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NATIONAL CONGRESS OF AMERICAN INDIANS
RECOMMENDATIONS ON THE FUTURE OF MEDICAID PROGRAMS

November 16, 2006

On behalf of more than 500 tribal nations, the National Congress of American Indians (NCAI) is pleased to present comments calling for the inclusion of American Indians and Alaska Native (AI/AN) beneficiaries of Medicaid services in the final report of the Medicaid Commission. NCAI is a member of the Centers for Medicaid and Medicare Services (CMS) Tribal Technical Advisory Group (TTAG). TTAG is a group of elected tribal leaders, or an appointed representative from their Area, who are nominated from the twelve areas of the Indian Health Services (IHS) delivery System. The TTAG serves as an advisory committee to the CMS on important health care matters associated with the Medicare, Medicaid, and State Children Health Insurance Programs.

Ensuring the well being of our tribal children and families is one of our highest priorities and greatest responsibilities as tribal governments. While tribal governments have learned how to reduce or overcome many of the barriers that we face in serving our children and families, securing adequate levels of funding for tribal services is still our greatest challenge. Our approach to addressing these budgetary and policy issues is based on our political status as sovereign nations and the unique trust relationship the federal government has with tribal governments. These principles of law have a constitutional origin and define how we view our relationship with the federal government and all of the agencies that operate within it. This relationship differs greatly from any status as an ethnic minority population.

The Charter for the Medicaid Commission requires recommendations to fulfill two goals, to find savings and to make the program better. As a member of TTAG, NCAI has a unique understanding of the potential negative impacts of some the proposed savings delineated by the Commission.

BACKGROUND

Medicaid Commission member, Valerie Davidson, sent a letter to the Commission containing much information regarding the trust responsibility that the federal government has to provide health care to the AI/AN population. Her letter contains all the relevant documentation regarding the issues discussed in the following NCAI comments.

Many AI/ANs endure health conditions and a level of health care funding that would be unacceptable to most other U.S. citizens. A vast range of public health indicators demonstrate that American Indians continue to suffer disproportionately from a variety of illnesses and diseases. The life expectancy of Native Americans is nearly six years less than any other race or ethnic group in America. The infant mortality rate is 150% greater for Indians than that of Caucasian infants. Thirteen percent of Native deaths occur in those younger than 25, a rate three times higher than the average U.S. population. The U.S. Commission on Civil Rights reported in 2003 that AI/ANs are " 650 percent more likely to die from tuberculosis, 318 percent more likely to die from diabetes, and 204 percent more likely to suffer accidental death compared with other groups."

NCAI RECOMMENDATIONS ON THE FUTURE OF MEDICAID PROGRAMS

Data from the 1997 Survey of Income and Program Participation found that 22 percent of the American Indian and Alaska Native (AI/AN) population has one or more disabilities. When compared with all other races in the U.S., this is the highest per capita rate of disability. Most of these permanent disabilities have their origins in untreated chronic disease.

Currently, AI/AN healthcare is often no more than emergency treatment. A vast majority of illnesses and deaths that occur from disease could be prevented if additional funding and modern health care services were available. These services are vital in providing a basic level of health care enjoyed by other Americans.

To address the horrific health disparities in Indian Country, Congress authorized various programs. To assist in funding these health programs, Congress also authorized the IHS and tribal health programs to recover reimbursements from both Medicaid and Medicare. Even so, Indian health programs are still funded at only 57% of need. A noteworthy comparison is that healthcare expenditures for AI/ANs are less than half what America spends for federal prisoners. Any reduction in the availability of Medicaid revenue will have a significant and negative effect on the ability of Indian health programs to provide even the restricted current level of health services to AI/ANs.

The effects are especially significant because the system is so dispersed and a majority of the operating units are so small. The IHS is responsible for services to more than 1.8 million AI/ANs located in 35 states. The IHS and tribal health programs provide services through 49 hospitals, 247 health centers, 5 school health centers, and 309 health stations, satellite clinics and Alaska Native community health aide clinics. In addition, the IHS and tribal health programs purchase health care, when it cannot otherwise be provided, through the contract health services program. Over 40% of IHS beneficiaries are also eligible for Medicaid services. The Medicaid Program is a central element of providing basic healthcare to the AI/AN population.

PROPOSALS FOR SAVINGS

The Commission has been provided with a number of proposals for achieving the $10 billion cost reductions in the Medicaid Program. Many of the Medicaid reductions discussed in the following proposals have the potential, albeit unintended, to negatively impact Indian health programs unless steps are taken to prevent such harm.

Each such impact is preventable. NCAI requests that the potential impact of avoiding such negative impacts be scored so the Commission can consider recommending provisions necessary to prevent harm to Indian health programs.

Prescription Drug Improvements. There are a number of proposals to control the cost of prescription drugs to the Medicaid program. They center on changing rules regarding rebates, providing authority for closing formularies, and adjusting the method by which the amount of reimbursement is calculated. NCAI believes the latter two could have serious impacts on Indian health programs that should be avoided.

Formulary Restrictions. Most Indian health programs operate a pharmacy program. These nearly universally already have closed formularies that have been developed to both take into account price and efficacy, but also the unique problems of service delivery that is faced by the Indian health system. The IHS and tribal formularies take into account ease of

administration to the patient, likelihood of negative reaction, difficulty in storage and useful life and other factors that health providers with a widely dispersed patient population who have limited access to health care facilities must consider.

NCAI recommends that any provision to allow states to restrict the Medicaid formulary should be modified to ensure that Indian health systems are exempt from such limitations.

Reimbursement Methodology. Among the proposals made by Health and Human Services (HHS) is one to change the basis for reimbursement from Average Wholesale Price ("AWP") to Average Sales Price ("ASP") and to limit the dispensing fee. Indian health system pharmacy programs do not operate like commercial pharmacies. They serve a distinct population under unique conditions. They are affected by small size, remote locations, and a limited infrastructure, and have few opportunities to achieve economies of scale. Plus, all IHS and Tribal pharmacies are part of a hospital or clinic operation. Indian health system pharmacists provide counseling on drug administration and usage, and work from patients' medical records; they do not merely fill a physician's written prescription. All of these factors affect "efficiency" and therefore cost.

Further, on an average prescription, the payment from Medicaid is 21 percent less than the documented cost of providing the drug to the patient. Any reduction in reimbursement methodology that is intended to reduce the overall recovery from that based on AWP will certainly result in further un-reimbursed costs.

NCAI recommends: (1) If the basis of reimbursement is changed, provide for flexibility in the dispensing fee to assure that states can protect access in rural and remote locations. (2) Provide expressly that pharmacies of the Indian health system may continue to be reimbursed on the basis of AWP less a percentage plus a dispensing fee (with neither the percentage or dispensing fee to be smaller than that paid in FY 2005), unless and until the infrastructure for determining the average cost of acquisition, pharmacy program administration, and dispensing (including patient counseling) on an ongoing basis is developed by IHS and made available to tribal health programs.

Asset Policy. The Indian health system has relatively few directly operated long term care facilities. The system is gradually developing home- and community-based long term care alternatives. Medicaid may be the only means by which an AI/AN elder can acquire long term care. AI/AN elders are generally reluctant to apply for Medicaid, however due to their deeply rooted belief that they are entitled to receive care from the IHS without personal expense and their fear of losing their, generally, few assets.

AI/AN elders and others needing Medicaid long term care should not have to exchange their estates, especially of unique assets, in order to obtain the care that IHS should be able to make available, but cannot due to its limited resources.

NCAI recommends that at a minimum, all assets of AI/AN individuals described in CMS's State Medicaid Manual, Section 3810.A.7 should be exempt from Medicaid eligibility calculations and estate recovery provisions.

Cost Sharing. "Cost sharing" is a somewhat generic term that can apply to premiums, co-payments, and deductibles. Cost sharing poses a unique financial barrier to care for all AI/ANs who are IHS beneficiaries. IHS is prohibited from charging its beneficiaries for

services. Therefore, the purpose of cost-sharing – encouraging appropriate consumer responsibility and utilization – is not accomplished. Instead, enrollee cost-sharing is merely cost-shifted to underfunded Indian programs who either absorb the costs through lower reimbursements or cash outlays from their Contract Health Services ("CHS") budgets, if the AI/AN is referred by an Indian health program to another health provider. The CHS provider may not charge the IHS beneficiary, so the Indian health program pays the co-pay or deductible.

If States are to be given additional flexibility with regard to cost sharing, it must not come at the expense of AI/ANs or Indian health system providers. NCAI recommends that the current law provisions regarding SCHIP should be retained and expanded to apply to all AI/ANs who are otherwise eligible to participate in a state's Medicaid program.

Coverage of Certain Services. One proposal advocates for increased flexibility in the mandatory and optional services that states may offer in their Medicaid program. There are two services of particular concern; Federally Qualified Health Center ("FQHC") services and Early, Periodic, Screening, Diagnosis and Treatment ("EPSDT") services. Many tribal clinics are enrolled in Medicaid as an FQHC. FQHC services are not recognized as a benefit category in the SCHIP statute. EPSDT is a critical service that should remain mandatory for all beneficiaries. Savings in the short-term should not be attempted at the expense of increased long-term costs. EPSDT is a critical component of disease prevention and of early identification of child abuse and other conditions that affect a child's health that will almost certainly result in increased costs to the Medicaid program if not addressed early on.

Since AI/ANs are especially dependent on Medicaid, a change in covered provider types and services has an especially large impact. Any such reduction will further reduce the level of funding available to the already drastically under-funded Indian health system. NCAI recommends: (1) Do not permit FQHC and EPSDT services to be eliminated or limited without further study of the impact on access. (2) If states are allowed to eliminate any mandatory Medicaid services or provider types, provide an exemption that requires continued reimbursement to Indian health programs on a basis at least equivalent to that authorized under the state's Medicaid plan in FY 2005.

Comparability and Statewideness. Under submitted proposals, states could vary benefits and conditions of participation from county to county or region to region. Such provisions have the potential to very negatively impact Indian health programs. While many states have achieved a good working relationship with the tribes and Indian health programs in their state, those relationships vary substantially and are often influenced by state/tribal issues unrelated to health care delivery. Implementation of this level of proposed flexibility could deliberately, or inadvertently, severely affect access to Medicaid by AI/ANs who live on or near a reservation that the state chose to include in the geographic regions to which it chose to limit services. To prevent even the possibility of such outcomes, certain protections need to be present if such flexibility is granted.

NCAI recommends that states should be prohibited from offering benefit packages that are less in amount, duration, or scope to AI/AN Medicaid beneficiaries than the benefits packages they offer to any other group of Medicaid beneficiaries anywhere in the state. This "most favored nation" rule should apply with respect to all AI/AN Medicaid beneficiaries, regardless of whether they live on or near a reservation.

Managed Care. SCHIP allows states to require participation in managed care, unlike Medicaid which prohibits a state from requiring an AI/AN to enroll in a manage care entity unless the managed care entity is the IHS, a tribal health program, or an urban Indian health program. This limitation ensures that AI/AN Medicaid beneficiaries are not involuntarily enrolled in a non-Indian managed care entity. The experience with such enrollments is that they disrupt continuity of the culturally competent care provided by their Indian health program, and, if for any reason the managed care entity does not enroll the Indian health program as one of its providers, results in the Indian health program providing uncompensated care, while the managed care entity benefits from premiums from the state. NCAI recommends there be a retention on the limitation on managed care enrollment found at 42 U.S.C. § 1396u-2(a)(2)(C), and extend it to SCHIP.

Waiver Authority. NCAI recommends: (1) The Secretary should be prohibited from granting any waiver, or approving any term or condition in such a waiver, that results in a reduction in benefits, or an increase in cost sharing, for any AI/AN beneficiary. (2) The Secretary should be prohibited from granting any waiver, or approving any term or condition in such a waiver, that is likely to shift costs to the federal IHS budget by reducing Medicaid revenues to an Indian health program or increase the costs that such a provider must incur in connection with premium or cost-sharing requirements applicable to AI/AN beneficiaries.

Payment Reforms and Medicaid Administrative Claiming.

The Department of Health and Human Services proposes to curb what it describes as various mechanisms that states use to allow government providers to return federal Medicaid back to the states, which in turn use the funds to draw down additional federal dollars. It also proposes to curtail Medicaid administrative spending that it views as inefficient. Both proposals create concern for tribal health programs. Several States have entered into contracts with tribes under which tribes carry out certain Medicaid outreach and education functions under Medicaid Administrative Match ("MAM") agreements. Audits of these contracts have shown excellent accountability for funds and compliance with regulations. These agreements have helped tribes improve Medicaid participation, which is often well below what would be expected given the relatively low income of AI/ANs. Tribes are an essential partner to assist with Medicaid administration functions. The under-enrollment of AI/AN will be further exacerbated is MAM funding for tribes is reduced.

NCAI recommends: (1) Do not impose new or more restrictive limits on reimbursement for Medicaid outreach, education, and enrollment activities. (2) Do not limit the extent to which tribal contributions can be used to match federal expenditures for those activities.

Access to health care by AI/ANs is limited by the geographic constraints imposed by the locations of reservations and other AI/AN communities and by the substantial under-funding of the Indian health system, even when Medicaid revenue (and other third-party revenue) is taken into account. Savings in the cost of the Medicaid program should not come at the expense of shifting costs and reducing revenue to Indian health programs.

Healthy communities can lead Indian Country into overall wellness and positive economic, educational, and social development. Adopting these recommendations is a vital step in helping the first Americans to bridge the health disparities gap that currently exists in this country. Healthy families are the keystone to healthy communities.

NCAI Recommendations on the Future of Medicaid Programs

NCAI realizes that Congress and the Administration must make difficult budget choices this year. As elected officials themselves, tribal leaders certainly understand the competing priorities that must be weighed. However, the federal government's solemn responsibility to address the serious needs facing Indian Country remains unchanged, whatever the economic climate and competing priorities may be. We at NCAI urge the Medicaid Commission to make a strong, across-the-board commitment to meeting the federal trust obligation by including AI/AN health issues in its final report. Such a commitment, coupled with continued efforts to strengthen tribal governments and to clarify the government-to-government relationship, truly will make a difference in helping us to support safe, stable, and healthy families in Indian Country.