Tribal Technical Advisory Group
To the Centers for Medicare & Medicaid Services
c/o National Indian Health Board 910 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

May 2, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave SW
Washington DC 20201

Re: Medicaid Work Requirements and Indian Country

Dear Ms. Verma:

On behalf of the Centers for Medicare & Medicaid Services' (CMS) Tribal Technical Advisory Group (TTAG)[1], I write to provide you with the TTAG's perspective on the efficacy and impact of Medicaid work requirements in Indian country. As you know, Medicaid work requirements were included as part of the manager's amendment to the American Health Care Act, and are being considered by a number of States developing Section 1115 Demonstration Waivers. For example, we understand that the State of Kentucky has submitted a Section 1115 Demonstration Waiver to CMS that contains work requirements. While the State of Kentucky's waiver proposal would not impact any Tribe as there are no Tribes in the State, we understand that other states, like Wisconsin and Maine, are considering similar proposals and others may follow suit.

We hope that Tribes will be consulted by their states as early as possible in the development of such waiver proposals. Early communication and consultation are key to an informed and collaborative decision-making process that ensures that both the state's and the Tribe's goals can be met. In furtherance of that goal, the TTAG offers the following observations on the impact that Medicaid work requirements could have in Indian country.

American Indian and Alaska Native (AI/AN) Medicaid beneficiaries are unique among Medicaid enrollees in that they also have access to Indian Health Service (IHS). As a result, the employment incentive structures created by Medicaid work requirements do not operate in the same way for AI/AN Medicaid beneficiaries who may forgo Medicaid coverage and rely instead on IHS coverage. This, in turn, will strain the underfunded IHS system. As a practical matter, many AI/AN 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. Many AI/ANs look to their Tribal governments for employment assistance rather than their state and as a result will not be able to demonstrate they are participating in State employment assistance programs. Finally, imposing work requirements on AI/AN Medicaid beneficiaries is inconsistent

[1] The TTAG advises the Centers for Medicare and Medicaid Services (CMS) on Indian health policy issues involving Medicare, Medicaid, and the Children's Health Insurance Program, and any other health care programs funded in whole or part by CMS. In particular, the TTAG focuses on providing policy advice designed to improve the availability of health care services to American Indians and Alaska Natives under these federal health care programs, including through providers operating under the health programs of the Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations.

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with the federal trust responsibility and congressional intent to increase Indian health system access to Medicaid resources.

We discuss each of these concerns in more detail below, and request that CMS consult with the TTAG directly on this critically important issue. The TTAG strongly supports providing maximum employment opportunities for AI/ANs across the United States, and share the goal of full employment opportunity for all AI/ANs in every State. We would fully support State efforts to provide Medicaid AI/AN enrollees voluntary access to employment training and opportunities. However, as discussed below, mandatory Medicaid work requirements will not achieve that goal in Indian country, but instead create a de facto barrier to Medicaid access for AI/ANs and have a deleterious effect on the continued financial viability of the Indian health system as a whole. As a result, the TTAG requests that CMS consider implementing an exception to any mandatory work requirements for AI/AN in any waiver proposal it reviews.

We note that other health reform proposals currently under consideration already contain exceptions to account for the unique status of the Indian health system and its relationship to the Medicaid program. For example, the American Healthcare Act would exclude Medicaid payments to states from counting against the spending caps imposed by new Section 1903A. Similarly, the recent March 16, 2017 proposal by Governors Snyder, Kasich, Sandoval and Hutchinson would exempt payments for services provided to AI/ANs from counting against any Medicaid caps, and exempt mandatory enrollment of AI/ANs into managed care. A similar exemption should be included with regard to any mandatory work requirements included in any Demonstration Waiver.

Mandatory Medicaid Work Requirements Will Not Achieve Their Intended Purpose in Indian Country

Mandatory Medicaid work requirements will not achieve their intended purpose in Indian country because the landscape of incentives is completely different from the rest of the country. Medicaid-eligible AI/ANs are unique in that they have the option not to enroll in Medicaid at all and instead fall back on the Indian health system for coverage. As discussed below, however, the Indian health system is sorely underfunded, and reliant on Medicaid resources to make up the difference. Imposing mandatory work requirements as a condition of Medicaid eligibility for AI/ANs will hinder AI/AN Medicaid enrollment and result in increased costs to the already over-stretched Indian health system. It will also result in increased costs to non-Indian healthcare providers, particularly those who must provide uncompensated emergent services to otherwise Medicaid eligible AI/ANs who elect to forego coverage due to work requirements.

Proponents of work requirements point to examples such as the State of Maine's experience in reducing beneficiaries of the Supplemental Nutrition Assistance Program (SNAP), which provides food stamps. Since 2014, when Maine began imposing food stamp work requirements

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on able-bodies adults without dependents, the state's enrollment of that population in the program was reduced by 90% because many did not meet the requirements.[2] Additionally, the state says that wages for that population have increased since the work requirement was implemented.[3] Rationales for imposing SNAP requirements in places like Maine include that the state provides training and community service options and that lower-skilled jobs are readily available, thus supporting arguments that work requirements can play a "gatekeeper" function to ensure that only those who really need support receive benefits.[4] But the underlying incentives that fuel the success of such programs are simply not present for AI/AN Medicaid beneficiaries.

As even some prominent proponents of welfare work requirements predict, work requirements may not be effective in the health care context because individuals can fall back on emergency room services. In the AI/AN context, this concern is heightened because the Indian health system does not merely provide emergency care but rather is tasked with the provision of all health care for AI/ANs. AI/ANs that elect not to enroll in Medicaid due to the difficulty or impossibility of meeting work requirements designed for the non-native population will still receive care from the Indian health system.

Work Requirements Often Cannot Be Met in Indian Country

Medicaid work requirements generally require that in order to be eligible for government assistance, recipients must demonstrate that they are working, seeking work, or participating in some other work-related activity such as job training. Unemployed individuals must demonstrate that they are meeting work requirements by accessing state employment programs. These requirements may be difficult, if not impossible for AI/ANs to meet.

Tribes wholeheartedly welcome economic development, job creation, and job training on or near Tribal lands. Tribal governments understand the goals of work requirements and share the objectives of increasing our citizens' employment rates and promoting self-sufficiency. However, imposing work requirements in communities where there are no jobs does not incent individuals to search for work. Instead, they can have the opposite effect and pose a de facto barrier to Medicaid access for Tribal citizens.

According to the Bureau of Indian Affairs' (BIA) most recent American Indian Population and Labor Force Report, which uses 2010 data, there are ten states in which fewer than 50% of

[2] Jennifer Levitz, After Linking Work to Food Stamps, Maine Seeks Same with Medicaid, Wall Street Journal (Apr. 14, 2017).
[3] *Id.*
[4] See Rachel Sheffield, Welfare Reform Must Include Work Requirements, The Heritage Foundation (Mar. 22, 2016), http://www.heritage.org/welfare/commentary/welfare-reform-must-include-work-requirements.

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AI/ANs living in or near Tribal areas are employed.[5] On some reservations, such as the Oglala Sioux Tribe's Pine Ridge Reservation, unemployment stands between 80 and 90%. In many Tribal communities, the employment figures actually mask the shortfall in private-sector employment opportunities. The BIA reports, for instance, that over 20% of all AI/ANs that are employed work for a Tribal, local, state, or federal government.[6] In South Dakota, between 40 and 45% of employed AI/ANs work for a government.[7] Unemployment among AI/ANs does not exist because of an unwillingness to work, but rather due to extreme economic depression. Significant infrastructure and other investment in Indian Country is needed to utilize the Tribal labor force and make private-sector employment attainable for Tribal citizens.

The lack of available jobs also makes it difficult for Tribal citizens to demonstrate that they are actively seeking employment. Tribal citizens rarely access State employment assistance programs because they rely on their Tribal governments for such services instead. As a result, work requirements that allow compliance by demonstrating access to State employment assistance programs will not provide relief to many AI/ANs.

When Congress has imposed work requirements on other programs in the past, such as the Temporary Assistance for Needy Families (TANF) program, it has included special provisions for Tribes. In recognition of Tribal sovereignty, Congress authorized Tribes to administer their own TANF programs.[8] The Secretary of Health and Human Services and each Tribe agree upon minimum work requirements that are consistent with the program's purpose, consistent with the economic conditions and resources available to each Tribe, and comparable to the requirements the federal government imposes on states.[9] AI/ANs living in areas with 50% or more unemployment are also exempt from TANF time limits.[10] Generally speaking, it is appropriate that work requirements include special provisions and exceptions for Tribes and Tribal citizens. As discussed above, however, the incentives are completely different in the TANF context than in the Medicaid context because there is no alternative assistance to TANF that AI/AN individuals can reliably fall back upon like the IHS. As a result, the Indian specific work exceptions in the TANF program do not go far enough to reach their desired ends in the

[5] The ten states are Alaska, Arizona, California, Maine, Minnesota, Montana, New Mexico, North Dakota, South Dakota, and Utah. Bureau of Indian Affairs, American Indian Population and Labor Force Report at 10 (Jan. 16, 2014), https://www.bia.gov/cs/groups/public/documents/text/idc1-024782.pdf.
[6] *Id.*
[7] *Id.*

[8] 42 U.S.C. § 612.
[9] *Id.*
[10] Id. § 608(a)(7)(D).

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Medicaid program. Instead, AI/ANs should be exempted from any mandatory work requirements in Medicaid.

Mandatory Work Requirements for AI/ANs are Inconsistent with Federal Treaty and Trust Obligations

Requiring AI/ANs to meet work requirements or demonstrate that they are eligible for an exception is fundamentally inconsistent with the United States' responsibility, founded in treaty and trust obligations, to provide health care for American Indians and Alaska Natives. The U.S. Constitution authorizes Congress to "regulate Commerce … with Indian Tribes."[11] Congress first appropriated funds specifically for Indian health care in 1832.[12] Since that time, Congress has used its authority over Indian affairs to create the Indian health system, enacting the Snyder Act in 1921 (P.L. 67-85) and the Indian Health Care Improvement Act (IHCIA) in 1976 (P.L. 94-437).

Congress declared in the IHCIA "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."[13] Despite this commitment, AI/ANs still face enormous health disparities. AI/ANs have significantly lower life expectancy than the overall population and are more likely to die of diabetes, unintentional injury, intentional self-harm or suicide, chronic lower respiratory diseases, chronic lower respiratory or liver disease, and influenza or pneumonia.[14]

AI/AN health disparities persist in part due to the decades-long, chronic underfunding of the Indian health system. The Indian Health Service is currently funded at only around 60% of need.[15] Average per capita spending for IHS patients in 2014, for instance, was only $3,107 compared with $8,097 nationally.[16]

Congress intended for Medicaid to help address this funding shortfall when it authorized IHS and Tribes to bill Medicaid in 1976.[17] The House of Representatives' report accompanying this legislation stated that "[t]hese Medicaid payments are viewed as a much-needed supplement to a

[11] U.S. Const. Art. I, § 8, cl. 3.
[12] Act of May 5, 1832, 4 Stat. 514; see Brett Lee Shelton, Legal and Historical Roots of Health Care for American Indians and Alaska Natives in the United States, The Henry J. Kaiser Family Foundation at 5 (Feb. 2004), available at http://kff.org/disparities-policy/issue-brief/legal-and-historical-roots-of-health-care/.
[13] 25 U.S.C. § 1602(1).
[14] See Indian Health Service, Factsheets: Disparities, https://www.ihs.gov/newsroom/factsheets/disparities/.
[15] See Indian Health Service, Frequently Asked Questions
[16] National Tribal Budget Formulation Workgroup, Recommendations on Indian Health Service Fiscal Year 2015 Budget (May 2015),
[17] 42 U.S.C. §§ 1395qq, 1396j.

health care program which has for too long been insufficient to provide quality health care to the American Indian."[18] Congress sought to ensure that Medicaid funding would be supplemental to IHS funding by enacting a complementary provision that prevents Medicaid reimbursements from being considered when determining IHS appropriations.[19]

To ensure that Indian health care remained a federal responsibility that was not shifted to states, in 1976 Congress also provided for a 100% federal medical assistance percentage (FMAP) for Medicaid services received through an IHS or Tribal facility.[20] Congress has also amended Medicaid numerous times to accommodate the unique nature of the Indian health system. In 1997, for example, Congress provided an exception for AI/ANs and others when allowing states new flexibility to mandate enrollment into managed care systems.[21] In 2009, it prohibited states from imposing premiums or cost-sharing on AI/ANs receiving covered services through the Indian health system;[22] ensured that certain trust-related property would be excluded from income eligibility determinations;[23] imposed Medicaid estate recovery protections for AI/ANs;[24] and established special rules to ensure Indian health care providers are fully reimbursed by states using managed care systems.[25]

Medicaid has become a critical component of the United States' fulfillment of its treaty and trust responsibility to provide for AI/AN health care. Reducing Medicaid dollars to the Indian health system is inconsistent with federal treaty and trust responsibilities and with Congress' intent in authorizing the Indian health system to bill Medicaid. Through the cession of millions of acres, Tribes provided the United States with its land base in return for certain guarantees. Among the most sacred of these guarantees is the provision of health care. Imposing additional requirements on Tribal citizens to access the care they have been promised, and for which Tribes have already paid a dear price, is fundamentally at odds with federal treaty and trust responsibilities.

Conclusion

Medicaid work requirements are designed to reduce disincentives to work created by the provision of federal support and to increase incentives to seek out employment and improve one's financial circumstances so that federal support is no longer needed. Medicaid work

[18] H.R. Rep. No. 94-1026-Part III at 21 (May 12, 1976, reprinted in 1976 U.S.C.C.A.N. 2796.
[19] 25 U.S.C. § 1641.
[20] 42 U.S.C. § 1396d(b).
[21] Balanced Budget Act of 1997 (P.L. 105-33).
[22] 42 U.S.C. §§1396o(j), 1396o-1(b)(3)(A)(vii).
[23] 42 U.S.C. §§ 1396a(ff), 1397gg(e)(1)(H).
[24] 42 U.S.C. § 1396p(b)(3)(B).
[25] 42 U.S.C. § 1396u-2(h).

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requirements will not fulfill that purpose if applied to Indian Country. Any proposals to move forward with work requirements, either as a matter of the federal Medicaid program or particular state plans, should include a clear and blanket exception for American Indians and Alaska Natives.

Thank you for considering the unique circumstances of Tribes as you evaluate State demonstration waivers that contain work requirements. We look forward to consulting with you further on this issue.

Sincerely,

W. Ron Allen, Chair
Tribal Technical Advisory Group

cc: Kitty Marx, Director, CMCS Division of Tribal Affairs