

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

Submitted via email: Seema.verma@cms.hhs.gov

August 14, 2018

Administrator Seema Verma
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Tribal Technical Advisory Group Follow-Up Items from July Face-to-Face Meeting

Dear Administrator Verma:

On behalf of the CMS Tribal Technical Advisory Group (TTAG)¹ to the Centers for Medicare and Medicaid Services (CMS), I write to follow-up on a number of discussion items and requests made at the July 25th TTAG Face-to-Face meeting, held in Washington DC. We are dismayed that you have not yet attended a Face-to-Face meeting, more than 16 months after your confirmation. All the meetings are held in DC so that it will be convenient for the Administrator to attend, despite the fact that many tribal leaders have to travel half a day or longer to get there. We repeat our request that you attend the next meeting scheduled for November 14th, 2018. We respectfully remind you that one of the purposes of the TTAG is to provide advice and recommendations to the CMS Administrator on the operation of CMS programs as part of the federal government's fulfillment of the Federal Trust responsibility. Vetting issues through the TTAG first avoids disputes and misunderstandings with tribes and tribal organizations down the road. It is difficult for the TTAG to fulfill this role when the Administrator does not attend the meetings of the TTAG nor meet with tribal leaders. While we very much appreciate Calder Lynch's attendance at our meetings, we believe that nothing replaces direct face-to-face interaction with the ultimate decision maker and that the Administrator would greatly benefit by directly hearing from and interacting with tribal leaders.

The following points illustrate issues and/or concerns that were expressed during the July 25th TTAG Face-to-Face meeting and their corresponding discussion.

¹ The TTAG advises CMS on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program, and any other health care programs funded (in whole or part) by CMS. In particular, TTAG focuses on providing policy advice to CMS regarding improving the availability of health care services to American Indians and Alaska Natives (AI/AN) under these federal health care programs, including through providers operating under the health programs of the Indian Health Service (IHS), tribes, tribal organizations, and Urban Indian organizations (I/T/Us or Indian health care providers).

Work and Community Engagement Requirements

The TTAG was disappointed to learn that CMS is maintaining its position that approving a State Demonstration Project that contains an exemption to work requirements would raise civil rights concerns. As we have previously stated, imposing work requirements on American Indians and Alaska Natives (AI/ANs) is inconsistent with the objectives of the Medicaid statute generally, as well as the objectives of the Medicaid statute that are specific to the Indian health system. As a result, CMS may not lawfully approve any State Demonstration Project under Section 1115 of the Social Security Act unless it exempts AI/ANs from mandatory work requirements.

The TTAG was also disappointed to hear that CMS is apparently no longer willing to consider alternatives to an exemption from work requirements for AI/ANs that have been proposed by State and tribal governments. During the last Secretary's Tribal Advisory Committee (STAC) meeting, CMS informed tribes that while it could not approve what it termed a "blanket" exemption for AI/ANs, it would consider other alternative exemptions that included AI/ANs as well as other individuals, such as one proposed by the State of Arizona that would exempt individuals who are not required to enroll in managed care. That is apparently no longer the case, as Mr. Lynch indicated during our TTAG meeting that the alternatives being proposed by States and tribes that include both AI/ANs and non-Indians were simply clever ways to achieve a full exemption for AI/ANs. It thus appears that CMS's opposition to an exemption for AI/ANs is not in fact due to any civil rights concerns founded in the law, but is rather rooted in a policy determination that no exemption to work requirements should be granted for AI/ANs.

As the TTAG has previously expressed, mandatory work requirements will create a barrier to Medicaid enrollment for AI/ANs that will affect them unlike any other group. They will result in many AI/ANs simply dis-enrolling from the Medicaid program and relying instead on the insufficiently funded IHS system. Congress sought to address the lack of IHS funding when it amended the Social Security Act (SSA) in 1976 to authorize the IHS to bill Medicaid "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."² This policy will result in cost shifting from Medicaid to the IHS, and result in reduction of medical assistance to AI/ANs across the country and further exacerbate the quality care challenges faced by IHS. This policy is misplaced, short sighted, and beyond the Secretary's authority to approve under Section 1115 of the Social Security Act.

We continue to oppose work and community engagement requirements for AI/ANs, and request that CMS exempt AI/ANs from such state imposed requirements. We also continue to request tribal consultation on this critically important issue for tribes.

In previous meetings with the TTAG and STAC, much of the opinion by federal officials has been that there was no statutory authority to provide such an exemption. While we have made it clear several times that such authority does exist, we also would like to direct your attention to language included in the recent House Committee Report on Appropriations that stated:

² H.R. REP. NO. 94-1026, pt. III, at 21 (1976), *as reprinted in* U.S.C.A.A.N. 2782, 2796.

Tribal Sovereignty.—Federally-recognized Indian Tribes are sovereign nations residing within a State. Moreover, Indian Tribes are political, sovereign entities to which the Federal government owes a trust responsibility. As a result of this responsibility, the Federal government has consistently held Indian Tribes as a unique group when applying Federal law and policy. Congress has routinely codified this relationship, most notably in the provision of health care by establishing a health system for Tribal populations exclusively. In addition, the Federal government has enacted exemptions to ensure States would not bear the burden of additional costs. Specifically, the Social Security Act provides a 100 percent Federal match for Medicaid services provided by an Indian or by an Indian Health Service or Tribally-operated facility. No discretionary action taken by any Administration can impede the direct relationship between the Federal government and the provision of health care for Indian Tribes.³

This language clearly demonstrates that CMS' policy contradicts the intent of Congress that the Medicaid program supports the provision of health care to AI/AN. We also attach several letters from Congress opposing CMS' policy determination (Attachments 1-4). **We ask that CMS strongly reconsider their policy decision and grant an exemption for AI/AN from state imposed work and community engagement requirements.**

At the TTAG meeting, an invitation was made to the TTAG to assist CMS in developing a Tribal specific webinar for the Community Engagement and Learning Collaborative. **We look forward to working with CMS on this webinar.**

CCIO

We have several concerns regarding the comprehensive Indian cost-sharing protections available under the Affordable Care Act (ACA) for eligible American Indians and Alaska Natives (AI/ANs)⁴ who enroll in qualified health plans (QHPs) offered through the Health Insurance Marketplace (Marketplace).

1. Enforcing Summary of Benefits and Coverage (SBC) Requirements Regarding Indian-Specific CSRs

In many cases, SBC documents prepared for QHPs offered through the Marketplace do not accurately describe the Indian-specific cost-sharing protections available to eligible AI/ANs under the ACA, as required by federal law and regulations.⁵ These inaccuracies both have slowed efforts to enroll AI/ANs in comprehensive health insurance through the Marketplace and, in some instances, represent that the QHP issuers are not applying the cost-sharing protections correctly.

³ H.R. REP. NO. 115-862, at 97 (2018)

⁴ The comprehensive Indian-specific cost-sharing protections are available to individuals enrolled in a federally-recognized tribe or shareholders in an Alaska Native village or corporation.

⁵ See 45 CFR 147.200.

It is recommended that CMS/CCIIO, in states where the agency directly enforces SBC requirements, take immediate steps to ensure that QHP issuers violating these requirements come into compliance. In addition, CMS/CCIIO should initiate a process to determine the need for agency intervention in states⁶-- including educating states and issuers in those states—that have responsibility for enforcing SBC requirements but have reportedly failed to do so⁷ (and, if after taking the initiative to educate states and the issuers in those states finding that these states have not substantially enforced SBC requirements, take appropriate enforcement action on their behalf).⁸

2. Modifying the Marketplace Notification Script to Prevent the Loss of Indian-Specific CSRs

A significant number of AI/ANs who enroll in QHPs offered through the Marketplace do not receive the comprehensive Indian-specific cost-sharing protections available to them under the ACA. For example, in calendar year 2017, 9% (2,770) of enrolled Tribal members with coverage through a Federally-Facilitated Marketplace (FFM) received no cost-sharing protections, and another 5.3% (1,671) of enrolled Tribal members received only partial (code 04 – 06) cost-sharing protections. These figures are an improvement over prior years but represent a substantial loss of statutory benefits for a significant number of individuals.

Of particular concern, it appears that many eligible AI/ANs in families with non-eligible individuals (*e.g.*, non-AI/ANs) do not receive adequate notice about the need to enroll in a different plan than their non-Indian family members to secure these cost-sharing protections. The healthcare.gov website does recommend that AI/ANs and non-AI/ANs enroll in separate plans, but it does not explain the consequences of an AI/AN ignoring this recommendation and enrolling in a “family” plan with a non-AI/AN family member(s). Without this explanation, the default choice for many AI/AN families enrolling through the FFM is “family” coverage. This lack of explanation likely has led to thousands of AI/ANs receiving only the partial CSRs available to the general population (or no CSRs at all), rather than the comprehensive protections for which they would otherwise qualify.

It is recommended that CMS/CCIIO modify the notification script that appears during the Marketplace (HealthCare.gov) application process to explain the rationale for providing AI/AN applicants with the option to enroll family members in the same or different plans and to indicate clearly the impact of enrolling family members in the same plan (*i.e.*, the loss of eligibility for the comprehensive CSRs for all AI/AN family members).⁹

⁶ See 45 CFR 150.209 through 150.219.

⁷ See 45 CFR 150.205.

⁸ See TTAG letter to CCIIO, “RE: Request for Enforcement Action on Summary of Benefits and Coverage Documents,” March 22, 2018.

⁹ See TTAG letter to CCIIO, “RE: Request for Modifications to Marketplace Application Process to Prevent Loss of Comprehensive Indian-Specific Cost-Sharing Protections for AI/ANs,” April 18, 2018, at <https://www.nihb.org/tribalhealthreform/wp-content/uploads/2018/04/TTAG-Letter-4-18-18.pdf>; see also TSGAC to TTAG, “RE: Recommendations for Improved Communication on Special Rule for Family Policies to AI/AN Marketplace Applicants to Prevent Loss of Comprehensive Indian-Specific Cost-Sharing Protections,” April 10, 2018.

3. Modifying the Federal Risk Adjustment Model to Account for the Loss of Indian-Specific CSR Payments for Bronze Plan Enrollment

The potential exists for AI/ANs who enroll in bronze QHPs offered through the Marketplace to incur (at least in part) the costs of the comprehensive Indian-specific cost-sharing protections available under the ACA, due to the elimination of direct federal funding of the Indian-specific (and general) CSRs.

In an effort to offset the loss of this funding, many states have taken an approach under which CSR-related increases in QHP premiums largely are “loaded” on silver plans, as eligible Marketplace enrollees must enroll in silver plans to receive the general cost-sharing protections.¹⁰ The premium tax credits (PTCs) subsequently increase for PTC-eligible silver plan enrollees and largely offset the increase in premiums. In contrast, Marketplace enrollees eligible for the Indian-specific cost-sharing protections can enroll in bronze plans and still receive the Indian-specific protections (and may or may not be eligible for PTCs). A similar dynamic is not available for bronze plan enrollees (whereby the defunding of the CSRs results in an increase in premiums which are then offset by an increase in PTCs), as the PTCs are based on silver plan premiums. To the extent that some other adjustment is not made, the CSR-related costs could (and have) shifted to AI/AN and other Marketplace enrollees through increased bronze plan premiums.

It is recommended that CMS/CCIIO consider modifying the federal risk adjustment model, either through the induced utilization factor or through some other mechanism, to account for the loss of CSR payments to issuers for the Indian-specific CSRs provided to AI/ANs enrolled in bronze plans.¹¹

4. Providing a Report on Enrollment of AI/ANs in FFM and SBMs for Calendar Year 2018

TTAG received annual reports from CMS/CCIIO on enrollment through the FFM for calendar years 2015, 2016 and 2017. The content of the reports was negotiated with Tribal representatives and includes a series of data elements that are key to understanding the volume and characteristics of AI/AN enrollments through the FFM. Additional data were provided for AI/AN enrollment through State-Based Marketplaces (SBMs) for calendar year 2017.

TTAG and other organizations have accessed these data in order to evaluate the success of enrollment assistance efforts and to identify deficiencies in Marketplace and / or Tribal and Indian Health Service activities. Several of the findings from these evaluations were shared with CMS/CCIIO along with corresponding recommendations.

¹⁰ These general protections require QHP issuers to reduce cost-sharing in their standard silver plans, which have an AV of 70%, to meet a higher AV: 94% for individuals up to 150% FPL, 87% for those from 151-200% FPL, and 73% for those from 201-250% FPL.

¹¹ See TTAG letter to CMS, “RE: Comments on Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment,” March 9, 2018, at <https://www.nihb.org/tribalhealthreform/wp-content/uploads/2018/03/TTAG-Comment-on-CMS-1041-with-header.pdf>.

A request for a similar set of data on AI/AN enrollment through the FFM and SBMs for calendar year 2018 was made by TTAG representatives to CMS/CCIIO representatives during the July 25, 2018, TTAG quarterly meeting. Receiving this data set will enable TTAG and other Tribal organizations to continue to identify and evaluate trends in Marketplace enrollment of AI/ANs.

It is requested that CMS/CCIIO provide a CY 2018 data set on AI/AN enrollment through FFM and SBMs as soon as is feasible.

Medicaid Coverage of DHAT Services

We were encouraged to learn from CMS that—despite its recent disapproval of Washington State’s State Plan Amendment (SPA) to cover them—CMS strongly supports Medicaid coverage for Dental Health Aide Therapist (DHAT) services. As you know, DHAT services in Alaska, New Zealand, and elsewhere have dramatically improved dental health in the remote communities they serve, particularly for children. A nationwide shortage of dentists, particularly acute in rural areas, and the high cost of dentists’ services mean that, in many parts of the United States and especially in Indian Country, dental services are simply not available. This leads not only to poor dental health in those communities, but also to higher rates of many other associated and serious health conditions.

DHATs offer a proven, economical, and effective way to address this problem and reduce dental and medical health disparities between urban and rural communities. Washington State has requested reconsideration of CMS’s decision denying its DHAT SPA, and our technical advisors believe CMS’s decision was in error. We strongly urge CMS to reconsider the matter carefully and in light of all the health benefits DHAT programs afford, to approve the SPA if possible, and to work with the State and affected tribes to find another path to DHAT coverage if the SPA cannot be approved as submitted.

Medicaid Clinic “Four Walls” Issue and Tribal FQHC Option

Tribal health organizations are still waiting for CMS to issue a long-promised set of FAQs on the Medicaid clinic “four walls” limitation, and on the pros and cons of being re-designated as tribal Federally Qualified Health Centers (FQHCs) reimbursed at the Office of Management and Budget (OMB) encounter rate. The issue has been pending now for more than 18 months, we are six months past CMS’ suggested January 18, 2018 deadline for tribes to advise their State that they are interested in the tribal FQHC option, and CMS’ grace period for tribes to come into compliance is almost half over.¹² **We ask again that the FAQs be issued promptly, and that CMS provide further technical advice and guidance through all-tribes calls and Webinars.**

We also urge CMS to review and reconsider its determination – reached in the waning days of the Obama administration – that its regulations and authorizing statutes actually impose a four-walls restriction on tribal clinic services. The applicable regulation, 42 C.F.R. 440.90,

¹² CMS “clarified” the four-walls limitation of the clinic benefit on January 18, 2017, encouraged tribes to notify their States by January 18, 2018 if they are interested in the tribal FQHC option, and advised that it would not begin auditing to enforce the four-walls limitation until January 30, 2021.

defines the clinic benefit to “include” off-site services furnished to homeless individuals, but it does not *exclude* coverage of off-site services to other recipients. Rather than requiring States and tribal clinics to jump through multiple hoops in order to continue to be paid at the encounter rate for services furnished outside the clinic’s four-walls, CMS could achieve the same result, more simply and uniformly, by simply interpreting the clinic regulation to permit coverage of off-site services for all recipients.

Medicaid Managed Care

The tribes greatly appreciate the inclusion of specific Indian provisions to the CMS Medicaid and CHIP Managed Care regulations, as well as the distribution of the CMCS Informational Bulletin in December, 2016 describing these provisions and including the Model Addendum for Indian Health Care Providers (IHCPs). Although this material has been available to States for over a year and a half, IHCPs are still experiencing significant difficulty to ensure proper implementation of the regulations.

The regulations, and the associated CMCS Informational Bulletin clearly describe that IHCPs are not required to enter a contract with Managed Care Organizations (MCOs) in order to be reimbursed. However, in some States, claims from IHCPs to MCOs continue to go unpaid due to the lack of a contract, despite persistent tribal efforts to educate the State Medicaid Agency and MCOs on the statute and regulations. In some States, MCOs improperly impose their own provider credentialing and other requirements on IHCPs that have elected not to contract with them. It has been very burdensome for IHCPs to attempt to bring these programs into compliance, particularly when working across State lines and when there are large numbers of MCOs.

States and IHCPs have also found it difficult to timely and accurately reconcile and make so-called “wrap payments” to IHCPs when MCOs pay less than the encounter rate published annually by IHS in the Federal Register. A much more efficient and timely approach is for the State Medicaid agency to require the MCO to pay the encounter rate, by addressing it as part of the contracting process with the MCO up front. However, if States are not familiar with the requirements, they are not informed well enough to make these arrangements prior to finalizing contracts with the MCOs.

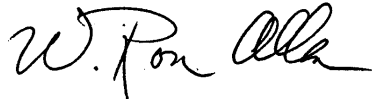
The TTAG recommends that CMS take a much more active role to educate States on their responsibilities and best practices, and to ensure that the requirements of ARRA Section 5006 are respected and enforced. CMS must conduct better oversight of State contracts with MCOs to create a chain of accountability that ensures that AI/ANs maintain access to the Medicaid program in managed care systems, and that IHCPs are properly and timely reimbursed for their services to the managed care beneficiaries they serve.

Conclusion

Thank you for considering the unique circumstances of tribes as you evaluate the follow-up items presented. We look forward to continue working with you on these important issues.

Please contact Devin Delrow, NIHB TTAG Alternate at ddelrow@nihb.org if you have additional questions.

Sincerely,

A handwritten signature in black ink, appearing to read "W. Ron Allen". The signature is fluid and cursive, with the first name "W." and last name "Allen" clearly distinguishable.

W. Ron Allen, Chair,
Tribal Chairman and CEO, Jamestown S'Klallam Tribe
Tribal Technical Advisory Group

cc:

Calder Lynch, Senior Counselor to the Administrator, CMS
Kitty Marx, Director, Division of Tribal Affairs, CMS

Attachments:

1. Senate Letter to Secretary Azar, April 27, 2018
2. Cole Letter to Azar and Administrator Verma, April 30, 2018
3. House Letter to Secretary Azar, May 1, 2018
4. House Letter to Secretary Azar and Administrator Verma, May 15, 2018

United States Senate

WASHINGTON, DC 20510

April 27, 2018

The Honorable Alex Azar
Secretary, U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, D.C. 20201

Dear Secretary Azar,

We write to express our growing concerns at the views expressed by the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) in a “Dear Tribal Leader” letter issued on January 17, 2018, and subsequent related statements made by HHS personnel on the issue of American Indian and Alaska Native (AI/AN) exemption from Medicaid work requirements. The views expressed fail to recognize the unique legal status of Indian tribes and their members under federal law, the U.S. Constitution, treaties, and the federal trust relationship. We call on the Department to respond expeditiously to the information requests on this matter outlined below.

In the January 17 letter entitled “Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries State Medicaid Director Letter,” Center for Medicaid and CHIP Services Director Brian Neale stated that the Agency is unable to require states to exempt AI/ANs from work and community engagement requirements because it is “constrained by statute.” Notably, Mr. Neale also attributed the Centers’ inability to require the exemption to “civil rights issues.” The letter provided no additional information outlining the basis for the Agency’s statutory constraints or civil rights concerns.

On the same day CMS sent the “Dear Tribal Leader” letter, members of the Secretary’s Tribal Advisory Committee (STAC) met with CMS Administrator Seema Verma, who indicated that the Agency based its views on the HHS’s Office of Civil Rights (OCR) interpretation that a work requirement exemption for AI/ANs would be “race based.” Tribal Leaders and organizations confirmed to our Offices that other Department officials have continued to cite OCR’s interpretation in meetings with Tribal Leaders on several subsequent occasions.

The U.S. Constitution empowers Congress to regulate commerce with Indian tribes. The “Indian Commerce Clause” is generally cited as the source of authority for the federal government to establish treaties, statutes, executive orders, and regulations that support a distinctive legal status under federal law for federally-recognized Indian Tribes. The Supreme Court has repeatedly upheld this unique political status and the government-to-government relationship between Tribes and the United States – most notably, in *Morton v. Mancari*, which affirmed that federal classifications fulfilling federal obligations to Indians are not based on race but instead on a political relationship between the Tribes and the federal government. This ruling -- combined with a number of statutes, regulations, and additional court decisions -- confirms that Tribes are not a racial group but rather political communities.

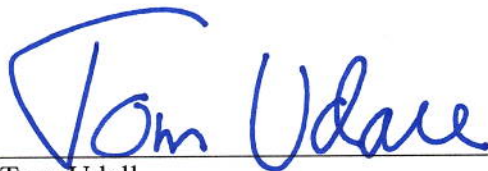
Shortly after the *Mancari* decision, Congress made clear its intent to leverage the Medicaid and Medicare programs for fulfillment of its trust and treaty obligations to Tribes through changes to sections 1905(b) and 1911 of the *Social Security Act*. Congress's extension of Medicaid and Medicare rests on the solid principles set forth by *Mancari* and its progeny: That 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. Medicaid participation now ensures that more than 50 percent of patients at some tribally operated health systems, 40 percent of patients at federally operated Indian Health Service facilities, and 25 percent of all AI/ANs nationwide have access to vital medical care.

Concerned that CMS appears close to approval of Section 1115 waivers from states where Indian tribes are located that would impose work requirements on AI/ANs, Tribal Leaders and organizations have met with HHS and CMS officials to discuss a work requirement exemption. They report that the Agency has provided little insight into the legal and policy foundation for the views expressed in the "Dear Tribal Leader" letter. Accordingly, the potentially devastating impacts that CMS's views on AI/AN Medicaid enrollment protections could have on AI/AN health care access combined with HHS' reported mischaracterization of the status of AI/ANs as "race based" by its officials raises significant concerns.

Given our own concerns regarding HHS' views and as part of our work in the Senate to ensure fulfillment of the federal government's trust responsibilities, we request the Department furnish following information:

- CMS's views of Tribal Leader and state requests to exempt AI/ANs from Medicaid work requirements;
- The statutory constraints that prevent CMS from exempting AI/ANs from Medicaid work requirement referenced in the January 17, 2018, "Dear Tribal Leader" letter; and
- Clarification of OCR's interpretation that such an exemption for AI/ANs "could raise civil rights concerns."

Sincerely,



Tom Udall
Vice Chairman
U.S. Senate Committee on Indian Affairs



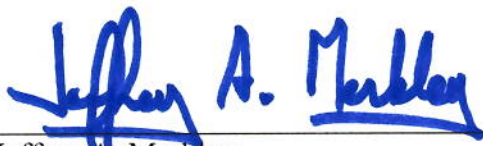
Charles E. Schumer
U.S. Senator



Maria Cantwell
U.S. Senator



Lisa Murkowski
U.S. Senator



Jeffrey A. Merkley
U.S. Senator



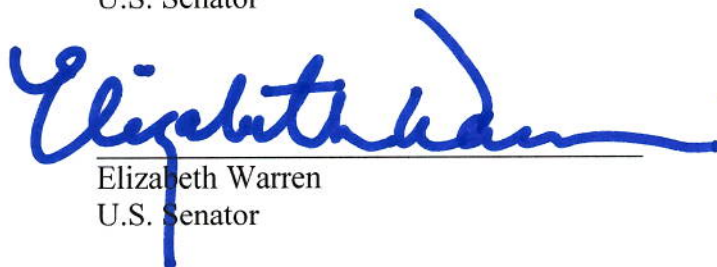
Heidi Heitkamp
U.S. Senator



Martin Heinrich
U.S. Senator



Catherine Cortez Masto
U.S. Senator



Elizabeth Warren
U.S. Senator



Tina Smith
U.S. Senator

TOM COLE
4TH DISTRICT, OKLAHOMA

DEPUTY WHIP

COMMITTEE ON APPROPRIATIONS
LABOR, HEALTH AND HUMAN SERVICES,
EDUCATION AND RELATED AGENCIES – CHAIRMAN
DEFENSE
INTERIOR, ENVIRONMENT,
AND RELATED AGENCIES

COMMITTEE ON RULES

COMMITTEE ON THE BUDGET



Congress of the United States
House of Representatives

April 30, 2018

PLEASE REPLY TO:

- ☐ 2467 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-6165
- ☐ 2424 SPRINGER DRIVE
SUITE 201
NORMAN, OK 73069
(405) 329-6500
- ☐ 711 SW D AVENUE
SUITE 201
LAWTON, OK 73501
(580) 357-2131
- ☐ SUGG CLINIC OFFICE BUILDING
100 EAST 13TH STREET, SUITE 213
ADA, OK 74820
(580) 436-5375

The Hon. Alex Azar
Secretary, Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Hon. Seema Verma
Administrator, Center for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Mr. Secretary and Mrs. Administrator:

I am writing to express my strong opposition to a recent decision by the Center for Medicare and Medicaid Services (CMS) to classify Native Americans as a racial group for the purposes of the Medicaid program. This ill-considered action undermines tribal sovereignty that ignores long-standing legal, statutory and regulatory policies putting federal-tribal relations firmly on a government-to-government basis.

At the outset, let me be clear that I approve of the CMS decision to allow states to impose work requirements on able-bodied Medicaid recipients. In addition, I support the Trump Administration's policy of granting states, Indian tribes, and local governments the flexibility they need to craft policy solutions that are effective in the specific contexts in which they operate.

My concerns stem from policies enunciated in a January 11, 2018 letter to state Medicaid directors and a January 17, 2018 letter to tribal leaders, both from CMS Director Brian Neale, that denies any exemption of tribal citizens from state Medicaid waiver requests issued under Section 1115 of the Social Security Act.

In short, the letters state that tribal citizens should be considered a racial group for the purposes of their receipt of benefits under the Medicaid program. This ill-informed CMS finding sweeps aside decades of Supreme Court jurisprudence, numerous statutes, long-established Executive Branch policies governing the relationship between sovereign governments and the Department of Health and Human Services' (HHS) own formal administrative policies. In addition to threatening tribal sovereignty, this shortsighted decision will have the added effect of reducing funds available to the Indian Health Service (IHS) —in effect, undermining Congress's intent in enacting Section 1911 of the Social Security Act to authorize IHS reimbursements under

Medicaid, which are paid exclusively with federal funds in accord with the federal trust relationship with American Indian and Alaska Native peoples.

I am enclosing a legal analysis of the matter prepared by my constituents the Chickasaw Nation that I believe is persuasive and gives an excellent summary of the relevant facts. In particular, I want to stress my belief that neither CMS nor HHS has the statutory authority to undertake such sweeping change in federal-tribal relations.

I am concerned that both HHS and CMS are unwittingly about to kick off what may be decades of expensive and needless litigation with tribes and other parties who may or may not have the best interests of Native Americans on all sides of this issue. HHS and CMS should stay in the safe harbor of current law and policy. In an era of difficult spending choices, soaring federal deficits and exploding cost structures in health care, we cannot afford to sign up for untold millions of legal fees for the federal government or for tribes—to say nothing of the federal government once again potentially squandering the trust of Native Americans and their elected leaders.

My purpose in writing is to reaffirm that the United States and tribal governments interact on a government-to-government basis and that programs enacted by Congress to benefit Native Americans are provided as a function of that political relationship. I further want to emphasize the importance that CMS should not administer Medicaid in any manner that would adversely impact IHS's access to funding.

I would be grateful if you would provide me the legal and policy justifications used to make this decision, HHS's analysis of the impact of this decision on individual Native Americans, tribes, the Indian Health Service, and the federal government's fulfillments of its tribal trust responsibilities.

I respectfully request that you immediately rescind these misguided policy decisions, engage in meaningful tribal consultation and treat tribes as the sovereigns they are—in this particular instance by allowing tribal governments to make decisions about imposing Medicaid work requirements on their own tribal members and citizens and not subordinate such authority to state or CMS policy. I look forward to your prompt action and reply. Thank you for considering my request.

Sincerely,



Tom Cole
Member of Congress

Congress of the United States
Washington, DC 20515

May 1, 2018

The Honorable Alex Azar
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Azar,

We write in response to recent reports that the Centers for Medicare and Medicaid Services (CMS) plans to subject American Indian and Alaska Native (AIAN) communities to state-imposed work requirements in the Medicaid program, a legally dubious decision that, if implemented, threatens our most fundamental trust responsibilities to tribes.

Additionally, we are extremely concerned that such a decision was made without full transparency and tribal consultation. The CMS Tribal Consultation Policy clearly outlines the substantial and meaningful consultation principles and processes between CMS and tribes on issues that have a significant and direct effect on tribes. It also clearly states:

"This [government-to-government] relationship is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race."

The trust relationship between the federal government and Native American communities was established in the hundreds of treaties signed between the federal government and tribes between 1787 and 1871. The Supreme Court has consistently held that these treaties create a unique relationship between the federal government and tribes - a principle known as the trust doctrine. The trust doctrine was very clearly explained by the 1977 Senate report of the American Indian Policy Review Commission:

"The purpose behind the trust doctrine is and always has been to ensure the survival and welfare of Indian tribes and people. This includes an obligation to provide those services required to protect and enhance tribal lands, resources, and self-government, and also includes those economic and social programs which are necessary to raise the standard of living and social well-being of the Indian people to a level comparable to the non-Indian society."

As you know, tribes are currently exempt from certain coverage requirements under the Affordable Care Act. Not only would refusal to exempt tribes from work requirements sought by some states ignore legal and administrative precedent and violate our trust obligations, it would erect significant barriers to care for vulnerable communities. While imposing these types of requirements in the overall Medicaid population would have serious effects on health and financial stability for millions of Americans, the implications for tribal communities are

alarming. As you know, the average unemployment rate in Indian Country was 12 percent in 2016, almost three times higher than the national average. Some communities face unemployment rates well above 50 percent. Drug overdose rates are well above the national average. Diabetes rates are almost twice the national average. Reducing access to health care among economically stressed communities with high rates of chronic disease would undermine important progress made in recent years to expand coverage and treatment options.

As Members of Congress committed to ensuring the federal government upholds its treaty obligations and works to reduce the glaring health disparities facing tribal communities, we request written responses to the following:

1. Please provide any reports, documents, memos, or reviews used by HHS as part of its process for this decision;
2. Please provide a full list of all consultations with tribal stakeholders held prior to HHS's decision;
3. Please provide an explanation for cancelling your appearance at HHS's annual budget consultation meeting with tribal representatives in Washington, D.C. last month;
4. Please provide an estimate of litigation costs to HHS if the agency moves forward with implementing this decision.

The unique relationship between the federal government and tribes is enshrined clearly in the Constitution. Any actions to undermine this fundamental relationship is a broken promise to Indian Country. Instead of breaking our promises, we ought to be committed and united in improving access to quality health care for all tribal communities.

We look forward to your prompt response on this critical issue.

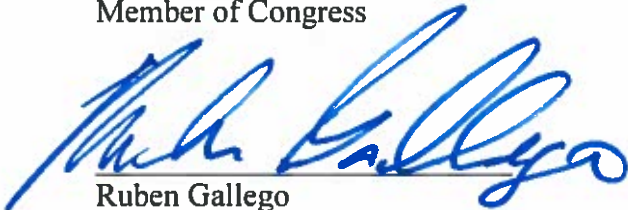
Sincerely,



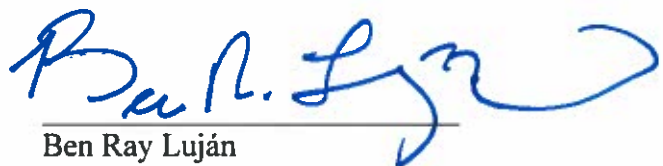
Tom O'Halloran
Member of Congress



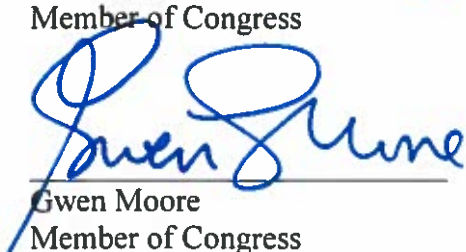
Walter Jones
Member of Congress



Ruben Gallego
Member of Congress




Ben Ray Luján
Member of Congress



Gwen Moore
Member of Congress



Kyrsten Sinema
Member of Congress



Jimmy Gomez
Member of Congress



Dina Titus

Member of Congress



Michelle Lujan Grisham

Member of Congress



Rick Larsen

Member of Congress



Mark Pocan

Member of Congress




David E. Price

Member of Congress



Daniel T. Kildee

Member of Congress



Raul M. Grijalva
Member of Congress



Jacky Rosen

Member of Congress



Ruben J. Kihuen

Member of Congress



Salud Carbajal

Member of Congress



Bonnie Watson Coleman

Member of Congress



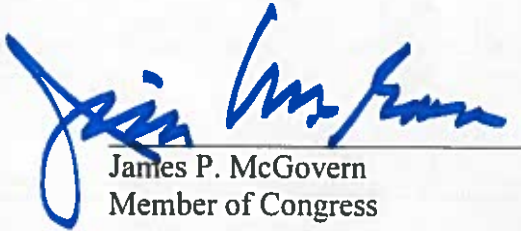
Keith Ellison

Member of Congress

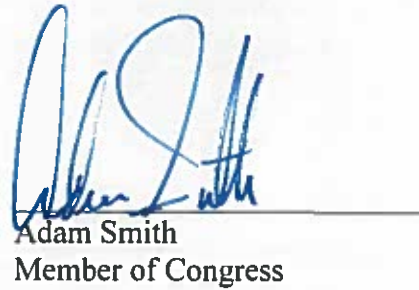


Rosa L. DeLauro

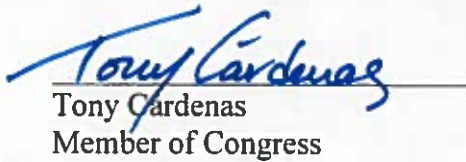
Member of Congress



James P. McGovern
Member of Congress



Adam Smith
Member of Congress



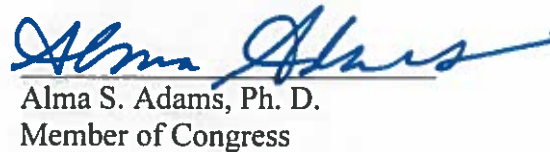
Tony Cardenas
Member of Congress



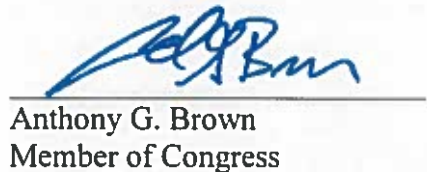
Ro Khanna
Member of Congress



Nannette Barragan
Member of Congress



Alma S. Adams, Ph. D.
Member of Congress



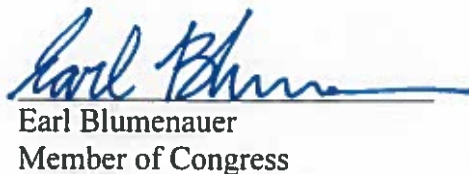
Anthony G. Brown
Member of Congress



Joe Courtney
Member of Congress



William R. Keating
Member of Congress



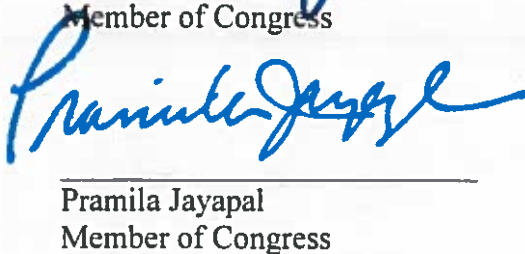
Earl Blumenauer
Member of Congress



Norma J. Torres
Member of Congress



Tulsi Gabbard
Member of Congress



Pramila Jayapal
Member of Congress



Donald S. Beyer Jr.
Member of Congress

Congress of the United States
Washington, DC 20515

May 15, 2018

The Hon. Alex Azar
Secretary, Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Hon. Seema Verma
Administrator, Center for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Mr. Secretary and Ms. Administrator:

We are writing to express our profound concern and strong opposition to a recent decision by the Center for Medicare and Medicaid Services (CMS) to undermine tribal sovereignty.

We are specifically referring to a January 11th letter to state Medicaid directors and a January 17th letter to tribal leaders, both from CMS Director Brian Neale. Beyond 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.

In short, the letters state that tribal citizens should be considered a racial group for the purposes of their receipt of benefits under the Medicaid program. This unprecedented CMS approach sweeps aside decades of Supreme Court jurisprudence, numerous statutes, long-established Executive Branch policies governing the relationship between sovereign governments and the Department of Health and Human Services' (HHS) own formal administrative policies. In addition to threatening tribal sovereignty, this shortsighted and ill-informed decision will have the added effect of reducing funds available to the Indian Health Service (IHS) —in effect, undermining Congress's intent in enacting Section 1911 of the Social Security Act to authorize IHS reimbursements under Medicaid. Those reimbursements direct federal funds in support of the federal trust relationship with American Indian and Alaska Native peoples.

We write to reaffirm that the United States and tribal governments interact on a government-to-government basis and that programs enacted by Congress to benefit Native Americans are provided as a function of that political relationship. We further write to emphasize that CMS should not administer Medicaid in any manner that would adversely impact IHS's access to funding.

We respectfully request that you immediately rescind these misguided policy decisions, engage in meaningful tribal consultation and treat tribes as the sovereigns they are under the law. In this particular instance we urge CMS to:

- (a) retract the previous January 11, 2018 guidance that proposes to subordinate sovereign tribal governments to Medicaid work requirements imposed by States;
- (b) affirm that exemptions granted to tribal citizens are based in their status as a political class, not a racial classification; and
- (c) commit to honoring the government-to-government federal trust relationship by conducting tribal consultations at the federal level, not delegating that responsibility to the states.

We look forward to your prompt action and reply. Thank you for considering our request.

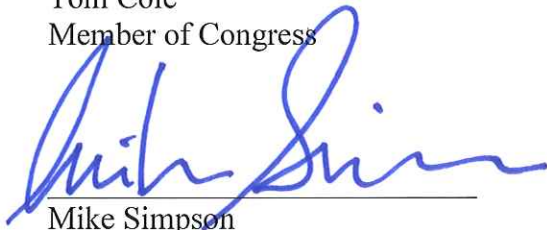
Sincerely,



Tom Cole
Member of Congress



Betty McCollum
Member of Congress



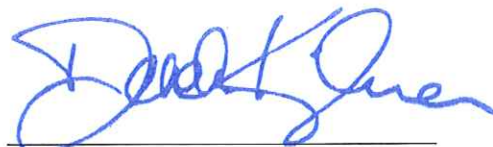
Mike Simpson
Member of Congress



Ken Calvert
Member of Congress



Walter B. Jones
Member of Congress



Derek Kilmer
Member of Congress



Don Young
Member of Congress



Michelle Lujan Grisham
Member of Congress


Juan Vargas
Member of Congress

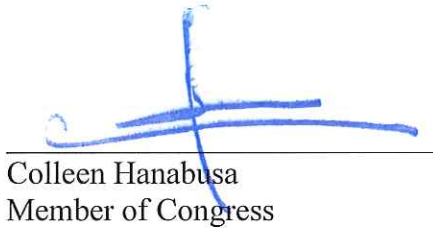

Tim Walz
Member of Congress



Steve Pearce
Member of Congress


Grace Napolitano
Member of Congress

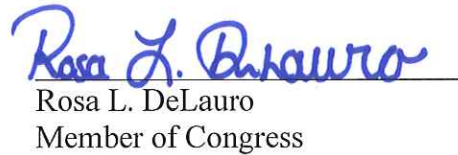

Collin Peterson
Member of Congress


Elise Stefanik
Member of Congress


Colleen Hanabusa
Member of Congress

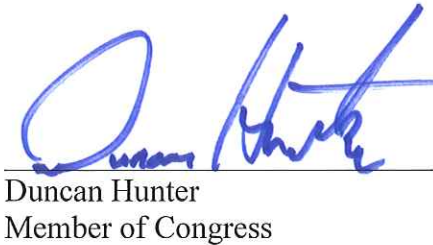

Peter DeFazio
Member of Congress


John B. Larson
Member of Congress


Rosa L. DeLauro
Member of Congress


Joe Courtney
Member of Congress

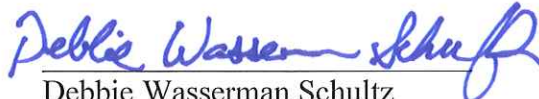

Jared Huffman
Member of Congress


Duncan Hunter
Member of Congress


Mario Diaz-Balart
Member of Congress


Tony Cardenas
Member of Congress


Ben Ray Lujan
Member of Congress



Debbie Wasserman Schultz
Member of Congress


Alcee L. Hastings
Member of Congress



Keith Ellison
Member of Congress


Erik Paulsen
Member of Congress


Mike Thompson
Member of Congress


Kyrsten Sinema
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Ruben Gallego
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Raul M. Grijalva
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Raul Ruiz
Member of Congress


Rick Nolan
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John Moolenaar
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Pramila Jayapal
Member of Congress



Mark Pocan
Member of Congress



Jack Bergman
Member of Congress



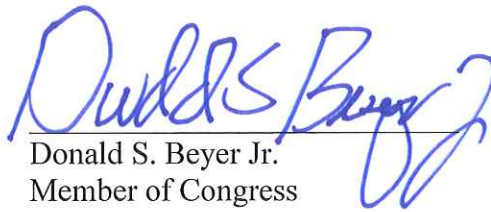
Dina Titus
Member of Congress



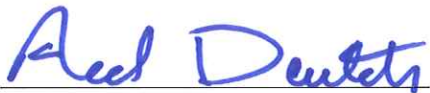
Charlie Crist
Member of Congress



Denny Heck
Member of Congress



Donald S. Beyer Jr.
Member of Congress



Ted Deutch
Member of Congress



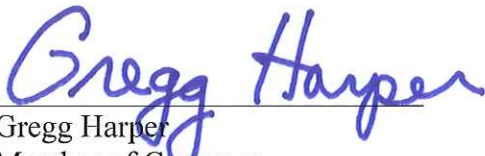
Martha McSally
Member of Congress



Norma J. Torres
Member of Congress



Jackie Walorski
Member of Congress



Gregg Harper
Member of Congress



Scott Tipton
Member of Congress




Greg Walden
Member of Congress



Daniel T. Kildee
Member of Congress



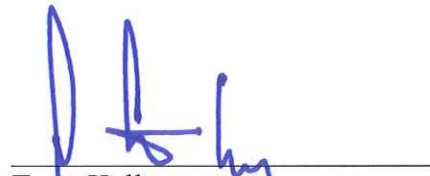
Mark Takano
Member of Congress



Pete Sessions
Member of Congress



Jacky Rosen
Member of Congress



Trent Kelly
Member of Congress



Paul Mitchell
Member of Congress



Sean Duffy
Member of Congress