National Indian Health Board

Results Summary: Listening Session on CMS Framework for Health Equity

On September 28, 2022, NIHB and the CMS held an in-person Listening Session on Health Equity during the NIHB 2022 National Tribal Health Conference in Washington, D.C. During this Listening Session, CMS presented the CMS Framework for Health Equity. Additionally, NIHB shared a summary of the results from previous health equity events. Participants then had an opportunity to provide additional feedback on how CMS can improve health equity work in Indian Country. About 100 participants attended the Listening Session.

The CMS Framework for Health Equity, published by the CMS Office of Minority Health in July 2022, lays out five priority areas for advancing health equity that will be pursued agency-wide. The Framework states, "As the nation's largest health insurer, the Centers for Medicare & Medicaid Services has a critical role to play in driving the next decade of health equity for people who are underserved. Our unwavering commitment to advancing health equity will help foster a health care system that benefits all for generations to come."

Figure 1: CMS Framework for Health Equity Priorities

The September Listening Session specifically focused on getting Tribal feedback on the Framework. Participants were glad to see the administration is working on health equity and claiming it as a priority, and they appreciated that CMS was actively seeking feedback from Tribes and were glad for the opportunity to participate in the process.

In general, participants agreed with the broad priority areas laid out by the CMS Framework for Health Equity. Most participants agreed that improving data – and especially improving the visibility of AI/AN within CMS data – is a critical step to advancing health equity. Many also commented on the relevance and importance of culturally tailored services in Indian Country, although some wanted to see this section go further. In general, the priorities around addressing inequities in policies and building capacity of health care organizations also resonated. Another commenter mentioned that it was promising to see references in CMS's health equity plans to "screening and broader access to health-related social needs" and to "improving coordination for dual-eligibles", as these support a holistic, empowering, strengths-based approach that elevates the voices of enrollees and expands focus on social determinants of health.

Unfortunately, most participants also felt the CMS Framework for Health Equity "misses the mark" in some important ways when it comes to Tribes. Multiple participants commented that it seemed like AI/ANs were being shoehorned into the plan, grouped in with everyone else experiencing inequities in a way that did not make sense and would not be effective in advancing health equity for AI/ANs. Participants agreed that any effective efforts for health equity in Indian Country must approach health equity plans through the lens of Tribal sovereignty, the nation-to-nation relationship, and the federal trust responsibility, as well as conceptualize the work around an understanding of AI/ANs as a group with a unique political status, not as a racial minority. Because the Framework does not include these things, most participants felt it held limited relevance to Tribal communities and AI/ANs. In the words of one commenter, "Their plan totally excludes us." This sentiment was commonly expressed by participants.

Other comments discussed how this framework appears to be more of a "health disparities plan" than a "health equity plan", since it contains little mention of the strengths, assets, and resilience of the people experiencing health inequities. Focusing solely on problems and disparities can leave the inaccurate, harmful impression that the communities experiencing inequities are somehow inherently deficient – thereby undercutting these communities' self-determination and setting the stage for government paternalism. Instead, a health equity plan should recognize that the answers for achieving health equity for a community lie within that community; the strengths, assets, and resilience of individuals and communities are vital to any effective path to health equity. The federal government is most effective in working towards health equity when it puts its resources behind supporting the leadership of local communities. Tribes know their people, communities, social and historical context, needs, and strengths best – Tribes are the experts in charting a path to health equity for their people.

Participants emphasized that if the agency is to succeed in accomplishing its laudatory goals for health equity, CMS will need to rethink its approach to health equity in Indian Country. As CMS moves forward in this critical health equity work, success will require both a nuanced understanding of

> "If you're going to address equity issues, you're going to have to deal with Indian people differently than you've done in the past. You're going to have to do something structurally different... You're going to have **to treat Tribal governments, Tribal programs from a different standpoint**."
>
> - Listening Session Participant

the unique context of Tribal health equity and a commitment to action.

CMS can strengthen their health equity planning through these four areas of focus that emerged from the September Listening Session:

- **Recognition**
- **Reimbursement & Resources**
- **Data**
- **Action & Accountability**

Recognition

Working towards health equity must begin with a fundamental understanding that **equity is not the same as equality**. While an "equality approach" would dictate that every person or community should be given the same thing in the same way, an "equity approach" recognizes that different individuals and communities will need different things for everyone to achieve optimum health. Health equity can never be achieved through a "one size fits all" approach, since every community has different needs, strengths, assets, social and historical context, cultural values, and other unique elements. This is especially true when it comes to American Indians and Alaska Natives, who have unique rights, political status, and history with the U.S. government. When U.S. government agencies like CMS set out to work on health equity for AI/AN, this work must take a different path, process, and form than health equity work supporting other populations and communities. CMS must recognize the unique position of Tribes and how approaching AI/AN health equity is distinct from other health equity work.

As one participant summarized their group discussion, this starts with "the political and legal recognition of Indian people, and that the framework should be or could be more inclusive and recognize this distinction of Tribal governments in the actual narrative of the framework." The participant went on to explain that it is essential to include this recognition in the CMS Framework for Health Equity "because unless it's actually included in the guiding document, then how is it possible for leadership to create policy priorities to carry out this responsibility to Indian people? And it's also important for the rank and file within the agency itself because unless it's some type of a guiding document or a policy priority of leadership, it doesn't become a priority for the rest of the people that are carrying out policies and priorities within the agency."

To effectively advance health equity in Indian Country, CMS must recognize:

- **Tribal sovereignty**
- **The federal trust responsibility**
- **"AI/AN" as primarily a political status, not a race**
- **The legitimacy and importance of Indigenous knowledge and traditional medicine**
- **The wide diversity of Tribes**

While some participants expressed the position that true support for Tribal sovereignty and fulfillment of the federal trust responsibility would mean ensuring Indian health programs were fully funded directly, instead of passing funding through Medicare and Medicaid, others pointed out some specific elements CMS should consider:

Meaningful consultation. Tribal consultation should be timely, meaningful, and robust. It requires two-way communication and collaboration, not just informing Tribes about decisions that have already been made. Tribal consultation must be held at the policy-development stage whenever a change is being considered that will impact Tribes or AI/AN – including sub-regulatory and nonregulatory guidance, like billing manuals and fee schedules. Documents like the CMS Framework for Health Equity should also go through Tribal consultation. Consultation should be with high-level government officials, as well as with agency subject-

matter experts and designated Tribal liaisons. As Medicaid is a federal program administered through states, CMS has a responsibility to ensure states are conducting all necessary Tribal consultations, and that these consultations are meaningful and robust.

Training on Tribal sovereignty and the federal trust responsibility. To honor the federal trust responsibility, CMS needs to ensure that anyone involved in implementing CMS programs has proper understanding of Tribal sovereignty and the federal trust responsibility, in addition to CMS's specific role in upholding them. This means ensuring sufficient training for CMS employees and the employees of state Medicaid agencies and managed care organizations. Participants cited a lack of understanding as a consistent barrier when working with these entities.

Self-governance in Medicaid programs. Respecting Tribal sovereignty, in large part, means deferring to local control - supporting Tribes and Urban Indian Organizations (UIOs) to make decisions for themselves on the best way to run programs. Ensuring sufficient flexibility and support for Tribes and UIOs to design their own solutions and priorities for health equity is both more effective and more respectful of Tribal sovereignty. One example shared in the Listening Session was how Alaska has assumed management of Medicaid travel for Tribal beneficiaries within the Tribal system, which was more effective and cost-saving in a state with so many unique travel challenges. As a participant explained, "that's a self-governance model of managing Medicaid travel on behalf of the Medicaid program. If you were to implement more self-governance processes into your systems, you could achieve many of the issues associated with addressing health disparities." Others suggested Tribes should also have the ability to approve their own Medicaid patients.

Flexibility in Medicare. Tribes and UIOs want the flexibility to be innovative in how they deliver Medicare services, including engagement with traditional medicine and other cultural treatment modalities embedded into Medicare services.

Uniform Medicaid eligibility & benefits for AI/AN. The federal trust responsibility is owed to all AI/AN people, regardless of their state of residency. Therefore, all AI/AN should have access to the same baseline benefits no matter where they live, while allowing for some flexibility above that baseline for regional variations to meet diverse needs. To start with, CMS should encourage expanded Medicaid eligibility for AI/AN in states that have not expanded Medicaid; for example, by recommending and approving so-called '1115 waivers'.

Challenges with state Medicaid programs. Several Listening Session participants mentioned that it was inappropriate and frustrating that Tribes must work with states with regard to Medicaid programs since Tribes hold a Government-to-Government relationship with the U.S., not with the states. This is especially problematic in that states have vastly different priorities and goals in running their Medicaid programs than Tribes do, since Tribes are trying to ensure access to all necessary services for AI/AN to achieve their optimum health, while many states are primarily trying to reduce costs. These kinds of state goals run counter to the fulfillment of the federal trust responsibility. Furthermore, since state Medicaid programs are often administered through managed care organizations and Accountable Communities of Health, Tribes must expend resources coordinating with these additional entities. CMS is responsible for easing this burden on Tribes, facilitating the inclusion of Tribal priorities and perspectives into state Medicaid programs, and ensuring all state Medicaid programs appropriately uphold the federal trust responsibility.

Careful attention to language. Overall, participants found it inappropriate that Tribes and AI/AN were lumped into "racial and ethnic minorities" within the Framework. While racism (of historical, structural, and other forms) has led to many of the inequities facing Indian Country today, participants broadly agreed that focusing on race is not helpful in solving the problem. Reframing the context of AI/AN health equity away from being a racial issue and instead focusing on the unique rights and political status of AI/AN is an

empowering, strengths-based approach that supports Tribal self-determination. Also, the CMS Framework for Health Equity states, "effectively addressing mental health disparities among American Indians and Alaska Natives requires understanding healing, locally relevant coping strategies, and treatment that is consistent with cultural beliefs and practices within *this community*" (emphasis added). However, describing 574 sovereign nations as a singular community is inappropriate. The diversity of Tribes is important; language like this reinforces the myth that Tribes are monolithic.

Reimbursement & Resources

"Respecting sovereignty includes ensuring access to funding and technical assistance to carry out sovereign decisions - resources that colonialism has withheld," one participant in the Tribal Health Equity Summit explained. Medicare and Medicaid can play a significant role in supporting Tribal sovereignty by ensuring Tribes and Indian health organizations have the resources and funding necessary to meet their people's needs. Some participants observed that addressing the resource gap would go a long way towards accomplishing the health equity priorities outlined in the Framework.

> "Most tribes have internal understanding of what they need but lack support and resources to handle them."
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> – Listening Session Participant

These are some of the areas mentioned where additional CMS resources to Indian Country would materially support health equity for AI/AN, and realize the priorities of the Framework:

- **Reimburse for traditional healing services.** Integrating traditional health services with medical, dental, and behavioral health services allows for holistic care to tend to the mind, body, and spirit of AI/AN individuals. Participants shared multiple examples of how various health care programs are more effective at improving health for AI/AN people when they incorporate traditional medicine. Tribal nations, Tribal organizations, and UIOs have developed processes and policies for credentialing traditional practitioners in parity with western clinical privileges. They have also developed several traditional health models that CMS can reimburse. Medicare and Medicaid reimbursement of traditional health services would further integrate culturally appropriate services to improve health outcomes for AI/AN and advance health equity. Designing the paths to credentialing and billing for traditional healing services must be Tribally led and approached with sensitivity and cultural humility, since traditional healing often includes protected, sacred practices.
- **Resolve the "four walls limitation".** CMS's "four walls" interpretation of the Medicaid clinic benefit will soon prevent Medicaid-enrolled clinics from billing for services provided outside the physical four walls of the facility, once the temporary grace period for such services expires. This includes vital services tribal programs have furnished for decades at the off-site locations where they are most effective, such as schools, community centers, patients' homes, and by mobile crisis response teams. Participants shared examples of successful, culture-based health programs that have been disrupted by the imminent end of the grace period and that will be jeopardized when they can no longer be provided in the most culturally appropriate or effective location. Participants emphasized that location matters and discussed the importance of Indigenous spaces and locations accessible to their patients. The "four walls limitation" is contrary to the stated goals of the CMS Framework for Health Equity, as it hinders Indian health providers from providing accessible, culturally appropriate care.
- **Improve Medicaid prior authorization practices.** CMS should work with states on prior authorization to cover additional services and improve access to care for AI/AN beneficiaries. Many Indian health providers find their patients may come in for one service, but then discover additional services are needed. Often the needed services could be provided immediately, if not for the prior authorization requirement. Patients would be better served – and health equity advanced – if they can receive

needed care immediately, instead of requiring a return trip that may present additional barriers to care. According to participants, these prior authorization practices are ineffective and can create "logistics nightmares."

- **Provide billing and coding support.** CMS should provide resources to ensure sufficient staffing for billing and coding at Indian health facilities and provide additional training on billing and coding for clinics and providers.
- **Ensure rural providers have resources to provide high-quality care, including telemedicine.**
- **Provide resources to address social determinants of health, including traditional foods and other cultural life ways.**

Data

High-quality, meaningful AI/AN health data is essential for identifying disparities, setting priorities, designing strategies, and highlighting successes related to health equity. American Indians and Alaska Natives have come be known as the "Asterisk Nation" for how often AI/AN data is withheld and replaced by an asterisk to denote that the sample size was too small or the data was statistically unreliable. Racial misclassification, missing data, and other quality issues continue to impede the representation of AI/AN in many data sets. With AI/AN people and communities so often missing from the data, this becomes one more form of erasure of American Indians and Alaska Natives – our experiences are not represented, our needs are not heard, and our very existence becomes invisible. Improving data practices is crucially important as a step to undo the centuries of AI/AN erasure contributing to the ongoing health inequities in Tribal communities.

At the same time, governmental agencies need to recognize that some AI/AN individuals may be reluctant to self-identify as AI/AN because of the long history of harmful federal Indian policy. Individuals must always have the option of declining to disclose racial identification or Tribal affiliation. In addition, protecting individual data privacy and Tribal data sovereignty are critical.

Listening Session participants cited several priorities around data:

- **Address data quality.** Improve and expand the collection and reporting of data that identifies AI/AN status. Some suggestions for steps forward included:
    - Create penalties and incentives for compliance with higher data standards.
    - Enforce mechanisms within Electronic Health Records (EHR) to support entering correct demographic data.
    - Ensure EHR's do not default to "white" as the race selection.
    - Provide more uniformity in Medicaid applications.
    - Include "Tribal affiliation" in addition to race, including the ability to enter multiple Tribal affiliations. This supports Tribal sovereignty and puts the emphasis on AI/AN as a political status rather than a race.
    - Deliver more communication to enrollees on why this data is collected and how it will be used (explaining why this is important may encourage more enrollees to disclose demographic information).
- **Standardize definitions of AI/AN** across agencies, databases, and data warehouses. A standardized metric would support interoperability among data sets and expand analysis opportunities, in addition to helping within other grant programs with substantial reporting requirements, like those from the Health Resources and Services Administration (HRSA).
- **Respect Tribal sovereignty.**
    - Ensure any data collected is Tribally driven, ensuring the data collected is meaningful to Tribal communities.
    - Use sovereignty language, not presented as race data, and use Tribal affiliation.

    - Ensure two-way flow of data – data about Tribal members is Tribal data; Tribes must have access to this data.
- **Address reporting burden.** CMS needs to ensure that any reporting burden is accounted for – including time and resources required to comply with reporting requirements.
- **Facilitate Tribal data access.** Tribes and Tribal epidemiology centers need access to data to identify priorities, monitor trends, and support public health. CMS is required by federal law to provide this data access, as Tribal epidemiology centers and Tribes are public health authorities. Participants described how important it is to have data on all their Tribal members with Medicare and Medicaid, no matter where patients seek care, and discussed how difficult it can be to access this data from non-Indian healthcare providers or state agencies. Participants cited access to Medicare and Medicaid data as essential for advancing Tribal health equity priorities.
- **Provide resources for improving data.** CMS should provide Indian healthcare providers the resources needed to improve data processes and enable compliance. Participants also suggested it would be helpful to have CMS funding to assist Tribes in designing and conducting Tribal specific social determinants of health data assessments.

Action & Accountability

In the face of the reality of the drastic health inequities and high rates of preventable disease, disability, and death in Indian Country, participants understandably expressed frustration and concern that the creation of the CMS Health Equity Framework could be one more intellectual exercise that would not result in tangible benefit for AI/AN people. Many participants felt the document was too general to make a meaningful difference. One of the top priorities expressed by participants is for CMS to take action for health equity without delay.

These are some of the first steps participants said CMS should take:

- **Implement the CMS TTAG policy recommendations.** The CMS Tribal Technical Advisory Group (TTAG) recommendations provide concrete solutions to address many of the issues that arose during the Listening Session. Listening Session participants emphasized that since the TTAG specializes in improving how CMS programs function for Indian Country, these recommendations are all key to supporting health equity for American Indians and Alaska Natives. (See the section beginning on page 16 for more information).
- **Expeditiously create a health equity implementation plan.** This plan should contain timebound, actionable goals (with related metrics for accountability) for all operational divisions within CMS. It should also include specifics for how to effectively implement health equity strategies in Indian Country, informed by the feedback in this report.

> "There are recommendations from past federal reports that have been made dating back almost a hundred years ago. These provide a work plan in terms of how to move forward… We talked about the Meriam Report [from 1928]. We talked about the Indian Policy Review Commission report in 1978. We talked about 'A Quiet Crisis' in 2003, about 'Broken Promises I' in 2004, and then 'Broken Promises II' in 2018. These five federal reports all document the disparities of Indian people. There have been improvements in these disparities, but there haven't been any differences in closing that gap.
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> And our position is this: if you're going to address disparities as a health equity issue within the Federal Government, you have to do something distinctively different than you've done in the past that's been demonstrated by these reports."
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> - Listening Session Participant

- **Incorporate & act on the input from the three health equity events.** Some participants said it would be helpful to add a Tribal-specific supplement to the CMS Framework for Health Equity to fully incorporate the feedback from all three Tribal health equity events this year. Others said such an addition would only be useful if it was expeditiously executed, written by Tribes, and contained actionable priorities; these participants emphasized that the plan cannot be more "exploration", but must lead to action and results.
- **Communicate with Tribes and Indian health care providers** about upcoming and recent policy changes.
- **Work with sister agencies and the CMS Department of Tribal Affairs** to ensure an all-agency response to health equity and full inclusion of Tribal priorities and perspectives in CMS's health equity plans.
- **Keep accountable for achieving these health equity priorities.** Ensure Tribal participation is included in the accountability mechanism, so Tribes can speak to how well CMS is fulfilling commitments to health equity in Indian Country.
- **Hold states accountable.** States are not always supportive of Tribal health equity even when CMS is making it a priority. CMS should provide states with appropriate guidance for instituting the changes necessary to advance health equity for AI/AN and institute accountability measures to ensure states follow through. CMS should ensure states hold timely, meaningful, robust Tribal consultations on state Medicaid policies. CMS can also incentivize states to use Tribal liaisons and Indian Health Advisory Boards to coordinate with Tribes more effectively.