes work requirements on our citizens

While Section 1115 grants broad discretion to the Secretary, it only authorizes the waiver of certain enumerated provisions in the Social Security Act. It does not authorize the Secretary to impose new requirements, such as work requirements.

In addition, CMS may only approve demonstration projects that are "likely to assist in promoting the [Act's] objectives." 42 U.S.C. § 1315(a); *Stewart v. Azar* at *5 (No. 18-152 (JEB)) (D.D.C., June 29, 2018). One of the Act's general objectives is to "furnish medical assistance" to individuals whose income and resources are insufficient to meet the costs of necessary medical services. *Stewart* at *33. It is difficult to see how CMS could advance that objective with regard to AI/ANs if the waiver at issue would result in significant incentives for AI/ANs not to enroll in Medicaid to begin with, or for those already enrolled to drop off and rely instead on the IHS.

The Act also sets out unique objectives that are specific to the Indian health system. In 1976, Congress amended the Medicaid statute to authorize IHS and tribally operated facilities to bill the Medicaid program in order to make Medicaid resources available to supplement funding for the chronically underfunded Indian health system.[1] Section 1911 of the Act, 42 U.S.C. §1396j, made IHS and tribal facilities eligible to collect reimbursements from Medicaid, and an amendment to Sec. 1905(b), 42 U.S.C. §1396d(b), ensured States would not bear the burden of costs associated with doing so by applying a 100 percent federal medical assistance percentage (FMAP) to Medicaid services provided to an Indian by an IHS or tribally-operated facility.

Congress's intent in enacting Section 1911 was to ensure that Medicaid funds be made available to help supplement inadequate IHS funding. Section 1911 was enacted "as a much needed supplement to a health care program which for too long has been insufficient to provide quality health care to the American Indian." H.R. Rep. 94-1026 at 21. It was intended "to enable Medicaid funds to flow into IHS institutions." H.R. Rep. 94-1026 at 20. Congress intended these resources be available to enable IHS facilities to meet the conditions of participation in the Medicare and Medicaid programs. *Id.*

Congress also taken additional steps to lower barriers to AI/ANs enrollment and participation in the Medicaid program. Congress amended the Act to authorize IHS, tribal and urban Indian programs to act as express lane agencies, 42 U.S.C. 1396a(e)(13)(F), it exempted AI/AN Medicaid enrollees receiving services through an IHS or through contract health service referral from premiums, co-pays or cost-sharing of any kind, 42 U.S.C. § 1396o(j)(1)(A), and it

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[1] The House Interior and Insular Affairs Committee noted that per capita spending on Indian health in 1976 was 25 percent less than the average American per capita amount. H.R. REP. No. 94-1026, pt. I, at 16 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652, 2655. According to the U.S. Commission on Civil Rights, IHS per capita spending for Indian medical care in 2003 was 62 percent lower than the U.S. per capita amount. U.S. Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System* (Sept. 2004), at 98.

authorized the Secretary to encourage States to work with tribes to increase AI/AN enrollment,

and required the Secretary to facilitate cooperation between States and tribes in implementing the Medicaid program. 42 U.S.C. § 1320b-9.

Imposing work requirements on AI/ANs works at cross purposes to all of these objectives. It would have the effect of dramatically decreasing enrollment in Medicaid for AI/ANs in Michigan, not increasing it. It would cut off access to Medicaid reimbursement for the Indian health system in the State, not increase access to that funding. Such a result would frustrate, rather than advance, the objectives of the Medicaid statute.

CMS's objections are misplaced and lack any basis in the law

CMS has stated that it cannot approve a waiver that contains an exemption for AI/ANs from work requirements because doing so would raise "civil rights concerns." CMS has not explained what those concerns might be, or provided any legal justification for that statement, because it cannot. CMS has ample legal authority to make accommodations for IHS beneficiaries in administering the Medicaid statute when doing so is rationally related to its unique trust responsibility to Indians. Under familiar provisions of Indian law that are routinely upheld by the courts, such actions are political in nature, and as a result do not constitute prohibited race based classifications. This is well-settled law that tribes and tribal organizations have explained to CMS, and which in the past CMS has relied on when approving other Indian-specific provisions in Section 1115 waivers and CMS Medicaid regulations. Rather than reiterate that authority here, we attach recent comments provided to CMS on this issue by the Tribal Technical Advisory Group to CMS.

Alternatives to Consider

As currently structured, the Amended Waiver would exclude a number of classes of individuals from having to participate in work requirements as a condition of Medicaid eligibility. As discussed above, we request that AI/ANs be included in the list of excluded classes of individuals from such requirements. If CMS cannot back off of its previously stated position, there are several other categories of individuals, which include AI/ANs and non-AI/ANs alike, that the State should exclude as well. These include:

- Exempting individuals who are not required to enroll in managed care in order to access Medicaid services and/or
- Exempting individuals who are exempt from cost-sharing in the Medicaid program.

Conclusion

We would like to thank the State for the opportunity to discuss these issues during our tribal consultation and to provide these additional comments on the Amended Waiver. We understand that Section 1115 Demonstration Waivers often involve an iterative process of discussion between the State and CMS, and we ask that the Tribe be kept informed of any developments on this issue as your discussions with CMS move forward.

Sincerely,

Matthew Wesaw
Chairman
Pokagon Band of Potawatomi Indians

Cc: Matt Wesaw, Chairman, Pokagon Band of Potawatomi Indians
Ed Williams, Esq., Pokagon Band of Potawatomi Indians

American Indian Health and Family Services
Of Southeastern Michigan, Inc.

Mínobínmaadzíwin "A Good Life"

To: State of Michigan
Re: 1115 Waiver Extension Application- Work Requirement Requested Exemption for Tribal Members

American Indian Health and Family Services of Southeastern MI, is a non-profit health center whose mission is to empower and enhance the physical, spiritual, emotional, and mental wellbeing of American Indian/Alaska Native individuals, families and other underserved populations in SE MI through culturally grounded health and family services./

I write this letter today with deep concern regarding the 115 Waiver Extenstion Application and specifically the states lack of exemption for Native Americans. As a general matter, we are concerned that work and community engagement requirements have the potential to significantly limit access to healthcare for the most vulnerable populations.

The Federal Government's trust responsibility for the provision of health care to AI/ANs has long been recognized and applies to all federal agencies.[2] Medicaid is one of the major programs the Federal Government utilizes in its implementation of this responsibility. 27% of nonelderly AI/AN adults, half of AI/AN children, and 40% of urban AI/AN UIHP patients are enrolled in Medicaid.[3] It is thus imperative that states that seek Section 1115 waivers do not impose any undue burdens or requirements on the AI/AN population that would limit their participation in the Medicaid program, including work and community engagement requirements. AIHFS herefore supports the exception for AI/ANs from its work requirement proposal language from Utah, which states that "[i]ndividuals with verified membership in a federally recognized tribe will not be required to participate, but they may participate in the work requirement if they choose. They will not lose eligibility if they fail to participate."[4] AIHFS notes that this should be interpreted as applicable to AI/ANs, including urban AI/ANs seen at UIHP facilities. Imposing this work requirement on the AI/AN population would be a violation of the trust obligation and this exception is therefore necessary for compliance with legal obligations. We thus request that the State of Michigan include this important exemption in their waiver application.

[2] In addition, this responsibility is not restricted to the borders of reservations and follows AI/ANs to urban centers where over 70% of AI/ANs live. *See* S. Rep. 100-508, Indian Health Care Amendments of 1987, Sept. 14, 1988, at 25.
[3] Henry J. Kaiser Family Foundation, Medicaid and American Indians and Alaska Natives (Sept. 2017); Indian Health Service, Office of Urban Indian Health Programs, UDS Summary Report Final – FY2016 (as of May 6, 2018).
[4] State of Utah, 1115 Primary Care Network Demonstration Waiver: Adult Expansion Amendment Request (June 22, 2018) at 6.

Furthermore, AIHFS cautions that any denial of AI/ANs exemption to work requirements on the basis of categorization of AI/ANs as a racial group is misguided and founded on an incorrect understanding of both law and facts.

First, Title VI of the Civil Rights Act of 1964 prohibits programs receiving federal financial assistance from discriminating on the basis of race, color or national origin. But Title VI does not preclude the federal government from requiring states to recognize unique obligations to AI/ANs under federal law. Based upon the unique legal status of Tribes under Federal law, the Federal government's trust and responsibility toward AI/ANs as authorized by Congress, CMS must affirmatively address barriers to healthcare for the AI/AN population.

Since the formation of the Union, the U.S. has recognized Indian Tribes as sovereign nations. This unique government-to-government relationship between Indian Tribes and the Federal Government is grounded in the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations, and executive orders that establish and define a trust relationship with Indian Tribes and AI/AN people. This relationship derives from this political and legal relationship and *is not based upon race.*

Congress has already enacted a statute requiring CMS to support the Indian health system through Medicaid. Section 1911 of the Social Security Act "made clear [Congress's] intent to leverage the Medicaid and Medicare programs for fulfillment of its trust and treaty obligations[.]"[5] These changes to the Social Security Act were political actions – political in nature – not a race-based classification.

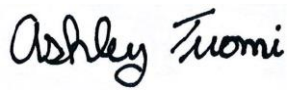
Moreover, the Supreme Court has recognized the principle that CMS has valid legal authority to single out IHS beneficiaries for special treatment in its administration of its programs, and has repeatedly upheld this unique political status and government- to-government relationship. In *Morton v. Mancari*, 417 U.S. 535 (1974), the Supreme Court held that, "[a]s long as the special treatment [for Indians] can be tied rationally to the fulfillment of Congress' unique obligation toward the Indians, such judgments will not be disturbed." *Id.* at 555. This principle has been reaffirmed numerous times both by the Supreme Court and every Federal Appellate Circuit Court of Appeals that has been presented with this issue.

[5] Letter of Bipartisan Senators to Department of Health and Human Services Secretary concerning AI/AN exemptions to Medicaid work requirements (April 27, 2018) [hereinafter "Senate Letter"].

Finally, the U.S. Senate reaffirmed that CMS has both the authority and the trust responsibility to ensure Medicaid is available to AI/ANs. The U.S. Senate Committee on Indian Affairs stated in a letter to CMS that Supreme Court precedent in *Morton* "— combined with a number of statutes, regulations, and additional court decisions – confirms that Tribes are not a racial group but rather political communities."[6] The Senators further state that Congress's extension of Medicaid to IHS beneficiaries rests on the "solid principles . . . [t]hat Congress can extend federal benefits to Indian tribes and their members as a means of fulfilling Congress's unique obligation toward tribes— all while abiding by the Equal Protection clause."[7]

For the aforementioned reasons, AIHFS supports the AI/AN exception from the work requirement that should be included in Michigan's 1115 demonstration waiver. This exception is consistent with Congressional practice and intent as well as Supreme Court precedent and is necessary to comply with the Federal Government's trust obligation to AI/ANs.

Sincerely,



Ashley Tuomi, CEO

Great Lakes Area Tribal Health Board

Resolution No. 18-001

Supporting the Government to Government Relationship Between the United States and Tribes and Protecting Tribal Sovereignty

WHEREAS, the Great Lakes Area Tribal Health Board (GLATHB) is a Tribal Health Board that serves thirty-four (34) Tribes, three (3) Service Units and four (4) Urban Indian Health Programs in Minnesota, Wisconsin, Michigan, Indiana, and Chicago, Illinois; and

WHEREAS, the GLATHB was developed to act as the conduit between the Bemidji Area tribes, tribal organizations, and urban Indian organizations to promote the spirit of self-determination and advocacy of tribal health care to the federal Indian health care system, while monitoring the federal and state legislation that may impact Indian health care; and

WHEREAS, GLATHB has adopted bylaws which authorize the Board of Directors to present and pass resolutions in support of actions that benefit its service area; and

WHEREAS, Since the formation of the Union, the United States has recognized Indian Tribes as sovereign nations; and

WHEREAS, A unique government-to-government relationship exists between Indian Tribes and the federal government and this relationship is grounded in the United States Constitution, numerous treaties, statutes, federal case law, regulations, executive orders evidencing the political and legal relationship that Indian Tribes enjoy with the federal government; and

WHEREAS, As part of its mission, GLATHB will continue to educate States, as well as the federal government, whether it be members of Congress or the Administration about the federal government's Trust Responsibility as well as the resulting provisions and protections afforded to American Indians based on the unique political status of Indian Tribes not on that of race; and

WHEREAS, In recognition of Tribal Sovereignty and the federal government's Trust Responsibility, American Indians are exempt from workforce enhancement and other extra-statutory requirements not otherwise authorized or consistent with federal statute; and

NOW, THEREFORE, BE IT RESOLVED, that the Great Lakes Area Tribal Health Board will continue to advocate for and support the unique government-to-government relationship between Indian Tribes and the federal government to promote and protect Tribal Sovereignty; and

BE IT FURTHER RESOLVED, that the Great Lake Area Tribal Health Board will continue to educate States, as well as the federal government, whether it be members of Congress or the Administration about the federal government's Trust Responsibility as well as the resulting provisions and protections afforded to American Indians based on the unique political status of Indian Tribes not on that of race; and

BE IT FINALLY RESOLVED, that the Great Lakes Area Tribal Health Board will continue to advocate for the unique political status of Indian Tribes, their members, and to take all action necessary and practical to ensure policymaking at both the federal and State level do not misinterpret policies mobilizing the federal Trust Responsibility and recognizing treaty rights on the basis of race.

CERTIFICATION

As Chair of the Great Lakes Area Tribal Health Board (GLATHB), I do hereby certify that the foregoing Resolution No. 18-001 was passed on August 28th, 2018, at a duly called meeting at which a quorum was present with 7 voting for, 0 voting against, and 0 abstaining.

Phyllis Davis, Chair

NOTTAWASEPPI HURON
BAND OF THE POTAWATOMI
A FEDERALLY RECOGNIZED TRIBAL GOVERNMENT

August 30, 2018

Matt Lori
Deputy Director, Policy, Planning and Legislative Services
333 S. Grand Ave
P.O. Box 30195
Lansing, Michigan 48909

Re: Nottawaseppi Huron Band of the Potawatomi
Comments Re: Healthy Michigan Plan §1115 Demonstration Waiver Extension Application Amendment

Dear Mr. Lori:

The Nottawaseppi Huron Band of the Potawatomi ("NHBP") appreciates the face-to-face consultation that was held to address the State of Michigan's ("State") request to amend the Healthy Michigan Plan §1115 Demonstration Waiver Extension Application ("the Proposal"). NHBP also appreciates the opportunity extended by Governor Snyder's Chief of Staff, Richard Posthumus, giving NHBP additional time to submit written comments on the State's Proposal.

Like many tribes across the nation, NHBP operates its own tribal health care facilities ("NHBP Health Clinics") on the Pine Creek Indian Reservation, at the FireKeepers Casino Hotel and in the City of Grand Rapids. The NHBP Health Clinics are full-service health clinics, offering primary care, walk-in services, dental services, behavior health and family services. These facilities provide health care services to both Native American and non-Native American clients. NHBP is the only tribe operating a health clinic in an urban area, City of Grand Rapids, with a large concentration of Native Americans from dozens of different tribes. On average, NHBP provides health services to 1813 patients who are enrolled members or descendants of other tribes each year. Of that number 318 are Medicaid recipients, with an additional 198 NHBP members and descendants who are Medicaid recipients.

NHBP understands, the State, pursuant to Public Act 208 of 2018, is requesting authority from the Centers for Medicare and Medicaid Services ("CMS") through the

Proposal[1] to implement changes in cost-sharing requirements for beneficiaries of the Healthy Michigan Plan ("HMP") for individuals with incomes between 100% and 133% of the federal poverty level as well as implement certain workforce engagement requirements for those individuals to maintain eligibility. NHBP has serious concerns with the State's plan to move forward with this Proposal without any meaningful opportunity for consultation and believes further consultation should take place before the State submits any Proposal that impacts Native Americans and tribal health programs.

The Tribe was first presented with notice of the HMP Application Amendment in December 2017; however, that notification did not include information as to how the HMP Application would be amended. The Tribe received another notice with more information in July 2018 - the same date the Proposal was made available for public comment. A conference call with the tribes was held on August 6, 2018, but little time was dedicated to allowing tribes to address concerns or voice any suggestions, revisions or objections as indicated by the notice. As a result of concerns expressed on the August 6th teleconference, an in-person Tribal/State consultation was held on August 27, 2018 - just 3 days before these written comments were due and little discussion was had regarding the logistics of implementation or tribal member reporting on these new requirements. Tribal Consultation, by agreement of the State, must occur before or in conjunction with policy/legislative/regulation development, not at the same time as the State's initiatives are made public.

While the Tribe appreciates that the Proposal recognizes that Native Americans are exempt by federal law from the cost-sharing requirements, it must be noted that no such exemption has been recognized for Native Americans regarding the work requirements. Furthermore, the Proposal fails to recognize Congress's intent that Medicaid be administered in a manner that supports Indian Health Services' ("IHS") provision of health care to Native Americans. Indeed, based on NHBP's experience and data, three things about the Proposal are abundantly clear, (1) mandatory work requirements will create a barrier to access to Medicaid that is unique to IHS beneficiaries as well as those individuals located in the most geographically isolated areas of the State where employment opportunities are limited or seasonal at best; (2) the Proposal's imposition of additional qualifying requirements for both Native Americans and non-Native Americans served by NHBP's Health Clinics will preclude Medicaid reimbursement for NHBP; and (3) the Proposal lacks a comprehensive list of

[1] The Proposal was not developed in accordance with the State-Tribal Accord (per Executive Directive 2001-2) entered into between Governor Engler (2002) and extended by both Governors Granholm and Snyder, which calls for a respectful government to government relationship when dealing with Michigan's Federally recognized Tribes of which Section V. Implementation reads:

> For purposes of this accord, "state action significantly affecting tribal interests" is defined as regulations or legislation proposed by executive departments, and other policy statements or actions or executive departments, that have or may have substantial direct effects on one or more tribes, on the relationship between the state and tribes, or on the distribution of power and responsibilities between the state and tribes. State action includes the development of state policies under which the tribe must take voluntary action to trigger application of the policy.

Consultation occurs before or in conjunction with policy, legislative, and regulation development, not at the same time as it is made available to the public.

exemptions to identify an individual as medically frail recognizing the broad spectrum of behavioral health diagnosises encompassed by ICD-10.

Crucial to NHBP's position is that Section 1911 of the Social Security Act, enacted over 40 years ago, authorizes IHS and tribally operated programs like NHBP's Health Clinics to bill the Medicaid program and receive reimbursement. Section 1911 was enacted to provide supplemental funding to the Indian health system and designed to ensure that Medicaid funds would "flow into IHS institutions." Unlike other Medicaid enrollees, IHS beneficiaries have access to the IHS system at no cost to them. Faced with mandatory work requirements, Native American enrollees will simply choose to no longer participate in the Medicaid program. That, in turn, will deprive the NHBP Health Clinics of Medicaid resources. This result is contrary to the Congressional intent of §1911 of the Social Security Act and thwarts the objectives of the Medicaid statute for purposes of Indian health.

An individual's eligibility for health care at NHBP's Health Clinic (or at any other IHS facility) is largely determined by federal law and does not depend upon whether that individual is complying with a State-created "experimental, pilot or demonstration project." The Proposal in its current form amounts to nothing more than a condition on NHBP's access to Medicaid reimbursement funding. Since an individual Indian or eligible descendant would be entitled to receive the same health care at NHBP's Health Clinic regardless of his or her qualification under the State's Medicaid plan, it is a certainty that the number of such persons who would participate in the State plan would decline, thus precluding Medicaid reimbursement for the services provided by NHBP. The interposition of this extra statutory State requirement would therefore result in a decrease in funding to support the NHBP Health Clinics. In addition, and importantly, as a matter of law, such decrease would be accomplished through an exercise of administrative discretion (i.e., CMS's approval of a State Medicaid plan waiver applications), not statutory directive or authorization. Finally, this exercise of discretion would undermine Congress's manifest intent that CMS administer Medicaid in a manner that supports IHS and improved health services for Native Americans. In fact, Congress has provided that IHS reimbursements from Medicaid be borne entirely by CMS, with no portion paid by any state.[2] Nothing in Congress's provision for IHS reimbursements—a framework that narrowly focuses on "services provided" and the facility providing those services—leaves room for CMS to impose additional requirements on program beneficiaries as a prerequisite to IHS's obtaining Medicaid reimbursements.

It is also important to note that mandatory work requirements for Native Americans are inconsistent with federal treaty and trust obligations. In fact, Congress declared in the Indian Health Care Improvement Act (P.L. 94-437), "that it is the policy

[2] 42 U.S.C. §1396d(b) "...the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization".

of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians...to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."[3] Despite this commitment in federal law, Native Americans still face enormous health disparities and continue to have a lower life expectancy than the overall population. NHBP conducted a census in 2014 wherein 42% of respondents reported being diagnosed with a chronic disease. Then in 2016 NHBP conducted a Community Health Needs Assessment. This survey revealed that 20% of respondents had been diagnosed with diabetes and 16% of respondents reported no health care coverage at all, including no private health insurance, no prepaid plan such as an HMO and no government plan such as Medicare or Medicaid. NHBP Members identified that cost was the main barrier to access to health care. Yet, the IHS is currently funded at around 60% of need.[4] Congress intended for Medicaid to help address this funding shortfall when it authorized IHS to bill Medicaid.[5] This is made clear by the legislative history surrounding such authorization which states that "[t]hese Medicaid payments are viewed as a much-needed supplement to a health care program which has for too long been insufficient to

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[3] 25 U.S.C. §1602, Declaration of national Indian health policy
Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—

(1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;
(2) to raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;
(3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;
(4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population;
(5) to require that all actions under this chapter shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this chapter and the national policy of Indian self-determination;
(6) to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and
(7) to provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

[4] See Indian Health Service webpage frequently asked questions at: https://www.ihs.gov/forpatients/faq/
Q: I am eligible for health care from the Indian Health Service, but the local Service Unit will not pay for the [surgery, health care, medicine] that I need? Why?
A: The Indian Health Service is funded each year through appropriations by the U.S. Congress...The Indian Health Service cannot always guarantee that funds are always available. Funds appropriated by the U.S. Congress currently cover an estimated 60% of health care needs of the eligible American Indian and Alaska Native people....

[5] 42 U.S.C. §§ 1395qq, 1396j

provide quality health care to the American Indian."[6] To ensure that Indian health care remained a federal responsibility that was not shifted to the states, Congress also enacted legislation to provide for a 100% federal medical assistance percentage for Medicaid services received through an IHS or tribal facility, like the NHBP Health Clinics.[7] Congress has also amended Medicaid numerous times to accommodate the unique nature of the Indian health system.[8] To be sure, Medicaid has become a critical component of the United States' fulfillment of its trust responsibilities to provide for Native American health care. Additional State mandated requirements on Native Americans which serve as a barrier to Medicaid are fundamentally at odds with the Federal government's treaty and trust responsibilities to the Indian tribes.

Finally, the current list of IDC-10 codes lacks significant behavioral health diagnoses that are likely to affect an enrollee's ability to meet the work requirements. Specifically, the current list of ICD-10 codes fails to include F31-F68.10, all of which may represent significant impairments to an individual's ability to be active 20 hours each week, let alone attain gainful employment. These ICD-10 codes include diagnoses such as severe bi-polar disorder, sever manic depressive disorder, certain adjustment disorders and other significant diagnoses which could very well lead to an individual being determined medically frail. In addition, the language used to describe a medically frail diagnosis seems to require that an individual self-report a claims analysis, and a health care provider referral. NHBP requests that the "and" be revised to an "or" as both would provide adequate evidence of such a determination by a health care professional.

For all the reasons explained herein, the Tribe is opposed to the implementation of work requirements for Native Americans in general and for enrolled members of the Nottawaseppi Huron Band of the Potawatomi specifically, and respectfully requests that the Michigan Department of the Health and Human Services:

1. Consider the addition of a specific exemption from the workforce engagement requirements for all persons who are enrolled members of federally recognized tribes or who receive health care at tribal health clinics.

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[6] H.R. Rep. No. 94-1026-Part III at 21 (May 21, 1976, reprinted in 1976 U.S.C.C.A.N. 2796).

[7] 42 U.S.C. § 1396(d).

[8] Balanced Budget Act of 1997 (P.L. 105-33)(providing an exception for American Indians/Alaskan Natives and others when allowing states new flexibility to mandate enrollment into managed care systems); 42 U.S.C. §§ 1396o(j), 1396o-1(b)(3)(A)(vii)(prohibited states from imposing premiums or cost sharing on American Indians/Alaskan Natives receiving covered services through HIS or a tribal facility); 42 U.S.C. §§1396a(ff), 1397gg€(1)(H)(ensured that certain trust-related property would be excluded from ineligibility determinations); 42 U.S.C. § 1396p(b)(3)(B)(imposed Medicaid estate recovery protections for American Indians/Alaskan Natives); 42 U.S.C. § 1396u-2(h)(established special rules to ensure Indian health care providers are reimbursed by states using managed care systems).

2. Revisit and revise the Proposal to include a more comprehensive list of behavioral health diagnoses when determining whether an individual is medically frail as well as clarify language regarding how such a determination is required to be made.

3. Include NHBP as a partner at the table during the revision process before submission to CMS in order to ensure the goals of the State/Tribal Accord are met.

4. Include NHBP in subsequent workgroups developed to implement the Proposal, if applicable.

Respectfully,

Jamie Stuck
NHBP Tribal Council Chairperson

cc: Richard Posthumus
Nick Lyon
Lorna Elliot Egan
MDHHS Medical Services Administration
Administrator Seema Verma
Hon. Alex M. Azar II