Arizona Section 1115 Waiver Amendment Request
Reimbursing Outpatient Care to Inmates on Reservation

I. Overview

The State of Arizona is home to 22 tribes and approximately 300,000 American Indians/Alaska Natives (AI/AN). Nearly half of the AI/AN population is enrolled with the Arizona Health Care Cost Containment System (AHCCCS), Arizona's single state Medicaid agency. Most of the AHCCCS enrolled AI/AN population receives their care on a fee-for-service basis through Indian Health Services (IHS) facilities and facilities operated under PL 93-638 (638 facilities). Medicaid is the most important third party payor to the IHS and 638 healthcare delivery system.

One of the largest 638 facilities, Tuba City Regional Health Care Corporation located on Navajo Nation, has recently had to absorb the cost of care for the population incarcerated within the Navajo Detention Facility at Tuba City, even though these patients are federal trustees for whom the facility would otherwise be receiving reimbursement from Medicaid. Lack of availability of Medicaid funding for the care provided to these inmates is proving unsustainable for the Tuba City Regional Health Care Corporation, one of the most critical providers of care to the AI/AN Medicaid enrolled population in Arizona.

The purpose of this demonstration is not to have Medicaid serve as the long-term funder for this care. Rather, the purpose of this request is to

- **Preserve access to care for a critical Medicaid population** that is largely American Indian living in rural and frontier areas; and
- **Collect data to establish a line item within the Indian Health Services** budget as more of these facilities are built on reservation.

Accordingly, AHCCCS seeks the following authority:

- **Comparability:** Waiver authority – Waiver from Section §1902(a)(10)(B) of the Social Security Act and corresponding regulations at 42 CFR §440.240, to allow the State to reimburse for outpatient services provided by Tuba City Regional Health Care Corporation to individuals incarcerated at Navajo Detention Facility at Tuba City.
- **Reimbursement CNOM:** Expenditure authority – waiver from 42 USC § 1396d(a)(29)(A) and 42 CFR § 435.1009(a)(1) – to allow the State to pay for outpatient services provided by Tuba City Regional Health Care Corporation to AHCCCS eligible individuals that are incarcerated in the Tuba City Jail.

II. Public Process

This amendment request was discussed in an open tribal consultation on August 15, 2013 that included tele-conferencing capabilties. (For meeting summary see http://www.azahcccs.gov/tribal/consultations/meetings.aspx.) No comments were received. This amendment request was also discussed at a meeting of the State Medicaid Advisory Committee on April 9, 2014. (See meeting summary at http://www.azahcccs.gov/community/meetings/SMAC.aspx.) This amendment request is posted to the AHCCCS website here: http://www.azahcccs.gov/reporting/federal/waiver.aspx.

Arizona Section 1115 Waiver Amendment Request
Reimbursing Outpatient Care to Inmates on Reservation

III. Data Analysis- "With Waiver" vs. "Without Waiver"

The services for which AHCCCS proposes to reimburse are currently reimbursed through the all-inclusive rate. Payments will be made with 100% Federal Financial Participation (FFP) dollars available only for services provided by Tuba City Regional Health Care Corporation to individuals incarcerated within Navajo Detention Facility who are otherwise Medicaid eligible and eligible to receive services within Indian Health Services or tribally owned or operated 638 facilities.

IV. Allotment Neutrality

N/A. The amendment does not impact the XXI population.

V. Details

The Arizona Health Care Cost Containment System (AHCCCS) administers Medicaid to over 1.4 million Arizonans. Arizona is also home to 22 tribes and approximately 300,000 American Indians/Alaska Natives. Over a quarter of the area of the State of Arizona is reservation land.

Nearly half of Arizona's AI/AN population is enrolled in the AHCCCS program. While Arizona follows a mandated managed care model, the AI/AN population maintains the option of receiving healthcare services on a fee-for-service basis, largely through Indian Health Services (IHS) facilities and facilities operated under PL 93-638 (638 facilities).

Arizona has a robust IHS and 638 healthcare delivery system. Despite the fact that the federal government has a trust responsibility to provide health care services to the AI/AN population enrolled in federally recognized tribes, these facilities depend on the Medicaid program as their largest and most important third party payor. The practical implications, from a financial perspective, of policies that limit the Medicaid fund flow into IHS and 638 facilities can not only be devastating to the specific facility impacted but also impairs the ability of the federal government to fulfill its trust responsibility and restricts access to care for Medicaid beneficiaries who depend on the IHS and 638 system.

One of the largest tribally operated 638 facilities, Tuba City Regional Health Care Corporation (TCRHCC), is experiencing such a challenge. TCRHCC is located within the Navajo Nation and serves Arizona's AI/AN population from all tribes across the State, but primarily individuals enrolled with the Navajo Nation. Recently, a 132 bed jail, the Navajo Detention Facility, was constructed in Tuba City with no budget for correctional health. The Navajo Detention Facility opened its doors in May 2013 and additional inmates are expected to be sent to this facility in the coming months. In May 2013, TCRHCC screened the inmates and the staff and discovered 44 tuberculosis (TB) exposures. In June 2013, the second suspected TB case proved to also be HIV positive. That inmate is in Flagstaff in an intensive-care unit.

Arizona Section 1115 Waiver Amendment Request
Reimbursing Outpatient Care to Inmates on Reservation

Three federal agencies share authority for tribal correctional healthcare at the Navajo Detention Facility: U.S. Department of Justice, Office of Justice Programs; U.S. Department of the Interior, Bureau of Indian Affairs; and the U.S. Department of Health and Human Services, Indian Health Services. None of these entities have a tribal correctional healthcare budget. Additionally, the Navajo Nation has no tax base to support the cost of operating the Navajo Detention Facility, including the healthcare needs of the inmates.

The Navajo Detention Facility presents a unique set of issues. Traditionally, jail facilities on reservation are outdated and hold a very limited population – up to a dozen in most cases. The Navajo Detention Facility is one of only three modern and larger correctional facilities on reservation and is the first modern corrections facility built on the Navajo Nation. These modern facilities are intended to house dramatically larger inmate populations (hundreds, not dozens) and incarcerate inmates for longer periods (months and years, not days/weeks). The Navajo Detention Facility is one of these new modern facilities built using funds from the American Recovery and Reinvestment Act of 2009 (ARRA). While an infirmary was built as part of the detention facility, no funding was included to actually provide correctional health, including infectious disease screening or treatment.

TCRHCC is technically the jail's healthcare authority, yet there are no funds to pay for the outpatient medical treatment of the Navajo Detention Facility inmates. Moreover, the annual federal allocation that TCRHCC receives to cover the cost of care for its current service area comprises just 16.31% of the total TCRHCC annual budget. Eliminating Medicaid funding for a significant portion of the patient base puts TCRHCC on an unsustainable path jeopardizing access to care for many AI/ANs, including a significant Medicaid population, who depend on that facility.

The demographics of the Navajo Nation lead to the conclusion that most of the Navajo Detention Facility jail population will be eligible for Medicaid. The 2010 Census revealed a 50% unemployment rate for Navajo Nation in 2007. At least 37% of Navajo Nation members live below poverty. However, Federal Financial Participation (FFP) is not allowed to cover outpatient services to incarcerated individuals (42 USC § 1396d(a)(29)(A) and 42 CFR § 435.1009(a)(1)).

While this limitation makes sense considering the responsibility of inmate healthcare for state and local governments, it does not comport with the federal trust responsibility for healthcare to the AI/AN population. Even while incarcerated, the AI/AN population remains a federal trustee, housed in a federally funded facility, located on federal trust land under the authority of the BIA who receive outpatient services from another federally funded and federally overseen facility (TCRHCC). Thus, the federal definition of an inmate of a public institution (42 CFR § 435.1010) is not applicable under this scenario. It must also be noted that under the current system, the federal trust responsibility with respect to the provision of health care has been largely sustained by the Medicaid program. Accordingly, the role of Medicaid must be considered in this discussion.

VI. Evaluation Design

A section 1115 demonstration at TCRHCC that would waive the federal prohibition against FFP for outpatient services provided to inmates of facilities located on reservation is critical to informing federal policy regarding correctional health of these institutions. If additional large-scale facilities such as Navajo Detention Facility are going to be built on reservation in the future, the issue of correctional health must be addressed. Today, the exposure to the Centers for Medicare and Medicaid Services (CMS) is minimal since the Navajo Detention Facility is one of only three such facilities, making this an excellent demonstration opportunity.

The charts created by TCRHCC in **Appendix A** outline best and worst case scenarios at TCRHCC that reflect outcomes with and without waiver. These charts serve as an excellent opportunity to evaluate the efficacy and importance of this demonstration.

Accordingly, the demonstration would support:

1. Collection of data to identify the needs and costs associated with tribal inmate healthcare that would be used to create a budget line item for IHS.
2. Creation of a new model of cross collaboration between tribal corrections and healthcare to protect the public health and decrease costs by supporting a continuum of care once the inmate is released.

VII. Conclusion

Arizona's Medicaid program is proposing to reimburse for outpatient services provided by Tuba City Regional Health Care Corporation, a tribally operated 638 facility, to the inmates of the Navajo Detention Center who would otherwise be Medicaid eligible. These inmates do not fit the definition of inmate of a public institution as defined in 42 CFR § 435.1010 because, as members of federally recognized tribes, they remain federal trustees while incarcerated. Under the federal trust responsibility, these inmates are entitled to health care through the IHS and 638 system. Medicaid is the largest payor of that system. Without maintaining Medicaid reimbursement, these facilities are unable to sustain services to Medicaid beneficiaries in this rural area.

The purpose of this demonstration is not to have Medicaid serve as the long-term funder for this care, but rather to (1) preserve access to care for a critical Medicaid population and (2) collect the needed data to support establishment a line item within the Indian Health Services budget as more of these facilities are built on reservation.

APPENDIX A

TUBERCULOSIS
TCRHCC has an Encounter Based Payment Methodology

An **Outpatient Encounter**, under the Code of Federal Register in 2013, is paid at $316.00. Facilities in Arizona are allowed 5 outpatient encounters per 24 hour period. One facility visit under a coordinated care model would average 3 encounters.	**Inpatient** is reimbursed at the all inclusive rates under the Code of Federal Register for the year 2013 is paid at $2165.00 per day.
$948.00 is cost of typical 3 encounter visit	$2,165.00 is cost of (1) 24 hour period of inpatient care

BEST CASE SCENARIO
in which FFP is extended to cover cost of providing inmates outpatient care

OUTPATIENT CARE AND COST	INPATIENT CARE AND COST
14 exposed inmates have latent Type 2 TB that does not turn active because they have healthy immune systems. All 14 are able to access 9 sessions of outpatient treatments, which is the recommended course of clinical care to prevent latent TB from becoming active. Each inmate's monthly outpatient visit includes 3 encounters for blood draw, chest xray and pharmacy visit.	Individual with active Type 1 TB requires 21 days of inpatient treatment in an isolated room at TCRHCC that has negative air flow ventilation designed to prevent spread of bacterium. Patient does not have complications from cohort diseases and will therefore not need readmission.
$8,532 per person annually	$45,465 Annually
$119,448 for 14 exposed people	

WORST CASE SCENARIO
in which FFP is not extended to cover cost of providing inmates outpatient care

OUTPATIENT CARE AND COST	INPATIENT CARE AND COST
14 exposed inmates all develop active Type 1 TB because they all have compromised immune systems. Outpatient care is unavailable to treat their chronic diseases. These 14 people each expose 14 more inmates, who are similarly at high risk of developing contagious Type 1 TB. 196 inmates become contaminated with this highly infectious disease that is spread by coughing, sneezing and hand contact.	Individual who is initial super spreader of TB requires 21 days of inpatient treatment, as do all other 195 people contaminated (this scenario does not consider future inpatient readmissions from co-morbidity diseases). TCRHCC has only has 4 negative air flow ventilation rooms to accommodate TB isolation and care. 192 inmates must be transported to definitive treatment off reservation, thus triggering Arizona's state wide disaster plan. TCRHCC exhausts 2/3rds of its annual IHS Contract Health Care allocation just to pay for costs of transferred inmates.
$0 outpatient cost	$25,000 per person for transportation x 192 = $4,800,000 Total cost of care for 196 active Type 1 TB cases = $13,711,140 Grand total = 18,511,140

APPENDIX A

COST SAVINGS FROM BEST CASE SCENARIO VERSUS WORST CASE SCENARIO = $903,081/per person

HIV/AIDS
TCRHCC has an Encounter Based Payment Methodology

An **Outpatient Encounter**, under the Code of Federal Register in the year 2013, is paid at $316.00. Facilities in Arizona are allowed 5 outpatient encounters per 24 hour period. One facility visit under a coordinated care model would average 3 encounters	**Inpatient** is reimbursed at the all inclusive rates under the Code of Federal Register for the year 2013 is paid at $2165.00 per day
$948	$2,165

BEST CASE SCENARIO
in which FFP is extended to cover cost of providing inmates outpatient care

OUTPATIENT CARE AND COST	INPATIENT CARE AND COST
Controlled disease process for patient with HIV diagnosis. Evaluated 6 times a year with a primary care doctor. 3 encounters per visit.	Due to access to outpatient medical services, with ongoing evaluation by primary care doctor, no inpatient admission necessary.
$948 x 6 = $5,688.00 Annually	$0.00 Annually

WORST CASE SCENARIO
in which FFP is not extended to cover cost of providing inmates outpatient care

OUTPATIENT CARE AND COST	INPATIENT CARE AND COST
HIV progresses to AIDS due to uncontrolled disease process. No access to outpatient medical services. Patient evaluated once in the emergency room.	HIV progresses to AIDS due to uncontrolled disease process. Patient admitted 8 times a year for 7 days per admission for End Stage Liver Disease.
$316.00 Annually	$121,240.00 Annually

COST SAVINGS FROM BEST CASE SCENARIO VERSUS WORST CASE SCENARIO = $115,552/per person

APPENDIX A

HEPATITIS C
TCRHCC has an Encounter Based Payment Methodology

An **Outpatient Encounter**, under the Code of Federal Register in the year 2013, is paid at $316.00. Facilities in Arizona are allowed 5 outpatient encounters per 24 hour period. One facility visit under a coordinated care model would average 3 encounters.	**Inpatient** is reimbursed at the all inclusive rates under the Code of Federal Register for the year 2013 is paid at $2165.00 per day
$948	$2,165

BEST CASE SCENARIO
in which FFP is extended to cover cost of providing inmates outpatient care

OUTPATIENT CARE AND COST	INPATIENT CARE AND COST
Controlled disease process for patient with HIV diagnosis. Evaluated 6 times a year with a primary care doctor. 3 encounters per visit.	Due to access to outpatient medical services, with ongoing evaluation by primary care doctor, no inpatient admission necessary.
$5,688.00 Annually	$0.00 Annually

WORST CASE SCENARIO
in which FFP is not extended to cover cost of providing inmates outpatient care

OUTPATIENT CARE AND COST	INPATIENT CARE AND COST
Uncontrolled disease process results in emergency room visit.	Uncontrolled disease process. Without access to outpatient medical services, disease process progresses. Patient is admitted 8 times a year for 5 days per admission for End Stage Liver Disease.
$316.00 Annually	40 x $2,165 = $86,600.00 Annually

COST SAVINGS FROM BEST CASE SCENARIO VERSUS WORST CASE SCENARIO = $80,912/per person

APPENDIX A

DIABETES
TCRHCC has an Encounter Based Payment Methodology

An **Outpatient Encounter**, under the Code of Federal Register in the year 2013, is paid at $316.00. Facilities in Arizona are allowed 5 outpatient encounters per 24 hour period. One facility visit under a coordinated care model would average 3 encounters.	**Inpatient** is reimbursed at the all inclusive rates under the Code of Federal Register for the year 2013 is paid at $2165.00 per day.
$948	$2,165

BEST CASE SCENARIO
in which FFP is extended to cover cost of providing inmates outpatient care

OUTPATIENT CARE AND COST	INPATIENT CARE AND COST
Controlled disease process for patient with diabetes. Evaluated 4 times a year with a primary care doctor. 3 encounters per visit.	Due to access to outpatient medical services, with ongoing evaluation by primary care doctor, no inpatient admission necessary.
$3792.00 Annually	$0.00 Annually

WORST CASE SCENARIO
in which FFP is not extended to cover cost of providing inmates outpatient care

OUTPATIENT CARE AND COST	INPATIENT CARE AND COST
Uncontrolled disease process results in emergency room visit.	Uncontrolled disease process. Without access to outpatient medical services, disease process progresses. Patient is admitted admitted 6 times a year for 3 days per admission for Diabetic Ketoacidosis.
$316.00 Annually	$38,970.00 Annually