

*Submitted via e-mail*

January 30, 2019

Jim Golden, Director CMS Managed Care  
Centers for Medicare and Medicaid Services  
7500 Security Blvd, Mail Stop [S2-01-16]  
Baltimore, Maryland, 21244-1850

***RE: Managed Care Issues in Indian Country***

Dear Director Golden:

On behalf of the Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG), I write to submit a letter documenting continuing problems that Tribes are encountering with Managed Care Organizations (MCOs). Many of these issues have been raised during previous TTAG Face-to-Face meetings and we seek formal acknowledgement and response from CMS to the ongoing challenges that Tribes are encountering with Managed Care Entities (MCEs). We kindly remind you that the purpose of the TTAG is to advise CMS on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and any other health care programs funded (in whole or part) by CMS. We hope to engage further with you on these issues at the February 20-21, 2019 TTAG Face-to-Face Meeting.

The TTAG and Tribes greatly appreciate the inclusion of specific Indian provisions in the Medicaid and CHIP Managed Care regulations, as well as in the distribution of the Center for Medicaid and CHIP Services (CMCS) Informational Bulletin, December 14, 2016, describing these provisions and including the Model Addendum for Indian Health Care Providers (IHCPs). Although this material has been available to States for over two years, IHCPs continue to experience significant barriers in ensuring MCO compliance with federal regulations.

**Regulatory Compliance**

Federal regulations—and the associated CMCS Informational Bulletin—clearly state that IHCPs are not required to enter a contract with Managed Care Organizations (MCOs) in order to be reimbursed for services provided to Medicaid-eligible American Indian/Alaska Native (AI/AN) participants who are enrolled in an MCO. However, claims from IHCPs to MCOs continue to be denied and unpaid in multiple states due to the lack of understanding and failure to implement the statute and regulations. Despite persistent Tribal efforts to educate State Medicaid Agencies and MCOs, the majority of MCOs continue to request contracts of IHCPs and attempt to impose their own provider credentialing requirements, which is further described below.

Even where IHCPs volunteer to contract with MCOs, they are experiencing difficulties. While it may appear that IHCPs could resolve reimbursement requests and other complications that they experience with MCOs simply by entering into contracts with the MCOs, in many cases that is not an option for IHCPs that require Tribal government approval in addition to approval by the local Tribal health care board. In many cases, MCOs insist on imposing their one-size-fits-all provider agreement on IHCPs, which includes contractual requirements that are inconsistent with IHCP provisions. For example, some MCO contracts impose state licensing and credentialing requirements on IHCP providers despite federal law that says IHCP providers do not have to meet those same requirements.<sup>1</sup> In addition, some MCO contracts contain payment mechanisms inconsistent with IHCP reimbursement provisions under the Medicaid statute.<sup>2</sup> The TTAG is aware of instances where MCO contracts contain prior authorization requirements—also inconsistent with IHCP provisions under Medicaid<sup>3</sup> and the Managed Care Rule. Further, MCO contracts require insurance coverage outside of the requirements of IHCPs under the Federal Tort Claims Act.<sup>4</sup> MCO standard contracts are designed for non-IHCP providers. The reality is that MCOs, in many cases, are not willing to negotiate and adapt standardized contracts to IHCPs. The TTAG developed the Managed Care Addendum to be helpful in this regard, but until CMS requires MCOs to adopt the Addendum for use with IHCPs, MCOs have no incentive to do so.

### **Payment and Timely Reimbursement**

Despite state and Federal regulations regarding timely payment of claims, MCOs continue to deny initial reimbursements for IHCP services. When MCOs fail to comply with IHCP payment protections under Section 5006 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5, it results in delays and denials of claims that IHCPs submit. 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-around payments, resulting in loss of predictable and much needed revenue for IHCPs.

### **Impact on Service Delivery and Health Outcomes**

The release of the Managed Care Rule, (CMS-2390-F) had a negative impact on the conflict free system of case management, within Home and Community-Based Services. The final rule, for example, did not contain language specific to IHCPs or to AI/AN participants. As a result, IHCPs and State Medicaid Agencies continue to misinterpret the conflict free system of case management as applied to IHCP providers within a MCO program.

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<sup>1</sup> 25 U.S.C. § 1621t.

<sup>2</sup> 42 U.S.C. § 1396u-2(h).

<sup>3</sup> 42 U.S.C. § 1396u-2(h).

<sup>4</sup> 28 U.S.C. §§ 2671-2680.

IHCPs in several regions have requested CMS guidance and outreach to resolve barriers to case and care management services within long-term care programs, specifically, when the State Medicaid Agencies administer these programs through MCOs. To date, CMS has not released agency guidance addressing Managed Care in the context of IHCPs, nor has it responded to the specific concerns raised in TTAG correspondence. Case and care management are critical components to program enrollment and individual service planning. Yet, most MCOs lack even a basic understanding of how to deliver culturally competent care and patient-specific services for AI/ANs. Instances in which frail elders do not receive proper medical assessments, or case management suited to their needs, are not uncommon due to poorly structured MCO models. As a result, the number of AI/AN participants in Medicaid Managed Care programs such as long-term care, remains lower than any other population of participants. Tribes have proactively addressed MCO shortcomings in correspondence with CMS regional offices and headquarters. In the more than three years following TTAG's first letter to the agency,<sup>5</sup> Tribes have yet to receive a proper response.

## **Recommendations**

The TTAG requests that CMS take a much more active role to educate states on their legal duties and best practices to ensure that the protections under Section 5006 ARRA are understood and applied. CMS must conduct better oversight of state contracts with MCOs to create a chain of accountability that ensures that AI/ANs maintain access to the Medicaid program in Managed Care systems. CMS must ensure that IHCPs are properly and timely reimbursed for their services to the Managed Care beneficiaries they serve. Too often, states inform the IHCP that they should resolve any outstanding issues with the MCO, yet the MCOs do not have personnel familiar with or qualified to cover IHCP issues. Instead, IHCPs are left trying to negotiate payment issues by calling the general MCO provider help lines, to no avail. IHCPs should not have to resort to legal action to resolve these issues once and for all. We therefore encourage CMS to make compliance with the requirements of 42 C.F.R. 438.14 a condition of *all* MCO provider agreements. CMS must also hold states accountable in enforcing those requirements—not only when entering the agreement, but on an ongoing basis.

Further, we encourage CMS to remind MCOs that their contracted providers may serve IHCP patients absent an agreement and that those services are reimbursable. This is critical if a Medicaid-insured patient requires a service that is not available at an existing IHCP. TTAG is aware of instances in which contract providers have not accepted IHCP referrals because MCO-IHCP agreements were not in place. Access to providers outside of the IHCP provider network

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<sup>5</sup> TTAG first addressed the application of Managed Care to IHCPs in 2015. See TTAG Comments to 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” (July 27, 2015), <https://www.nihb.org/tribalhealthreform/wp-content/uploads/2015/07/TTAG-Comment-on-CMS-2390-P.pdf>.

can be a matter of life and death for Indian Country's most vulnerable and medically needy patients.

Given the uniqueness of the Indian health care system and its patients, we remind CMS of its duty to conduct meaningful Tribal consultation prior to rulemaking to ensure that Tribes are not adversely impacted by CMS policies. Many of the problems identified in this letter—non-compliance to non-payment—were outlined in TTAG's 2015 comment.<sup>6</sup> While we understand that CMS has to work within the Federal regulatory system to the Managed Care program, we remind the agency of its duty to fulfill the Trust responsibility and of the government-to-government relationship that exists between Tribes and the Federal government. Tribes and their nations must not be treated as a third-party caught between Federal and state governments as they administer Medicaid Managed Care programs. We look forward to discussing these issues and more with CMS at the next TTAG meeting on February 20-21, 2019.

Sincerely,

A handwritten signature in black ink, appearing to read "W. Ron Allen". The signature is fluid and cursive, with the first name "W." and last name "Allen" clearly distinguishable.

W. Ron Allen, Chair  
Tribal Technical Advisory Group

cc:

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

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<sup>6</sup> TTAG Comments to CMS-2390-P, *supra* note 5.