Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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July 23, 2013

Cindy Mann
CMS Deputy Administrator/Director
Center for Medicaid and CHIP Services (CMCS)
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-08010

RE: Comments to Arkansas's 1115 Waiver: Premium Assistance for Medicaid

Dear Ms. Mann,

On behalf of the Tribal Technical Advisory Group (TTAG) to the Centers for Medicare & Medicaid Services (CMS), I am writing in response to Arkansas's request for a Section 1115 waiver to purchase private insurance through the Health Insurance Marketplace (Marketplace) for newly eligible Medicaid beneficiaries. Although there are no federally-recognized Tribes or health care facilities operated by the Indian Health Service (IHS), Tribes and Tribal organizations, and urban Indian organizations (collectively referred to as "I/T/U") in Arkansas, its Medicaid program serves significant numbers of American Indians and Alaska Natives (AI/ANs) and actually has agreements with tribal health programs located in neighboring Oklahoma. In addition, the TTAG anticipates that this proposal may set a precedent that other states are likely to follow. Several States that have federally-recognized Tribes and/or I/T/Us, including Oklahoma, Louisiana, and Maine, are considering a similar model as the Arkansas model, and we understand that others may do so as well. Therefore, the decisions made by the Centers for Medicare and Medicaid Services (CMS) in reviewing the Arkansas application could have far-reaching effects. For that reason, we are taking this opportunity to submit our comments directly to you, instead of through the state comment process.

The TTAG advises Center of Medicare and Medicaid Services (CMS) on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program, and any other health care program funded (in whole or part) by CMS. In particular, the TTAG focuses on providing policy advice to CMS regarding improving the availability of health care services to American Indians and Alaska Natives (AI/AN) under these Federal health care programs, including through providers operating under the health programs of the Indian Health Service, Indian Tribes, tribal organizations and urban Indian organizations (I/T/U).

In March 2013, CMS issued an FAQ on the Arkansas proposal and section 1115 demonstrations to provide premium assistance for the purchase of qualified health plans (QHPs) in the Marketplace.

TTAG was pleased that CMS affirmed in no uncertain terms that in any arrangement involving premium assistance, "beneficiaries remain Medicaid beneficiaries and continue to be entitled to all benefits and cost-sharing protections."

As you know, AI/ANs are entitled by law to special benefits and protections in the Medicaid program. For example, in 2003 Congress amended Section 1932 of the Social Security Act to prohibit States from requiring that AI/ANs enroll in managed care plans. In 2009, Congress enacted special rules that allow AI/ANs to select an I/T/U as their primary care provider in managed care plans, and provided that managed care plans must agree to pay I/T/Us for covered managed care services as a condition of participating in the Medicaid program.[1] In 2009, Congress amended the Medicaid statute to prohibit States from imposing any premium or cost-sharing on an Indian for a covered service provided by the IHS, a health program operated by an Indian tribe, tribal organization or urban Indian organization, or through referral under contract health services.[2] These "benefits and cost-sharing protections" are integral to the Medicaid program as it applies to AI/ANs and to I/T/U providers, and must be preserved and accounted for in any section 1115 demonstration to provide premium assistance for the purchase of QHPs in the Exchange. Although AI/ANs are entitled to different cost-sharing protections in the Marketplace, TTAG was pleased to see that any section 1115 premium assistance demonstrations will be governed by Medicaid rules, and that the Medicaid benefits and cost-sharing protections will continue to apply.

The Arkansas proposal states that the demonstration will not modify the State's current Medicaid and the Children's Health Insurance Program (CHIP) outside of eligibility, benefits, cost-sharing, or delivery systems. (p. 7.) While there are no federally-recognized Tribes and no I/T/U facilities in Arkansas, there are 24,302 AI/ANs in Arkansas of which an estimated 4,770 are below 138% federal poverty level (FPL)[3] and would be eligible for Medicaid. Many Medicaid-eligible AI/ANs in Arkansas are members of Oklahoma Tribes who live in Arkansas but receive care at I/T/Us in Oklahoma. In FY 2012, there were 7,661 individuals active users of the Oklahoma City Area (OCA) Indian Health Service facilities who were identified as Arkansas residents. Both the Cherokee Tribe of Oklahoma and the Choctaw Nation of Oklahoma have entered into contractual arrangements with the Arkansas Medicaid program that allows their Tribal health programs to bill the Arkansas Medicaid program for services that these Tribes provide to Arkansas Medicaid-eligible individuals. These arrangements must be allowed to continue under any waiver approved by CMS. In addition, TTAG, as discussed above, was pleased to see that CMS has indicated that it will ensure that the Medicaid cost-sharing protections will continue to apply, and that AI/ANs who receive health care services through an I/T/U will be exempted from any co-payments or deductibles under Section 5006 of ARRA. We believe this should be added to the conditions that will apply to the demonstration project if it is approved.

[1] 42 U.S.C §1396p(b)(3)(B), as added by Sec. 5006(c) of the American Recovery and Reinvestment Act of 2009, Pub.L. 111-5.
[2] 42. U.S.C §1396u-2(h), as added by Sec. 50006(d) of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5.
[3] American Community Survey of the U.S. Census Bureau, 2008

Being clear about the limitation on cost sharing that can be applied to AI/ANs is critical since under the Arkansas model, beneficiaries will have cost sharing obligations. Although in year one of the Demonstration, those with incomes under 100% FPL will not have cost-sharing obligations, for years two and three, Arkansas plans to submit amendments to the waiver to implement cost sharing for Demonstration participants with incomes from 50-100% FPL, and individuals with incomes of 100-138% FPL will be responsible for cost sharing amounts in both the State plan and in the Marketplace. For individuals with incomes between 100-138% FPL, aggregate annual cost sharing will be capped at 5% of 100% FPL ($604 for 2014). The Arkansas Demonstration should clearly state that pursuant to 42 U.S.C. §§ 1396o(j), 1396o-1(b)(3)(A)((vii) and (b)(3)(B)(x), and 18071(d), AI/ANs will not have to pay any cost sharing.

It is also critical that the Demonstration not have the effect of changing the relationships between AI/ANs and their I/T/U providers or reducing payments to I/T/U providers. Congress has repeatedly recognized the importance of assuring the stability and viability of such providers in Medicaid and the Marketplace, as well as in their relationships with other payers by establishing special rules regarding third-party recovery.[4] Section 5006 of ARRA provided two critical protections for I/T/Us that deliver Medicaid services. The first is the right to be paid the full amount that would have been paid notwithstanding the fact that AI/ANs may not be charged any enrollment fees, premiums, or similar charges, nor may any deduction, copayment, cost sharing or similar charge be imposed.[5] The second is the right to be paid by managed care plans even if the I/T/U provider is a non-participating provider in the managed care plan.[6] These and other protections, including certain licensing exemptions,[7] need to be assured in the demonstration. The most effective way to accomplish this is to require that all plans deem all I/T/U providers that are enrolled as providers under the Medicaid program (including any individual health professionals who assign payment to an I/T/U) to be participating providers in any such plan, and to require that payments to the I/T/U providers be no less than they would be under the Medicaid State Plan. Without these conditions of approval for the Demonstration project, I/T/U providers may find themselves having to invest limited resources in establishing their right to receive these protections under Medicaid and negotiating with plans that are frequently unfamiliar with the special status of I/T/Us.

We support Arkansas's decision to provide continuity of coverage: twelve-month continuous enrollment to prevent churning and periods of no coverage. We agree that it will control churning and believe it will improve health outcomes, which ultimately helps control costs.[8]

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[4] The broadest application of this policy is found in Section 206 of the Indian Health Care Improvement Act, as amended by Section 10221(a) of the ACA, and codified at 25 U.S.C. § 1621e.

[5] See, 42 U.S.C. § 1396o(j)(1)(B)

[6] 25 U.S.C. § 1396u-2(h).

[7] 25 U.S.C. §§ 1621t and 1647a.

[8] We note that the ACA provides special enrollment periods for AI/ANs under the health insurance exchanges in which an AI/AN may enroll in an exchange plan on a monthly basis, however we assume that this protection will not be needed under the waiver since Medicaid does not have limited enrollment periods. If we are mistaken, then we believe one of the conditions of approval should be that enrollment in the demonstration project coverage should be open at all times.

We thank you for the opportunity to comment, and we hope you take these recommendations and concerns into consideration in future waiver proposals to ensure that all AI/ANs receive all benefits and cost sharing protections that they are entitled to. Under section 1902(a)(73)(A) of the Social Security Act, states with one or more I/T/Us must seek advice prior to any submission of a waiver. Although Arkansas does not have any federal-recognized Tribes or I/T/Us within its borders, it has entered into arrangements with Oklahoma I/T/Us who serve patients enrolled in the Arkansas Medicaid program. We hope that CMS ensures that other States that have federally-recognized Tribes and/or I/T/Us will consult with these tribal entities prior to submitting their proposals. If you have any questions, please contact Jennifer Cooper at jcooper@TTAG.org.

Sincerely,

Valerie Davidson

Chair, TTAG

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