

Report to CMS
Indiana Tribal Consultation for HIP 2.0



Submitted
8/21/2014

On July 23, 2014, the Indiana Family and Social Services Administration (FSSA) served formal notice to the Tribal Chair and Health Director of the Pokagon Band of Potawatomi (Tribe) regarding the State's submission of the Healthy Indiana Plan 2.0 (HIP 2.0) Section 1115 waiver application and the Healthy Indiana Plan (HIP) Section 1115 waiver renewal application pursuant to the requirements set forth at 42 CFR 431.408(b).

In accordance with the consultation process outlined in the Center for Medicare and Medicaid Services (CMS) July 17, 2001 letter to State Medicaid Directors, the State met with the Health Director of the Tribe as well as other tribal representatives on August 5, 2014 to present and discuss the waivers. The meeting took place at the tribal offices located in Dowagiac, Michigan, with representatives from CMS joining via conference call. The State team consisted of the Secretary of FSSA, Dr. John Wernert, as well as a representative from Governor Pence's office and additional FSSA support staff. The State presented the HIP 2.0 program in its entirety and discussed any possible effects that the program may have on the Tribe.

On August 4, 2014, prior to the formal consultation, the State received formal comments from the Tribe regarding the waivers, including the potential impact on tribal members (Tribe's Formal Comments). The State's response to each of the concerns raised in the Tribe's Formal Comments are listed below:

- 1) *"Mandates members into managed care as a condition of participation in Medicaid in a manner inconsistent with tribal federal rights under 42 U.S.C. § 1932(a)(2)(C)."*

The State understands the Tribe's concerns as it relates to the difficulties of coordinating Indian Health Services (IHS) programs and services within a managed care system. However, it is the State's preference to continue to seek a waiver of this provision in order to place all HIP 2.0 members, including tribal members, into managed care so that all individuals are able to experience the benefits of coordinated care that such placement creates. As a part of this, the State is seeking to waive the requirement put forth in 42 U.S.C. § 1932(a)(2)(C).

However, the State would like to ensure that the managed care program is structured in a way to alleviate the concerns of the Tribe. At a minimum, the State will continue to include protections for IHS providers as well as Native American HIP members desiring to seek services from IHS providers within the HIP managed care contracts. See the State's response to Item 4 below for more details regarding these contractual protections for Indian healthcare providers.

- 2) *"Requires tribal members to maintain "personal responsibility" accounts under either HIP Basic or HIP Plus to participate in the Medicaid program, a federal health benefits program used to help meet the federal trust responsibility to provide health care to American Indians and Alaska Natives."*

As explained during the tribal consultation, individuals enrolled in the HIP Basic plan are not required to contribute monthly payments to their POWER Accounts. Instead, the POWER Account would be fully funded by the State with \$2,500 when an individual is determined eligible for the program. HIP is structured as a high deductible health plan, and the POWER account is used to fund the deductible. Although the POWER account and deductible is fully

funded by the State with no cost-sharing required of the individual, the program design allows the member to receive monthly account statements that detail the cost of the utilized services and how their account was utilized to cover deductible expenses. The member is essentially able to manage a fully funded health savings account, but without any financial “skin in the game”. In addition, if a HIP Basic member completes certain preventive health care and is able to manage the account judiciously, they will be eligible for up to a fifty percent (50%) discount in the cost of participating in the program’s enhanced “HIP Plus” plan in subsequent years.

The State’s proposed plan for the Native American HIP members would follow this model, although, unlike the original HIP Basic plan structure, Native American members would not be subject to copayments for services. Therefore, although all members will maintain a “personal responsibility” account, enrollment in the HIP Basic benefit package and the maintenance of a POWER Account will only serve to further educate tribal members on the services they are receiving and the costs of those services, without requiring them to directly participate in any cost-sharing.

- 3) *“Requires tribal members to make payments to these “personal responsibility” accounts in order to access a benefits package that meets Alternative Benefit Plan requirements in a manner inconsistent with Medicaid premium and cost-sharing exemptions for American Indians and Alaska Natives, 42 U.S.C. §§ 1396o(j), 13960-1(b)(3)(A)(vii) and (b)(3)(B)(x).”*

The State sought to address tribal concerns regarding the Medicaid cost-sharing protections set forth in Section 5006 of the American Recovery and Reinvestment Act of 2009. In doing so, the State proposed that all Native Americans who apply and are found eligible would be automatically enrolled in HIP. All eligible Native Americans would be eligible to receive the “HIP Basic” benefit package, which the State anticipates will be designated as “Minimum Essential Coverage” (MEC) by CMS upon approval of the waiver. Further, HIP Basic covers all ten “Essential Health Benefits” (EHB’s) but without any cost-sharing being assessed for services received. However, all eligible Native Americans would still be provided the opportunity to choose to enroll in the enhanced “HIP Plus” plan by making monthly POWER Account contributions consistent with general program requirements.

The Tribe’s Formal Comments expressed significant concern that the “HIP Basic” benefit package was a bare benefits plan that did not meet Alternative Benefits Plan (ABP) requirements. The HIP Basic benefit package, as previously stated, covers all ten EHB’s that are set forth in Section 1302 of the Patient Protection and Affordable Care Act (ACA). Similarly, the HIP Plus benefit package is also structured to meet all ABP requirements; however, it offers additional enhancements and services not otherwise required to be covered, such as vision and dental services, in order to induce members to make monthly financial contributions towards their health care.

- 4) *“Provides no guarantee that other critical tribal Medicaid protections would be met. These include the right of tribal Medicaid enrollees to choose Indian health care provider as primary care provider,*

42 U.S.C. § 1396u-2(h)(1), the right of such Indian health care providers to be paid by managed care entities for the provision of covered services, 42 U.S.C. § 1396u-2(h)(2), including the right to receive wrap around payments by the State, 42 U.S.C. § 1396u-2(h)(2)(C)(ii)."

As stated above, the HIP managed care contracts include certain protections regarding Indian healthcare providers. The precise language from the contracts is included below:

"An Indian health care provider is defined as the Indian Health Service (IHS) or an Indian tribe, tribal organization or urban Indian organization (often referred to as I/T/U).

Section 5006 of ARRA provides certain protections for Indian health care providers in Medicaid and CHIP. As outlined in section 5006(d) of ARRA, the Contractor shall:

- Permit any Indian member who is eligible to receive services from a participating Indian healthcare provider to choose to receive covered services from that Indian healthcare provider, and if that Indian healthcare provider participates in the network as a PMP, to choose that Indian healthcare provider as his or her PMP, as long as that Indian healthcare provider has the capacity to provide the services.
- Demonstrate that there are sufficient Indian healthcare providers in the Contractor's network to ensure timely access to services available under the Contract for Indian members who are eligible to receive services from such providers. CMS intends to issue regulations regarding sufficiency of Indian healthcare providers in states like Indiana where few Indian healthcare providers are available and the Contractor will be held to these standards.
- Reimburse Indian healthcare providers, whether in- or out-of-network, for covered services provided to Indian members who are eligible to receive services from such providers either at 1) a rate negotiated between the Contractor and the Indian healthcare provider, or 2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the services were provided by an in-network provider that is not an Indian healthcare provider.
- Make prompt payment to all in-network Indian healthcare providers as set forth in Section 9.4.3.
- Not reduce payments to Indian healthcare providers, or other providers of contract health services (CHS) under referral by an Indian healthcare provider, for covered services provided to an Indian member by the amount of a co-payment or other cost-sharing that would be due from

the Indian member if not otherwise prohibited under Section 5006(a) of ARRA.

Section 5006(d) requires that the State provide a supplemental payment to non-FQHC Indian healthcare providers for covered services provided to Indian members. The amount of the supplemental payment is the difference, if any, of the rate paid by the Contractor for the services and the rate that applies to the provision of such services under the State plan. To the extent [Indiana Medicaid] requires utilization and/or reimbursement data from the Contractor to make a supplemental payment to an Indian healthcare provider, the Contractor shall provide the requested data within 30 days of the request."

- 5) *"Seeks a waiver that would allow the State to no longer provide reimbursement under the Medicaid program for non-emergency transportation. Non-emergency transportation is a significant cost that must be borne by the Tribal Health Department to effectively meet the health care needs of its citizens, and Medicaid reimbursement for those services is critically important to the Tribe."*

The State has never provided reimbursement for non-emergency transportation under the HIP program, as a key tenet of the HIP is that it serves non-disabled adults between the ages of 19 and 64. It is the opinion of the State that these individuals have the ability and the means to acquire transportation, whether it be private or public transportation, to receive the health services that they seek.

The State's requested waiver for non-emergency transportation does *not* apply to any HIP members eligible for HIP State Plan benefits (ABP exempt populations, including Section 1931 low-income parents and caretaker relatives, medically frail, and pregnant women). The non-emergency transportation waiver also does not apply to other Medicaid programs, including the Hoosier Care Connect and Hoosier Healthwise programs.

During the tribal consultation on August 5, 2014, the State outlined the ways that the HIP 2.0 program would potentially benefit the Tribe. The State showed the benefits of being enrolled in managed care as well as attempted to allay concerns regarding the HIP Basic benefit package, which is designed to meet all ACA requirements, including MEC. During the consultation, the tribal representatives discussed possible placement of eligible Native Americans into a traditional Medicaid State Plan benefit package. The State does not believe that inclusion in this benefit package is appropriate or necessary to comply with federal requirements since the HIP Basic benefit package is designed to meet Alternative Benefit Plan requirements and to be considered minimum essential coverage for newly eligible adults. In fact, unless expressly exempt pursuant to 42 CFR 440.315, all newly eligible adults must be enrolled in an Alternative Benefit Plan, which means that newly eligible Native Americans would have to be enrolled in one of the two HIP benefit packages, rather than a traditional fee for service State Plan benefit package.

In the Tribe's Formal Comments and again during the tribal consultation, the Tribe also expressed concern surrounding the enrollment of all tribal members into managed care. As an alternative, the tribe proposed carving out all Native Americans from mandatory enrollment in managed care so that they may receive services on a fee for service basis through IHS providers. The Tribe further expressed

that the treatment of Native Americans in HIP 2.0, as originally proposed, may be unduly burdensome on the State and the Managed Care Entities (MCEs) that are contracted with the State. However, the State does not believe the creation of an Indian specific benefit package within the existing HIP structure to merely exempt cost-sharing requirements would be unduly burdensome for the State or the MCEs. In fact, the ability to provide these services without cost-sharing is being preemptively put into place so that the State may abide by the cost-sharing protections that are afforded to Native Americans under federal law. The more burdensome approach may be to create a new and separate fee for service program for newly eligible adult Native Americans, which would exist outside of the HIP structures and processes that are currently being developed in anticipation of program implementation.

The State understands that the concerns of the Tribe regarding managed care stem in part from the belief that tribal members may not continue to receive services through Indian health care providers at the Tribe's Michigan clinic. The State is currently taking steps to ensure that tribal members will be able to continue to receive services from Indian health care providers, including those otherwise out of network.

The State will continue to work with both CMS and the Tribe to further ensure that all federal regulations not otherwise waived will be met throughout the design and implementation of the Healthy Indiana Plan. The State respects the government to government nature of our relationship with Native Americans and believes we have a shared goal in providing the highest quality healthcare for our residents.