National Indian Health Board

National Congress of American Indians

June 13, 2017

Secretary Tom Price
Administrator Seema Verma
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Medicaid Reform for the Indian Health System

Dear Secretary Price and Administrator Verma:

On behalf of the National Indian Health Board (NIHB)[1] and the National Congress of American Indians (NCAI)[2] and all of Indian Country, we write today to highlight the critical role that the Medicaid program plays in keeping the Indian Health System (IHS) system afloat and to affirm our partnership with you in reforming the Medicaid program so that it can better meet the needs of our people.

American Indians and Alaska Natives are among the nation's most vulnerable populations, and yet the IHS remains woefully underfunded. IHS is currently funded at around 60% of need,[3] and average per capita spending for IHS patients is only $3,688 compared with $9,523 nationally.[4] Most of our citizens live in areas of chronic unemployment, which leaves many of them without any form of coverage other than Medicare and Medicaid. Without supplemental Medicaid resources, the Indian health system would not survive.

Yet access to Medicaid remains a challenge for American Indians and Alaska Natives (AI/ANs) and the IHS system. AI/ANs are a uniquely vulnerable population, and uniquely situated in the Medicaid program. Unlike other Medicaid enrollees, AI/ANs have access to IHS services to fall back on at no cost to them. As a result, the incentives are completely different for AI/ANs in

[1] Established in 1972, 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/AN). 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 93-68, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

[2] NCAI is the oldest, largest and most representative organization of Tribal Governments in the United States. Founded in 1944, NCAI advocates for Tribal Governments in all areas of policy making.

[3] See Indian Health Service, Frequently Asked Questions, https://www.ihs.gov/forpatients/faq/.

[4] Indian Health Service, IHS 2016 Profile, https://www.ihs.gov/newsroom/factsheets/ihsprofile/.

Medicaid. Medicaid conditions of eligibility designed to encourage healthy behaviors do not work when mandatory in Indian country. Instead, they lead to Medicaid disenrollment.

We welcomed the letter you sent to State Governors pledging to work in partnership with the States to reform and streamline the Medicaid program. We support reforms that will increase State flexibility and make Medicaid more effective at addressing the country's most vulnerable populations, including Indian country. 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. Improvements to the Medicaid program, therefore, should move forward in a manner that respects Tribal sovereignty and upholds Federal treaty and trust responsibilities.

Tribes understand the need for States to innovate in Medicaid in the manner that makes the best sense for the populations they serve, but Tribal health programs must have room to do the same for their citizens. Like States facing federal mandates, Tribes are often confronted with State Medicaid program requirements that may make perfect sense for their citizens, but fail to account for the unique attributes of the Indian health system. Like States, Tribal governments are in the best position to address the unique needs of their citizens and the Indian health system that serves them. We hope to be able to work with you to achieve a result where Tribal programs can work with States to adapt the Medicaid program to their own needs without interfering with or delaying State goals and priorities.

We offer a short background on the importance of the Medicaid program to the IHS system, and an outline of some the unique challenges Tribes face in maintaining access to Medicaid for their citizens. We hope this information will be helpful to you as you work with Tribes and States across the country in implementing Medicaid reform.

The Importance of Medicaid to the IHS system

The Indian health system provides services to 2.2 million AI/ANs and has facilities in 36 States across the country. In the Indian Health Care Improvement Act, Congress 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."[5] Despite this commitment, AI/ANs still face enormous health disparities.[6] AI/AN health disparities persist in part due to the decades-long, chronic underfunding of the Indian health system. The vast majority of our facilities are located in rural, underserved areas with high unemployment rates. Many IHS and Tribal facilities have difficulty attracting providers, particularly for specialty services. Nationwide, IHS has a 20 percent vacancy rate, and a 30 percent vacancy rate for physicians. Many of our facilities are aging and in need of repair or replacement.

[5] 25 U.S.C. § 1602(1).
[6] See Indian Health Service, Factsheets: Disparities, https://www.ihs.gov/newsroom/factsheets/disparities/.

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."[7] In authorizing IHS to bill Medicaid, Congress also took steps to ensure that the Federal government did not shift responsibility for Indian health care to the States. Congress amended the SSA to provide for 100% Federal Medical Assistance Percentage (FMAP) for services received through an IHS or Tribal facility.[8] This provision ensures that all Medicaid services provided to AI/ANs that are received through an IHS or Tribal facility are reimbursed to the States at a 100% match by the United States. It was an 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.*[9]

Congress intended that Medicaid funding be supplemental to IHS funding, and not replace it. As a result, Congress enacted a provision of law that ensures that Congress must not take into account collections from Medicare, Medicaid (and later, CHIP) in determining IHS appropriations.[10]

Medicaid has proven to be a critically important resource for IHS and Tribal health systems. The funding it has provided has helped extend scarce IHS discretionary appropriations, including Purchased/Referred Care (PRC) funding. PRC funding is used to cover the cost of care by providers outside the IHS system when an IHS or Tribal facility cannot provide the service itself. Medicaid helps extend PRC funding, which otherwise routinely runs out before the end of the year.

Medicaid has also made the IHS system more entrepreneurial. Before access to Medicaid, the IHS system was largely entirely dependent on appropriated funds, as most IHS beneficiaries lacked access to private forms of coverage. Medicaid provided a source of third party revenues to the IHS, which encouraged IHS and Tribal providers to build their business office capacities to seek alternate resources. This, in turn, has helped to drive innovation in the Indian health system, particularly in Tribally operated Indian health facilities.

<u>Medicaid Reform Must Ensure Continued Access for American Indians and Alaska Natives</u>

We are aware that many States may be considering State Plan Amendments (SPAs) or Waivers that would impose certain eligibility conditions, including (1) Premiums and Co-pays; (2) Work Requirements; (3) Time Limits; and (4) Mandatory Managed Care. These reforms may be appropriate for States to consider in modernizing and reforming Medicaid for their citizens, but they will not work in Indian country. Instead of incentivizing healthy behaviors, they will hinder access to Medicaid for Indian people. This is because unlike other vulnerable populations, AI/ANs

[7] H.R. REP. NO. 94-1026, pt. III, at 21 (1976), *as reprinted in* U.S.C.A.A.N. 2782, 2796.
[8] 42 U.S.C. § 1396d(b).
[9] H.R. REP. NO. 94-1026, pt. III, at 21 (1976), *as reprinted in* 1976 U.S.C.C.A.N. 2782, 2796.
[10] 25 U.S.C. § 1641(a).

have access to the IHS system at no cost to them. Rather than meeting these requirements in order to obtain coverage, AI/ANs will simply elect not to enroll in Medicaid at all.

For example, Congress has provided that AI/ANs are exempt from Medicaid premiums, co-pays or cost sharing of any kind.[11] This is in fulfillment of the United States' trust responsibility to AI/ANs, and has removed a significant barrier to Medicaid access for AI/ANs. If circumvented through a waiver, many AI/ANs would find Medicaid coverage unaffordable and not enroll, and IHS and Tribal facilities would lose access to critical Medicaid resources.

Work requirements pose a similar challenge. While we support full employment for our citizens, making work requirements a condition of Medicaid eligibility will not encourage them to find work. It will instead discourage them from enrolling in Medicaid at all. Many Tribal citizens are located in remote rural areas with limited employment opportunities. While some work requirement proposals would create exceptions for individuals who can demonstrate they are looking for work, those proposals require accessing State employment programs. Tribal citizens generally look to their Tribal governments for employment assistance programs, not State programs, and as a result will not be able to demonstrate they are seeking employment through State programs. A better approach, and one that Tribes would support, is to make voluntary employment assistance programs available for American Indian and Alaska Native Medicaid enrollees. Doing so would encourage work while maintaining access to Medicaid as a bridge to other coverage.

Time limits would also be devastating to the Indian health system. While we understand the goal of encouraging Medicaid enrollees to help themselves off the program by finding work and associated health care coverage, time limits are inappropriate for the Indian health system. As discussed above, the Medicaid program is a critical component of the United States' trust and treaty responsibility, and essential to support the IHS system. Until the IHS system is fully funded, access to Medicaid must continue. Time limits should not be imposed on American Indians and Alaska Native Medicaid enrollees.

Managed care can also pose a challenge unless it is designed to account for the Indian health system. Tribes already participate in a managed care delivery system through the Indian health system. Care is coordinated within the IHS system, and with outside providers through the Purchased/Referred Care program. Unless specifically designed to account for the Indian health system, managed care systems often impose care coordination and prior authorization requirements that run counter to how Tribal programs manage care. The end result is an additional layer of red tape and bureaucracy stemming from two overlapping systems that hinders care coordination for Indian Medicaid beneficiaries rather than helping them. Enrollment in managed care should be maintained as an option for American Indians and Alaska Natives, but should not be mandated.

[11] 42 U.S.C. §1396o(j).

Congress recognized this when it included a provision in Section 1932(a)(2)(C) of the SSA that provides that AI/ANs shall not be mandated into Medicaid managed care through a SPA. Congress has also enacted a series of other protections for the Indian health system in managed care, including the ability of AI/ANs to choose an Indian health care provider as their primary provider, 42 U.S.C. § 1396u-2(h)(1); the right to prompt payment for Indian health providers from managed care entities, 42 U.S.C. § 1396u-2(h)(2); and the provision of State wrap-around payments to Indian health providers when a Managed Care Organization pays less than what would be paid under the State plan (the encounter rate), 42 U.S.C. § 1396u-2(h)(2)(C)(ii). These important protections should be maintained, as they are critical to ensuring continued access to the Medicaid program as States move to managed care systems.

Working with Tribes and States to Achieve Medicaid Goals

We understand the need for State innovation and choice in Medicaid, and believe that States can easily meet their Medicaid goals while ensuring continued access to the Medicaid program for the Indian health system and American Indian and Alaska Native Medicaid enrollees. States receive 100 percent FMAP for services received through the IHS and Tribal healthcare providers, so adapting their programs to account for the unique attributes of the Indian health system comes at no additional cost to the States. We believe there are several ways CMS can encourage a positive outcome for States and for Tribes.

1. Early Consultation

Many Tribes have good working relationships and partnerships with their State Medicaid programs. Tribes have worked with their State programs to implement Medicaid expansion, support waivers, including Indian-specific waivers, and created positive open consultation policies. The best results are achieved through open and early dialogue, so that Tribal programs can weigh in on State plans and priorities at the outset, rather than being forced to adapt at the last minute.

The issues that have arisen between States and Tribes regarding waiver or SPA approvals have occurred when States develop their proposals without any regard for how they will impact AI/AN access to the Medicaid program. As discussed above, many of these proposals may be beneficial to the State, but would inadvertently hurt Tribal programs. Early consultation is key to avoiding such conflicts, and respects the Nation-to-Nation relationship between the United States and Tribes.

2. Use of Tribal Standard Terms and Conditions

The Tribal Technical Advisory Group (TTAG) to CMS, has developed a set of Tribal Standard Terms and Conditions (STC) that can be used and attached to State Waivers. These Tribal STCs set out federal requirements and understandings with the State to facilitate American Indian and Alaska Native access to the Medicaid program. The State of Indiana recently signed an agreement

incorporating Tribal STCs with the Pokagon Band. Tribal STCs are in place between the Tribes of Kansas and the Kansas Department of Education and Health. Tribal STCs were recently approved as part of a 1915(b) waiver in Idaho, and are currently being negotiated in several other states as well. They should be encouraged nationally.

3. CMS Encouragement of Tribal Specific Medicaid Programs

Many Tribes have successfully worked with their States and CMS to submit Indian specific waivers that have been incredibly successful in Indian country. These waivers, which provide facility-based reimbursement for IHS and Tribal healthcare facilities, were approved in Arizona, Oregon and California. The States of Wyoming and Oklahoma currently have similar waivers pending with CMS for approval. We encourage CMS to approve these waivers, as they reflect the ability of States and Tribes to work together to adapt State programs to meet the critical needs of Indian people.

We also encourage CMS to look at the impact that Medicaid expansion has had in Indian Country. While we recognize the Administration's view that Medicaid expansion has been a departure from Medicaid's core mission, expansion has been transformative in Indian country. Tribal programs that would routinely run out of funds to make referrals for needed care halfway through the year are now able to pay for preventive care. Preventive care has dramatically improved health outcomes for our people and is a more efficient use of federal healthcare resources. We hope this Administration will work with Tribes to ensure that expansion is maintained as an option for American Indians and Alaska Natives.

We understand that States have been seeking additional flexibilities with regard to federal requirements. Tribes have the same motivation with regard to State requirements that do not fit well with the Indian healthcare delivery system. We encourage CMS to work with the TTAG to explore ways to create Tribal specific set asides in the Medicaid program, through waivers or otherwise. Doing so will impose no additional costs on the States, and will allow Tribes to tailor the Medicaid program to their needs, all while allowing the States to develop their own approaches in an expeditious manner.

4. Behavioral Health and the Opioid Crisis

We were very encouraged to hear that addressing the opioid crisis and behavioral health issues is a priority for HHS and this administration. As you know, Indian country has been hit particularly hard by the opioid crisis and other substance abuse issues. According to the Centers for Disease Control and Prevention, in 2012 Native Americans had the highest rate of use of prescription painkillers for nonmedical reasons, and in 2014 they had the highest rate of death from opioid

overdoses of any ethnic or racial group.[12] The Indian Health Service states that the rate of drug-related deaths among AI/ANs is nearly twice that of the general population.[13]

To date, resources have been insufficient for Tribes and the IHS to tackle this problem on their own. We look forward to discussing opportunities to partner with States and with CMS and HHS to bolster our efforts in this area.

One issue that has hindered Tribal integration of behavioral and physical health is the Medicaid Institutions for Mental Disease (IMD) exclusion. Tribal hospitals and clinics are often the only physical structures Tribes have that are equipped to house individuals with behavioral and mental health issues. The IMD exclusion has prevented many Tribal health programs from providing mental health in the only facilities they have that can do so. While CMS recently relaxed that rule for managed care, it did not do so under a fee-for-service model, which Indian Country relies on. We ask that CMS create a similar exclusion for Tribal facilities.

Conclusion

The unique relationship between Medicaid and the Indian health system means that the Administration has the tools it needs to allow States to design Medicaid programs that best fit non-Indian populations while simultaneously respecting Tribal sovereignty and maintaining Medicaid as a critical source of funds for the Indian health system. The National Indian Health Board and the National Congress of American Indians stands ready to partner with CMS to work on Medicaid reform to create better healthcare outcomes for our people, and we look forward to meeting with you soon.

Sincerely,

Vinton Hawley
Chairman
National Indian Health Board

Jacqueline Pata
Executive Director
National Congress of American Indians

Cc:

Stacey L. Ecoffey, Principal Advisor for Tribal Affairs, Office of Intergovernmental Affairs, Immediate Office of the Secretary, Department of Health and Human Services

Kitty Marx, Director, CMCS Division of Tribal Affairs, Centers for Medicare and Medicaid Services

[12] National Congress of American Indians, Reflecting on a Crisis: Curbing Opioid Abuse in Communities, October 2016, http://www.ncai.org/policy-research-center/research-data/prc-publications/Opioid_Brief.pdf.
[13] Indian Health Service, Press Release, "New Effort Targets Drug Overdoses in Indian Country", December 16, 2015, https://www.ihs.gov/newsroom/pressreleases/2015pressreleases/new-effort-targets-drug-overdoses-in-indian-country/.