NIHB Tribal Caucus Recommendations
Phoenix Area IHS Region

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Issues: Tribal Health Steering Committee for the Phoenix Area Indian Health Service

Since its establishment in 1981, the Tribal Health Steering Committee for the Phoenix Area Indian Health Service (THSC) has provided advisement to IHS in terms of making recommendations and guiding Tribal consultation to address issues that are common among the Tribes served by the Phoenix Area IHS. The Steering Committee is comprised of Tribal Leaders that reflect the geographic and demographic diversity of the Tribes and their unique health care delivery challenges in the Phoenix Area. It serves as the *Tribal Area health board* for the region and provides advisement on national and state health policies that impact American Indian people and the medical and public health care services provided by IHS, Tribal and urban Indian health care programs. The Phoenix Area Caucus convened at the NIHB Tribal Health Conference in September 2017. The following lists some of the top health policy matters that are currently under discussion by Tribal Leaders in the region.

TOPIC: AFFORDABLE CARE ACT (ACA) REPEAL/REPLACEMENT- IMPACT ON AMERICAN INDIAN TRIBES

Tribes in the Phoenix Area are examining the potential impacts to American Indian/Alaska Natives (AIAN) who receive health care through Indian Health Care Providers (IHCPs) under the American Health Care Act (AHCA), the Better Care Reconciliation Act (BCRA) and the Graham-Cassidy Amendments that's been under consideration by the Senate since September 13, 2017. Improvements in access to health care have been noted since the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, as evidenced by a 35% drop in the uninsured rate for AI/AN. The ACA reauthorized and made permanent the Indian Health Care Improvement Act (IHCIA), a law originally passed in 1976. IHCIA is the mainstay authority for the provision of medical, behavioral and preventive services that benefit AI/AN nationwide. Further to enhance AIAN participation in the individual insurance market, the ACA instituted measures so that health insurers and IHCPs work effectively and it provided critical cost sharing protections that have opened the door for AIAN to obtain individual marketplace coverage.

New BCRA Language

The latest version of the BCRA reported as of July 20, 2017, now incorporates $200 billion to be used by states that expanded Medicaid up to 138% FPL in 2014, to aid individuals that fall off of Medicaid enroll in private insurance. The Congressional Budget Office has scored the bill and noted that $200 billion is 17% of the bill's total $1.2 trillion in health coverage cuts that would begin in 2020. Language in the bill provides that states can use federal Medicaid waivers to undo any harm caused by the bill. It should be noted, however, that waivers must be budget neutral and can't restore federal funding that the President and Congress have cut. While some state Medicaid programs have instituted waivers to protect IHCPs, they require diligent efforts to develop appropriate language and of course, consultation and consensus of the Tribes.

The BCRA and the recently introduced Graham-Cassidy amendments to repeal and replace the ACA have not remedied lack of funding for the ACA's risk corridor program which provides funds to be paid out to insurers that suffer losses because they participate in the Marketplace and cover individuals that need significant coverage. This situation has led to the exiting of insurers from the Marketplace. Numerous health insurance companies have filed lawsuits seeking payment. Several are pending, but recently the U.S. Court of Federal Claims dismissed the lawsuit filed by Blue Cross Blue Shield of North Carolina. The judge ruled that the ACA nor its implementing regulations "addresses, nor establishes, a deadline for the payment," therefore, BCBSNC is not entitled to payments, "until, at a minimum, the agency completes its calculations for payments due for the final year." In order to sustain access to the individual insurance market, Congress should provide a sustainable high risk pool, risk/corridor or reinsurance program, or the difficulties noted by opponents of the marketplace will continue.

Medicaid Cuts/Conditions of Eligibility

Tribes in the Phoenix Area have voiced opposition to the AHCA, the BCRA and more recently to the Graham-Cassidy amendments to the AHCA bill. Each bill radically alters the Medicaid program by rolling back Medicaid expansion and creating a per capita model or a block grant model that will cap provided to the states over the next few years. The bills contain exemptions from the financial cap for certain individuals, including those who receive services through an IHCP. An exemption for individuals served by IHS and Tribal health care facilities is based on Section 1905(b) of the SSA that instituted Medicaid payments at the 100% *federal medical assistance percentage* (FMAP) in 1976. Maintaining the 100% FMAP is extremely important. However, language in the bills does not ensure that individuals served by IHCPs will be exempted from cuts to eligibility or benefit limitations and provider rate reductions instituted by states. Such cuts would harm AIAN patients due to the long term financial restraints that will dismantle the Medicaid program and diminish reimbursement to IHCPs.

Tribes in the Phoenix Area have voiced concerns regarding the ACA repeal and replacement language that would permit states to impose work requirements as a condition of Medicaid eligibility. Many Tribes are located in rural areas. The unemployment rate is high, for example, averaging 25% among Tribes in Arizona where there are limited economic development opportunities.

TOPIC: MEDICAID WAIVERS AND MODELS OF CARE

Tribes in the Phoenix Area have been apprised of the HHS and Centers for Medicare and Medicaid Services (CMS) directives advising state governors of the Administration's commitment to give states greater flexibility to develop Medicaid programs that meet the needs of the population and a fast tracking the process to expedite approvals of Medicaid Section 1115 Demonstration Waivers and extensions. Secretary Thomas Price and CMS Administrator Seema Verma further noted their intent to utilize the Section 1115 demonstration authority to approve requested authorities such as assisting beneficiaries obtain employment, enforcing premium or cost-sharing and ending coverage of non-emergency transportation.

The member Tribes of the Inter Tribal Association of Arizona and the Navajo Nation had voiced concerns and opposed on Arizona's pending legislative directed waiver since it passed and was signed into law by Governor Doug Ducey in 2015. It includes a requirement that the Arizona Health Care Cost Containment System (AHCCCS) apply to CMS by March 30th of each year for a Waiver (or amendments) to the Section 1115 Demonstration. If approved it will impose the following:

- The requirement for all able-bodied adults to become employed or actively seeking employment or attend school or a job training program.
- The requirement for able-bodied adults to verify on a monthly basis compliance with the work requirements and any changes in family income.
- The authority to ban an eligible person from enrollment for one year if the person knowingly failed to report a change in family income or made a false statement regarding compliance with the work requirements.
- Lifetime coverage for all able-bodied adults limited to five years except for certain circumstances.

Despite the negative ramifications of the measures in SB 1092, Tribes sought the establishment of workgroups in 2016 to address three American Indian waivers; continuation of uncompensated care payments for State capped services, American Indian Medical Home (AIMH) and traditional healing. As of this writing only the AIMH has been approved by CMS.

Tribes in Utah were apprised of the proposed waiver that's being developed by the Medicaid program in that state on July 14, 2017. The waiver was initially requested during the prior CMS administration however, it was not approved. With the new administration now in place, Utah would like to re-submit the initial request that would limit childless adult enrollment in the Section 1115 Primary Care Network (PCN) Demonstration. The request includes a work requirement and restricting the number of eligible months to 60 months in one's lifetime. IHS/638's would be exempted from the lifetime cap, but not the work requirement or other provisions that include eliminating retroactive and presumptive eligibility. These measures alone will cause significant hardship on AI/ANs who may meet the proposed eligibility requirements, which include that a childless adult is chronically homeless or involved in the justice system and is in need of substance use or mental health treatment.

TOPIC: TRIBAL EMERGENCY MEDICAL SERVICES LACK OF ADEQUATE REIMBURSEMENT

Emergency Medical Services (EMS) provided by Tribes through P.L. 93-638 contracts with the Indian Health Service in Arizona are reimbursed at fee-for-service rates established by AHCCCS. These rates are currently up to three times less than the same services provided by ambulance companies certified by the Arizona Department of Health Services (ADHS). A prior Arizona Health Care Cost Containment System (AHCCCS)/Tribal Workgroup met two years ago to reevaluate the reimbursement methodology for Tribal EMS providers. As a result, there was a 15% increase to the rates in October 2016, but it has not remedied the inequivalent rates that Tribal EMS agencies experience despite the fact that they meet all the required standards of care such as; 1) Emergency Medical Technicians and Paramedics maintain certification, 2)

certified staff participate in continuing education, 3) medical oversight is provided by a medical director, and 4) following State of Arizona Red Book/Protocols. AHCCCS requires Tribal EMS agencies to maintain a provider registration number and a National Provider Identification (NPI) which includes licenses, disclosures, and agreements in order to obtain third party reimbursement.

Arizona requires ground ambulances operating in non-Tribal jurisdictions to apply for and negotiate reimbursement rates by acquiring a Certificate of Necessity (CON). Tribes do not participate in the CON system. The CON system is in place to regulate ground ambulance services by the state of Arizona and to make sure that adequate emergency medical services are provided. The certificate, approved by the Arizona Department of Health Services (ADHS), describes the geographic service area, level of service (advanced life support or basic life support), hours of operation, response times, effective date and expiration date of the CON and any limiting or special provisions for emergency medical services in the specific geographic area.

At present, none of the Tribes in Arizona participate in the CON system due to concerns of Tribal sovereignty and financial data disclosure. Section 1647a of the Indian Health Care Improvement Act states that an Indian Health Care Provider (IHCP) or entity is eligible to receive payment for Medicaid covered services if the provider meets generally applicable state requirements of participation. It further states that if the entity meets all of the applicable standards for such licensure, it shall be deemed to have met the standards regardless of whether the entity obtains the license.

Currently, the ADHS has formed another Tribal EMS workgroup to determine next steps, including if Tribes should consider applying for the CON despite the issues of data collection and ramifications on tribal sovereignty. They will also review the process that ADHS had instituted in past years to accept CMS certification as evidence of meeting state licensure standards or establishing MOU's or IGA's with Tribes to perform courtesy surveys of the EMS departments. Just recently, the workgroup learned that the San Carlos Apache Tribe (SCAT) will be seeking the CON. The workgroup hopes to learn the outcome of the SCAT CON application.

TOPIC: RESOURCES NEEDED FOR TRIBES TO PROCESS MEDICAID ELIGIBILITY DETERMINATIONS

Tribal members are hampered in the Medicaid eligibility determination process when state eligibility workers do not understand the exempted provisions for AI/AN income allowances derived under American Recovery and Reinvestment Act (ARRA). The patient can be working with County and/or State representatives over a course of several months until all appropriate documentation has been finalized and accepted for Medicaid determination. Turnover at the state and county levels continue to be a problem. As such, it is imperative that our AI/AN Medicaid beneficiaries are covered by retroactively so that clinics and hospitals can receive payments prior to the final determination.

In Arizona, six Tribes operate TANF programs: 1) Hopi Tribe, 2) Navajo Nation, 3) Pascua Yaqui Tribe, 4) Salt River Pima-Maricopa Indian Community, 5) San Carlos Apache Tribe, and

the 6) White Mountain Apache Tribe. Many of the Tribes have expressed interest in learning more about how they could conduct Medicaid eligibility for the tribal populations they serve. Language in the Arizona Revised Statutes (A.R.S. 36-2902.02) provide Tribes this authority, however it's not been pursued by AHCCCS via a waiver.

Tribes in the states of Minnesota, Montana, Washington, and Wisconsin perform their own Medicaid determinations and each approached acquiring this authority differently. Some Tribes had to amend state law, work with their state Medicaid program to request a waiver from CMS or request a state plan amendment. Technical assistance is requested to provide further information on how the six TANF Tribes in Arizona can begin performing their own Medicaid eligibility determinations.

TOPIC: LEVERAGING THE 100% FEDERAL MEDICAID ASSISTANCE PERCENTAGE (FMAP) FOR TRIBAL AND INDIAN HEALTH SERVICE (IHS) HEALTH CARE FACILITIES

States may be reluctant to establish Medicaid optional benefits if the Medicaid program is based on block grants or a per capita system. States should consider leveraging the 100% FMAP to design benefits that meet the needs of the American Indian/Alaska Native population served at IHS and tribally operated facilities. Tribes in Arizona made the case for needed adult emergency dental services during the 2016 Arizona legislative session. The legislature passed and the Governor approved that Arizona Long Term Care Services (ALTCS) members receive a $1000 per member per year dental benefit. In 2017, the capped benefit was expanded to all adults. At the July 2017 AHCCCS Tribal Consultation Meeting, Tribes were informed that this capped amount will apply to care received at an IHS or Tribal facility, despite the 100% FMAP is afforded to the State for services provided at these facilities and that an uncompensated care waiver for emergency dental without a cap has existed since 2012.

Tribes provided information to legislators about the 1976 IHCIA provision that affords 100% FMAP to IHS and Tribal facilities for services provided to Medicaid patients. The Tribes sought to amend state law to include an exemption from capped dental services since it does not impact the state budget. In addition, the exemption would be based on the status of IHS/638 facility exemptions that should not be interpreted as a population exemption. Ultimately, the amendment was defeated based on the view that the current CMS administration would likely disapprove this type of waiver because it would be considered population-based, rather than based on the reason 100% FMAP measure was originally established in 1976, as a result of the Federal Trust Responsibility and the Nation-to-Nation political relationship between Tribes and the United States.

For further information regarding this issue paper:

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