National Indian Health Board

August 25, 2021

Daniel Tsai
Deputy Administrator & Director
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Texas Healthcare Transformation and Quality Improvement Section 1115 Demonstration Waiver.

Dear Mr. Tsai:

On behalf of the National Indian Health Board (NIHB),[1] I write to you regarding Texas's application to extend their Healthcare Transformation and Quality Improvement section 1115 demonstration waiver. We are generally concerned about the expansion of risk-based managed care and its impact on the Indian health care system. When Managed Care Organizations (MCOs) enter a contract with a state, the two sides agree upon a reimbursement rate that the MCO will provide to providers. However, Indian Health Care Providers (IHCPs) are entitled to receive payment at the Office of Management and Budget (OMB) encounter rate [2], which is different than the MCO's contracted rates. IHCPs encounter difficulty working with MCOs to be reimbursed at this rate.

Additionally, Tribal leaders have expressed concerns as to whether the MCOs are adhering to the Indian managed care protections. Tribes regularly face issues when seeking reimbursement from MCOs because the IHS, Tribal, and Urban Indian (collectively known as the I/T/U) system is misaligned with managed care networks. These difficulties create multiple hardships for providers. First, these delays force IHCPs to absorb the cost of care until the reimbursement can be processed. It also forces IHCPs to use staff time to work with the MCO and state to resolve these difficulties, resulting in diversion from other, mission critical activities.

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[1] Established in 1972, the National Indian Health Board (NIHB) is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

[2] More information about reimbursement methodologies for IHCPs can be found here:
https://www.ihs.gov/businessoffice/reimbursement-rates/

As we outline in this letter, it is critically important that CMS minimize the interactions between IHCPs and the state. In order to achieve this, **we believe that CMS should exempt any care provided through IHCPs from any risk based managed care arrangement.**

Trust Responsibility

The United States owes a special duty of care to Tribal Nations, which animates and shapes every aspect of the federal government's trust responsibility to Tribes. Rooted in treaties and authorized by the United States Constitution, the federal government's unique responsibilities to Tribal Nations have been repeatedly re-affirmed by the Supreme Court, legislation, executive orders and regulations.[3] In 1977, the Senate report of the American Indian Policy Review Commission stated that, "[t]he purpose behind the trust doctrine is and always has been to ensure the survival and welfare of Indian tribes and people." This trust responsibility is highlighted recently in the Department of Health and Human Services (HHS) Strategic Plan FY 2018–2022:

> Importantly, the Federal Government has a unique legal and political government to-government relationship with Tribal governments and a special obligation to provide services for American Indians and Alaska Natives based on these individuals' relationship to Tribal governments.[4]

The trust responsibility establishes a clear relationship between Tribes and the federal government.[5] The Constitution's Indian Commerce Clause, Treaty Clause and Supremacy clause, among others, provide the legal authority and foundation for distinct health policy and regulatory decision making by the United States when carrying out its unique trust responsibility to provide for the health and welfare of AI/ANs and support for the Indian health system that provides their care.

Indian Managed Care Protections

The state must ensure that the MCOs are affording the protections provided to AI/AN beneficiaries by the applicable federal regulations and statutes. All contracts between a State and an MCO, which enroll AI/ANs, must permit all AI/AN beneficiaries to select an IHCP as their primary care provider.[6] The MCOs must also allow AI/ANs to receive services from an out-of-network IHCP and reimburse accordingly.[7] Tribes have and continue to have issues with reimbursement from MCOs. These issues often result in delays in reimbursement, which forces the IHCP to assume the cost of providing care while they wait for a reimbursement that may be significantly delayed or may never come at all. This places an undue burden on IHCPs, forcing them to expend limited resources to cover payments to which they are entitled.

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[3] The Court has consistently held that the federal government has a trust responsibility to Tribes, which has formed the foundation for federal/Tribal relations. *See* Seminole Nation v. United States, 316 U.S. 286 (1942), United States v. Mitchell, 463 U.S. 206, 225 (1983), and United States v. Navajo Nation, 537 U.S. 488 (2003).
[4] Introduction, "Cross-Agency Collaborations", https://www.hhs.gov/about/strategic-plan/introduction/index.html
[5] In Worcester v. Georgia, 31 U.S. 515 (1832), the Supreme Court explicitly outlined that the relationship between the federal government and the Tribes is a relationship between sovereign nations and that the states are essentially third party actors.
[6] As provided by 42 C.F.R. § 438.14(b)(3)
[7] As provided by 42 C.F.R. § 438.14(b)(4)

Reimbursement

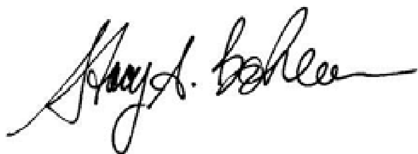
We also have concerns about risk-based managed care and its impact on reimbursement rates. IHCPs are reimbursed at the OMB rate, which considers the costs incurred by IHCPs. This rate often exceeds the amount that MCOs contract with the states to reimburse. In a risk-based model, this can lead to IHCPs being reimbursed for less than they may have otherwise been reimbursed.

We want to reiterate that services provided through Indian Health Service (IHS) and Tribally-operated facilities are eligible for the 100% Federal Medical Assistance Percentage (FMAP), meaning that the state is not liable for any of the expenses associated with the care provided through those facilities. Tribes can receive reimbursement through alternative payment methods, such as the OMB encounter rate, without the state or MCO incurring additional financial exposure. **CMS must exempt payment for care provided by IHS and Tribal facilities from any risk-based arrangement.**

Conclusion

We urge CMS to carefully consider this waiver and its impact on the Indian health system. As discussed, IHS and Tribal providers are eligible for the 100% FMAP and therefore, state and MCOs do not incur financial exposure for the care provided in those facilities. Further, since the trust responsibility is between the federal government and the Tribes, federal agencies have an additional duty to protect IHCPs from the impact of state policies that may adversely affect the financial health of the system. We believe that risk-based arrangements could result in a lowering of the reimbursement rates for IHCPs. There should be a carve out for care provided through IHCPs. Care provided by IHS and Tribal facilities must be exempt from any risk-based arrangement and **IHCPs should be reimbursed directly by the Texas Medicaid program.** Thank you in advance for your consideration of our comments.

Sincerely,



Stacy A. Bohlen, CEO
National Indian Health Board