CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.

Submitted via e-mail to: publicinput@dhcs.ca.gov

April 27, 2018

Nathan Nau, Chief
California Department of Health Care Services
Managed Care Quality and Monitoring Division
1501 Capitol Avenue,
Sacramento, CA 95899

Re: Comments on the Department of Health Care Services Managed Care Quality Strategy Draft Report

Dear Chief Nau:

I write today on behalf of the California Rural Indian Health Board (CRIHB), a network of 15 Tribal Health Programs, controlled and sanctioned by 44 federally recognized tribes, serving American Indian and Alaska Native (AIAN) people residing in California through 40 satellite clinics. I write this letter to recommend that the Department of Health Care Services (DHCS) address the unique circumstances and requirements specific to Indian Health Service facilities, Tribal Health Programs, and Urban Indian Health Programs (I/T/U) in its 2018 Managed Care Quality Strategy Report.

BACKGROUND ON INDIAN PROVISIONS IN MEDICAID MANAGED CARE

In 1976, the Indian Health Care Improvement Act amended the Social Security Act to permit reimbursement by Medicare and Medicaid for services provided to American Indians and Alaska Natives in Indian Health Service (IHS) and tribal health care facilities. In doing so, Congress recognized that many American Indians and Alaska Natives (AIAN) people, especially those residing in very remote and rural locations, were eligible for but could not access Medicaid and Medicare services without traveling sometimes hundreds of miles to Medicaid and Medicare providers located off-reservation.

The Indian Health Care Improvement Act[1] also provided states with a 100% Federal Medical Assistance Percentage (FMAP) for Medicaid services provided through an IHS or Tribal facility.

Protections for AIAN and ITU were further augmented by Section 5006 of the American Recovery and Reinvestment Act (ARRA) of 2009[2]. ARRA precludes states from imposing Medicaid premiums or any other Medicaid cost sharing on Indian enrollees who have used the Indian health system. ARRA also emphasizes the state-tribal relationship by formally requiring that states consult with the tribal community on Medicaid and CHIP policy matters. Specifically, states must

[1] 25 USC § 1601, et seq.
[2] 42 USC Section 1396u-2(h)(2)

seek advice from designees of Indian health programs and Urban Indian organizations in the state when Medicaid and CHIP matters have a direct effect on Indians, Indian health programs or urban Indian programs. States must also describe the process for seeking advice from Indian health programs and urban Indian organizations in their Medicaid and CHIP state plans.

The Medicaid Managed Care and Children's Health Insurance Program (CHIP) Managed Care Final Rule (Final Rule), at 42 Code of Federal Regulations (CFR) Section 438.340, requires each state Medicaid agency to implement a written quality strategy to assess and improve the quality of health care and services furnished by all Medicaid managed care entities in that state.

RECOMMENDATIONS

1. **No section of the draft 2018 Managed Care Quality Strategy Draft Report mentions the impact on or participation of I/T/U stakeholders. CRIHB recommends that DHCS include a section specifically addressing I/T/U unique circumstances and programs related to Managed Care.**

For example, this additional section could be entitled "Impacts to Indian Health", or the report could address I/T/U impacts, circumstances, and requirements as a separate chapter to each section.

2. **CRIHB recommends that the DHCS Managed Care Quality Strategy Report include information on the Indian Health Program-Organized Delivery System.**

The DHCS Substance Use Disorder Compliance Division is implementing the Drug Medi-Cal Organized Delivery System portion of its 1115 Medi-Cal 2020 Demonstration Waiver in a phased approach due to the tremendous system redesign. Phase Five, known as the Indian Health Program-Organized Delivery System, is the last phase of implementation. The Drug Medi-Cal Organized Delivery System section (Sec 2.3, page 10) of the DHCS Managed Care Quality Strategy Draft Report makes no mention of any Indian component and only describes County participation. This is not representative of the initiative's scope.

3. **CRIHB recommends that the State specify network adequacy and availability of services standards for managed care specific to AIANs and I/T/Us.**

The section entitled "Network Adequacy Standards" (Sec 3. P.11) does not include requirements involving AIANs and I/T/Us. The Final Rule requires the DHCS Managed Care Quality Strategy Report to include the state-defined network adequacy and availability of services standards for managed care. DHCS published these standards in July 2017[3], in compliance with the network adequacy provisions of the Final Rule and subsequently amended[4] to reflect changes under

[3] Available at http://www.dhcs.ca.gov/formsandpubs/Documents/FinalRuleNAFinalProposal.pdf
[4] Available at http://www.dhcs.ca.gov/formsandpubs/Documents/FinalRuleNAStandards3-26-18.pdf

4400 Auburn Blvd., 2nd Floor, Sacramento, CA 95841
Phone: 916-929-9761 · Fax: 916-929-7246 · www.crihb.org · firstname.lastname@crihb.org

Assembly Bill 205 (Wood, Chapter 738, Statutes of 2017), which codified and amended California's network adequacy standards.

The State needs to specify network adequacy and availability of services standards for managed care specific to Indians and IHCPs. Cross-reference to the contractual requirements in 42 CFR § 438.14 is insufficient.

4. **CRIHB recommends that DHCS exercise its flexibility under 42 CFR § 438.14 and specify in its managed care contract that the managed care plans *must* offer a provider agreement to all IHCPs in the service area**:

> The standard in § 438.14(b)(1) for the sufficiency of IHCPs [Indian health care providers] in a managed care network must consider the anticipated Indian enrollment and the capacity of network IHCPs to meet the needs of that population. States would have the flexibility to specify in the managed care contract that the managed care plans must offer a provider agreement to all IHCPs in the service area or establish other measures of network adequacy similar to § 438.68 or other appropriate measures.[5]

5. **CRIHB recommends, and CMS encourages, the State and plans to use the CMS-developed addendum Indian Health Care Addendum for Contracting with Medicaid and CHIP Managed Care Entities.[6]**

Many I/T/Us continue to experience provider credentialing and contracting issues with managed care plans. I/T/U requirements for liability coverage and provider credentialing comply with the Indian Health Care Improvement Act, but these requirements may be different from what managed care plans typically allow. Utilization of the Indian Health Care Addendum for Contracting with Medicaid and CHIP Managed Care Entities would facilitate contracting and benefit both the managed care plan and IHCP. The managed care plan would be assured of its compliance of federal and state law and the IHCP would be assured it was entering into a contract that recognizes all the Indian – specific contracting protections afforded by law.

6. **CRIHB recommends that DHCS follow the suggestions, methods, and resources found in the Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability[7], to assist in**

[5] Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed.Reg. 27746 (May 6, 2016)
[6] The addendum is available for download at https://www.medicaid.gov/federal-policy-guidance/downloads/cib121416.pdf.
[7] Lipson, Debra J., Jenna Libersky, Katharine Bradley, Corinne Lewis, Allison Wishon Siegwarth, and Rebecca Lester (2017). Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability. Baltimore, MD: Division of Managed Care Plans, Center for Medicaid and CHIP Services, CMS, U.S. Department of Health and Human Services.

monitoring managed care plan compliance, ensuring access to care, identifying enrollee needs and provider capacity, and developing network standards.

Sincerely,

Original Signed by

Mark LeBeau, PhD, MS
Chief Executive Officer

cc: Sandra "Sam" Willburn, DHCS Primary, Rural, and Indian Health Division

Enclosure: Addendum

4400 Auburn Blvd., 2nd Floor, Sacramento, CA 95841
Phone: 916-929-9761 · Fax: 916-929-7246 · www.crihb.org · firstname.lastname@crihb.org

Model Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (IHCPs)

1. Purpose of Addendum; Supersession.
The purpose of this Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the network provider agreement by and between ________________________________(herein "Managed Care Plan") and ___________________________________ (herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the Managed Care Plan'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.[1]

2. Definitions.
For purposes of this Addendum, the following terms and definitions shall apply:

(a) "Indian" means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual is a member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:

- Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
- Is an Eskimo or Aleut or other Alaska Native;
- Is considered by the Secretary of the Interior to be an Indian for any purpose;
- Is determined to be an Indian under regulations issued by the Secretary.

The term "Indian" also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

(b) "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(c) "Managed Care Plan" includes a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Manager (PCCM) or Primary Care Case Managed Entity (PCCM entity) as those terms are used and

[1] Please note that if the contract includes Medicaid and separate CHIP beneficiaries this Addendum can be used for both populations if references to Medicaid are modified to reference both Medicaid and CHIP. If you have a separate managed care contract for CHIP that includes IHCPs, please use this addendum and replace the references to Medicaid with references to CHIP.

defined in 42 C.F.R. 438.2, and any subcontractor or instrumentality of such entities that is engaged in the operation of a Medicaid managed care contract.

(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) "Tribal health program" has the meaning given in the IHCIA Section 4(25), 25 U.S.C. § 1603(25).

(g) "Tribal organization" has the meaning given in the IHCIA Section 4(26), 25 U.S.C. § 1603(26).

(h) "Urban Indian organization" has the meaning given in the IHCIA Section 4(29), 25 U.S.C. § 1603(29).

3. Description of IHCP.
The IHCP identified in Section 1 of this Addendum is (check the appropriate box):

/_/ 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 Plan 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 IHCP 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. Section 1916(j) of the Social Security Act, (42 U.S.C. §1396o-(j)), 42 C.F.R. 447.56 and §457.535.

5. Enrollee Option to Select the IHCP as Primary Health Care IHCP.
The Managed Care Plan shall allow any Indian otherwise eligible to receive services from an IHCP to choose the IHCP as the Indian's primary health care provider if the IHCP has the capacity to provide primary care services to such Indian, and any referral from such IHCP to a network provider shall be deemed to satisfy any coordination of care or referral requirement of the Managed Care Plan. Section 1932(h)(1) of the Social Security Act, (42 U.S.C. § 1396u-2(h)), 42 CFR 438.14((b)(3), and 457.1209.

6. Agreement to Pay IHCP.
The Managed Care Plan shall pay the IHCP for covered Medicaid managed care services in accordance with the requirements set out in section 1932(h) of the Social Security Act, (42 USC 1396u-2(h)), 42 CFR 438.14 and 457.1209.

7. Persons Eligible for Items and Services from IHCP.
(a) Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136.

(b) No term or condition of the Managed Care Plan's network provider agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The Managed Care Plan 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 IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

8. Applicability of Federal Laws not Generally Applicable to other Providers.
Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving MCO enrollees. Applicable provisions may include, but are not limited to, those laws cited in Appendix A.

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

10. Insurance and Indemnification.
(a) Indian Health Service. The Indian Health Service (IHS) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that 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. Nothing in the managed care plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.

(b) Indian Tribes and Tribal Organizations. A provider which is an Indian tribe or a tribal organization operating 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, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed Care Plan will be held harmless from liability. This is because Indian tribes and tribal organizations operating under a contract or compact to carry out programs, services, functions, and activities, (or programs thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, are covered by the FTCA, which means the United States consents to be sued in place of employees of a tribe or tribal organization (including contractors) for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of employees acting within the scope of their employment. Nothing in the Managed Care Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate such provider, any employee of such provider, or any personal services contractor to perform any act outside the scope of his/her employment.

(c) Urban Indian Organizations. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability to the extent the provider attests that it is covered by the FTCA. Nothing in the Managed Care Plan network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such provider or any employee of such provider to perform any act outside the scope of his/her employment.

11. Licensure and Accreditation.

Pursuant to 25 USC 1621t and 1647a, the managed care organization shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, the managed care organization shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.

12. Dispute Resolution.

In the event of any dispute arising under the Managed Care Plan’s network provider agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Notwithstanding any provision in the Managed Care Plan’s network agreement, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.

13. Governing Law.

The Managed Care Plan’s network IHCP 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 Plan’s network IHCP 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.

14. Medical Quality Assurance Requirements.
To the extent the Managed Care Plan imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCIA (25 U.S.C. § 1675).

15. Claims Format.
The Managed Care Plan shall process claims from the IHCP 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 IHCP 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.

16. Payment of Claims.
The Managed Care Plan shall pay claims from the IHCP in accordance section 1932(h)(2) of the Act, (42 U.S.C. §1396u-2(h)), 42 C.F.R. 438.14(c)(2), and 457.1209, and shall pay at either the rate provided under the State plan in a Fee For Service payment methodology, or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is higher.

17. Hours and Days of Service.
The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the Managed Care Plan as to its hours and days of service. At the request of the Managed Care Plan, such IHCP shall provide written notification of its hours and days of service.

18. Coordination of Care/Referral Requirements.
The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the Managed Care Plan.

19. Sovereign Immunity.
Nothing in the Managed Care Plan's network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

20. Endorsement.
IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the managed care plan.

APPROVALS

For the Managed Care Plan: **For the IHCP:**

Date: ___________________________ | Date: ________________________________
___________________________________ | ____

APPENDIX A

(a) The IHS that is an IHCP:
(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) IHCIA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is an IHCP:
(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;
(6) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is an IHCP:
(1) IHCIA, 25 U.S.C. § 1601 et seq.
(2)Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(3) HIPAA, 45 C.F.R. Parts 160 and 164.