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SUBMITTED VIA: *www.regulations.gov*

January 14, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2408-P
P.O. Box 8016
Baltimore, MD 21244-8013

RE: Comments on Medicaid and Children's Health Insurance Plan (CHIP) Managed Care Proposed Rule (CMS-2408-P)

Dear Administrator Verma:

On behalf of the NPAIHB, I write to comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule, *Medicaid and Children's Health Insurance Plan (CHIP) Managed Care (CMS-2408-P)*, published in the Federal Register on November 14, 2018. Established in 1972, the NPAIHB is a non-profit, Tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638, advocating on behalf of the 43 federally-recognized Indian Tribes in Idaho, Oregon, and Washington on specific health care issues. NPAIHB operates a variety of important health programs on behalf of our member tribes, including the Northwest Tribal Epidemiology Center, [1] and works closely with the IHS Portland Area Office. Thank you for the opportunity to provide comments and recommendations on the proposed Medicaid and CHIP Managed Care Rule and its impact on Northwest Tribal communities.

BACKGROUND

In 1976, Congress authorized the Indian Health Service (IHS) as a way to provide critically important resources to the underfunded Indian health system and to help meet its federal trust responsibility for the health care of American Indian and Alaska Native (AI/AN) people. This authorization allowed tribes to bill Medicare and Medicaid for services and since then, Medicaid is a critically important component of the Indian health funding stream, and allows many Indian Health Care Providers (IHCPs) to begin to address some of the chronic health disparities faced by Indian people in the United States. Without meaningful access to Medicaid resources, many IHCPs would be unable to maintain current levels of service. Northwest Tribes and IHCPs expect the Centers for Medicare and Medicaid Services (CMS) to uphold the statutory and regulatory Indian managed care provisions to ensure that AI/AN beneficiaries have access to needed services in both the managed care system and fee-for-service (FFS). With the focus on managed care, Northwest Tribes and IHCPs are

[1] A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.l. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

concerned that the Medicaid fee-for-service system (FFS) is being neglected. Currently, the AI/AN population faces a severe lack of access to non-IHCP both in the FFS system and managed care networks. Northwest Tribes and IHCPs are concerned that movement towards payment incentives such as value-based purchasing might further diminish AI/AN access to specialty care in both the FFS system and in managed care. The burden on medical providers to use other payment systems represents a disincentive to non-IHCP providers to provide care to AI/AN beneficiaries when considering the significant health disparities of AI/ANs. We insist that CMS take this background into consideration in its managed care rule making.

GENERAL COMMENTS

NPAIHB supports CMS's initiative to revise its managed care regulations. However, we believe managed care regulations need to be further revised to accomplish several critically-important goals for Indian Country.
These goals include that CMS:

- Ensure that the AI/AN protections from mandatory managed care in Section 1932(a)(2)(C) of the Social Security Act and regulations at §438.14 are applied consistently and across initiatives such as Section 1115 and 1915(b) Waivers.

- Ensure that the American Recovery and Reinvestment Act of 2009 (ARRA) 5006 Medicaid managed care protections are meaningfully implemented in the managed care regulations for those AI/ANs and Indian health providers who voluntarily elect to enroll in managed care.

- Ensure that other provisions of the rule account for the unique status and needs of the Indian health system.

Despite the 2016 Rule which codified a range of Indian managed care protections at §438.14 and CMCS' Informational Bulletin summarizing the relevant Indian provisions, Northwest IHCP are still experiencing issues related to implementation and compliance with the regulations, including:

Payment Issues

The Indian managed care regulations and CMCS Informational Bulletin clearly state that IHCPs are not required to enter a contract with Managed Care Organizations (MCOs) in order to be reimbursed. However, claims from IHCPs to MCOs in our Area continue to be denied and unpaid due to the lack of a contract and despite persistent tribal efforts to educate the State Medicaid Agency and MCOs on 1932(h)(2) of the Indian Health Care Improvement Act (42 U.S.C. §1396u-2(h)), 42 C.F.R. 438.14(c)(2), and 457.1209.

Prior Authorizations

MCOs impose coordination of care and prior authorization requirements that are inconsistent with how Indian health care providers already coordinate care both within their own systems and with outside providers through PRC. Ultimately, this results in patients not having timely access to care

which may worsen their health condition and result in increased costs to CMS. The 2016 Rule at §§438.14(b)(6) and 457.1209 added a new requirement to specify that MCOs, PIHPs, PAHPs, and PCCM entities (if applicable) must permit an out-of-network IHCP to refer an Indian to a network provider for covered services. While this provision was intended to avoid duplicate visits to a network provider to obtain a referral and any delay in treatment when referrals are made under these circumstances there is still an issue with prior authorizations. Out-of-network IHCPs are still required to obtain prior authorizations from MCOs for Indian beneficiaries which delays coordination of care and AI/AN patients receiving timely access to care. This regulation must be revised to allow out-of-network IHCPs to provide prior authorizations for specialty care within MCO networks.

Auto Enrollment

In Oregon, a few tribes have had an issue periodically with some AI/ANs being involuntary enrolled in managed care from the fee-for-service system (FFS) without the patient requesting enrollment into an MCO. While IHCPs have been working with MCOs to resolve the issue, the issue continues to occur. States need to improve oversight of MCO systems to ensure that Indians are not being automatically enrolled into managed care. This creates an administrative burden on IHCPs and AI/AN beneficiaries.

Behavioral Health Organization Managed Care

An IHCP can conduct a mental assessment, but when the AI/AN is in need of inpatient services they have to go to a MCO to get access to an inpatient bed. There are too many assessments, leading to our patients having to go through many obstacles to receive services. For AI/AN patients with mental health illnesses, these obstacles can lead to loss of life. Furthermore, a corrective action plan and penalties should be imposed on behavioral health organizations (BHO) and MCOs who do not ensure that AI/AN consumers are afforded the same access, rights and benefits available to all other Medicaid beneficiaries.

NPAIHB recommends that MCOs/BHOs must accept AI/AN patients at any point in time regardless of whether the AI/AN patient is currently receiving mental health, chemical dependency, or physical health services at an IHCP and needs additional care within the State BHO/MCO systems. AI/AN patients should be able to transition care between both the BHO/MCO and IHCP systems with minimum disruption. For example, there should be no required referrals or unnecessary paperwork required. In this regard, NPAIHB recommends a need for CMS to improve oversight in State contract requirements with MCOs/BHOs.

SPECIFIC COMMENTS

NPAIHB makes the following specific comments on the proposed rule:

Special contract provisions related to payment § 438.6(c)

Section 438(c)(1)(iii) states that the State may require the MCO, PIHP, or PAHP to adopt a minimum fee schedule for network providers that provide a particular service under the contract using State plan approved rates or using other rates than the State plan approved rates, provide a

uniform dollar or percentage increase for network providers, adopt a maximum fee schedule for network providers, or adopt a cost-based rate, a Medicare equivalent rate, a commercial rate, or other market-based rate for network providers that provide a particular service under the contract. Tribal communities are located in rural areas and access for AI/AN to specialty providers in MCO networks are very limited. There are few specialty care providers within several Northwest tribal communities. This may also require AI/AN beneficiaries to travel long distances to access specialty care or require some IHCP to use very limited community health representatives (CHR) to transport patients.

In addition, specialty care providers are not being paid enough by MCOs to participate in networks in areas with tribal communities. This results in providers not accepting patients for visits. In a few instances IHCPs have converted the AI/AN Medicaid beneficiaries' need for health care to a Purchased and Referred Care (PRC) claim, which providers are then willing to honor. This is likely because the PRC program often pays more for the services than is allowed in the state's Medicaid program. NPAIHB recommends that the State require the MCO, PIHP, or PAHP to work with IHCPs to determine the particular services or providers needed and to increase payment rates for services that are lacking in areas with tribal communities.

Network adequacy standards § 438.68(b)(1)-(2)

The proposed rule *§ 438.68(b)(1)-(2)* would remove the requirement that states use time and distance standards to ensure health plans provider network adequacy and requires a state to develop a quantitative network adequacy standard. The proposed rule would allow states to use an alternative standard such as minimum provider-to-enrollee ratios, maximum travel time or distance to providers, minimum percentage of contracting providers accepting new patients, maximum wait times for an appointment, or hours of operation requirements. The proposed rule also eliminates time and distance standards for long-term services and supports and would allow states to use any quantitative network adequacy standard. In addition, the proposed rule would allow states to define the specialists to which network adequacy standards apply.

Managed care networks are lacking specialty care providers that serve several Northwest tribal communities. Tribes have had the experience of network providers refusing to provide services to AI/AN Medicaid enrollees who need access to specialty care claiming that they are not taking new patients or the available appointment times are scheduled so far out that it does not provide timely access to care. This is harming our AI/AN patients because they cannot get access to the services they need. States must consult with tribes to determine the quantitative network adequacy standards, and specialists to which the standards would apply, that would fill the gaps in coverage for AI/ANs in tribal communities and increase access to care.

Networks will continue to be inadequate for AI/ANs if there are not a sufficient number of IHCPs participating in MCO networks. Section §§438.14(b)(1) and 457.1209 requires every MCO, PIHP, PAHP, or PCCM entity, to the extent the PCCM entity has a provider network, to demonstrate that there are sufficient number of IHCPs participating in the network to ensure timely access to services available under the contract from IHCPs for Indian enrollees who are eligible to receive services. MCOs often limit the number of providers in their networks and are reluctant to offer provider agreements to IHCPs despite network adequacy standards §§438.14(b)(1) and 457.1209. States must ensure that MCO, PIHP, PAHP, or PCCMs, are complying with this requirement.

Lastly, while managed care networks increase their coverage area, it is important to consider the impact on the Indian health system's reliance on the fee-for-service system. Some of our tribes have experienced specialty providers abandoning the fee-for-service (FFS) system which has reduced the number of specialty providers for AI/AN patients in the FFS system. FFS providers are not being paid enough compared to managed care providers, therefore there is a need for more resources for FFS providers.

Information requirements – cultural competency training § 438.10(h)(1)(vii)

The proposed rule at § 438.410(h)(1)(vii) would remove the requirement that MCOs identify in their provider directories whether a provider has completed cultural competency training. The 2016 final rule requires plan directories to indicate whether a provider has completed cultural competence training. MCO providers in the Northwest often lack cultural competency in working with AI/AN people. NPAIHB requests that this requirement not be removed so that our AI/AN people can identify providers who have received training. In the alternative, states should maintain a list of MCO providers who have completed cultural competency training to work with AI/AN beneficiaries.

Medicaid managed care quality care rating system § 438.334(b) and (c))

Section § 438.334(b) states that "CMS, in consultation with States and with other stakeholders and after providing public notice and opportunity to comment, will develop a framework for a Medicaid managed care quality rating systems (QRS)...." The term stakeholders has been used by Department of Health and Human Services (HHS) agencies, on occasion, to include tribal governments. If the term stakeholders is meant to include "tribal governments," NPAIHB recommends that this provision be revised to clearly state that CMS will consult with Tribes or tribal governments since the term stakeholder minimizes the government-to-government relationship with tribes. In addition, under § 438.334(c), NPAIHB is concerned about the proposed elimination of CMS prior approval for alternative QRS measures. This essentially means the State controls the content and oversight of their contracts with individual MCOs with limited input from CMS. This creates a situation where the State may develop alternative QRS measures that do not work well with IHCPs or that do not consider the unique features of IHCP or meet the needs of AI/AN people.

Definition of disability § 438.34 (b)(6)

The proposed rule would broaden the definition of disability when addressing health disparities in the state's managed care quality strategy. Under the 2016 final rule, states must have a written quality strategy for assessing and improving the quality of care and services furnished by health plans and PCCM entities. The quality strategy must describe the state's plans to reduce health disparities based on certain demographic factors including disability. This requirement applies to health plan contracts effective on or after July 2018. Current regulations identify enrollees with a disability based on whether they qualify for Medicaid in a disability-related eligibility pathway. Under the proposed regulations, "disability" would not be limited to those who qualify for Medicaid based on a disability. It recognizes that enrollees with disabilities may qualify for Medicaid on another basis (such as low income) and that there are other definitions of and sources

to determine disability, such as the Americans with Disabilities Act (ADA) and other federal and state laws. CMS proposes this change to avoid an "unintentionally narrow" definition of disability for purposes of identifying enrollees with disabilities for whom health disparities should be assessed under the state's managed care quality strategy. NPAIHB agrees with this proposed change using the broader definition of disability.

CONCLUSION

The public notice and comment period is not a substitute for Tribal consultation pursuant to the CMS Tribal Consultation Policy and Executive Order 13175. The Federal government's trust responsibility provides the legal justification and moral foundation for Indian specific health policymaking— with the objectives of enhancing AI/AN access to health care and overcoming the chronic health status disparities of this segment of the American population.

Indian health care programs are unique. Tribal health programs implement the United States' trust responsibility to provide health care services to AI/ANs. The IHS is the primary federal agency tasked with carrying out this responsibility; however, the federal trust responsibility extends to every branch of the federal government and to every Executive Department and agency, including CMS. Therefore, NPAIHB requests that CMS honor its trust responsibility by taking into account the unique needs of the Indian health system and continue to partner with our Area to improve access for AI/AN beneficiaries to all Medicaid services. We thank you for this opportunity to provide our comments on this Proposed Rule.

If you have any questions about the information discussed above, please contact Laura Platero, Government Affairs/Policy Director at (503) 407-4082 or by email to lplatero@npaihb.org.

Sincerely,

Andrew C. Joseph Jr.

Andrew C. Joseph, Jr.
NPAIHB Chair
Colville Tribal Council Member

cc: Kitty Marx, Director, Division of Tribal Affairs/IEAG/CMCS