Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board | 910 Pennsylvania Avenue, SE | Washington, DC 20003 | (202) 507-4070 | (202) 507-4071 fax

July 3, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via regulations.gov

Re: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality

Dear Administrator Brooks-LaSure:

On behalf of the CMS Tribal Technical Advisory Group (TTAG), I write to provide a response to the Centers for Medicare and Medicaid Services (CMS) proposed rule, Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality" (CMS-2439-P). This is an important step toward ensuring Medicaid and CHIP managed care enrollees get the care they need by strengthening standards for timely access to care and better addressing health related social needs. However, we hope CMS considers the unique circumstances under which the Indian health system operates, and how some of the proposals may not work for Indian Country. We ask that you consider the following comments and recommendations from the TTAG as you finalize this rulemaking.

Preamble to Comments:

Before commenting specifically on this proposal, we highlight important context including the deep inequities in this nation's health care delivery system and the Biden administration's commitment and urgent effort to eliminate them. Over the last year, the entire federal government, including CMS, has been working to respond to the President's Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (EO 13985).

For the first time, the federal government is taking a systematic approach to address equity issues. CMS has responded by first issuing its CMS Strategic Plan, "Pillar: Health Equity" that laid out CMS' definition of health equity and a broad strategy to advance equity through its programs. More recently, CMS has published its Framework for Health Equity 2022-2032, which is a more detailed ten-year plan intended to address equity and health disparity issues across Medicare, Medicaid, CHIP, and the Health Insurance Marketplaces.

Important to understand about health disparities is that American Indian and Alaska Native (AI/AN) people were once one of the healthiest people on this continent, before United States' colonial policies of termination, assimilation, and boarding schools caused an "intergenerational pattern of cultural and familial disruption"[1] that drive health disparities to this day. These drivers have manifested in extraordinarily high and disproportionate rates of infant and maternal mortality, cancer, cardiovascular disease, depression and other behavioral health conditions, among other ailments. Nationwide, AI/AN people suffer from disability rates that are 3 to 4% higher than any other population group. This data precedes the impacts of the COVID-19 pandemic which has resulted in a dramatic reduction of life expectancy for AI/AN people as noted by the CDC in their recent report. Tribal governments can foster thriving communities."[2] Efforts to address these disparities often feature culturally inappropriate interventions and inadequate understandings of the historical effects of United States policies and ongoing trauma of AI/AN people.[3] It is this history that is the root cause of the significant health disparities that affect AI/AN populations.

The TTAG is deeply appreciative that the President's EO 13985 and the CMS Framework for Health Equity provide an opportunity to focus on these concerns and that the CMS Framework provides an opportunity to design, implement, and operationalize policies and programs to address health equity issues. The TTAG has always taken the position that CMS has ample legal authority to undertake distinct policies and programs specifically focused on AI/AN beneficiaries and the IHS programs that provide their care, because of their unique legal and political status under the U.S. Constitution and the duties owed by the federal government under its treaty and trust responsibilities to AI/ANs.[4]

Under established principles of Indian law, programs and policies that are specifically established for Indigenous people and organizations do not constitute prohibited race-based classifications; rather, they are based on the unique political relationship between the federal government and Indian Tribes. This unique legal relationship, taken together with EO 13985 and CMS' Framework for Health Equity, provides a sound basis for CMS to adopt the TTAG recommendations on the Proposed Rule. We trust you will agree that the TTAG recommendations are directly related to CMS' Framework discussed in "Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps." The TTAG's recommendations fit clearly within the intended outcomes of this chapter and other priority areas of the Framework.

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[1] "Federal Indian Boarding School Initiative Investigative Report", Department of Interior, Assistant Secretary Bryan Newland, May 2022.
[2] *Ibid*.
[3] "Indigenous Health Equity," Abigail Echo-Hawk, Director, Urban Indian Health Institute, August 7, 2019.
[4] *See* "Legal Basis for Special CMS Provisions for American Indian and Alaska Native," Appendix A, CMS-TTAG Strategic Plan 2020-2025.

Comments and Recommendations:

I. Ensure the State Directed Payments Do Not Limit Reimbursement to Indian Health Care Providers at the IHS All-Inclusive Encounter Rate

The TTAG is concerned about the "state directed payments" in which the state directs managed care plan to pay certain providers in certain ways. We want to ensure that any state-directed payment does not inadvertently limit reimbursement to IHCPs at the IHS OMB All-Inclusive Encounter Rate.

The TTAG has reiterated the importance of the OMB encounter rate and has urged the agency to help facilitate the education with Medicare Advantage (MA) plans and all Managed Care Entities that support equitable access of AI/AN beneficiaries – who often have high health needs – in the MA program. This request has been brought to CMS through the TTAG for a couple years now, and CMS has recently confirmed that it is working on reconciling this request with the Indian Health Care Improvement Act (IHCIA) and other provisions governing MA and managed care entity plans.

Many state plans require MA plans to pay Indian health care providers at the IHS OMB rates. In states where MA plans are not required to pay Indian health care providers at the IHS OMB rates, the States are required to make a supplemental wrap payment to Indian health care providers so that they are paid at the IHS OMB rates. 42 C.F.R. §§ 438.14(c)(2) and (3). We request that CMS ensure that these new requirements for state directed payments do not apply to these separately authorized payment mechanisms for Indian health care providers in managed care.

II. Ensure Tribal Health Programs Do Not Experience Payment Delays Due to Additional Administrative Requirements Imposed by Managed Care Entities

The adoption of managed care has shifted significant administrative burdens and costs onto Tribal Health Programs. Managed care entities routinely deny or delay claims and payments to Tribal Health Programs, which lead to delayed or unpaid claims for patients served at Tribal clinics and may require Tribal Health Programs to hire additional billing staff. For example, Tribes in Washington constantly experience impacts of current rebilling burdens and interruptions in Medicaid payments due to working with up to five separate managed care entities in some regions, and each of those five impose its own separate, authorization and referral processes. When these for-profit entities refuse to pay, or pay late, Tribal Health Programs are not made whole. A lot of re-education is also needed with each managed care entity due to high turnover, and the lack of understanding how the Indian health system interacts with managed care, particularly when it comes to claims and reimbursement.

The TTAG asks CMS to hold the managed care entities accountable and reduce administrative burdens on Tribal Health Programs. In addition to the strain on staff time and resources, these additional administrative requirements could likely impact the downstream payment process and cause delays in payment for services rendered to Medicaid beneficiaries, which is counter to the objectives of this proposed rule. CMS

can reduce these burdens by requiring: (1) an ITU addendum, (2) implementation of training on Tribal Sovereignty, Federal Indian Law related to Medicaid (i.e. Right of Recovery in 25 U.S.C. § 1621(e), and the Indian health delivery system to all managed care entity staff, and (3) uniform referral/authorization requirements and prompt payment requirements in 42 U.S.C. § 1396u-2(h)(2)(B).

III. Require Managed Care Plans to Report on Payment Rates

It is critical for us to be able to see what rates managed care plans are paying to providers. As the TTAG reiterates time and time again, the Indian health system is underfunded, and we must ensure that Indian Health Care Providers (IHCPs) are being paid the correct rate by these plans in a timely manner. In Washington State, IHCPs are reimbursed at the encounter rate, however, the timeliness of reimbursement is an ongoing problem. This reporting would allow us to see if they're paying the encounter rate. We request that all managed care plans be required to report on payment rates.

The TTAG has urged CMS to require managed care plans to pay IHCPs at the IHS all-inclusive encounter rate to ensure that they are able to continue to provide the necessary care to our people. In addition, we urge CMS to inform and remind managed care plans of their ability to pay at IHS OMB rates.

IV. Require Managed Care Plans to Report on Denial Decisions

We urge CMS to require managed care plans to report on denial of claims, recoupments, and the reasoning behind those denials and recoupments. Idaho is a prime example of state reporting. Idaho requires managed care plans to report on a number of metrics,[5] including rates of denials and the reasoning for those denials. This information has been critically important to the Portland Area in ensuring that they have the statistics as a tool to advocate for better services for AI/AN people in that region.

V. Ensure Fee-for-Service Beneficiaries Retain the Same Access to Care as those in Managed Care

Tribes are having a hard time finding space for their fee-for-service (FFS) beneficiaries. There are limited FFS beds remaining in facilities after managed care plans come in and are able to pay more, disincentivizing providers from taking FFS patients. The discrepancy in payment rates between managed care and FFS is driving this problem. The lack of space for FFS beneficiaries is essentially pushing them into enrolling in managed care simply to gain access to the care they need.

[5] Idaho provides the following metrics: total members; number of encounter claims adjudicated; number of claims pending; number and percentage of encounter claims paid; number and percentage of encounter claims denied; number and percentage of clean claims submitted within date range processed to paid or denied status within 30 days/60 days/90 days of submission; total dollars billed in date span for claims that have been adjudicated; total dollars paid for encounter claims in date span; top 5 claim denial reasons; number of appeals from IHCP that claims were incorrectly denied; number and percentage of claims that were appealed on the basis of the wrong payment rate; and percentage of appeals resolved in IHCPs favor.

Additionally, this drives AI/ANs to seek care outside of the IHS/Tribal (I/T) system, which has a cascading impact on the Indian health system. We need CMS to work to ensure FFS is not left behind and restricted in this move toward increased beneficiary enrollment in managed care. Ensuing network adequacy in the provider mix is crucial to providing sufficient primary care access to folks.

VI. Exempt Indian Health Care Providers from the Appointment Wait Time Maximum and Other New Requirements

The I/T system often faces challenges with recruiting and retaining both administrative and clinical staff. The low staffing rates, particularly on the clinical side, create a challenge in abiding by these wait time maximums. There are very few available providers, especially for behavioral health services, so the 28-day maximum wait time for an appointment is not possible to attain for some facilities. We are concerned that the IHCPs contracted with managed care plans will not be able to meet these requirements, and therefore will face penalty that will only hinder their ability to serve their communities.

VII. Ensure the New Requirements Do Not Disincentivize Service of Medicaid Beneficiaries

While the TTAG understands the incentives that may arise from the proposed requirements like the maximum wait time and the secret shopper surveys, we are concerned about the ancillary impact these may have on IHCPs.

VIII. Establish New Requirement for Managed Care Entities to Have a Tribal Liaison as a Singular and Knowledgeable Point of Contact for IHS Providers

While this is a requirement in some states, it is not widespread which is problematic as roughly 40 states have some type of Medicaid managed care plan. By and large, managed care organizations (MCOs) are not familiar with the provisions and authorities preserved to Tribal nations as sovereign governments and their community members enrolled in Medicaid and managed care plans. This lack of knowledge results in AI/AN enrollees being deprived of their federally preserved rights within Medicaid programs, often failing to receive the level of care they need. Establishing a requirement for a Tribal liaison and guidelines for the position would be a step forward in closing the equity gap for AI/AN enrollees of managed care plans.

IX. Establish Guidelines for Managed Care Plans Regarding IHS Service Providers

As noted, there is a significant lack of understanding of the authorities of Tribal nations in regard to their provision of Medicaid allowable services as a Medicaid reimbursable provider. Many managed care plans incorrectly add tribal providers as a “natural support” in Medicaid waiver programs. This incorrect categorization results in tribal providers being deprived of appropriate payment and reimbursement for the Medicaid

allowable services being provided to Medicaid eligible AI/AN members. A potential resolution is to establish minimum guidelines to managed care plans requiring training of key staff, such as case managers, as it relates to Tribes as reimbursable providers. These guidelines should require a managed care plan to create a corrective action plan and submit that plan to CMS when found to be non-compliant with this guidance and with the tenets of Section 5006 of the American Recovery and Reinvestment Act (ARRA).

Conclusion

This rulemaking is an important step toward ensuring Medicaid and CHIP managed care enrollees get the care they need by strengthening standards for timely access to care and better addressing health related social needs. However, we hope CMS remembers and consider the unique circumstances under which the Indian health system operates – which we have outlined above – and how some of the proposals in this rule may not work for Indian Country. We appreciate your consideration of the above comments and recommendations and look forward to engaging with the agency further.

Sincerely,

W. Ron Allen, CMS TTAG Chair
Jamestown S'Klallam Tribe, Chairman/CEO