

ENTRY POINT



Maintaining access: Staff from Tuba City Regional Health Care Corporation board a mobile medical unit that will provide care to residents on the outskirts of western Navajo Nation.

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Propping Up Indian Health Care Through Medicaid

Medicaid expansion in Arizona has helped the Indian Health Service and tribally run health systems improve access.

BY JESSICA BYLANDER

The mobile medical unit leaves Tuba City, Arizona, at 8 a.m. sharp. That's Navajo time—often an hour ahead of the rest of the state, which doesn't observe daylight savings. The van's destination is LeChee, a small town an hour and a half north, in the northwest corner of the expansive

Navajo Nation. The van is outfitted like a doctor's office, with two exam tables, sinks, basic medical equipment, and refrigerators and freezers containing vaccines. It drives like a big rig, rattling down the highway through the deep canyons and craggy red rock formations of western Navajo Nation, avoiding the unpaved roads.

The mobile unit is run by Tuba City Regional Health Care Corporation, a health system in Navajo Nation that is overseen by a nonprofit tribal organization and that provides care to members of the Navajo, Hopi, and San Juan Southern Paiute tribes. It's one of only a handful of health systems on Navajo lands that are run by tribal organizations rather than the Indian Health Service (IHS), the federal entity charged with delivering health care to American Indians and Alaska Natives. About 60 percent of the 567 federally recognized tribes in the United States have completed the steps necessary to run their own health systems, known as self-governance: a planning phase, a formal request to participate, and a demonstration of three years of financial stability. (One of the largest tribes, Navajo Nation has not yet elected to take on self-governance throughout the entire tribe.) Other tribes or tribal organizations are considering the move, and most oversee at least portions of their health systems.¹

Of course, it's one thing to take ownership of a health care system, particularly one that serves one of the sickest and often most rural populations in the country.² It's quite another to achieve financial success.

But Tuba City Regional Health Care, for one, has done so, reporting around a 3 percent profit margin each year, says CEO Lynette Bonar. And it's grown, too: from a staff of 75 health care providers and 525 total employees in 2002, the year the tribal organization began taking over the health system, to 250 providers and more than 1,100 employees today, Bonar says. The health system fully transitioned to self-governance in 2010, negotiating a "compact" with IHS that guaranteed the tribal organization a lump sum of money to manage all health programs and services with little oversight from the agency.³ Before self-governance, western Navajo Nation was served primarily by one IHS hospital in Tuba City and a small clinic in Dinnebito, Arizona, Bonar says. Now it has a seventy-two-bed hospital (the former

IHS facility with a few upgrades); satellite clinics in Flagstaff, Cameron, and LeChee, Arizona; the mobile medical unit; and mobile units that provide dental care and telehealth. The health system does a relatively booming business—693,129 patient visits in fiscal year 2015.³

“What we were able to do is double our care, double our economic support of the community, and, number one, improve our services,” says Bonar, who is Navajo.

Bonar attributes the health system’s success to a few factors. For example, tribally run health systems can apply for grants, such as one from the Health Resources and Services Administration that pays for the mobile units—something that IHS-run health systems are not eligible to do. Self-governance also gives tribes more control over exactly how they use their federal health care dollars, and the extent to which they can reinvest any profits they make into their own health systems. On the one hand, if a health system struggles financially, there’s no federal headquarters or operations in other geographic areas to bail it out. On the other hand, successful tribes get to keep their hard-earned profits.

But perhaps the biggest factor in the Tuba City health system’s success, accounting for a whopping 65 percent of its third-party reimbursement dollars and thus much of its growth, is Medicaid. Or, more specifically, Medicaid expansion. Arizona is one of the thirty-one states that, along with the District of Columbia, expanded eligibility for Medicaid under the Affordable Care Act (ACA) to nearly all residents with incomes at or below 138 percent of the federal poverty level (\$27,821 for a family of three in 2016).⁴ Nineteen of the states that expanded Medicaid contain at least one federally recognized tribe.⁵ Arizona is home to twenty-two.

Though according to treaties and trust agreements, American Indians and Alaska Natives are entitled to health care provided through IHS or tribal facilities, IHS is known as the “payer of last resort.” In other words, if a patient has any other type of health insurance, that will be tapped first to pay for care.

So it’s no surprise that in Arizona, tribes and their advocates are worried

about what proposed health reforms in the administration of President Donald Trump could mean for Medicaid and the ability of Indian health systems to stay afloat. According to the Self-Governance Communication and Education tribal consortium, in states with at least one tribe, nearly 1.5 million American Indians and Alaska Natives were enrolled in Medicaid in 2015, including 149,385 in Arizona—up from 128,848 in 2013, before the expansion. In 2015, 1,025,585 were on Medicaid in expansion states, as were 459,880 in nonexpansion states.⁵ In fiscal year 2016 IHS and tribally run facilities received \$808 million in Medicaid funding.⁶

“What’s really important is that we keep our third-party funding, that Medicaid doesn’t become more stringent for us to access,” Bonar says.

But with potential changes on the table, such as work requirements for Medicaid enrollees, an end to federal funding of the Medicaid expansion, and per capita spending limits for states, tribes in Arizona and elsewhere may have cause for concern.

Medicaid in Indian Country

The mobile medical unit parks outside of LeChee’s brick-and-mortar clinic, which is short on providers and needs the extra help. Patients trickle in throughout the day to see the nurse practitioner on duty and her nursing assistant. One patient leaves with her eye bandaged; another is treated for knee pain during a break from her job in the nearby, off-reservation town of Page, Arizona. A third wants the stitches on his finger removed, but he can’t provide the necessary proof of a recent tetanus shot. He leaves, determined to remove the stitches himself. Some patients traveled more than an hour to get to the mobile unit, which provides care at ten locations in the region.

As each patient is registered, Clarissa Begay, a patient navigator and benefits coordinator from Tuba City Regional Health Care, asks the same question: “Do you have health insurance?”

Many patients who visit the mobile medical unit do, through Arizona’s Medicaid program—the Arizona Health Care Cost Containment System, or AHCCCS. Many others are eligible for insurance, and it’s Begay’s job to help

them get covered.

At Tuba City Regional Health Care Corporation, Begay and other benefits coordinators work diligently to make sure that Medicaid or other third-party payments, rather than IHS dollars, are used to pay for care whenever possible. Bonar says that tribally run health systems seem to be more aggressive about ensuring that these dollars are captured, be it from Medicaid, Medicare, or commercial insurers. At Gila River Health Care, a health system run by the Gila River Indian Community south of Phoenix, about half of the visits in fiscal year 2016 were covered by Medicaid, and compared to the money the tribe got from IHS, third-party payments made up twice as much of the health system’s operating revenue.⁷

But it’s not just tribally run systems that depend on payments from Medicaid. Urban Indian Health Programs—nonprofits that are funded through a variety of sources and serve natives and nonnatives alike—have never received more than 1 percent of the IHS budget and thus rely heavily on payers such as Medicaid, says Walter Murillo, CEO of Native Health, an Urban Indian Health Program in Phoenix.

“At the height of the recession, before the ACA, we had an 85 percent uninsurance rate at our west clinic [in Phoenix],” Murillo says. Now the uninsurance rate is under 10 percent at that clinic and throughout the Native Health system, he says, crediting the Medicaid expansion. Native Health recently received a grant from the Centers for Medicare and Medicaid Services to enroll more American Indians in Medicaid or Marketplace plans and other social benefit programs.

Even IHS seems to be becoming savvy about getting the most out of Medicaid: Recently the Whiteriver IHS Service Unit in Arizona implemented a new auditing process that allowed it to recoup an average of \$2.5 million more per quarter on third-party claims by detecting payment sources that had previously been missed.⁸ In July 2016 IHS launched a pilot program aimed at increasing Medicaid and Medicare enrollment of IHS patients at six health facilities in four states, including the Phoenix Indian Medical Center and facilities in Montana, North Dakota,

and South Dakota.⁹

One particular area where extra Medicaid funding has allowed tribes to really stretch IHS dollars is in referrals to private health care providers outside of IHS or tribal facilities. “Purchased/referred care,” as it is called, would cover, for example, a visit to a hospital or specialist in Phoenix if the hospital in Tuba City couldn’t provide the care a patient needed. The visit would be paid for with IHS dollars at a rate negotiated with the private providers.

But the IHS budget for these referrals has historically been so tight that only the most critical care (medical priority level 1) could be paid for, and everything else had to wait. An infamous saying within Indian Country—“Don’t get sick after June”—refers to the fact that at a certain point in the year, IHS funds run out, and purchased/referred care, in particular, may be denied or deeply rationed.

“Level 1 is life and limb,” says Mary Smith, the former IHS principal deputy director. “In states where there was Medicaid expansion, IHS was able to [pay for] care for above level 1.”

This means that the referral dollars could go toward preventive services, primary care, and chronic care (medical priority levels 2–4)—for instance, in situations where a person didn’t live near a tribal or IHS facility, or when tribal or IHS facilities were understaffed and couldn’t provide timely care.^{10,11}

“I can’t underestimate the impact that any kind of rollback on the Medicaid expansion would have for American Indian and Alaska Native people and for IHS,” Smith says.

Concerns About Cuts

The day after the LeChee trip, the mobile medical unit is stationed in front of a small market in Kaibeto (or K’ai’bii’to’ in the Navajo language), a community along State Road 98 that is over an hour from Tuba City. Job options in Kaibeto include hourly work at that small market, positions at the local boarding school, and a handful of local government jobs. Some tribe members will drive to the nearest cities for work, but others won’t bother.

Recent health reform proposals from the House and Senate would have given states the option of adding a work re-

Self-governance gives tribes more control over exactly how they use their federal health care dollars.

quirement as a condition of receiving Medicaid benefits. Arizona has been trying to add such a requirement to its Medicaid program in the past couple of years, so far unsuccessfully.¹² Arizona Senate Bill 1092, enacted in 2015, requires AHCCCS to apply for a waiver or amendments to Arizona’s current section 1115 waiver—every year until such a new waiver or amendment is approved—to add the work requirement and a provision that caps lifetime eligibility for Medicaid at five years for most able-bodied adults. Though the move was a nonstarter in the administration of President Barack Obama, the Trump administration has signaled its support for waivers intended to increase employment or job training.¹³

In Indian Country, however, unemployment is high. Arizona is one of several states where fewer than half of Native American adults living on or near tribal lands are working.¹⁴ Tribes want to improve those numbers by training people for skilled jobs and increasing job options, but the Medicaid requirement might be a bridge too far, advocates for tribes say.

“We always want people to be gainfully employed when you can be,” says Marilyn Malerba, chief of the Mohegan Tribe, in southeastern Connecticut, and chairwoman of the IHS Tribal Self-Governance Advisory Committee. “On the other hand, if you’re in an area that has 60 percent unemployment rate, you’re really just being punished for the fact that there is no work locally.”

If it’s harder to sign up for Medicaid, Malerba adds, many people in Indian Country just won’t do it, since they always have the option of receiving health care through IHS or tribal facilities.

“We encourage our tribal citizens, if they’re eligible for alternate resources, to apply for them because that allows our meager Indian Health Service dollars to go further,” she says.

The potential work requirement and

Medicaid expansion rollback aren’t the only aspects of ACA repeal and replacement efforts that have some members of tribes worried. Some are also concerned that switching Medicaid to state-run block grants would shift the responsibility for providing Indian health care from the federal government to the states, which might not be in a tribe’s best interest. The Senate and House bills from May and June clarified that Medicaid claims from IHS and tribal health care facilities would continue to be paid entirely with federal dollars, rather than state funds.^{15,16} (Urban Indian Health Programs aren’t included in this arrangement, however.) In addition, the recent proposals would have exempted IHS and tribal health care facility reimbursements from per capita spending caps and from optional block granting. As of late July those proposals had stalled; a newer bill would simply repeal the ACA and give Congress time to craft a replacement. Tribes are concerned that any ACA replacement would gut the Medicaid program, adversely affecting care for American Indians and Alaska Natives as states look for ways to tighten their belts.¹⁶ The Congressional Budget Office projected that the Senate’s June 22 discussion draft of the Better Care Reconciliation Act would reduce Medicaid spending by 26 percent by 2026.¹⁷

The GOP is also interested in repealing the cost-sharing reduction provisions in the ACA. These provisions made it particularly affordable for Native Americans to buy plans in the Marketplaces. Under the ACA, American Indians and Alaska Natives with incomes of 100–300 percent of the federal poverty level could enroll in a Marketplace plan that had no copayments, deductibles, or coinsurance—and they might have qualified for premium tax credits as well. An estimated 60,000 American Indians and Alaska Natives were enrolled in a Marketplace plan as of December 2016.¹⁸

There are a few things about the GOP reform efforts that some members of tribes appreciate, however. One is the elimination of the mandate for employers to provide health coverage, which most tribal governments opposed. Another is the permanent reauthorization of the primary legislation governing the Indian health system (the Indian Health

Care Improvement Act, originally passed in 1976 and updated and permanently reauthorized under the ACA). Among other things, the Indian Health Care Improvement Act clarifies that tribes and IHS can bill Medicaid and other third-party payers and that this money shouldn't offset the federal funding that tribes are entitled to.⁶ Finally, tribes are optimistic that reform efforts will include some funding to address the opioid epidemic, which has hit Indian Country particularly hard.¹⁹

"There are some things in the ACA that didn't work out for tribes that we'd like to try to change," says Aaron Payment, secretary of the National Congress of American Indians and chairperson of Sault Tribe of Chippewa Indians.

Funding Needs For Aging Facilities

Lynette Bonar sits at her desk at Tuba City's hospital, burdened with back-to-back meetings and a lot on her mind. It seems she's always thinking ahead about what else the health system needs—and always considering how to pay for it.

One thing she'd been looking forward to from the current administration was a new proposal to upgrade the nation's infrastructure, a stated priority of the president. IHS hospitals are forty years old, on average, which is almost four times older than other US hospitals.²⁰ These older facilities no longer meet tribes' needs and can even pose risks to patients, IHS says. In its 2016 facilities needs assessment, the agency estimated that its current facilities meet

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only about 52 percent of the space needs of the American Indian and Alaska Native population.²⁰

Tuba City's hospital, built in the 1970s, is in desperate need of upgrades, Bonar says.

"Last year we had to spend \$1.3 million on our boilers," she says. "One of the biggest expenses of an old building is keeping it up-to-date."

In 2011 Tuba City Regional Health Care spent about \$7 million to build a three-story modular building on the hospital campus to keep up with growing demand.

"We had four internal medicine doctors in three or four exam rooms," Bonar says. "If you know anything about health care, [you know] that is very inefficient."

The organization may have to wait years for upgrades to the main hospital. The current IHS construction priorities list was last updated in 1991 and, according to the Indian Health Care Improvement Act, every project on it must be completed before new facilities are added to the list.²¹

"It's going to be years before they open

that list up again," Bonar says.

The Trump administration's fiscal year 2018 budget request proposed to "support" \$1 trillion in public and private infrastructure investments (including some federal funding). However, some tribe members did not see anything positive for them in the fiscal year 2018 request for the Department of Health and Human Services, which proposed to reduce IHS funding by \$300 million from the amount authorized in the fiscal year 2017 omnibus spending bill, to \$4.7 billion.²²

The budget request achieves most of its cuts to the IHS through major reductions to IHS facilities funding, the National Indian Health Board says.²³

"Certainly there are a lot of challenges at the agency, and there's some management challenges," Smith, the former IHS principal deputy director, says. To be sure, these challenges need to be addressed so that funds can be spent as effectively and efficiently as possible. "But you can't parse out those types of challenges from the physical infrastructure challenges that these facilities have," Smith says. "I was disappointed in the administration's budget for IHS and hope that Congress is paying attention." ■

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