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On behalf of the Tribal Technical Advisory Group to the Centers for Medicare and Medicaid Services Department of Health and Human Services FY 2013 Budget and Policy Tribal Consultation

I. Introduction

On behalf of the Tribal Technical Advisory Group (TTAG) to the Centers for Medicare and Medicaid Services (CMS), I am pleased to offer this testimony today. I am Jason Dollarhide, 2nd Chief, Peoria Tribe in Oklahoma. I serve as the National Congress of American Indians' (NCAI) representative on the TTAG. As you know, TTAG advises CMS on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and any other program administered by CMS. TTAG has formally been in existence since 1993 and was codified in Federal statute in 2009 in the American Recovery and Reinvestment Act (ARRA).

Most recently, with the enactment of the Patient Protection and Affordable Care Act (ACA) in 2010, TTAG has been working to provide technical assistance to a variety of offices within CMS that have responsibility for ACA implementation. Most specifically, TTAG has recently been engaged with the new Center for Consumer Information and Insurance Oversight (CCIIO), the entity with primary responsibility for implementation of the health insurance exchange provisions of the ACA. Not only are there a host of new issues to be worked through to ensure that American Indians and Alaska Natives (AI/AN) receive the services and achieve the health outcomes envisioned by the health reform law, there are many new CMS employees that need to become educated on the health systems and challenges particular to Indian Country.

As you well know, the Department's task of implementing the health reform legislation is immense. Just one area alone – the expansion of Medicaid mandatory eligibility to individuals below 133% of the federal poverty level in all States – is projected to increase the Medicaid rolls by 50%, and will be a critical vehicle for bringing additional resources to and broadening access for Indian people. In addition, the Indian Health Care Improvement Act (IHCIA), after a decade of effort, was reauthorized as a part of the broader health reform law and successful implementation requires the full efforts of not only CMS, but also the Indian Health Service (IHS) and other Federal agencies such as the Veterans Administration and the Office of Personnel Management. Not only are there scores of provisions of the ACA and IHCIA before us to implement, but certain provisions of ARRA and CHIPRA (the Children's Health Insurance Program Reauthorization Act) remain to be fully implemented.

We have achieved a great deal since this time last year. In addition, we are heartened by the efforts taken by the Administration to better understand – before they are implemented – how policies and implementation approaches will impact Tribal citizens and our communities. For instance, the Department recently announced the availability of additional funds for the establishment of State-level health insurance exchanges under the ACA and included a statement that States will be required to establish and implement a process for consultation with Tribes as

one of the conditions for receiving Federal assistance. While progress is being made, we must not ignore the fact that there are also long standing unresolved issues, including the lack of recognition of AI/AN as a distinct political group and not a racial minority. This continues to result in unnecessarily constraining the options available to HHS agencies to address the unacceptable health disparities suffered by AI/AN throughout Indian Country.

II. Top Health and Human Services Priorities

1. Full support and funding for Tribal participation in the TTAG activities.
2. Successful implementation of recently enacted health reform legislation, including the ACA and the reauthorized and amended IHCIA.
3. Understanding and mitigation of potentially negative impacts of State budget cuts on Indian health.
4. Effective and on going consultation with Tribes regarding new laws, funding and policies.
5. Resolution of long-standing TTAG issues.

III. Describe Top Health and Human Services Priorities

1. Full support and funding for Tribal participation in TTAG activities.
    - TTAG is an important and efficient mechanism for CMS to gain the necessary expertise on how Department policies – before they are implemented – may impact Indian people. Increased resources are needed to support Indian Country-generated analysis of potential impacts and possible remedies. In fact, ACA implementation dramatically increases the need for the technical impact analyses performed by the TTAG.

2. Successful implementation of recently enacted health reform legislation, including the ACA and IHCIA.
    - The "CMS TTAG American Indian Alaska Native Strategic Plan 2010-2015" (Strategic Plan) articulates the goals and activities that need to take place in order to ensure that Indian people and the Indian health programs that serve them across the country can effectively participate in Medicare, Medicaid and CHIP.
    - Since the Strategic Plan was drafted prior to the enactment of the ACA, it needs to be updated to incorporate and reflect the opportunities and challenges presented by the new law.

3. Understanding and mitigation of potentially negative impacts of State budget cuts on Indian health.
    - Many States are and will continue to reduce their Medicaid and CHIP programs in ways that have negative impacts on health programs for American Indians and Alaska Natives. These include elimination of optional Medicaid benefits, cuts in eligibility and provider rates, and elimination of other health programs that rely on State dollars. The negative implications for access to services and available funding for Indian health programs is significant.
    - Understanding the potential negative impacts from budget cuts and facilitating State efforts to avoid or mitigate these is an immediate challenge before us all. For example, one Navajo facility in Arizona has experienced a $2.5 million loss in revenue so far this fiscal year as a result of the elimination of Medicaid optional services. This facility is projecting a $6.5 million total reduction in Medicaid revenues this year from these cuts. We are encouraged that CMS, in two recent actions, has demonstrated a willingness to work with State officials to enable Indian health providers to continue to offer the eliminated optional

services, but the desired outcome has not yet been achieved because of conditions imposed by CMS that States cannot accept. .

4. Effective and on-going consultation with Tribes regarding new laws, funding and policies.
   - A continued commitment to effective Tribal consultation is key to achieving the health outcomes for AI/AN that we are all working to achieve. To be clear, consultation occurs in a direct government-to-government dialogue. TTAG is not a substitute for Tribal consultation; however, it is a critical component. The technical work provided by TTAG is designed to supplement the Tribal input and to support the Tribal priorities articulated in the broader Tribal consultation activities of HHS and CMS.
   - Federal law requires State Medicaid and CHIP programs to seek the advice of Indian health programs before submitting proposals to CMS. And, as noted, States will be required to consult with Tribes in the design and administration of the exchanges. In order to effectively perform the required consultation, resources are needed at the Tribal level to ensure effective participation by Tribes in the processes.
   - It is useful to remember that when States engage CMS and Tribes on Medicaid, CHIP and other program operations, the States can be reimbursed for much of their related costs through administrative claiming. Tribes do not have this avenue available to them directly; under current law, their administrative claiming activities and funding must be channeled through the States. Either through a streamlined administrative claiming process or through specific appropriations for the Tribal staffing and technical assistance provided to TTAG and to State agencies, increased resources are needed to support the engagement of Tribes.

5. Resolution of long-standing TTAG issues.
   - Access to Medicaid administrative matching dollars for all Tribes: Tribes, as do States, engage with CMS to provide advice and to seek direction on Medicaid and CHIP program operations, such as how to better facilitate enrollment of Indian people in Medicaid and CHIP. An important vehicle to cover the costs of this Tribal engagement is to provide funding for these essential activities through Medicaid administrative match (MAM). TTAG, since it was first constituted, has worked with CMS to make MAM more accessible for Tribes. Now is the time to take a more serious look at how this can be accomplished in the most cost effective way possible for all interested Tribes.
   - Completion of a CMS Tribal Consultation policy: Now that a new HHS Tribal consultation policy has been issued, TTAG and CMS are resuming work on a revised CMS consultation policy. We look forward to completing a consultation policy as soon as possible.
   - Resolution of issues related to interstate Medicaid access: Particularly for AI/AN children who attend out of State boarding schools and Indian youth and adults in need of culturally appropriate behavioral health services, access to Medicaid reimbursements for care provided in another state has been difficult. Work is underway to identify potential solutions, and we encourage CMS to seriously consider the recommendations that are ultimately developed to removing barriers to accessing the needed care.

IV. Identify Top Budget Specific Issues

The “CMS TTAG American Indian Alaska Native Strategic Plan 2010-2015” was completed one year after the FY 2010 budget formulation cycle and was formally adopted in June, 2009. The Strategic Plan’s FY 2013 budget recommendations are used as the baseline for this FY 2013 budget formulation cycle. The Strategic Plan’s Appendix B and C provide detailed information on

funding recommendations by fiscal year. The Strategic Plan budget recommendations assume that the current level of funding will be maintained for the CMS Tribal Affairs Group's (TAG) staffing of Indian activities and for the support of TTAG activities.

When the Strategic Plan was written, health care reform was only a distant possibility. Faced now with key ACA implementation activities through 2013, Tribes are requesting additional resources to plan and prepare for the major provisions that become effective in 2014. At this critical time, there needs to be adequate resources to support the internal operations of the CMS Tribal Affairs Group as well as the work of the external TTAG as an advisory body.

1. For the CMS Tribal Affairs Group: There needs to be an adequate budget to support its work to facilitate Tribal issues within the agency as well as adequate funding for its work to effectively communicate to external parties and to conduct Tribal technical assistance.

2. In support of TTAG's mission: The Strategic Plan recommends for FY 2013 a minimum of $2,530,000 allocated as follows for each of the five Strategic Plan goals:
   - Goal 1: Execute CMS's legal and political obligation to engage in meaningful consultation with Tribes and work closely with the Tribal Technical Advisory Group ($410,000)
   - Goal 2: Identify current and future administrative, regulatory, and legislative policies that unfavorably impact AI/AN beneficiaries and Indian Health Service, Tribal and Tribal organization, and urban Indian organization (I/T/U) providers. Consult with Tribes and work closely with TTAG and IHS at all stages of the policy development process to design mutually-beneficial solutions. ($385,000)
   - Goal 3: Implement strategies to increase AI/AN enrollment in CMS programs, and improve Tribal access to health care services funded by those programs. ($1,230,000)
   - Goal 4: Develop and improve CMS data systems in order to evaluate and expand the capacity of CMS to serve AI/ANs. ($310,000)
   - Goal 5: Establish and improve access to CMS funded Long Term Care (LTC) services throughout Indian Country. ($195,000)

3. For I/T/U Providers: In order to effectively implement ACA provisions related to Medicaid expansion and access to exchange plans in Indian Country, an additional budget is needed to fund education, outreach, enrollment and systems modifications at each I/T/U site.
   - For Tribes, adequately preparing for Medicaid expansion and exchange implementation will require significant one time resources. In particular, Tribal activities are needed in the years prior to the January 2014 effective date of several key ACA provisions.
   - For this purpose, TTAG recommends that $40 million be allocated for distribution directly to all I/T/U sites that are interested in conducting local planning, education, outreach and enrollment activities in FY 2013.

We respectfully request that CMS and the Department include and support these budget recommendations in their budget submissions to the Office of Management and Budget.

V. Identify Top Policy and Legislative Specific Issues

Although we are identifying the following key policy and legislative issues within the testimony on the National HHS Tribal Budget and Policy Consultation Session for FY2013, TTAG is also working to advance these issues, if possible, in the current year. These are just a handful of the key policy recommendations TTAG has made to CMS.

1. <u>Advancing Access to Comprehensive Health Care Services</u>
   - **Designate I/T/U Providers as "Essential Community Providers":** Under the Affordable Care Act, health plans offered through an Exchange must include in their networks essential community providers that serve "predominantly low-income, medically-underserved individuals." These are precisely the individuals served by the Indian health system. Rather than require a facility-by-facility determination of ECP status, TTAG is recommending that the 45 hospitals, 600 ambulatory care facilities and 34 urban Indian programs that comprise the I/T/U Indian health system nationally be designated as ECPs required to be included in exchange health plan networks. Not only would such designation assure that I/T/U providers are offered network contracts, network provider status would also facilitate access of AI/ANs to specialty care available within these networks. In addition, knowing their health programs will have network status will provide an incentive for Tribes to encourage their members to enroll in exchange plans and help achieve the ACA's goal of reducing the number of Americans who are uninsured.
   - **Provide an Option for Tribes to Group Pay Premiums on behalf of Tribal Members in an Exchange:** TTAG recommends that a mechanism be established for Tribes to directly pay the unsubsidized portion of premiums on behalf of their members who enroll in an Exchange plan. There is no ACA prohibition of such a group pay option, but there is neither a clear mechanism specified under the ACA that will enable a Tribe to pay premiums on behalf of eligible members. We recommend that CMS require exchanges to establish a group pay option for Tribes. While establishing a group pay option will require some upfront effort by a state exchange, that effort will result in greater efficiencies for the exchange and for participating health plans, and will advance the ACA's goal of expanding the number of Americans with comprehensive health insurance coverage.

2. <u>Expanding Available Resources</u>
   - **Enable Access to Meaningful Use Incentive Payments:** There is a need for CMS to acknowledge that both the Medicare and Medicaid laws include outpatient facilities operated by Tribes, Tribal organizations and urban Indian organizations in the definition of Federally Qualified Health Centers (FQHC), and thus to declare that these entities are able to use the "needy individual" count when determining patient volume to qualify for meaningful use incentive payments as Medicaid providers. Without such action, many of the I/T/U providers will not have access to the MU EHR incentive payments, and will not be able to comply with the meaningful use requirements.
   - **Facilitate Implementation of Section 405(c) of IHCIA:** Section 405(c) of the IHCIA requires the Departments of Veterans Affairs (VA) and Defense (DoD) to reimburse IHS and Tribal health providers for services provided to eligible DoD and DVA beneficiaries. The provision became effective March 23, 2010, but IHS, DoD, and DVA have not yet established a reimbursement procedure. Although CMS does not have direct responsibility for implementation of this provision, TTAG would like to call your attention to the analysis prepared by the National Indian Health Board (NIHB) dated February 10, 2011 that identifies actions CMS can take to expedite implementation, minimize the potential loss of revenues to Indian health programs, and reduce administrative and health service expenditures under Medicare and Medicaid.

3. <u>Building the Foundation for Improving and Monitoring AI/AN Health Outcomes</u>
   - **Adopt Uniform Definition of Indian for Application of ACA Indian Specific Provisions:** CMS has adopted a uniform definition of Indian for the Medicaid program, which can be found at 42 C.F.R. § 447.50. To facilitate the integration of Medicaid and exchange plan

enrollment required by the ACA, the major national Indian organizations – including the NCAI and NIHB – have endorsed using the CMS definition for implementation of ACA Indian specific provisions. Having a uniform definition is critical as two different agencies of the Federal government (HHS and the Internal Revenue Service) are responsible for implementing key provisions of the ACA that are dependent on this definition: eligibility for cost-sharing protections (HHS) and eligibility for waiver of penalties (IRS).

- **Ready Systems to Support Identification of AI/ANs:** Indian-specific protections and benefits are included in the ARRA and more recently in the ACA. It is critical that Medicaid data systems are modified now and exchange information systems are established from the start to incorporate AI/AN identifiers in order to assure that providers and health plan administrators can easily identify AI/ANs who are eligible for these protections and benefits.
- **Expand Capacity to Access and Use Indian-Specific Data:** TTAG, with critical support from the CMS Tribal Affairs Group, has begun to develop the capacity to pull various sources of Indian-specific health services data together. The California Rural Indian Health Board has been the central entity performing the work on this effort. TTAG would like to acknowledge the investment made by CMS and to encourage CMS to continue this effort. We would also encourage CMS and sister agencies to begin to access these data to better inform decision making on AI/AN health issues.

VI. Summary of Tribal Testimony Submission

The ACA offers tremendous opportunities to improve the health outcomes of AI/AN, and to strengthen the Indian health system created by the Federal government to carry out its trust responsibility for Indian health.

To fully realize these opportunities, it is critical that timely and effective consultation occur between CMS and Tribes and between States and Tribes. We believe we are making progress in this regard. TTAG is an important component in achieving effective Tribal input on health care issues. It is vital that CMS continue its support, and if possible enhance its support, for TTAG and the technical analysis it produces.

Successful implementation of health reform for Indian people has already and will continue to benefit from the leadership of President Obama, Secretary Sebelius and Administrator Berwick in communicating a commitment to inclusivity for American Indians and Alaska Natives. TTAG looks forward to continuing to work with CMS to translate this commitment into initiatives such as securing cross-agency cooperation to establish consistent eligibility determinations for Indian patients, establishing health plan networks that include I/T/U providers, and creating delivery and information systems that are responsive to the needs of all American Indians and Alaska Natives.

Thank you.