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July 27, 2015

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-2390-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Comments of the United South and Eastern Tribes, Inc. 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"

The United South and Eastern Tribes, Inc. (USET) is pleased to provide the Centers for Medicare and Medicaid Services (CMS or the Agency) with the following comments in response to the agency's June 1, 2015 Notice of Proposed Rule Making (NPRM) for the 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 rule (CMS-2390-P). We also welcome this opportunity to provide recommendations on how CMS can work to protect important managed care exemptions for Indians and work with state Medicaid agencies, in a concerted way, to ensure implementation of the rule complements the Indian health system.

USET is a non-profit, inter-Tribal organization representing 26 federally recognized Indian Tribes from Texas across to Florida and up to Maine.[1] Both individually as well as collectively through USET, our member Tribes work to improve health care services for American Indians. Our member Tribes operate in the Nashville Area of the Indian Health Service (IHS), which contains 36 IHS and Tribal health care facilities. Tribal members may receive health care services at IHS facilities, as well as in Tribally operated facilities operated under agreements with the IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638.

Introduction

USET appreciates the Agency's continued effort to engage Tribes in the comment and review process of the NPRM. We commend CMS in its efforts to update and modernize the Medicaid program by aligning with other insurers and implementing delivery system reform. This is an important opportunity to better align and advance

[1] USET member Tribes include: Eastern Band of Cherokee Indians (NC), Mississippi Band of Choctaw Indians (MS), Seminole Tribe of Florida (FL), Miccosukee Tribe of Indians of Florida (FL), Chitimacha Tribe of Louisiana (LA), Seneca Nation of Indians (NY), Coushatta Tribe of Louisiana (LA), Saint Regis Mohawk Tribe (NY), Penobscot Indian Nation (ME), Passamaquoddy Tribe Pleasant Point (ME), Passamaquoddy Tribe Indian Township (ME), Houlton Band of Maliseet Indians (ME), Tunica-Biloxi Tribe of Louisiana (LA), Poarch Band of Creek Indians (AL), Narragansett Indian Tribe (RI), Mashantucket Pequot Tribal Nation (CT), Wampanoag Tribe of Gay Head (Aquinnah) (MA), Alabama-Coushatta Tribe of Texas (TX), Oneida Indian Nation (NY), Aroostook Band of Micmacs (ME), Catawba Indian Nation (SC), Jena Band of Choctaw Indians (LA), Mohegan Tribe (CT), Cayuga Nation (NY), Mashpee Wampanoag Tribe (MA), and Shinnecock Indian Nation (NY).

service delivery for Medicaid Indians, a chronically underserved population with worsening health disparities. Ensuring proper coordination and management of care for this vulnerable group will be an important step towards meeting a critical objective of the Indian Health Care Improvement Act (IHCIA) by achieving the highest health outcomes possible for Indians. Although we are eager to help guide CMS in this process, we were underwhelmed with the quality of Tribal consultation on this important policy issue. We do not believe that a one-time webinar presentation on the NPRM, which offered very little opportunity for dialogue, meets the criteria for meaningful consultation. Furthermore, we do not believe this fulfills the requirements for Tribal consultation set out in Executive Order 13175. Pursuant to this Executive Order CMS must: 1) encourage Indian Tribes to develop their own policies to achieve program objectives; 2) where possible, defer to Indian Tribes to establish standards; and 3) in determining whether to establish Federal standards, consult with Tribal officials as to the need for Federal standards and any alternatives that would limit the scope of Federal standards or otherwise preserve the prerogatives and authority of Indian Tribes. CMS must facilitate a consultative forum that allows for more collaboration and participation among Tribal organizations and federal partners on this rule.

Managed Care in Indian Country

On April 15, 2015, USET submitted a joint letter with the Northwest Portland Area Indian Health Board to Victoria Wachino, Acting Director, Center for Medicaid and CHIP Services. The letter requested meaningful Tribal consultation and delineated a number of concerns about the implementation of the American Recovery and Reinvestment Act (ARRA) protections for Indians and the introduction of managed care in Indian Country. USET continues to have the same concerns as those outlined in the April 2015 letter and hereby requests that CMS take those concerns into account when making any revisions to the proposed rule.

It is USET's experience that managed care models are incongruous with the unique way that health care is delivered in the Indian health system. As a result of decades of chronic underfunding to the Indian Health Service (IHS), access to timely and comprehensive health care for Indians has proven to be a significant challenge. Similarly, Indian Health Care Providers (IHCPs) continue to have difficulties being reimbursed by the Medicaid program from managed care entities. The additional barriers created by introducing private managed care entities into the Indian health system, for patients they were not designed to serve, further exacerbate existing access to care issues. This is a critically important issue as almost 58% of Medicaid is delivered through managed care. Although we acknowledge the intent of this regulation is to modernize the way that Medicaid delivers care in an effort to reduce cost and improve health, we believe the regulation would have the opposite effect in Indian Country.

One of the major issues with managed care in Indian health care is the limitations on "in network" providers and inadequate access to specialty care. In the Indian health system, members of federally recognized Tribes have access to primary care, basic medical, and behavioral services at their local clinic, and can be referred out to specialists for priority conditions through the Purchased/Referred Care (PRC) program (formerly known as "Contract Health Services"). Many Tribal health organizations have longstanding agreements with such providers in order to expand access to services for their members. When private managed care entities deliver services through the Medicaid program, they impose strict provider networks which often exclude PRC providers and primary care IHCPs. Additionally, USET member Tribes are located in rural areas where Health Professional Shortage Areas (HPSA) scores are high and access to specialty care can require a 20-50 mile drive. The rationing of providers in rural Tribal communities where access to medical care is already limited can have devastating effects on individual patients and the management of community health and wellness at large. This access-to-care

issue is further complicated by the improper application of payment rules when care is furnished at facilities operated by the Indian Health Service, Tribes or Tribal organizations, or urban Indian organizations (ITUs).

Often, when an IHCP is listed as "out of network," managed care entities will deny payment despite the ARRA protections that require compensation, regardless of their network participation, and despite CMS's 2010 State Medicaid Director Letter informing states about those protections. *See* CMS State Medicaid Director Letter, Re: ARRA Protections for Indians in Medicaid and CHIP (Jan. 22, 2010) [hereinafter "CMS State Medicaid Director Letter"].[2] Managed Care Organizations' (MCOs) lack of familiarity with the Indian health system allows these types of payment issues to persist. Ultimately, it becomes the burden of the Tribal health program to recover payment for denied claims, which adds an unnecessary administrative burden and drains essential resources for the ITU. To combat this issue, USET area Tribes have repeatedly tried to contract with private insurance networks, including managed care plans, to include IHCPs, but they have been met with opposition. The contract terms for providers in private networks, including Federally Qualified Health Plans (QHPs), TRICARE, and Federal Employee Health Benefit Plans, impose restrictions that are not applicable to IHCPs under federal law. For example, the recently reauthorized IHCIA allows Indian health organizations to employ providers with medical licensure from any state, 25 U.S.C. § 1621t, and IHCPs are covered by the Federal Torts Claim Act under the ISDEAA, 25 U.S.C. §§ 450f(d), 458aaa-15(a). These special provisions were intended to address the health care workforce shortages that were pervasive in Indian country and are consistent with how the IHS operates. MCOs and private provider networks often require in-state licensure and malpractice insurance for network-participating providers. This is complicated by the fact that many USET member Tribes have ongoing issues with provider retention and are frequently having to re-authorize new providers. As a result, IHCPs are not included in these networks, which effectively limits the number of providers and eliminates essential third party resources for the Indian health facility. These network adequacy issues lead to poor coordination of care for our most at-risk American Indian patients.

In addition to the numerous administrative challenges associated with implementing managed care network adequacy in Indian country, there are several other inefficiencies that lead to extra costs for the state and taxpayers. MCOs often require visits to in-network primary care providers (PCP) before authorizing payment to the referred specialist. This is particularly problematic for Indians that receive primary care services at their out-of-network ITU and are referred to approved in-network specialty care providers. If the MCO refuses to recognize a referral provided by an out-of-network IHCP, the Indian patient would have to see a different primary care provider who is in-network in order to obtain a referral. This results in the United States paying twice for the same service, is an unreasonable burden on the Indian patient and results in delayed access to specialty care. These duplicative efforts encourage overuse of health care, cost thousands of federal tax dollars, and do not lead to better health outcomes. Ensuring that a referral from an ITU to a specialist, regardless of the ITU's network status, is sufficient for payment is critical to reduce the cost of treatment for Indians.

Due to the historic difficulties the IHS has had with private managed care organizations, Congress established important protections for American Indian patients through the Balanced Budget Act of 1997, Pub. L. 105-33, and the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. 111-5. Despite these laws, however, managed care organizations continue to arbitrarily assess premiums and cost-sharing to Indian patients, as well as auto-assign PCPs to Indians despite the statutory language prohibiting this in ARRA.

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[2] Available at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10001.PDF.

Preamble to NPRM and ARRA Protections

Section 1932(a)(2)(c) of the Social Security Act was a critical amendment to the Act, enacted through Sections 4701-4710 of the Balanced Budget Act of 1997, Pub. L. 105-33. Section 1932(a)(2)(c) protects American Indians and other vulnerable groups from being mandatorily enrolled in managed care through Medicaid State Plan Amendments. The 105th Congress recognized the unique way in which the Indian Health Service provided care to Indian patients and sought to prevent the administrative backlog and associated costs of mandating Indians into managed care. However, in recent years, states have attempted to utilize other authorities like Section 1115 and 1915(b) to expand their Medicaid program and attempt to mandatorily enroll American Indians into managed care. Currently, only four (4) of the twelve (12) states in which there are USET member Tribal reservations have expanded Medicaid, and there are many more Tribal members living in other states that have not expanded Medicaid. USET continues to monitor this issue as many states will use these authorities to expand or modify their programs and attempt to circumvent the Section 1932 protection for Indians. We are especially troubled with the language in the preamble to the NPRM, which makes the blanket statement that states can mandate managed care for American Indian Alaska Native beneficiaries through these authorities. We believe that this is inconsistent with the principle goal of the Section 1932(a)(2)(c) amendment.

The language that USET finds particularly concerning is in the preamble to the NPRM:

> CMS may grant a waiver under section 1915(b) of the Act, permitting a state to require all Medicaid beneficiaries to enroll in a managed care delivery system, including dually eligible beneficiaries, American Indians and Alaska Natives, or children with special health care needs. …
>
> CMS may also authorize managed care programs as part of demonstration projects under section 1115(a) of the Act that includes waivers permitting the state to require all Medicaid beneficiaries to enroll in a managed care delivery system, including dually eligible beneficiaries, American Indians/Alaska Natives, or children with special health care needs.

80 Fed. Reg. at 31100.

Section 1915(b) waivers may not be implemented if they "substantially impair access to such services of adequate quality as may be medically necessary." 42 U.S.C. § 1396n(b)(1)–(2).[3] In all cases, Indians should be exempt from participation in managed care through the Section 1915(b) waiver authority. This will prevent the undue burden and hardship placed on American Indian and Alaska Native beneficiaries by further limiting providers. Timely access to services becomes a major barrier when providers are limited through managed care, particularly in rural areas where many of our reservations exist. This change will better align the Medicaid waiver authorities with the limitations of the Section 1932 amendments.

Although we do not agree that CMS has the legal authority to mandate Indians into managed care through waivers, we appreciate the administration's commitment to date not to approve waivers that set out to do so. We remain concerned, however, that the language in the preamble to the NPRM provides states with a regulatory

[3] *See also* CMS, "At-a-Glance" Guide to Federal Medicaid Authorities Useful in Restructuring Medicaid Health Care Delivery or Payment (April 2012), http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/At-a-glance-medicaid-Authorities.pdf.

avenue to mandate Medicaid managed care for Indians. While we appreciate CMS's prior commitment not to mandate Indians into managed care, we believe this is a great opportunity to include specific language in the regulation to codify this commitment. Ultimately, it is not the role of state governments to coordinate or administer care for American Indians and Alaska Natives. Protecting the Indian patients from the harmful effects of Medicaid managed care is an essential function of the Federal government's trust responsibility.

Proper Implementation of Section 5006 of the ARRA

Section 5006 of the ARRA established several important rules to protect the Indian health system from any financial and administrative complications of implementing managed care. Pub. L. 111-5. Compliance with these rules, however, is irregular, and CMS has not established a viable mechanism to monitor and enforce these rules. Issues with full and timely payments to providers, compliance with network adequacy, and other challenges continue to persist in Indian Country. For Indian patients that wish to voluntarily enroll in managed care networks, the proper application of these rules is essential to their access to timely and cost-effective care. USET urges CMS to further develop these regulations to ensure a more rigorous review of state programs and establish appropriate channels for recourse.

There are several payment provisions that protect both individual Indian patients and Indian health organizations at-large. For Indian patients, the law prevents premiums, enrollment fees, and cost sharing from being assessed for Indians receiving care at ITUs or through referral at a PRC provider. Section 5006(a) amended Section 1916 of the Social Security Act to provide that:

> No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services for which payment may be made under this title.

42 U.S.C. § 1396o(j)(1)(A).

Notwithstanding these provisions, private managed care organizations often fail to educate their non-IHCPs to comply with cost sharing protections for Indian patients. In its 2010 State Medicaid Director Letter regarding the Indian-specific protections in ARRA, CMS notes: "States are encouraged to inform non-ITU providers who participate in CHS about the absence of cost-sharing." CMS State Medicaid Director Letter at 2. "Encouragement" has not worked. CMS must do more to ensure these cost sharing protections are implemented and Indian patients can continue to receive care at the ITU of their choice.

The law also permits any Indian to choose their ITU provider as their primary care doctor regardless of the provider's participation in the network. 42 U.S.C. § 1396u-2(h)(1). This is typically nullified when MCOs auto-assign primary care physicians and exclude IHCPs. To address this, ITUs must use essential resources for mitigating the administrative and financial challenges that auto-enrollment imposes. In order to ensure Indian patients who elect to enroll in managed care are protected, USET recommends providing continuous and on-going education about the ARRA protections to MCOs and their network providers. This important intervention is another way the federal government can meet its trust responsibility to Indian patients.

ARRA also protects Indian health facilities by ensuring adequate reimbursement for services, as well as the integrity of the Indian health system by including network adequacy requirements for MCOs. 42 U.S.C. § 1396u-2(h)(2). The ARRA protections require managed care entities to demonstrate that there are a sufficient number of ITU participating providers "to ensure timely access to covered Medicaid managed care services." 42 U.S.C. § 1396u-2(h)(2)(A)(i). Likewise, CMS's 2010 State Medicaid Director Letter requires "each managed care entity to demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers." CMS State Medicaid Director Letter at 5. However, CMS's guidance should apply ARRA's protections to specifically require that MCOs offer contracts to all IHCPs in their service area using an Indian Managed Care Addendum, similar to the Indian Addendum used for IHCPs to contract with QHPs. The Addendum that was created for QHPs delineates important aspects of the Indian health system, including: persons eligible for services, special licensure for IHCPs, and other applicable federal laws. It has been an important instrument used by Tribes to educate private insurance organizations about the Indian health system. USET urges CMS to clarify and enforce the requirements for network adequacy while requiring an Indian Managed Care Addendum to support these important agreements and partnerships. We recommend the use of the attached Indian Managed Care Addendum drafted by the Tribal Technical Advisory Group (TTAG) for this purpose.

There are several payment provisions within ARRA to ensure Indian health facilities are paid in full by MCOs and their state plan. The first is that ITUs must be paid regardless of network participation, and without deductions by any amount of cost-sharing. 42 U.S.C. §§ 1396o(a), 1396u-2(h)(2)(A)(ii). With respect to the rate of payment, ARRA requires that ITU providers, whether participating in the network or not, be paid (1) at a rate negotiated between the managed care entity and the ITU provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an ITU provider. 42 U.S.C. § 1396u-2(h)(2)(A)(ii). Another payment provision in ARRA requires that ITUs receive the same payment that would have otherwise been paid to them under the state plan. 42 U.S.C. § 1396o(j)(1)(B). The statute then mandates a wraparound payment from the state to make up for any shortfall from managed care reimbursement rates. 42 U.S.C. § 1396u-2(h)(2)(C)(ii). This rate, usually referred to as the "IHS encounter rate," was established in recognition of the unique way in which care is delivered within the Indian Health System and the special relationship Tribes have with the federal government.

USET recommends that CMS clarify and condense these payment requirements into a single regulation that would allow Tribes to receive the state plan amount or encounter rate, whichever is higher, directly from the MCO. This approach would reduce the administrative burden on both the state and Tribes to seek a single payment from the MCO. This would also allow Tribes the flexibility to utilize whichever rate they have negotiated with the state, whether that is the encounter rate, FQHC or another agreed upon amount. Although ARRA does not require the managed care plans to pay the encounter rate to the IHCPs directly, it doesn't prohibit CMS from asking states to encourage managed care entities to do so. Clarifying this payment provision will better align the rule with the payment provisions in the Affordable Care Act, which allow for wraparound payments to QHPs for the amount of cost sharing. 42 U.S.C. § 18071(c)(3). This simplified payment language is an important clarification that should be included in the Managed Care Indian Addendum. We encourage CMS to revisit these ARRA protections and issue a more simplified payment provision that will help Tribes, the state, and managed care organizations work in better accordance with each other. *See also* our comments below on proposed Section 438.4.

Other Provisions of the NPRM

In addition to CMS's treatment of the Indian-specific ARRA and Section 1932 provisions in the NPRM, we believe there are several other portions of the proposed regulations that warrant further, careful examination by CMS in order to identify the potential impacts on the Indian health system. We offer the following examples in an effort to modernize and harmonize the ways that CMS and the Indian Health system work together.

Enrollment Protections (§ 438.54)

Although we believe Indians should be exempt from mandatory enrollment in managed care, we seek additional protections for Indians if they become enrolled in an MCO. USET believes that the enrollment and beneficiary support provisions of the NPRM should seek parity with some of the special protections for Indians in the Affordable Care Act by allowing greater enrollment flexibility and assistance to patients. American Indian patients should not have to forgo the freedom of choice in their health care, due to their Medicaid eligibility or income level. The preamble of the NPRM provides:

> Under section 1932(a)(4)(A)(ii)(I) of the Act, beneficiaries in a mandatory managed care program have the right to change plans without cause within 90 days of enrolling in the plan and every 12 months; enrollees may also change plans for cause at any time. When the beneficiary does not actively select a managed care plan in the timeframe permitted by the state, states have generally used the default assignment process to assign individuals into plans. Section 1932(a)(4)(D) of the Act and current implementing regulations at 438.50(f) outline the process that states must follow to implement default enrollment (also commonly known as auto-assignment) in a mandatory managed care programs.

80 Fed. Reg. at 31133.

To better align MCO enrollment with the ACA and ensure Medicaid Indians are afforded similar levels of choice in their healthcare, USET suggests allowing American Indians and Alaska Natives the option of monthly special enrollment periods to opt into a plan or change plans, regardless of cause. This will also mitigate any administrative complications from auto-enrolling Indians into managed care plans that do not suit patients' health needs.

The NPRM also suggests a minimum time period of 14 days between the time the consumer is notified that they will be enrolled into a managed care program and the date they become covered by the MCO. 80 Fed. Reg. at 31122. USET believes 14 days is not sufficient to contact our hard-to-reach rural Indian populations. Many of our Tribes have inadequate access to internet and electronic messaging, particularly in Maine, where access to broadband is limited to select areas of the community. Furthermore, patients receiving the notification may not understand the vocabulary in the letter and may need assistance to decipher its meaning. In order to provide adequate time to allow patients to receive communications and consult with their IHCP, we suggest a minimum time period of 30 days for notification of enrollment and coverage.

Beneficiary Support System (§ 438.71)

Ensuring that Medicaid-eligible Indians have the same level of support that an Indian patient with higher income enrolling in a QHP plan would have under the ACA should be a critical aim of the rule. The preamble to the NPRM acknowledges the importance of enrollment support for Medicaid patients, yet it provides no ITU-specific and culturally competent options for American Indian patients:

> This additional assistance includes having access to personalized assistance—whether by phone, internet, or in person—to help beneficiaries understand the materials provided, answer questions about options available, and facilitate enrollment with a particular health plan or provider. Some states have found that having such personalized assistance has helped to limit the numbers of beneficiaries assigned through their default enrollment process.

80 Fed. Reg. at 31136.

We understand that assistance via phone, written materials, and internet are successful for some populations, but the most successful of these interventions for Indians patients has been in-person counseling. Indian patients have had the best success being advised directly by their IHCPs. Relationships between patients and IHCPs are built on trust, making the IHCPs best suited for explaining to their patients how private MCOs align with the services already provided through the Indian health system. Ensuring that Medicaid-eligible Indians have access to knowledgeable counselors and assistors to help them navigate their plan options is essential.

However, the proposed regulations seem to preclude organizations that receive Medicaid funding from assisting in enrollment efforts:

> However, in paragraph (c)(2), we clarify that any individual or entity providing choice counseling services is considered an enrollment broker under our regulations, and therefore, must meet the independence and conflict of interest standards of § 438.810 to provide those services. This means the entity cannot have a financial relationship with any MCO, PIHP, PAHP, PCCM, or PCCM entity which operates in the state where the entity is providing choice counseling. This would include participating with the MCO, PIHP, PAHP, PCCM, or PCCM entity as contracted provider.

80 Fed. Reg. at 31137

We are generally concerned that IHCPs that serve many functions, including delivering health care and patient advocacy, would not be in compliance with the proposed rule if the IHCPs assist Indian patients with understanding their managed care options. In the same way that ITUs receive funds to assist in enrollment into traditional Fee-for-Service (FFS) Medicaid and through navigator grants for QHP enrollment, IHCPs should not be impacted by the conflict of interest provision regarding enrollment into Medicaid managed care. To rectify this, we suggest clarifying the term "broker" to distinguish them from an entity, like an ITU, that provides both health care and "choice counseling." In order to make Medicaid more accessible for low-income Indians in states that plan to mandate managed care, CMS should clarify that IHCPs do not have a conflict of interest by providing counseling to Medicaid-eligible Indian patients.

Information Standards (§ 438.10)

Standardized Consumer Information: USET supports TTAG's request of standardized materials for the purpose of defining terminology in model enrollee handbooks and notices. However, MCOs should be required to include

information specific to working with the Indian health system. The handbook should include language that informs beneficiaries that they can continue to access their ITU regardless of their network participation and outline other Indian-specific protections in Medicaid. We suggest this be included as part of the standard materials distributed to everyone. The materials to be included in the handbook should be submitted to the CMS TTAG for review and also be piloted with a target group of Indian patients to ensure that information is clear and culturally competent. In addition to the above suggestions, we support the requirement that these materials come in paper format at no cost and be provided within five (5) calendar days. This will help reach the many American Indian beneficiaries without access to the internet.

Medicaid Estate Recovery: USET believes that all American Indians and Alaska Natives should have a blanket exemption from Medicaid estate recovery because this practice is in direct conflict with the Federal government's trust responsibility to Indians. This practice also discourages American Indian patients from enrolling in Medicaid for fear of the long-term financial implications of this decision, leaving them uninsured. With this understanding, we suggest that CMS require states to inform Indians—prior to enrollment—if they will be subject to Medicaid estate recovery requirements. However, general information will not suffice, and states should be also required to issue a written statement as to whether the Indian person qualifies for an exemption from estate recovery. USET also supports the TTAG suggestions that the NPRM should do the following:

1) Delineate how the amount of estate recovery will be calculated to potential beneficiaries in clear and simple language, including an annual report of costs accrued that are eligible for recovery.

2) Issue separate regulations explaining how costs are calculated for estate recovery for people enrolled in managed care plans.

3) Establish standards for states to distinguish between "Medicaid enrollment" and "Medicaid managed care plan selection" and require beneficiaries to sign consent forms that confirm they are aware they are subject to estate recovery.

4) Provide specific counseling for American Indian beneficiaries regarding the types of ownership that are eligible for estate recovery and the types that are exempt.

While we believe Medicaid estate recovery contradicts the Federal government's trust responsibility, we hope the above suggestions will help to protect Medicaid-eligible Indians and to encourage their participation in Medicaid.

Capitation Rates (§ 438.4)

In the NPRM, there is a provision that prevents higher capitation rates paid to MCOs for populations with a greater Federal Financial Participation (FFP) percentage. USET believes AI/ANs should be exempt from this rule in order to recognize the special rules for AI/AN patients and streamline proper payments to ITUs. The proposed regulation reads as follows:

> [W]e propose in paragraph (b)(1) to prohibit different capitation rates based on the FFP associated with a particular population. We believe that such practices represent cost-

> shifting from the state to the federal government and are not based on generally accepted actuarial principles and practices.

80 Fed. Reg. at 31120.

USET is concerned that there may be uncertainty for states in complying with this regulation when it comes to the American Indian population. We understand from the preamble that CMS has proposed this restriction as a way to address potential cost-shifting—to prevent a state from paying higher capitation rates for Medicaid enrollees who are in eligibility groups for which the state receives a higher FFP rate. *See* 80 Fed. Reg. at 31,120. However, USET is concerned that the proposed rule fails to take into account the fact states receive 100% FFP for services, and pay a special rate, for care furnished to American Indian patients at an IHCP.

CMS can eliminate confusion for states by explicitly stating that states can provide higher capitation rates to MCOs for the anticipated enrollment of IHS beneficiaries into the plan. Rather than an MCO paying traditional FFS payment to providers, IHCPs bill at an IHS encounter rate which, as noted earlier, was established specifically for the Indian health system. Allowing higher capitation rates (from states to MCOs) would help MCOs meet the suggested payment provision that requires managed care entities to pay a minimum of the IHS encounter rate directly to the ITU. In cases where the MCO would typically pay less, the plan could pay the full encounter rate without the need to recover the difference from the state. Ultimately, this would reduce the administrative burden on the Tribe, MCOs and states. CMS should clarify this provision to ensure that it aligns with special rules that apply to the Indian health system.

Conclusion

USET appreciates the opportunity to provide these comments. We are encouraged by CMS's efforts to modernize its managed care regulations and better align the Medicaid delivery system with existing federal law and the Indian Health system. Should you have questions or require additional information, please do not hesitate to contact Ms. Liz Malerba, USET Director of Policy and Legislative Affairs, at (202-624-3550) or by e-mail at lmalerba@usetinc.org.

Sincerely,

Brian Patterson
President

Kitcki A. Carroll
Executive Director

CC: USET member Tribes
Wanda Janes, USET Deputy Director
Dee Sabattus, USET Director of Tribal Health Program Support
Hilary Andrews, USET Health Policy Analyst
File

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

Model Medicaid Managed Care Addendum for Indian Health Care Providers

1. Purpose of Addendum; Supersession.

The purpose of this Medicaid Managed Care Addendum for Indian health care providers is to apply special terms and conditions necessitated by federal law and regulations to the network provider agreement by and between _____ (herein "Managed Care Entity") and _____ (herein " Provider"). To the extent that any provision of the Managed Care Entity's network provider agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.

2. Definitions.

For purposes of the Qualified Health Plan issuer's agreement, any other addendum thereto, and this Addendum, the following terms and definitions shall apply:

(a) "Contract health services" has the meaning given in the Indian Health Care Improvement Act (IHCIA) Section 4(5), 25 U.S.C. § 1603(5).
(b) "Indian" has the meaning given in 42 C.F.R. § 447.50(b)(1).
(c) "Provider" means a health program administered by the Indian Health Service, a tribal health program, an Indian tribe or a tribal organization to which funding is provided pursuant to 25 U.S.C. § 47(commonly known as the "Buy Indian Act"), or an urban Indian organization that receives funding from the IHS pursuant to Title V of the IHCIA (Pub. L. 94-437), as amended, and is identified by name in Section 1 of this Addendum.
(d) "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCIA Section 601, 25 U.S.C. § 1661.
(e) "Indian tribe" has the meaning given in the IHCIA Section 4(14), 25 U.S.C. § 1603(14).
(f) "Managed Care Entity" means a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Management (PCCM) or Primary Case Managed Care Entity (PCCM entity) as defined in 42 C.F.R. § 438.2.
(g) "Tribal health program" has the meaning given in the IHCIA Section 4(25), 25 U.S.C. § 1603(25).
(h) "Tribal organization" has the meaning given in the IHCIA Section 4(26), 25 U.S.C. § 1603(26).
(i) "Urban Indian organization" has the meaning given in the IHCIA Section 4(29), 25 U.S.C. § 1603(29).

3. Description of Provider.

The Provider identified in Section 1 of this Addendum is (check the appropriate box):

/_/ The IHS.

/_/ An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450 et seq.

/_/ A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450 et seq.

/_/ A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).

/_/ An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.

4. Cost-Sharing Exemption for Indians; No Reduction in Payments.

The Managed Care Entity shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services. Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care provider through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. 42 U.S.C. § 1396o(j).

5. Treatment of Certain Property From Resources for Medicaid and CHIP Eligibility.

The Managed Care Entity shall disregard certain property from resources for purposes of determining the eligibility of an individual who is an Indian eligible for medical assistance as set forth in Sec. 1902 of the Social Security Act. 42 U.S.C. §1396a(ff).

6. Enrollee Option to Select the Indian Health Care Provider as Primary Health Care Provider.

The Managed Care Entity agrees that any Indian otherwise eligible to receive services from the Indian Health Care Provider may be allowed to choose the Indian Health Care Provider as the Indian's primary health care provider if the Indian Health Care Provider has the capacity to provide primary care services to such Indian, and any referral from such IHCP shall be deemed to satisfy any coordination of care or referral requirement of the Managed Care Entity. 42 U.S.C. §1396u-2(h).

7. Agreement to Pay Indian Health Provider.

The Managed Care Entity agrees to pay the Indian Health Care Provider for covered Medicaid managed care services in accordance with the requirements set out in Sec. 1932(h) of the Social Security Act. 42 U.S.C. 1396u-2(h).

8. Persons Eligible for Items and Services from Provider.

(a) The parties acknowledge that eligibility for services at the Provider's facilities is determined by federal law, including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136. Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the Provider's programs.

(b) No term or condition of the Managed Care Entity's agreement or any addendum thereto shall be construed to require the Provider to serve individuals who are ineligible under federal law for services from the Provider. The Managed Care Entity acknowledges that pursuant to 45 C.F.R. 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the Provider. Provider acknowledges that the nondiscrimination provisions of federal law may apply.

9. Applicability of Other Federal Laws.

Federal laws and regulations affecting the Provider, include but are not limited to the following:

(a) The IHS as a Provider:

(1) Anti-Deficiency Act, 31 U.S.C. § 1341;
(2) ISDEAA, 25 U.S.C. § 450 et seq.*;*
(3) Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(6) Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2;
(7) Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164; and
(8) IHCIA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is a Provider:

(1) ISDEAA, 25 U.S.C. § 450 et seq.*;*
(2) IHCIA, 25 U.S.C. § 1601 et seq.*;*
(3) FTCA, 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;

(5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
(6) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is a Provider:

(1) IHCIA, 25 U.S.C. § 1601 et seq. (including without limitation pursuant to the IHCIA Section 206(e)(3), 25 U.S.C. § 1621e(e)(3), regarding recovery from tortfeasors)*;*
(2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
(3) HIPAA, 45 C.F.R. Parts 160 and 164.

10. Non-Taxable Entity.

To the extent the Provider is a non-taxable entity, the Provider shall not be required by a Managed Care Entity to collect or remit any federal, state, or local tax.

11. Insurance and Indemnification.

(a) Indian Health Service. The IHS is covered by the FTCA which obviates the requirement that IHS carry private malpractice insurance as the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. 28 U.S.C. §§ 2671-2680. Nothing in the Managed Care Entity provider agreement shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment. The IHS shall not be required to acquire insurance, provide indemnification, or guarantee that the Managed Care Entity will be held harmless from liability.

(b) Indian Tribes and Tribal Organizations. A Provider which is an Indian tribe, a tribal organization, or employee of a tribe or tribal organization shall not be required to obtain or maintain professional liability insurance to the extent such Provider is covered by the FTCA pursuant to federal law (Public Law 101-512, Title III, § 314, as amended by Public Law 103-138, Title III, § 308 (codified at 25 U.S.C. § 450f note); and 25 C.F.R. Part 900, Subpart M; 25 U.S.C. §458aaa-15(a); and 42 C.F.R. § 137.220). Nothing in the Managed Care Entity network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such Provider or any employee of such provider to operate outside of the scope of employment of such employee. Such Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the Managed Care Entity will be held harmless from liability.

(c) Urban Indian Organizations. To the extent a Provider that is an urban Indian organization is covered by the FTCA pursuant to Section 224(g)-(n) of the Public Health Service Act, as amended by the Federally Supported Health Centers Assistance Act, Public Law 104-73, (codified at 42 U.S.C. §

233(g)-(n)), 42 C.F.R. Part 6, such Provider shall not be required to obtain or maintain professional liability insurance. Nothing in the Managed Care Entity network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such Provider or any employee of such Provider to operate outside of the scope of employment of such employee. Such Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the Managed Care Entity will be held harmless from liability.

12. Licensure of Health Care Professionals.

(a) *Indian Health Service.* States may not regulate the activities of IHS-operated health care programs nor require that IHS health care professionals be licensed in the state where they are providing services, whether the IHS employee is working at an IHS-operated facility or has been assigned to a health care program of a tribe, tribal organization, or urban Indian organization. The parties agree that during the term of the Managed Care Entity's agreement, IHS health care professionals shall hold state licenses in accordance with applicable federal law, and that IHS facilities shall be accredited in accordance with federal statutes and regulations.

(b) Indian tribes and tribal organizations. Section 221 of the IHCIA, 25 U.S.C. § 1621t, exempts a health care professional employed by an Indian tribe or tribal organization from the licensing requirements of the state in which such tribe or organization performs services, provided the health care professional is licensed in any state. Section 408 of the IHCIA, 25 U.S.C. § 1647a, provides that a health program operated by an Indian tribe or tribal organization shall be deemed to have met a requirement for a license under state or local law if such program meets all the applicable standards for such licensure, regardless of whether the entity obtains a license or other documentation under such state or local law.The parties agree that these federal laws apply to the Managed Care Entity's agreement and any addenda thereto.

(c) Urban Indian organizations. To the extent that any health care professional of an urban Indian provider is exempt from state regulation, such professional shall be deemed qualified to perform services under the Managed Care Entity's agreement and all addenda thereto, provided such employee is licensed to practice in any state. Section 408 of the IHCIA, 25 U.S.C. § 1647a, provides that a health program operated by an Indian tribe or tribal organization shall be deemed to have met a requirement for a license under state or local law if such program meets all the applicable standards for such licensure, regardless of whether the entity obtains a license or other documentation under such state or local law. The parties agree that this federal law applies to the Managed Care Entity's agreement and any addenda thereto.

13. Licensure of Provider; Eligibility for Payments.

To the extent that the Provider is exempt from state licensing requirements, such Provider shall not be required to hold a state license to receive any payments under the QHP issuer's network provider agreement

and any addendum thereto.

14. Dispute Resolution.

In the event of any dispute arising under the Managed Care Entity's network provider agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. The laws of the United States shall apply to any problem or dispute hereunder that cannot be resolved by and between the parties in good faith. Notwithstanding any provision in the Managed Care Entity's network agreement, the Provider shall not be required to submit any disputes between the parties to binding arbitration.

15. Governing Law.

The Managed Care Entity's network provider agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail. Nothing in the Managed Care Entity's network provider agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

16. Medical Quality Assurance Requirements.

To the extent the Managed Care Entity imposes any medical quality assurance requirements on its network providers, any such requirements applicable to the Provider shall be subject to Section 805 of the IHCIA, 25 U.S.C. § 1675.

17. Claims Format.

The Managed Care Entity shall process claims from the Provider in accordance with Section 206(h) of the IHCIA, 25 U.S.C. § 1621e(h), which does not permit an issuer to deny a claim submitted by a Provider based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

18. Payment of Claims.

The Managed Care Entity shall pay claims from the Provider in accordance with federal law, including 42 U.S.C. § 1396u-2(h)(2), and 42 C.F.R. 438.14(c)(2), and shall pay at either the rate provided under the State plan in a FFS payment methodology, or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is higher.

19. Hours and Days of Service.

The hours and days of service of the Provider shall be established by the Provider. Though not required prior to the establishment of such service hours, the Managed Care Entity and the Provider may negotiate and agree on specific hours and days of service. At the request of the Managed Care Entity, such Provider shall provide written notification of its hours and days of service.

20. Purchase/Referred Care Requirements

The Provider shall be able to make other referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the Managed Care Entity.

21. Sovereign Immunity.

Nothing in the Managed Care Entity's network provider agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

22. Endorsement.

An endorsement of a non-federal entity, event, product, service, or enterprise may be neither stated nor implied by the IHS Provider or IHS employees in their official capacities and titles. Such agency names and positions may not be used to suggest official endorsement or preferential treatment of any non-federal entity under this agreement.

APPROVALS

For the Managed Care Entity:	**For the Provider:**
Date	Date
_____	_____