Tribal Technical Advisory Group
To the Centers for Medicare & Medicaid Services
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Submitted via: http://www.regulations.gov

January 14, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
HHS – Department of Health & Human Services
Room 445-G, Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care (CMS-2408-P)

Dear Administrator Verma:

On behalf of the Tribal Technical Advisory Group (TTAG), I write to submit comments on the proposed rule, "*Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care*," published in the Federal Register on November 14, 2018.

The TTAG advises the Centers for Medicare and Medicaid Services (CMS) on Indian health policy issues involving Medicare, Medicaid, the CHIP, and any other health care programs funded (in whole or in part) by CMS. In particular, the TTAG focuses on providing policy advice designed to improve the availability of health care services to American Indians and Alaska Natives 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.

Background

In 1976, Congress authorized the Indian Health Service (IHS) and Tribal health facilities to bill Medicare and Medicaid as a way to provide critically important resources to the underfunded Indian health system and help meet its federal trust responsibility for the health care of American Indian and Alaska Native people. Since then, Medicaid resources have become a critically important component of the Indian health funding stream, and allowed many IHS and Tribal facilities 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 Indian health programs would be unable to maintain current levels of service. Managed care continues to challenge Indian health programs' access to Medicaid resources, and poses a barrier to American Indian and Alaska Native participation in the Medicaid program. Medicaid managed care is not succeeding in Indian country.

General Comments

In many instances, Managed Care Organizations (MCOs) are posing barriers that threaten AI/AN's access to critical Medicaid resources. MCOs often have little to no familiarity with the Indian health system and routinely disregard the rights of AI/ANs and Indian health providers under the Medicaid statute, the Indian Health Care Improvement Act, and other federal laws. AI/ANs continue to find it difficult to access Indian health care providers (IHCPs) in managed care settings, and IHCPs continue to have difficulties being reimbursed by the Medicaid program from MCOs.

The TTAG and Tribes support CMS's initiative to revise its managed care regulations. However, managed care regulations must be revised to accomplish several critically important goals for Indian Country. The TTAG offers recommendations that refer back to the comment letter from 2015.[1] We reiterate the following:

- CMS must ensure that the AI/AN protections from mandatory managed care in Section 1932(a)(2)(C) of the Social Security Act apply across the board, including through Section 1115 Demonstration Waivers.

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

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

Delivery System and Provider Payment Initiatives under MCO, PIHP, or PAHP Contracts (§ 438.6(a) and (c))

Many Tribes are being denied payment from claims they have submitted to local MCO plans. Additionally, Tribes have stated that MCOs are not reimbursing IHCPs in a timely manner or not being reimbursed at all in their respective states.

In some States, claims from IHCPs to MCOs continue to be denied and unpaid due to the lack of a contract, despite persistent Tribal efforts to educate the State Medicaid Agency and MCOs on the statute and regulations. In some States, MCOs improperly impose their own provider credentialing and other requirements on IHCPs that have elected not to contract with them. It has been very burdensome for IHCPs to continue to submit complaints and appeal claims, all because

[1] Tribal Technical Advisory Group ("TTAG") Comment. (July 27, 2015). TTAG Comments on CMS-2390-P, "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability: Proposed Rules" Retrieved from https://www.nihb.org/tribalhealthreform/wp-content/uploads/2015/07/TTAG-Comment-on-CMS-2390-P.pdf

these programs are out of compliance with the CMS regulations, particularly when working across State lines and when there are large numbers of MCOs.

Furthermore, IHCPs are experiencing equal difficulty entering into contracts with MCOs. While it may appear at first blush that IHCPs could address many of the reimbursement and other issues they are experiencing with MCOs by simply entering into contracts with MCOs, in many cases that is simply not an option for IHCPs. In many cases, MCOs insist on imposing their one size fits all provider agreement on IHCPs, which include contractual requirements that are inconsistent with IHCP rights under federal law. For example, MCO contracts impose state licensing and credentialing requirements on IHCP providers they are not required to meet, or are inconsistent with federal law. MCO contracts contain payment mechanisms inconsistent with IHCP reimbursement rights under the Medicaid statute. MCO contracts contain prior authorization requirements inconsistent with IHCP rights under the Medicaid statute and Managed Care Rule, and MCO contracts require insurance coverage requirements inconsistent with IHCP coverage under the Federal Tort Claims Act.

MCO contracts are designed for non-IHCP providers, and MCOs in many cases are simply not willing to negotiate and adapt them for IHCPs. As a practical matter, IHCPs are required to enter into lengthy and often unfruitful negotiations with MCOs if they wish to assert their federal rights. As a result of this, many IHCPs choose to elect their right not to contract with MCOs and be reimbursed as is their right. States and IHCPs have also found it difficult to timely and accurately reconcile and make so-called "wrap-around payments" to IHCPs when MCOs pay less than the encounter rate published annually by IHS in the Federal Register. In many cases, States have significantly delayed payment of wrap payments, resulting in loss of predictable and needed revenue for IHCPs. Many of these issues would be resolved if CMS add a component that informs the review process as to what Indian Health Service/Tribal Health/Urban Indian Health (I/T/U's) are, how they are handled and how they going to be paid, during the MCO Contract review process at CMS.

For over two years, Tribes have consistently brought these issues of non-compliance to CMS regional and headquarters offices with no resolution.

Information Requirements (§ 438.10)

In a health care system as complex as that created by Medicaid managed care, where patients may be asked to navigate multiple coverage and treatment sources, timely, accurate, and highly accessible information tailored to the population is essential. One of the more substantive and alarming changes are those proposed changes that would significantly alter and relax the 2016 standards for language and format at § 438.10. The TTAG recommends that the proposed rule maintain the existing standards that were adopted in the 2016 final Medicaid managed care regulations.

First, the rule would lengthen the time-period governing when a managed care plan must notify enrollees that their physician has left the network. The current standard is 15 calendar days following notice of provider termination. The proposal would now lengthen that period to within 30 days of actual termination. So, for example, if a provider gives notice on April 1 terminating

her network membership as of September 30th, the contractor could delay notification to her patients until 30 days prior to her departure. This obviously cuts down substantially on patients' ability to find another network provider in the plan or alternative to request a cause-related enrollment with a new plan.

Second, claiming a desire to align with the 21st Century Cures Act, the agency proposes to eliminate from managed care provider directories whether providers have undergone cultural competence training. The proposed rule would require only that managed care directories indicate only actual cultural and linguistic capabilities. However, member handbooks, appeal and grievance notices and other notices that are critical to obtaining services are also vital documents, and therefore should be made available in each prevalent non-English language in its service area.

The rule would relax the frequency with which paper provider directories must be updated if contractors offer mobile-enabled directories. Updating paper directories is time-consuming and challenging, since provider networks can change frequently. On the other hand, no single element of Medicaid managed care may be more important to beneficiaries than knowing who is in the network. In its justification, CMS notes that 64 percent of low-income households own a smart phone. This, of course, overlooks the 36 percent who do not. The agency also assumes that everyone who owns a smart phone knows how to navigate complex plan websites to get to provider directory information or read such information in electronic format. In relaxing the provider directory rule, CMS "reminds" managed care plans of their obligations to provide auxiliary aids and services in the case of members with disabilities who need such aids for communications.

Another striking information change has to do with the current obligation of contractors to make written materials accessible to plan members with visual disabilities or whose primary language is not English. Current policy requires that all written materials must include taglines in the prevalent non-English languages in the state, and materials must be use a font size no smaller than 18 points. Noting that 18-point font size increases length and eliminates use of written documents such as "postcards" and "trifold brochures", CMS proposes to amend the written materials provision to specify first, that only those written materials that are "critical to obtaining services for potential enrollees" must meet access standards. Second, the agency would replace the 18-point font requirement with the "conspicuously visible" standard used in federal regulations implementing the civil rights provision of the Affordable Care Act, PPACA § 1557. The rule specifies that the "critical" standard apply to provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices. Ironically, therefore, the postcards and trifold cited by CMS as the basis for relaxing the rule may not contain information considered to be "critical". Other key information also may fall outside the scope of the proposed change, which provides no standards for objectively determining when information is "critical".

Medicaid Managed Care Quality Rating System (QRS) (§ 438.334)

We are 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 is allowed to fall back on its own interpretation which is not entirely accurate nor does it take into consideration the needs of Tribes and protections afforded to them.

For example, in one instance, a LTSS waiver filing only allows for Tribal case management if, and only if, a Tribe enters into a three-way contract with the State and an MCO. Part of this is attached to the quality and risk assurance models/requirements. This requirement setup deprives almost three-fourths of the Tribal population to have ongoing case management through a Tribal provider, despite ARRA protections for AI/ANs. The more "flexible" CMS is without at least a bulletin of best-practices, the more States are floundering in serving the needs of Tribal people within MCO-based systems.

Conclusion

We thank you for the opportunity to provide comments and recommendations and look forward to further engagement. The TTAG stands ready to answer any questions or provide technical assistance that CMS may have.

Sincerely,

W. Ron Allen, Chair
Tribal Technical Advisory Group

Cc:

Kitty Marx, Director, CMCS Division of Tribal Affairs, Centers for Medicare and Medicaid Services