

# National Indian Health Board



December 20, 2019

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

## **Re: Potential Tribal Implications of Tennessee’s Medicaid Section 1115 Demonstration - TennCare II - Amendment 42 (Block Grant)**

Dear Administrator Verma:

On behalf of the National Indian Health Board (NIHB),<sup>1</sup> I write to comment on the Tennessee Section 1115 Demonstration: TennCare II – Amendment 42. This waiver seeks to transition Tennessee’s Medicaid system into a hybrid block grant system. This waiver, as written, poses concerns to Tribes and American Indians and Alaska Natives (AI/ANs) and it sets a negative precedent for Indian health for the reasons we highlight below.

### Background

On May 24, 2019, Tennessee Governor Bill Lee signed H.B. 1280 into law, which directed the governor to submit a proposal to CMS to transition the state’s Medicaid system, “TennCare,” to a hybrid block grant system. In September 2019, a draft of their proposal was released to the public. After a public comment period, the state finalized their proposal in November 2019.

The proposal outlines the state’s commitment to reducing costs, reiterating their desire to reverse the incentive for states to spend more state money in order to access more money from the federal government. To this end, the proposal repeatedly states that its proposed reforms are in the spirit of fiscal responsibility.

It also outlines the way that the hybrid model will be achieved. The block grant will only be used to cover “core medical services” to TennCare’s “core population.” All other expenses, including outpatient pharmacy services, will be covered under the traditional Medicaid funding model. It

---

<sup>1</sup> Established in 1972, the National Indian Health Board (NIHB) is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

will also exclude expenditures on behalf of individuals who are dually enrolled in Medicare and TennCare.

### Tribal Population in Tennessee

Approximately 25,000 American Indians/Alaska Natives (AI/AN) live in Tennessee.<sup>2</sup> While there are no federally recognized Tribes in Tennessee, it is clear that there are Tribal interests within its borders. Many of these AI/AN people are members of federally recognized Tribes. As is often the case with Tribal populations, many have moved away from Tribal lands to attend school or to seek opportunities for work. Despite living away from their Tribal lands, many of these Tribal citizens travel to and from Tribal reservations and may have occasion to seek medical services in their Tribal clinics and hospitals or Indian Health Service Hospitals. This care includes emergency services that TennCare would cover for AI/AN enrolled in the program.

The 1115 proposal makes no mention of Tribes or AI/AN people. While existing law guarantees certain protections to AI/ANs, Tribes and even the Indian health system as a whole, increased state autonomy and decision-making could pose a risk to those protections and benefits.

### Trust Responsibility and 100% FMAP

Approximately 25,000 American Indians/Alaska Natives (AI/AN) live in Tennessee. The federal government has a trust responsibility to Tribes and AI/ANs and this creates a unique relationship between Tribes and the federal government. While there are no federally recognized Tribes in Tennessee, there are thousands of AI/AN residents in the state that could potentially be affected by this proposal.

In addition, Tribes operating emergency services, treating Tribal citizens enrolled in TennCare, could be impacted negatively. For example, Tribal Hospitals, which are located close to Tennessee, even though not currently TennCare providers, could still bill TennCare for eligible AI/ANs as an “out-of-state emergency provider<sup>3</sup>.” This also applies to any IHS eligible AI/AN who has a medical emergency while out of state, creating a clear interest in this block grant for IHS eligible AI/ANs in Tennessee. If the state reaches the capped funding amount, would TennCare still pay Tribal providers or IHS providers for emergency services provided to AI/ANs enrolled in TennCare?

Although the proposal does not mention Tribes or AI/ANs, Tennessee does suggest that they can use state funding to cover any gaps that may arise by a premature exhausting of block grant funds. How will this interface with the 100% Federal Medical Assistance Percentage<sup>4</sup> (FMAP)? If the federal government has committed to reimbursing 100% of the costs for AI/AN people who visit

---

<sup>2</sup> For example, the seat of government of the Eastern Band of Cherokee Indians (EBCI), a federally recognized Tribe, is located within approximately 30 miles of the Tennessee / North Carolina border at Cherokee, North Carolina. The EBCI has over 15,000 enrolled members, the majority of whom reside on the Tribe’s lands (lands held in trust by the United States for the benefit of the Tribe) in North Carolina, but some members reside in Tennessee.

<sup>3</sup> TennCare’s Medicaid rules defines an “out-of-state emergency provider” as “...a provider outside the State of Tennessee who does not participate in TennCare in any way except to bill for emergency services, as defined in this Chapter, provided out-of-state to a particular MCC’s enrollee.” See Section 1200-13-13-.01(90).

<sup>4</sup> The FMAP refers to the share of the payment to the provider that the federal government pays when a Medicaid member receives services.

IHS and Tribal facilities then what happens if TennCare funds are already exhausted when such an occurrence happens? This proposal leaves that as an open question with no definitive answer.

#### Tennessee's waiver proposal - Setting a national precedent

Our other concern lies in the precedent that this block grant's approval would provide and its impacts on AI/AN people. If Tennessee's block grant is approved, then it will surely serve as a blueprint for other states. What happens when a state with a larger AI/AN population and federally recognized Tribes within its borders decides to implement this system? Other states already have indicated their desire to use 1115 waivers to implement block grants or per caps. Earlier this year, Alaska governor Mike Dunleavy declared a desire to be the first state to operate their Medicaid system under a federal block grant and commissioned a study to test its feasibility in the state. Earlier this month Oklahoma governor Kevin Stitt indicated that he would be interested in pursuing a block grant for his state's Medicaid program. Given Alaska and Oklahoma's sizable AI/AN populations, this could be cause for concern. The approval of Tennessee's program would give these states a blueprint to work from, which not only excludes mention of Tribes and AI/AN people, but also holds potential to cut access to care for some of the populations experiencing the greatest health disparities. AI/AN people must be addressed in this proposal, not just for the AI/AN people of Tennessee but also because of the precedent that this will set for AI/AN people in other states and the Indian health system overall. Furthermore, we ask CMS to develop specific guidance for states which will ensure Indian benefits and protections remain intact under any block grant or per cap scheme.


#### Indian Exemption

To ensure all legally required Indian benefits and protections remain, CMS should consider providing an Indian exemption for the block grant or per cap financing structure. This would ensure that care for AI/ANs is not capped or rationed once state spending reaches the maximum federal funding level, and it would also ensure that the costs for Indian beneficiaries receiving care in the Indian health system come from the federal government, which would be consistent with the idea that the federal government, not the states, has a trust responsibility to Tribes.

#### Conclusion

The demonstration, as currently constructed, can create a negative precedent as other states move to implement block grants. The fate of IHS eligible AI/ANs was not considered in the construction of this proposal and we hope that CMS will consider this omission as you make a determination on this application.

Sincerely,



Stacy A. Bohlen  
CEO  
National Indian Health Board