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Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS-2390-P  
P.O. Box 8016  
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**RE: Comments 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”**

On behalf of the Indian Health Service Tribal Self-Governance Advisory Committee (TSGAC), I write to offer the following comments on CMS’s Proposed Rule to modernize the Medicaid and CHIP managed care regulations, CMS-2390-P.<sup>1</sup> Due to the breadth of the Proposed Rule, our comments are somewhat lengthier than usual. As a result, the following is a Table of Contents with page numbers:

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<sup>1</sup> 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, 80 Fed. Reg. 31,097 (June 1, 2015) (“Proposed Rule”).

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## I. Introduction

In 1976, Congress authorized the Indian Health Service (IHS) and Tribal health facilities to bill Medicare and Medicaid as a way to provide critically important resources to the underfunded Indian health system and help meet its federal trust responsibility for the health care of American Indian and Alaska Native people. Since then, Medicaid resources have become a critically important component of the Indian health funding stream, and allowed many IHS and Tribal facilities to begin to address some of the chronic health disparities faced by Indian people in the United States. Without meaningful access to Medicaid resources, many Indian health programs would be unable to maintain current levels of service.

Managed care threatens Indian health programs’ access to Medicaid resources, and poses a barrier to American Indian and Alaska Native participation in the Medicaid program. Simply put, Medicaid managed care has not succeeded in Indian country. Medicaid managed care system providers often have little to no familiarity with the Indian health system and routinely disregard the rights of American Indians and Alaska Natives (AI/ANs) and Indian health providers under the Medicaid statute, the Indian Health Care Improvement Act, and other federal law. AI/ANs continue to find it difficult to access Indian health care providers (IHCPs) in managed care settings, and IHCPs continue to have difficulties being reimbursed by the Medicaid program from managed care entities. These issues and others<sup>2</sup> pose insurmountable barriers for AI/ANs in accessing the Medicaid program.

The TSGAC supports CMS’s initiative to revise its managed care regulations. However, we believe the managed care regulations must be revised to accomplish several critically-important goals for Indian country:

1. Ensure that the AI/AN protections from mandatory managed care in Section 1932(a)(2)(C) of the Social Security Act apply across the board, including through Section 1115 Demonstration Waivers.
2. Ensure that the American Recovery and Reinvestment Act of 2009 (ARRA) 5006 Medicaid managed care protections are meaningfully implemented in the managed care regulations for those AI/ANs and Indian health providers who voluntarily elect to enroll in managed care.
3. Ensure that other provisions of the rule account for the unique status and needs of the Indian health system.

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<sup>2</sup> Anna Gorman, *Getting A Medi-Cal Card Doesn’t Always Guarantee Health Care*, (July 23, 2015), <http://khn.org/news/getting-a-medi-cal-card-doesnt-always-guarantee-health-care/>.

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## II. CMS Should Not Implement Regulations That Allow States to Make Managed Care Mandatory for American Indians and Alaska Natives

### A. Mandatory Managed Care Poses a Significant Barrier for AI/AN Medicaid Beneficiaries in Accessing the Medicaid Program

Quite frankly, Medicaid managed Care Entities (MCEs) do not work in Indian country. Although they differ from state-to-state and program-to-program, as a general rule Medicaid managed care systems share many, if not all, of the following characteristics:

- MCEs require that Indian health providers have contracts in place in order for their Tribal members to have access to services provided by their network providers. This often results in AI/AN having no access to specialty care services managed by managed care entities.
- MCEs auto-assign beneficiaries to particular plans and particular providers in a manner inconsistent with the right of Tribal Medicaid enrollees to choose an Indian health care provider as their primary health care provider in 42 U.S.C. § 1396u-2(h)(1). The administrative burden associated with correcting these issues is extremely timely and expensive, costing CMS, the states, and Tribes valuable resources and ultimately affecting the quality and timely care that a patient receives. CMS pays these costs through the administrative claiming of activities to the states.
- MCEs limit the number of providers in their networks and are reluctant to offer provider agreements to IHCPs.
- MCEs impose Medicaid premium and cost-sharing exemptions in a manner inconsistent with AI/AN premium and cost-sharing exemptions at 42 U.S.C. §§ 1396o(j), 1396o1(b)(3)(A)(vii) and (b)(3)(B)(x).
- MCEs fail to pay IHCPs for the provision of covered services in a manner inconsistent with 42 U.S.C. § 1396u-2(h)(2).
- When MCEs do pay, they pay at rates inconsistent with the OMB encounter rate for Indian health facilities, requiring the Tribe to ask the state to make a wraparound payment under 42 U.S.C. § 1396u-2(h)(2)(C)(ii). Some states have inconsistent payment policies treating Tribes differently to deal with the varying relationships between MCEs and Tribes by either paying 100% of the encounter rate to the Tribe or making the Tribe receive payment first from the MCE and then ask the state to make the wraparound payment.
- MCEs employ non-negotiable network provider agreements that require Indian health facilities to waive their federal rights under the Indian Health Care Improvement Act and

other laws. MCEs often impose licensing and provider certification requirements on Indian health providers, which is inconsistent with the Indian Health Care Improvement Act. This often restricts timely—or in some instances, complete—access to care and payments to IHCPs.

- MCEs impose coordination of care and prior authorization requirements that are inconsistent with how Indian health providers already coordinate care - both within their own systems and with outside providers through Purchase/Referred Care (formerly “contract health,” hereinafter “PRC”) services. In the case of prior authorization, in most instances, CMS is inefficiently paying for the same service twice since the Indian health provider is reimbursed for the service and then the patient may be required to see a managed care network provider to which the state pays for another service. Ultimately, this results in patients not having timely access to care, which may worsen their health condition and result in increased costs to CMS.
- MCEs are operated by private healthcare providers who have little or no familiarity with the Indian health system or incentive to adapt their profit models to account for the unique attributes and federal protections of the Indian health system.

As discussed below, while the Indian Medicaid protections imposed by ARRA 5006 address some of these issues, they do not address all of these issues. Nor are they self-enforcing. The ARRA protections have been in place since they were enacted by Congress in 2009, yet those protections are still routinely disregarded by MCEs, despite CMS’s issuance of a State Medicaid Director’s Letter on January 22, 2010 (SMDL #10-001). While we support CMS’s proposal to codify the ARRA protections in the Managed Care regulations, as discussed below, we do not believe that the ARRA protections themselves will prove sufficient to ensure meaningful access to the Medicaid program for AI/ANs and Indian health care programs in managed care systems.

CMS has recognized the issues posed by mandating managed care in Indian country and has rejected every attempt by states to date to waive Section 1932(a)(2)(C) through a Section 1115 demonstration waiver. As discussed below, however, CMS should take the opportunity to formalize this policy in its managed care regulations.

**B. CMS’s Managed Care Regulations Must Be Revised to Clarify that Section 1932(a)(2)(C) Cannot be Waived Through a Demonstration Waiver**

To the Administration’s credit, CMS has consistently refused to mandate AI/ANs into managed care through Section 1115 waivers. CMS refused to do so in recent waivers it approved in New Mexico and Kansas, and has continued to do so in waivers related to Medicaid expansion. For example, although the new Michigan waiver expanding Medicaid has a managed care component, participation in managed care remains optional for AI/ANs in that state. The same is true for the HIP 2.0 waiver recently approved in the state of Indiana. In addition, CMS has refused to mandate AI/AN participation in premium assistance models like those recently

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approved in Arkansas and Iowa.

This *de facto* policy has been essential in ensuring continued access to the Medicaid program for AI/ANs as states seek to use the 1115 waiver process to radically alter their Medicaid programs through mandatory managed care and premium assistance Medicaid expansion models. CMS should take the opportunity it has now to formalize and codify this policy in regulation. Doing so is critical to maintaining meaningful access to the Medicaid program and the resources it brings to the Indian health system for years to come and in successive Administrations.

In 1997, Congress took the opportunity in the Balanced Budget Act to allow states to impose mandatory managed care systems through State Plan Amendments (SPAs). But when it did so, Congress specifically prohibited states from mandating Indians into managed care through Section 1932(a)(2)(C) of the Act. This was Congress’s last directive to CMS on this issue.

While we understand that CMS has taken the position that the Indian managed care protections in Section 1932(a)(2)(C) applies only to SPAs, that reading of the statute is inconsistent with Congress’s intent to protect Indians from being forced into managed care. Section 1932(a)(2)(C) is critically important to Indian country, yet the Proposed Rule states that it can be freely waived by CMS in the case of a Section 1115 Waiver Demonstration or new Waiver Amendment. 42 C.F.R. § 438.50(a). Section 1932(a)(2)(c) was enacted with the intent of protecting AI/ANs from mandatory managed care, and this specific protection should not be able to be waived.

Section 1932 was enacted through Sections 4701-4710 of the Balanced Budget Act of 1997, Pub. L. 105–33. It was designed to allow states to mandate mandatory participation in managed care systems without having to apply for a waiver. As CMS stated when first implementing the rule, “[a]mong other things, section 1932 of the Act permits States to require most groups of Medicaid beneficiaries to enroll in managed care arrangements without waiver authority granted under section 1915(b) or 1115(a) of the Act.” 67 Fed. Reg. 40,989, 40,990 (June 14, 2002).

Section 1932 placed important limitations on that authority, however, providing that certain vulnerable groups must not be mandated into managed care. For example, Congress enacted Section 1932(a)(2)(c), to protect AI/ANs and Tribal health systems from the barriers created for AI/ANs by managed care systems. Section 1932(a)(2)(C) provides that no state may require AI/ANs to enroll in a Medicaid managed care system, unless the managed care system is operated by the IHS, a Tribe or Tribal organization, or an urban Indian organization.

(C) Indian enrollment.—A state may not require under paragraph (1) the enrollment in a managed care entity of an individual who is an Indian (as defined in section 4(c) of the Indian Health Care Improvement Act of 1976 (25 U.S.C. §

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1603(c)) unless the entity is one of the following (and only if such entity is participating under the plan):

- (i) The Indian Health Service.
- (ii) An Indian health program operated by an Indian Tribe or Tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 § et seq.).
- (iii) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act (25 U.S.C. § 1601 et seq.).

42 U.S.C. § 1396u–2(a)(2)(C).

This limitation is designed to protect AI/ANs and Tribal health clinics from the difficulties of participating in Medicaid MCEs with no experience or incentive to work with Indian health systems. It ensures that Indians and IHCPs will be able to continue to access Medicaid through fee for service in a direct government-to-government relationship with the state without having to go through a private managed care contractor as an intermediary.

While Section 4710(c) of the Balanced Budget Act limited Section 1932’s effect on existing 1915(b) and 1115 waivers, that limitation was time-limited and intended only to grandfather in existing waivers. CMS recognized the limited effect of Section 4710(c) in the preamble to the Final Rule (67 Fed. Reg. 40,989 [June 14, 2002]) it promulgated in 2002:

Section 4710(c) of the BBA provided for a time-limited exemption from the requirements in sections 4701 through 4710 for approved waiver programs or demonstration projects under the authority of sections 1115 or 1915(b) of the Act. Specifically, the BBA in section 4710(c) provided that none of the provisions contained in sections 4701 through 4710 would affect the terms and conditions of any approved section 1915(b) waiver or demonstration project under section 1115, as the waiver or demonstration project was in effect on the date of the enactment of the BBA (that is, August 5, 1997.) We interpreted this “grandfather provision” to apply only for the period for which the waiver or demonstration project was approved as of August 5, 1997. Thus, at the expiration of any 2-year waiver period under section 1915(b), or at the end of the period for which a demonstration project was approved under section 1115, the grandfather provision in section 4710(c) would no longer apply.

67 Fed. Reg. at 40,993.

The preamble to the Proposed Rule states that CMS may grant a Section 1915(b) or 1115(a) waiver that requires AI/ANs to enroll in a managed care system. 80 Fed. Reg. at 31100. In addition, proposed Section 438.50 states that the protections which apply to keep Indians from being mandated into managed care do not apply in the case of a Section 1115 or 1915(b) waiver.

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80 Fed. Reg. at 31,266.

While CMS may have intended to merely restate its view of the law on this issue, the inclusion of these provisions in the preamble and the structure of the rule run counter to its *de facto* policy of not waiving the Indian mandatory managed care protections. As it stands, the only statement CMS made in the Proposed Rule regarding mandating Indians into managed care is that CMS believes it has the authority to do so in the case of a waiver. Rather than express CMS’s *de facto* policy, these statements will serve as an open invitation to states to pursue waivers that seek to mandate Indians into managed care, and suggests that CMS has reversed its policy.

One of the greatest achievements of this Administration has been its commitment not to approve any demonstration waiver proposed by a state that mandates Indians into managed care. Former CMCS Director Cindy Mann pledged to the Tribal Technical Advisory Group (TTAG)<sup>3</sup> that CMS would not do so, and CMS kept its word. While the TSGAC disagrees with CMS that it has the legal authority to mandate Indians into managed care through a waiver, the TSGAC also strongly supports the position CMS has taken in the past by refusing to grant waivers that mandate Indians into managed care. **The TSGAC strongly urges CMS to revise the rule so that it codifies its *de facto* policy, and that it announces that policy in the Final Rule.**

### **III. Comments on CMS’s Proposal to Implement the ARRA Protections (Section 438.14)**

In 2009, Congress enacted a set of important new Medicaid protections for AI/ANs in Section 5006 of the American Recovery and Reinvestment Act of 2009 (ARRA). As discussed above, while important, these protections are not a substitute for protecting AI/ANs from enrolling or being enrolled in managed care in the first place. However, they do provide important protections for AI/ANs who *elect* to participate in managed care.

The ARRA 5006 protections provide, in relevant part:

- That no enrollment fee, premium, or similar charge and no deduction, copayment, cost sharing or similar charge may be imposed on AI/ANs with regard to services received through the Indian health system or through contract health services, and payment to an Indian health provider may not be reduced by the amount of any enrollment fee, premium, or similar charge and no deduction, copayment, cost sharing or similar charge that would otherwise be due. 42 U.S.C. §§ 1396o(j), 1396o-1(b)(3)(A)(vii) and

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<sup>3</sup> The TTAG advises the Centers for Medicare and Medicaid Services (CMS) on Indian health policy issues involving Medicare, Medicaid, CHIP, and any other health care programs funded (in whole or in part) by CMS. In particular, the TTAG focuses on providing policy advice designed to improve the availability of health care services to American Indians and Alaska Natives under these federal health care programs, including through providers operating under the health programs of the Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations.

(b)(3)(B)(x).

- AI/AN Medicaid managed enrollees may choose an Indian health care provider as their primary health care provider. 42 U.S.C. § 1396u-2(h)(2).
- Indian health providers have a right to be promptly paid by managed care entities whether they are participating providers or not. 42 U.S.C. § 1396u-2(h)(2).
- The State plan must provide for a wraparound supplemental payment to be made to Indian health providers (whether participating or not) to bring the payment amount made by the MCE up to the rate that applies for the provision of such services by the Indian health provider (usually the encounter rate). 42 U.S.C. § 1396u-2(h)(2)(C)(ii).

These Indian managed care protections were enacted to ensure that AI/ANs who *elect to participate* in managed care can continue to use their Indian health provider and that the Indian health providers will be paid. They were designed to supplement, not replace, Section 1932(a)(2)(C). They were not designed to be a solution for all of the problems that are posed by mandating managed care participation in the first place. However, these protections remain important for AI/ANs and Indian health providers, as many managed care systems provide AI/ANs the option to enroll in managed care.

**Overall, the TSGAC is very supportive of CMS’s decision to codify the ARRA protections in the managed care rules and is generally supportive of proposed Section 483.14.** We believe that including these statutory protections in the regulations should underline their importance to both states and to Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), and Primary Care Case Managers (PCCMs). We suggest revisions to proposed Section 438.14 in the attached TSGAC redline edit to that Section. We also offer the following specific comments on proposed Section 483.14:

A. Section 483.14(b)(1) – Network Adequacy

Proposed Section 438.14(b) seeks to address network adequacy issues for AI/AN patients enrolled in a state’s managed care system. As discussed elsewhere in these comments, AI/AN individuals should not be required to participate in Medicaid managed care. When AI/ANs *elect* to participate, CMS must ensure that the IHCPs can—consistent with federal law—participate in the managed care networks, receive timely payments, and continue to care for patients consistent with the IHCP’s own health system under existing federal and Tribal law (*e.g.*, make referrals in accordance with their PRC priorities and procedures). We offer the following recommendations for strengthening § 438.14(b):

1. Require that the MCEs offer to contract with *all* IHCPs in their service area



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To meet the requirement of Section 438.14(b)(1) that there be “sufficient” IHCPs in the networks, the regulations should be amended to require MCEs to demonstrate sufficiency by offering network provider agreements using an Indian Managed Care Addendum to all IHCPs in their service area who request one. Any IHCP who wishes to be in the network must be allowed in the network; any limitation that MCEs place on the number of providers in their networks should not apply to IHCPs. Many AI/ANs as a general rule seek care through the Indian health system, which coordinates with outside providers through the PRC system. Such AI/ANs will generally not seek care at IHS facilities other than the ones to which they regularly go for care. A regulation that requires managed care plans to enroll only certain IHCPs, but not others, would effectively mean that only certain IHCPs would gain the benefits of enrollment, such as reduced transaction costs associated with billing the plans.

We note that elsewhere in the Proposed Rule, CMS states its intention of aligning the managed care regulations with the regulations for Medicare and the federally-facilitated marketplaces. Since 2015, the Federally Facilitated Marketplace (FFM) has required Qualified Health Plans (QHPs) to offer contracts to all IHCPs in their service areas using the Indian Addendum developed for those plans. CMS should harmonize the managed care regulations with the requirements for QHPs in the FFM by imposing the same requirement on managed care plans through this regulation. The state of Washington has indicated its intent to develop an administrative policy for managed care plans to offer a contract to Indian health programs that are located in the plan’s geographic service area.<sup>4</sup> The Washington State Health Care Authority (WA-HCA) indicated its intent to require managed care plans to offer and enter into a contract to Indian health programs within 90 days and to use an Indian Addendum that has been developed and recommended by Washington Tribes. If a contract does not evolve at the end of the 90 day period, the Indian health program may appeal to the WA-HCA which in turn will begin a 90 day administrative timeline for the WA-HCA, the managed care plan, and the Indian health program to develop a contract. It is not clear what the administrative remedy will be for the Tribes and WA-HCA if a contract does not materialize at the end of the 90 day appeal deadline.

However, it is clear that at least one state in Indian Country is developing some administrative requirements around this contracting issue because of the difficulty that Indian health programs have had entering into contracts with managed care plans. It would be best if CMS developed clear and consistent policies around this issue in the final regulation that adopts similar requirements to what the State of Washington is discussing with Tribes.

In the preamble related to Section 483.14, CMS asks whether there should be a contract addendum for IHCP participation in managed care networks similar to the those created for QHPs and organizations delivering the Medicare Part D benefit. The answer to that question is “yes,” and the Indian addendum must be required—not optional.

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<sup>4</sup> Healthier Washington Initiative Tribal Technical Workgroup meeting held on June 25, 2015 and documented in meeting notes.

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Any contracts between MCEs and IHCPs must apply the special terms and conditions applicable to IHCPs as necessitated by federal law and regulations. Without an Indian Addendum, the provider agreements would require IHCPs to meet certain requirements that do not apply under federal law (e.g., being required to have malpractice insurance that is superfluous to Federal Tort Claims Act (FTCA) coverage, or to comply with state licensing requirements that do not apply under Section 221 of the Indian Health Care Improvement Act, 25 U.S.C. § 1621t).

If CMS does not require an Indian addendum but makes it optional, CMS would be placing the burden on IHCPs to negotiate terms they should not have to negotiate. In the QHP context, Indian Tribes and Tribal organizations have found that QHPs in State Plans, which are not required to offer contracts to Indian Health Service, Tribal, or urban Indian Organization (I/T/U) providers or use the Indian Addendum, have not offered contracts to I/T/Us. This has been the challenge in the state of Oregon and their Coordinated Care Organizations (CCOs) to contract with Indian health programs. At the beginning of Oregon’s 1115 Waiver to implement the new CCOs the Oregon Health Authority (OHA) hired a Tribal contracting specialist to facilitate the development of contracts between the CCOs and Indian health programs.

However it has taken almost three years for contracts between the CCOs and Indian health programs to finally materialize (Oregon’s 1115 Waiver to implement CCOs was approved on December 18, 2013) due to Indian health programs having to negotiate around statutory and regulatory issues that govern the Indian health system (e.g. FTCA and liability coverage, hours of coverage, non-discrimination, among others) that are at odds with managed care plan template contract language. It was not until Oregon’s recent required use of an Indian Addendum that contracts between several CCOs and Indian health programs have been executed. The TSGAC believes that similar success will result across Indian Country if a similar requirement is made in the final regulations.

The TTAG has drafted an Indian addendum for managed care plans (Attached). It is based on the QHP addendum, with the addition of certain ARRA-imposed requirements for managed care plans. We strongly urge CMS to adopt the addendum for use by managed care plans and to encourage its use by requiring MCEs to demonstrate sufficiency of IHCPs in their network by offering all IHCPs in their service area who request it a network provider agreement using the attached managed care Indian addendum.

We provide proposed language in the attached redline edit to Proposed Section 483.14.

## 2. Implement Strong Oversight And Enforce The Rules

CMS must ensure strong oversight of states and their managed care plans to ensure they are complying with the Indian-specific requirements. For example, the quality assessment activities required by Part 438, Subpart E of the Proposed Rule (e.g., state program review, annual program reporting by managed care plans, state review and approval of managed care

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plans and re-review every 3 years, state comprehensive quality strategies, and external quality reviews) must address compliance with the Indian-specific provisions set forth in § 438.14 and access to care for AI/AN enrollees. The quality assessment requirements in Subpart E should cross-reference § 438.14.

Additionally, CMS must require that managed care plans actively and regularly provide verification to CMS that they are complying with the Indian-specific requirements. Additionally, the regulations must require states to hold their managed care plans accountable and there should be consequences for failing to meet the IHCP network adequacy requirements and the other Indian-specific provisions.

We also recommend that CMS offer technical assistance by keeping a current list of the IHCPs in the managed care plans’ service areas so that the plans know who to contact about participating in the network. CMS has done this in the QHP context, but the list is incomplete. We believe CMS can do better about coordinating the list with IHS and Tribal programs and ensuring that in the Medicaid managed care context, the managed care plans have the list and know who they are supposed to contact.

B. Section 483.14(b)(5) – Access to Services in States with Few or No IHCPs

Proposed Section 483.14(b)(5) provides that in states where timely access to covered services cannot be ensured due to few or no IHCPs, the managed care entities would be deemed to meet the network adequacy standards of Section 483.14(b)(1) if Indian enrollees were either permitted to access out of state IHCPs or the circumstance is deemed to be good cause for disenrollment from the managed care entity in accordance with part 438.56(c).

We support the concept that an AI/AN enrollee who is located in a state with few or no IHCPs could access services from out of state IHCPs. This is particularly important for Tribes whose reservations and Contract Health Services Delivery Areas (CHSDA) borders cross state boundaries. In cases where there are few other IHCPs, an AI/AN enrollee in a managed care plan in their state of residence should be able to access an IHCP in a different state. The managed care plans should be encouraged to allow this to occur.

However, managed care plans should only be able to demonstrate sufficient IHCPs pursuant to CMS’s proposed approach in Section 483.14(b)(5) if there are no IHCPs in the state (i.e., remove “few or” from the Proposed Rule). As discussed above, the only way for a MCE to demonstrate a sufficient network of providers is to offer network provider agreements with all IHCPs in the area they serve. If a managed care entity is operating in a state without any IHCPs, however, they should be able to demonstrate sufficient IHCPs by authorizing AI/AN enrollees to receive services at out-of-state IHCP providers.

We do not believe that the managed care plans should be able to demonstrate network sufficiency by deeming the lack of IHCP providers to be sufficient cause for AI/AN enrollees to disenroll under section 483.56(c). While that section provides standards for voluntary

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disenrollment, it does not state what occurs in the event an individual voluntarily dis-enrolls when managed care is the only form of Medicaid available. Would that individual become ineligible to receive Medicaid services in such an event? Disenrollment under those circumstances should not be cause for the managed care entity to demonstrate IHCP network sufficiency.

C. Sections 483.14(b)(2) and (c)(2) – Payment to IHCPs

Sections 483.14(b)(2) and (c)(2) implement the payment requirement provisions of ARRA. Under part 483.14(b)(2), the state’s contract must require that IHCPs, whether participating or not, be paid for covered services provided to Indian enrollees at either a rate negotiated with the MCE, or in the absence of such a negotiated rate, a rate not less than the MCE would pay to non-IHCP participating providers. Part 483.14(c)(2), however, grants IHCPs who are not enrolled as FQHCs, whether participating or not, the right to receive payment at the rate provided in the state plan or the encounter rate, and requires the states to make a supplemental “wrap around” payment to the IHCPs for the difference between what the managed care plan pays and the state plan or encounter rate amount.

The TSGAC generally supports these provisions, as they accurately implement the ARRA right of payment protections. The TSGAC specifically supports the provision in Proposed Section 483.14(c)(2) that provides that IHCPs have the right to payment at either the State plan rate or the encounter rate. The TTAG believes this section is unclear, however, as to which rate would apply. In most cases, the state plans should provide for payment to IHCPs at the encounter rate, although there may be exceptions. The [[Insert Tribe]] believes this section should be revised to clarify that IHCPs should have the right to payment at either the rate set out in the State plan or the encounter rate, whichever is higher. This would implement the IHCP’s right to be paid at the IHS encounter rate, but also allow an IHCP to benefit from any higher rate it may have negotiated with a state and implemented through the State plan.

The TSGAC recognizes that the ARRA protections set out the requirement that managed care plans must pay at either a negotiated rate or the rate they pay other providers, and puts the responsibility on the states to make up any difference between that rate and the State plan or encounter rate IHCPs have a right to be paid. While the ARRA does not provide authority to require the managed care plans to pay the encounter rate to the IHCPs directly, it does not prohibit CMS from encouraging states to persuade MCEs to do so. Washington has indicated its intent to develop a direct Medicaid IHS/OMB encounter payment to Tribes with the state and MCO, not the Tribe, being responsible for the wraparound payments. Doing so results in a significant reduction in administrative burdens for the states, the managed care plans, and IHCPs.

If, on the other hand, the state retains the responsibility for paying the wraparound, the regulation should create a standard for prompt payment, for example within 30 days of billing by the IHCP.

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#### **IV. Reduce Referral Barriers to Adequate Access to Specialty Providers**

The Proposed Rule does not adequately address managed care coordination with the IHCPs’ own health systems under existing federal and Tribal law. For example, managed care plans routinely impose coordination of care and prior authorization requirements that are inconsistent with how IHCPs already coordinate care – both within their own systems and with outside providers through PRC. Imposing managed care referral requirements on IHCPs results in CMS often paying twice for the same service if the IHCP is out-of-network (*e.g.*, the IHCPs are reimbursed for providing services to the patient, but then the patient may still be required to see a managed care network provider to obtain a referral for specialty care, resulting in another payment to the managed care plan for the same service). This is not only inefficient for the patients involved and negatively affects their timely access to care, but and it also costs more for taxpayers.

Some Tribes have experienced situations in which specialty providers in managed care networks have refused to provide services to AI/AN Medicaid enrollees who need access to specialty care, claiming that they are not taking new patients or their appointment times are scheduled so far out that it does not provide timely access to care. However, in certain instances the Indian health programs were able to convert the AI/AN Medicaid enrollees’ need for health care to a PRC referral, and then the providers were willing to honor the PRC referral and see the patient, likely because the PRC program may pay more for the service than is allowed in the state’s Medicaid program. This demonstrates how the providers in managed care networks are effectively locking out AI/AN Medicaid patients from access to specialty care, which likely violates the Medicaid programs access to care standards.

To address these concerns, we recommend that the final rule require MCEs to waive the requirements for referrals and prior authorizations. The IHCP will handle referrals consistent with its own internal referral process for specialty care consistent with similar requirements in the PRC program. A referral by an IHCP, whether in-network or not, should be deemed to meet any coordination of care or referral requirement of the managed care entity. In the attached Model Addendum for contracts with IHCPs, discussed above, we include language stating that referrals by IHCPs to in-network providers shall be deemed to meet any coordination of care and referral obligations of the managed care program. This standard should not only be included in the Addendum, but should also be specifically added to the regulations and apply to referrals by all IHCPs, whether in-network or not.

Since IHCPs are entitled to be paid for services provided under Section 206 of the IHCIA and, on the basis of 100% FMAP, including such a requirement in the final rule will not impose any additional financial burden on the states. This will also save CMS and the federal government taxpayer dollars since they will no longer have to pay for the duplication of services by the managed care plan and the IHCP.

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## V. Enrollment Protections

While we believe that AI/AN should remain in a Fee-for-Service (FFS) Medicaid program unless they opt into a managed care program, there should be additional protections for AI/AN in the unfortunate event that mandatory enrollment in managed care is approved by state and CMS over the objections of Tribes. The main enrollment protections discussed in the preamble and presented in the regulations are described as follows:

“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 program.

80 Fed. Reg. at 31,133.

To better align Medicaid with enrollment in a QHP, as indicated in the preamble as a goal, *the Medicaid program should allow AI/AN to have monthly special enrollment periods where they can opt into a plan or change plans, regardless of cause.*

The Proposed Rule proposes a minimum time period of 14 days between the time that a consumer is notified that he or she will be moved into a managed care program and the date on which the consumer becomes covered by the managed care entity. The preamble states: “We believe that 2 weeks is sufficient time given that, elsewhere in this proposed rule, we are encouraging states to move to more rapid methods of communicating with enrollees.” (80 Fed. Reg. at 31,138). For many AI/AN living in rural areas, 14 days is not sufficient. Many do not have access to internet services and may not be receiving electronic notifications. U.S. Postal Service mail delivery often takes longer to these remote rural areas. Furthermore, many people do not have their mail delivered at home and instead pick it up at the post office, and that could happen on a less than daily basis. Even after they receive notification, people often do not understand the meaning of the letter because the vocabulary is unfamiliar. This means that they would likely either ignore the letter or consult with their IHCP, but appointments may not be available for this purpose for several weeks. We suggest a minimum time period of 30 days for AI/AN, with states being able to extend that time period for circumstances that are known to delay decision-making.

## VI. Disenrollment and changing plans

Section 1932(a)(4)(A) of the Social Security Act specifies that a State plan must permit disenrollment without cause from a managed care entity during the first 90 days of enrollment

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under mandatory managed care programs. The preamble explains:

“We propose in paragraph (c)(2)(i) to revise the regulation to limit the 90-day without cause disenrollment period to the first 90 days of an enrollee’s initial enrollment into any MCO, PIHP, PAHP, or PCCM offered through the State plan; therefore, an enrollee would have only one 90-day without cause disenrollment per enrollment period.” 80 Fed. Reg. at 31,136

Many AI/AN may not use the managed care plan in the first 90 days and may not be aware of any issues that would make them want to change plans. The monthly special enrollment periods for Indians recommended above would take care of this problem.

## **VII. Beneficiary Support System (§438.71)**

The preamble acknowledges the importance of personal assistance in helping some beneficiaries evaluate their choices. However, the vision of personal assistance is somewhat limited in the proposed regulations and not very personal:

“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 number of beneficiaries assigned through their default enrollment process.” 80 Fed. Reg. at 31,136

For AI/AN, a personal approach would be to talk with someone they know and trust, primarily a trained benefits counselor at the I/T/U clinic. However, this is not an option that is readily available through the proposed regulation. The preamble describes it this way:

“This personalized assistance concept is similar to existing programs in the Marketplace or State Health Insurance Programs (SHIPs) for Medicare beneficiaries, with someone assisting the beneficiary in a helpful, neutral and non-coercive way to make an informed choice that best suits their health care needs. Choice counseling is currently defined in §438.810 and we propose to move the definition to §438.2 and define the term as the provision of information and services designed to assist beneficiaries in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among managed care health plans and primary care providers. Choice counseling does not include making recommendations for or against enrollment into a specific MCO, PIHP, or PAHP.” (page 146)

However, the regulations seem to prohibit an organization from being a Medicaid provider and also assisting with enrollment:

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“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 a contracted provider.”  
80 Fed. Reg. at 31,137

This is unlike the Marketplace which is allowed to provide Navigator grants to Tribes and Tribal Organizations under the Affordable Care Act. Similarly, the I/T/U providers have been obtaining the training to carry out the responsibilities of Certified Application Counselors (CAC) under the ACA, including assisting people to enroll in Medicaid through the single streamlined application on line.

Currently, many I/T/U facilities are receiving funding from Medicaid to provide enrollment assistance at the same time that they are providing health services to AI/AN. The issues surrounding conflicts of interest should be no different for assisting AI/AN.

The use of call centers has been a failure for AI/AN trying to enroll in the Marketplace because the people employed by the call center do not have experience or sufficient training about the Indian health care delivery system, do not have skills for cross cultural communication with AI/AN, and rely on inadequate scripts on computers that do not answer specific questions.

Oddly, the proposed regulations use the term “broker” to describe the person who provides unbiased choice counselling. However, in ACA an insurance broker is allowed to have a conflict of interest (because he/she receives payment from an insurance company), while the Navigators and CACs are expected to be free of those conflicts of interest. It is not considered a conflict of interest under ACA to receive money for delivering health services; it is only a conflict of interest to sell insurance policies and be paid a fee for doing so by the insurance company. If CMS is trying to better align Medicaid managed care with the Marketplaces, then the term “broker” should not be used for someone doing “choice counselling.”

The important point here is that AI/AN who are eligible for Medicaid have not enrolled proportionally to other populations. Experience has shown that the best way to increase participation in Medicaid is for IHCP to facilitate the enrollment process. There is no reason to think that this would be any different for enrollment in Medicaid managed care plans. The staff at IHCP clinics have the best training on the interface between Indian health care and Medicaid, the greatest cultural competency in relating to and communicating with AI/AN, and the highest level of trust among AI/AN. It makes no sense to exclude them from being choice counselors,



or exclude them from being network providers. They should not have to choose between these two roles.

To succeed in enrolling AI/AN in Medicaid managed care or FFS if that is an option, it is important to get this right. It is the experience of the I/T/U that personal assistance from a trained benefits coordinator at the IHCP clinic is more effective than any other approach, including providing written materials, on-line information, call centers, or translators.

CMS requests comments on whether entities that provide non-Medicaid federally-financed protections to beneficiaries that includes representation at hearings should be allowed to also contract with the Medicaid agency to provide choice counseling as long as appropriate firewalls are in place. In the case of Indian health clinics, no firewalls are needed. Tribes and Tribal Organizations wear many hats that involve representing both Tribal member and the health care delivery organizations. If a person wants to seek different counsel, they should be entitled to do so. But, Tribes and Tribal Organizations should not be prohibited from assisting their Tribal members at hearings and other proceedings.

**We recommend that CMS better align the Medicaid Managed Care regulations with ACA regulations for Navigators and CACs by clarifying that being an IHCP provider in network does not constitute a conflict of interest in assisting people to enroll in plans.**

### **VIII. Suspension of Payments to a Network Provider**

The preamble set forth conditions for suspending payments to network provider for which there is a “credible allegation of fraud”:

“Under this provision, the responsibility of MCOs, PIHPs, and PAHPs would be limited to promptly suspending payments at the direction of the state until notified by the state that the investigation has concluded.” 80 Fed. Reg. at 31,130.

At the same time, the MCO, PIHP and/or PAHP stand to benefit from any withholding of payment to providers:

“In addition, we believe that the retention of recoveries made by the managed care plan further supports the overall program integrity oversight and monitoring framework for managed care plans proposed in §438.608.” 80 Fed. Reg. at 31,131.

We believe that the MCO, PIHP and/or PAHP have a conflict of interest when they report suspected overpayments or fraud to the state if they get to retain the overpayment amounts. Their job is to supervise the providers and the billing, so they should not have paid the bills in the first place if they were doing the job for which they retain the balance after the medical loss

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ratio. Since the overpayment is a payment of federal and state funds, any overpayment should be returned to the federal and state government. We note that the preamble states:

“The proposal in §438.608(d) does not prohibit the federal government or states from retaining the appropriate share of recoveries of overpayments due to their own audits and investigation.” 80 Fed. Reg. at 31,131.

CMS is soliciting comments on this proposal to allow MCOs, PIHPs, and PAHPs to retain overpayment recoveries of payments made to providers that were excluded from Medicaid participation or that were due to fraud, waste or abuse that were made by the managed care plan and also on alternative approaches to determining when a recovery may be retained by an MCO, PIHP, or PAHP.

The experience of behavioral health providers in rural New Mexico should be instructive here. As we understand it, 15 not-for-profit organizations that had been providing services in rural areas were barred from Medicaid participation during an investigation that took several years and exonerated all of the organizations for which the investigations were completed by the Office of the Attorney General for the State. The impact of these investigations was to bankrupt the behavioral health providers and drive them out of business, disrupt the relationships between people who were mentally ill and their longstanding providers, drive qualified mental health professionals out of hard-to-fill positions in rural areas, and destroy a system of provision of behavioral health services. This was all done after a very limited audit of each non-profit organization based on a very small sample size, with no opportunity for the providers to see the audit report or respond to the audit findings.

It is unclear to what extent the Behavioral Health Managed Care Organization overseeing the contracts with the rural providers benefited from this financially, and to what extent the actions were politically motivated to bring the business to an out-of-state provider who may have had political connections to the Governor. However, the publically available information suggests that the overbilling was done by a third party administrator, was done after a change in the computerized billing system, and did not involve massive amounts of overpayment. Furthermore, all 15 non-profits were charged with “credible allegations of fraud” at the same time, which would lead a reasonable person to think that there could be a systems problem with the new computer system or training to use it, rather than abuse.

What we should learn from this experience is that there needs to be a partnership between CMS, the state, the MCO, PIHP or PAHP, and the providers to work together to make sure that the complex billing process is utilized appropriately. There should be no immediate assumption of fraud or abuse without first considering whether there is sufficient training for personnel in rural areas to adapt to new billing systems. The regulations should provide for more due process for providers, to include the following steps:

1. The MCO, PIHP or PAHP should identify any patterns of billing that seem inappropriate.

2. If billing problems are identified, the MCO/PIHP/PAHP should reach out to the provider organizations to offer training on billing to make sure that they understand any new billing rules or requirements.
3. If it is perceived that billing problems persist, there should be an audit with a sufficient sample size and representative sample of claims audited.
4. After there is an audit that suggests a problems, there should be an opportunity for any organization that has been audited to see the report and respond to any irregularities.
5. There should be corrective action and a follow-up audit by a different auditor, if requested by the provider.
6. Repayment of any overpayments should be negotiated by the provider, MCO and state.
7. Allegations of fraud and abuse should only be made after due process that indicates an unwillingness of the provider to take corrective actions and repay any overpayments that have been negotiated.
8. Any re-payments should go to the state and federal governments, not the MCO/PIHP or PAHP.

Particularly within the Indian health system in rural areas, it is difficult to find, train and retain people who are skilled and knowledgeable in billing. In the transition from FFS to Medicaid Managed Care, it is likely that there is increased complexity in the billing process. Mistakes can be made, but mistakes are not the same as fraud and abuse. There needs to be a partnership that works together to strengthen systems, not threatening to disrupt sources of payment for services provided. The Indian health encounter rate simplifies this process, but it is still possible that there are MCOs who do not want to work with the I/T/U and would allege wrongdoing. As the New Mexico cases illustrate, organizations may feel so intimidated by the billing process that they hire an outside organization to bill for them, and still they may be charged with fraud and abuse. CMS needs to rebalance this process through this regulation. We recommend two ways to do that:

1. Define “credible allegation” to include a sufficient audit sample, and due process to allow the provider to respond to any problems.
2. Define the process that provides protections to the providers and strengthens the partnerships between CMS, the state, the MCOs and the providers.

We note that the preamble discusses the possibility for states to not suspend payments to a network provider pending the investigation. However, in the case of New Mexico, this was applied inconsistently or inappropriately. Therefore, we do not believe that this provision is sufficient to avoid the kinds of hardships that occurred for the residents of rural New Mexico in other states. We further note that MCO’s, PCCM and PCCM entities are given due process in §438.708 Termination of an MCO, PCCM or PCCM entity contract. At minimum, the network providers should be given an equivalent due process before their payment is stopped and/or their contracts are terminated for fraud, waste or abuse.

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We recommend the following edits to this portion of the regulation:

(8) Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with §455.23 of this chapter.

(d) Treatment of recoveries made by the MCO, PIHP or PAHP of overpayments to

providers. (1) Contracts with a MCO, PIHP, or PAHP must specify that the MCO, PIHP or PAHP ~~retains the following:~~ must return to the state any collection of overpayments made to a network provider who was barred from the Medicaid program or the result of fraud, waste, or abuse.

~~(i) Payments made to a network provider that was otherwise excluded from participation in the Medicaid program, and subsequently recovered from that network provider, by an MCO, PIHP or PAHP.~~

~~(ii) Payments made to a network provider due to fraud, waste or abuse, and subsequently recovered from that network provider, by an MCO, PIHP or PAHP.~~

(2) Each MCO, PIHP, or PAHP requires and has a mechanism for a network provider to report to the MCO, PIHP or PAHP when it has received an overpayment, to return the overpayment to the MCO, PIHP or PAHP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO, PIHP or PAHP in writing of the reason for the overpayment.

(3) Each MCO, PIHP, or PAHP must report annually to the state on their recoveries of overpayments.

(4) The state must use the results of the report in paragraph (d)(3) of this section for setting actuarially sound capitation rates for each MCO, PIHP, or PAHP consistent with the requirements in §438.4.

(5) For purposes of paragraph (d) of this section, an overpayment is any payment made to a network provider by a MCO, PIHP, or PAHP to which the network provider is not entitled to under title XIX of the Act IX.

## **IX. Information Standards (§438.10)**

Standardized Consumer Information. We support the concept of having standardized managed care definitions and terminology, and model enrollee handbooks and notices for use by managed care plans. However, we believe that AI/AN beneficiaries need information that clearly states that they can continue to access their IHCP whether they are in-network or out-of-network, and explains other special protections for Indians. This could be included in the standard materials that are distributed to everyone, or it could be provided as a supplement for AI/AN so that it is written from the perspective of an Indian health user. In either case, the model materials that are being developed should be reviewed by the CMS TTAG, and may also need to be tested with the

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target group of AI/AN Medicaid recipients to make sure that the information is clear, understandable and culturally-appropriate.

Paper format. Because there may be limited access to computers among AI/AN beneficiaries, we support the requirement that all information must be made available to enrollees and potential enrollees in paper format upon request at no cost and provided within 5 calendar days.

Non-English language versions. CMS is proposing that “provider directories, member handbooks, appeal and grievance notices and other notices that are critical to obtaining services be considered vital documents, and therefore would have to be made available in each prevalent non-English language in its service area.” Unfortunately, this usually doesn’t help AI/AN very much. Many Tribes have populations that are too small to qualify as “prevalent” in the U.S. Census statistics that are used in making this determination. Also, many people who have low literacy in English may speak their Tribal language fluently, but not read it. A better approach for AI/AN is to have native language speakers available to explain the provisions in person. This is most likely done through the ICHP clinic staff.

Topics Covered. Information for states to provide to potential enrollees is listed in the preamble as follows:

“In paragraphs (e)(2)(i) through (x), we propose a minimum list of topics that the state would need to provide in the information they send to potential enrollees; this includes disenrollment rights, basic features of managed care, populations excluded from enrollment, service area of each managed care plan, covered benefits, provider directory information, cost sharing, network adequacy standards, care coordination services available, and quality indicators for each MCO, PIHP, PAHP, and PCCM entity.” 80 Fed. Reg. 31,161.

This list is very technical and does not include information specific to protections for AI/AN enrollees. It also does not tell how to change plans and how to access services. Updated provider directories are important for plan selection and we support putting this on-line so that it can be updated frequently. Also, it is important to see the formularies that are used by different managed care organizations prior to selecting a plan, and those should be provided on-line with an opportunity to query a specific drug, using various names for it that are in use commonly.

## **X. Medicaid Estate Recovery**

Medicaid estate recovery is not one of the topics listed for standardized consumer information for potential enrollees. While Congress mandated estate recovery in the 1993 Omnibus Budget Reconciliation Act (OBRA)<sup>5</sup>, there are some protections for AI/AN. The California Rural Indian Health Board (CRIHB) has written a briefing paper on this subject (see Attachment 2). The briefing paper explains why this is an extremely important issue for AI/AN:

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<sup>5</sup> Pub. L. No. 103-66, 107 Stat. 312 (codified as amended at 42 U.S.C. § 1396p).

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“The California Rural Indian Health Board (CRIHB)’s member Tribes and clinics have noted four important ways in which estate recovery negatively affects AI/AN Medicaid enrollment: (1) estate recovery primarily affects beneficiaries of very modest means who, like many AI/ANs, rely upon Medicaid for long term care services, are often uninsured, and often lack the resources for comprehensive estate planning;<sup>6</sup> (2) estate recovery undercuts widely held AI/AN cultural beliefs about intergenerational legacies, an especially complex and historically charged issue for AI/AN people (particularly in California); (3) Medicaid-eligible individuals cite the fear of estate recovery as a factor against enrolling in Medicaid, thus leaving them uninsured and more likely to forego preventive care or otherwise require uncompensated care; and (4), patients are not given adequate information concerning the rules governing estate recovery at the time they seek to apply for or enroll in Medicaid.” (pages 4-5).

Furthermore, the briefing paper explains that Medicaid estate recovery has meaning for AI/ANs that is tied to historical trauma and federal Indian law:

“The unjust nature of this history means that estate recovery today adds insult to injury in the eyes of California’s AI/AN population, who view the system as requiring AI/ANs to give the federal government additional land or other resources in exchange for the health care to which they are already entitled. And California Indians are not alone: health care that was promised in exchange for cessions of millions of acres of lands should not be contingent upon AI/ANs nationwide being forced to cede even more land, assets, or possessions.” (p.8)

Given this background, the decision for potential beneficiaries to enroll in Medicaid in general, and in Medicaid managed care specifically, demands an informed consent. At the very least, applicants should be told ahead of time whether or not they are subject to estate recovery before they enroll in Medicaid. It is not enough to provide general information that is only available for applicants who take the initiative to find it online themselves, or ask about it specifically during the enrollment process. Rather, there should be a determination made and, before Medicaid enrollment occurs, the applicant should be given either an exemption from estate recovery in writing or else a definitive statement that the individual does not qualify for an exemption and might ultimately be subjected to estate recovery.

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<sup>6</sup> Estate recovery avoidance requires obtaining complex legal and financial advice concerning, among other matters, probate, taxation, and Medicaid recovery, and may be practically unattainable for individuals who qualify for Medicaid. Impoverished AI/ANs who cannot rely on IHS-funded services for care may have little choice other than to agree to accept Medicaid benefits or forego health services altogether. They also may not know the dangers of estate recovery until they are informed about their obligations after the passing of a loved one.

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While this issue may seem to go beyond the Medicaid Managed Care regulations, in part because it also applies to FFS Medicaid, there are some aspects of the issue that are specific to the Proposed Rule.<sup>7</sup>

First, it fits into the list of topics to be covered under beneficiary protections, beneficiary support systems, and information standards. Not only should these regulations spell out how the amount of estate recovery will be calculated, but it should also be explained in clear and simple language to potential beneficiaries. In addition, any individual subject to estate recovery should receive an annual report of costs both in the previous year and cumulative which accrue to estate recovery.

Second, there should be regulations explaining exacting how costs are calculated for estate recovery for people who are enrolled in managed care plans. For example, are costs not included in the medical loss ratio to be charged to the individual’s estate? With FFS, there could be a list of specific charges for an individual that are paid by the state. However, under a capitated system, the state pays a premium on behalf of Medicaid beneficiaries that is an average of what it costs for all individuals in the same risk category. People who live in rural and Tribal areas are likely to use fewer services, since fewer services are available in areas with low population density. Estate recovery could over collect from Indian country and other rural communities if it is based on capitation rates.

Third, when states convert their entire Medicaid program to managed care, there may be no distinction between the Medicaid enrollment process and the plan selection process. At some point, consumers should be either be told they are exempt from estate recovery or sign a form that consents to having their estate repay the state for their health care services.

Fourth, as touched on above, current practice in nearly all states is for estate recovery information to be very generally described in generally-applicable educational materials that individuals are often responsible for obtaining on their own initiative. This type of information should be proactively distributed to applicants, including an individualized assessment of the beneficiary’s ultimate liability for estate recovery. For AI/AN, this should additionally include individual counselling about what types of ownership are included in estate recovery and what types are exempt. The AI/AN exemptions are very technical, and as the TTAG has repeatedly encountered while conducting trainings on related exemptions under Modified Adjusted Gross Income and federal income taxation, are not readily understandable even by policy experts, let alone individuals attempting to enroll in Medicaid. Without adequate information, the current status quo disseminates confusion and discourages AI/AN interaction with the system generally.

To be clear, we think that there should be a blanket exemption from Medicaid Estate Recovery for all AI/AN. At the very least, though, AI/AN should be told about their individual

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<sup>7</sup> We also believe that this issue is pressing enough that it is generally relevant to any regulations moving forward in which CMS seeks to improve any facet of the Medicaid program.

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liability for estate recovery at the time of enrollment so that they are not discouraged from enrolling based on rumors as to how the program works, and so that their families will not ultimately be confronted with estate recovery years down the line.

## **XI. Capitation Rates (483.4)**

In the Proposed Rule, Section 438.4 pertains to the regulations guiding states in the development of capitation rates paid to managed care entities serving Medicaid enrollees. In general, states must develop the capitation rates in accordance with generally accepted actuarial principles and practices.

In addition, CMS has proposed adding the following qualifier to the regulations guiding the development of capitation rates (at § 438.4(b)(1)):

“Any proposed differences among capitation rates according to covered populations must not be based on the Federal financial participation [FFP] percentage associated with the covered populations.”<sup>8</sup>

By adding this provision, CMS seeks to prevent states from paying higher capitation rates (all other things being equal) for Medicaid enrollees in eligibility groups for which a state receives a higher FFP rate (such as the Medicaid expansion and CHIP populations) as compared with capitation rates paid for populations reimbursed at the standard FFP percentage. The discussion in the preamble on this topic reads:

“[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.”<sup>9</sup>

The TSGAC is concerned about potential uncertainty among states as they attempt to comply with this provision and about potential confusion among CMS staff as they conduct enforcement activities related to this provision.

**The TSGAC recommends that CMS take steps to minimize the possibility for confusion in the compliance with, and enforcement of, this provision with respect to how the provision applies to, and interacts with, the development of rates and the delivery of services by IHCPs to Medicaid enrollees who are IHS beneficiaries.**

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<sup>8</sup> 80 Fed Reg at 31,257.

<sup>9</sup> 80 Fed Reg at 31,120.



CMS is aware of states eligibility to receive 100 percent FFP for services provided by an Indian health care program when the program is serving a Medicaid enrollee who is an IHS beneficiary. In addition, CMS is aware of the existence of payment rates, sometimes referred to as the “IHS” or “OMB” encounter rates, specific to Indian health care programs.<sup>10</sup>

It is our understanding from discussions with CMS staff that, in including this provision, the agency does not seek to impose general prohibitions on states against the development of capitation rates for managed care entities, including Indian Medicaid managed care entities, that might be higher as a result of anticipated enrollment of IHS beneficiaries (*i.e.*, a covered population with a higher associated FFP percentage) in the managed care plan. Nonetheless, a different reading of this provision could develop over time.

The TSGAC recommends—to minimize the possibility of confusion by states in complying with this provision, as well as uncertainty by CMS staff when enforcing this provision—that the agency, in the preamble to the final version of the Proposed Rule, clearly indicates that a state can develop capitation rates higher than they might be otherwise as a result of the anticipated enrollment of IHS beneficiaries in the Medicaid managed care plan, including an Indian Medicaid managed care plan. We recommend the following edits to this portion of the regulation.

**§ 438.4 Actuarial soundness.**

(a) *Actuarially sound capitation rates defined.* Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.

(b) *CMS review and approval of actuarially sound capitation rates.* Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must do all of the following:

- (1) Have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must not be based on the Federal financial participation percentage associated with the covered populations.
- (2) Be appropriate for the populations to be covered and the services to be furnished under the contract.

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<sup>10</sup> Under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. § 248 and § 249(b)), Public Law 83–568 (42 U.S.C. § 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. § 1601 et seq.), the OMB/IHS rates are approved for inpatient and outpatient medical care provided by IHS facilities for Medicare and Medicaid beneficiaries, and beneficiaries of other Federal programs, and for recoveries under the Federal Medical Care Recovery Act (42 U.S.C. §§ 2651–2653), excluding Medicare Part A inpatient services.

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## **XII. Need for Additional Tribal Consultation on the Proposed Rule**

As demonstrated by the breadth of our comments, the Proposed Rule has the potential to significantly impact both AI/AN access to Medicaid and Tribal health program reimbursement. It is critical that CMS work directly with the TTAG and other Tribal entities to ensure that the Final Rule reflects suggestions from Indian Country about minimizing any disruption for individual AI/ANs or Tribes as a whole.

Accordingly, the TSGAC is very concerned with the lack of meaningful Tribal consultation concerning the Proposed Rule to date, which CMS recognizes “has Tribal implications” and is subject to the CMS Tribal Consultation Policy.<sup>11</sup> For example, CMS states in the preamble that in fulfillment of its consultation requirements, it held an All Tribes Call in May 2014 and considered comments that it received.<sup>12</sup> But while certainly appreciated, the All Tribes Call was not an adequate consultation mechanism: it involved CMS staff discussing the general scope of the Rule for the majority of the allotted time, and responding to almost every Tribal question by asking that the individual submit their inquiry in a comment. Further, it was not clear whether the agency officials staffing the call had any prior experience with the Indian health system, or instead had just been asked to essentially note Tribal concerns rather than engage in a substantive policy dialogue with Tribal stakeholders. This does not constitute acceptable Tribal consultation, particularly for a Proposed Rule that is as comprehensive and affects as many Tribal interests as this one.<sup>13</sup>

In addition, because (as CMS notes) the Proposed Rule has “Tribal implications,” the Rule is subject to Executive Order 13175. This requires any agency “undertaking to formulate and implement policies” affecting Tribes to:

- Encourage Indian Tribes to develop their own policies to achieve program objectives;

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<sup>11</sup> 80 Fed. Reg. at 31,168.

<sup>12</sup> *Id.* In addition, while CMS included an “Indian” section in the Proposed Rule, there are far more provisions that significantly impact Tribal health programs than the ones included in those few paragraphs.

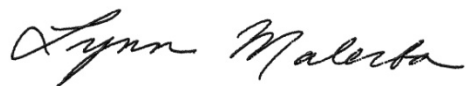
<sup>13</sup> The TSGAC is equally concerned with what appears to be the opinion of certain CMS staff that consultation necessarily requires the presence of Tribal leaders, rather than their designated technical advisors. This is a fundamental misunderstanding of the government-to-government relationship between Indian Tribes and the United States. Tribal leaders do not reject consultation that is not directly with the President or a member of Congress: rather, such consultation occurs with the President’s designees in the relevant federal agencies. Likewise, Tribal leaders may absolutely delegate the task of meeting with federal officials to their technical experts rather than appearing personally (electronically or otherwise).

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- Where possible, defer to Indian Tribes to establish standards; and,
  - 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.

We believe that the standards we are proposing are necessary in order to ensure that AI/ANs may continue to access the Medicaid program in a meaningful way and to ensure continued third party revenue for Tribal health programs. EO 13175 accordingly requires both additional Tribal consultation<sup>14</sup> and amendments to the current proposals as set out in this comment.

In closing, we appreciate the opportunity to comment on such an important proposed rule. Should you need additional information or have questions regarding these comments, please contact me at (860) 862-6192; or via email: [lmalerba@moheganmail.com](mailto:lmalerba@moheganmail.com). Thank you.

Respectfully submitted,



Marilynn “Lynn” Malerba  
Chief, The Mohegan Tribe of Connecticut  
Chairwoman, Tribal Self-Governance Advisory Committee  
Board Member, Self-Governance Communication and Education Tribal Consortium

Attachments: 1. Redline of Proposed Rule  
2. Proposed Managed Care Indian Addendum  
3. CRIHB Briefing Paper on Medicaid Estate Recovery

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<sup>14</sup> CMS also states in the Preamble that “prior to publication of the final rule, we will conduct further Tribal consultation. This consultation process is in addition to the notice and opportunity for comment otherwise provided in the rulemaking process.” 80 Fed. Reg. at 31,168. CMS should discuss directly with the TTAG the form in which this additional consultation will take. Also, if CMS is suggesting that generally-applicable notice and comment is akin to actual consultation that is incorrect.

## TTAG REDLINE OF PROPOSED § 438.14

### § 438.14 Requirements that apply to MCO, PIHP, PAHP, PCCM, and PCCM entity contracts involving Indians, Indian health care providers (IHCPs), and Indian managed care entities (IMCEs).

(a) Definitions. As used in this section, the following terms have the indicated meanings:

Indian means any individual defined at [25 U.S.C. 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:

(i) Is a member of a Federally recognized Indian tribe.

(ii) Resides in an urban center and meets one or more of the four criteria:

(A) 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;

(B) Is an Eskimo or Aleut or other Alaska Native;

(C) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(D) Is determined to be an Indian under regulations promulgated by the Secretary;

(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose;

(iv) 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.

Indian health care provider (IHCP) under [42 CFR 447.51](#) 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](#)).

Indian managed care entity (IMCE) under section 1932(h)(4)(B) of the Act means a MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

(b) Network requirements. All contracts between a State and a MCO, PIHP, PAHP, PCCM, and PCCM entity, to the extent that the PCCM or PCCM entity has a provider network, which enroll Indians must:

(1) Require the MCO, PIHP, PAHP, PCCM entity to demonstrate that there are sufficient IHCPs participating in the provider network of the MCO, PIHP, PAHP, or PCCM entity to ensure timely access to services available under the contract from such providers for Indian enrollees who are eligible to receive services. **In order to demonstrate there are sufficient IHCPs participating in the network, the MCO, PIHP, PAHP or PCCP must offer to enter into a network provider agreement with the Indian Managed Care Addendum to all of the IHCPs in their service area who request such an agreement within 30 days of receiving the request.**

(2) Require that IHCPs, whether participating or not, be paid for covered services provided to Indian enrollees who are eligible to receive services from such providers as follows:

(i) At a rate negotiated between the MCO, PIHP, PAHP, PCCM, or PCCM entity, and the IHCP, or

(ii) In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the MCO, PIHP,

PAHP, or PCCM entity would make for the services to a participating provider which is not an IHCP; and

(iii) Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under §§ 447.45 and 447.46 of this chapter.

(3) Permit any Indian who is enrolled in a MCO, PIHP, PAHP, PCCM or PCCM entity that is not an IMCE and eligible to receive services from a IHCP primary care provider participating as a network provider, to choose that IHCP as his or her primary care provider, as long as that provider has capacity to provide the services.

(4) Permit Indian enrollees to obtain services covered under the contract between the State and the MCO, PIHP, PAHP, PCCM, or PCCM entity from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive such services.

(5) In a State where timely access to covered services cannot be ensured due to no IHCPs, an MCO, PIHP, PAHP and PCCM will be considered to have met the requirement in paragraph (b)(1) of this section if—

(i) Indian enrollees are permitted by the MCO, PIHP, PAHP, or PCCM entity to access out-of-State IHCPs; or

(ii) If this circumstance is deemed to be good cause for disenrollment from both the MCO, PIHP, PAHP, or PCCM entity and the State's managed care program in accordance with § 438.56(c), **and there is a fee for service alternative.**

(c) Payment requirements. (1) When an IHCP is enrolled in Medicaid as a FQHC but not a participating provider of the MCO, PIHP, PAHP and PCCM entity, it must be paid an amount equal to the amount the MCO, PIHP, PAHP, or PCCM entity would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from the State to make up the difference between the amount the MCO, PIHP, PAHP or PCCM entity pays and what the IHCP FQHC would have received under FFS.

(2) When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of an MCO, PIHP, PAHP and PCCM entity or not, it has the right to receive the same amount it would be paid if the services provided to the Indian enrollee were 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.**

(3) Where the amount a IHCP receives from a MCO, PIHP, PAHP, or PCCM entity is less than the amount required by paragraph (c)(2) of this section, the State must make a supplemental payment to the IHCP to make up the difference between the amount the MCO, PIHP, PAHP, PCCM, or PCCM entity pays and the amount the IHCP would have received under FFS or the applicable encounter rate. **To reduce administrative burden associated with this requirement, the State may require or encourage MCO, PIHP, PAHP PCCM and PCCM Entities to make payment in the full amount required by paragraph (c)(2).**

(d) Enrollment in IMCEs. An IMCE may restrict its enrollment to Indians in the same manner as Indian Health Programs may restrict the delivery of services to Indians, without being in violation of the requirements in § 438.3(d).

## **Subpart B—State Responsibilities**

42 CFR § 438.50

### **§ 438.50 State Plan requirements.**

(a) General rule. A State plan that requires Medicaid beneficiaries to enroll in MCOs, PCCMs, or PCCM entities must comply with the provisions of this section, except when the State imposes the requirement—

(1) As part of a demonstration project under section 1115 of the Act; or

(2) Under a waiver granted under section 1915(b) of the Act;

Provided that, the State may not enroll Indians as defined in 438.14(a) in an MCO, PCCM or PCCM entity unless each Tribe in its service area consents to such enrollment prior to approval of a demonstration project under section 1115 of the Act or under waiver granted under section 1915(b) of the Act

(b) State plan information. The plan must specify—

- (1) The types of entities with which the State contracts.
- (2) The payment method it uses (for example, whether FFS or capitation).
- (3) Whether it contracts on a comprehensive risk basis.
- (4) The process the State uses to involve the public in both design and initial implementation of the managed care program and the methods it uses to ensure ongoing public involvement once the State plan has been implemented.

(c) State plan assurances. The plan must provide assurances that the State meets applicable requirements of the following statute and regulations:

**\*31267** (1) Section 1903(m) of the Act, for MCOs and MCO contracts.

(2) Section 1905(t) of the Act, for PCCMs and PCCM or PCCM entity contracts.

(3) Section 1932(a)(1)(A) of the Act, for the State's option to limit freedom of choice by requiring beneficiaries to receive their benefits through managed care entities.

(4) This part, for MCOs, PCCMs, and PCCM entities.

(5) Part 434 of this chapter, for all contracts.

(6) Section 438.4, for payments under any risk contracts, and § 447.362 of this chapter for payments under any nonrisk contracts.

(d) Limitations on enrollment. The State must provide assurances that, in implementing the State plan managed care option, it will not require the following groups to enroll in an MCO, PCCM or PCCM entity:

(1) Beneficiaries who are also eligible for Medicare.

(2) Indians as defined in § 438.14(a), except as permitted under § 438.14(d).

(3) Children under 19 years of age who are—

(i) Eligible for SSI under Title XVI;

(ii) Eligible under section 1902(e)(3) of the Act;

(iii) In foster care or other out-of-home placement;

(iv) Receiving foster care or adoption assistance; or

(v) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the State in terms of either program participation or special health care needs.



## 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 IHCA.

#### **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 IHCA, 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) IHCA, 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) IHCA, 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 IHCA, 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 IHCA, 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 IHCA, 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 IHCA, 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 IHCA, 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

\_\_\_\_\_

\_\_\_\_\_



**CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.**  
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Medicaid Estate Recovery as an Obstacle to Medicaid Enrollment  
for American Indians and Alaska Natives

Executive Summary

When certain Medicaid patients receive specific types of long-term care services, federal law requires state Medicaid agencies to recover assets from the patient's estate. Although some property held by American Indians and Alaska Natives (AI/ANs) is exempt from these "estate recovery" rules, these protections are not exhaustive and certain AI/AN fee land and personal property remain subject to forfeiture.<sup>1</sup> In addition, existing estate recovery notification procedures are inadequate to fully educate AI/ANs about the program and allow them to make informed decisions about whether or not to enroll in Medicaid. This is fundamentally unjust for AI/ANs because of the unique historical trust and treaty relationship between Indian people and Tribal governments and the United States, as well as the special trust responsibility owed to AI/ANs recognized in the Indian Health Care Improvement Act (IHCIA).<sup>2</sup>

Background

*History and Purpose of Estate Recovery Requirements.* In order to alleviate some of the financial costs of the Medicaid program, the original 1965 Medicaid statute permitted recovery from the estates of a deceased beneficiary who was (1) older than sixty-five at the time that he or she received benefits under a State Medicaid plan, and (2) had neither a surviving spouse nor a "surviving child who is under age 21 or is blind or permanently and totally disabled."<sup>3</sup> Prior to 1993, twelve states had implemented estate recovery programs.<sup>4</sup>

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<sup>1</sup> 42 U.S.C. § 1396p(b)(3)(B); *see also* State Medicaid Manual § 3810(7).

<sup>2</sup> *See* 25 U.S.C. § 1601(1) (recognizing that "Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people").

<sup>3</sup> Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 343 (codified as amended at 42 U.S.C. § 1396a(a)(18)).

<sup>4</sup> UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE ASSISTANT SECRETARY FOR POLICY & EVALUATION, MEDICAID ESTATE RECOVERY 2 (Apr. 2005) [hereinafter MEDICAID ESTATE RECOVERY].

However, Congress subsequently mandated estate recovery in the 1993 Omnibus Budget Reconciliation Act (OBRA).<sup>5</sup> With certain exceptions, and subject to hardship waivers (discussed below), States are currently required to recover the costs of:

- Services provided to individuals in nursing facilities, intermediate care facilities for the mentally retarded, or other medical institutions who, as a condition of receiving Medicaid, are required “to spend for costs of medical care all but a minimal amount of [their] income required for personal needs” and who “cannot reasonably be expected to be discharged and return home.”<sup>6</sup>
- The following services provided to beneficiaries who were fifty-five years or older at the time of care: nursing facility services, home and community-based services, “related hospital and prescription drug services,” and, at the option of the State, almost any other item or service covered under a Medicaid State plan.<sup>7</sup>
- Nursing facility and “other long-term care services” for individuals who received Medicaid by having additional resources disregarded in connection with receipt of benefits under a long-term care insurance policy.<sup>8</sup>

At a minimum, the State must seek to recover from “all real and personal property and other assets included within the individual’s estate, as defined for purposes of State probate law,” and may also elect to recover from “any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.”<sup>9</sup> In light of the potentially significant pool of resources subject to estate recovery, there is an entire industry of tax, probate, and legal experts dedicated towards helping individuals avoid this process.<sup>10</sup>

*Exemptions for AI/ANs.* Federal law requires States to develop standards under which they will waive otherwise-applicable estate recovery provisions “if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.”<sup>11</sup> These standards

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<sup>5</sup> Pub. L. No. 103-66, 107 Stat. 312 (codified as amended at 42 U.S.C. § 1396p).

<sup>6</sup> 42 U.S.C. § 1396p(a)(1)(B).

<sup>7</sup> 42 U.S.C. § 1396p(b)(1)(A)-(B).

<sup>8</sup> 42 U.S.C. § 1396p(b)(1)(C).

<sup>9</sup> 42 U.S.C. § 1396p(b)(4).

<sup>10</sup> See, e.g. Konstantinos Volakos, “Protecting Your Home From Medicaid Estate Recovery,” available at <http://livingtrustnetwork.com/estate-planning-center/introduction-to-estate-planning/what-the-experts-say/protecting-your-home-from-medicaid-estate-recovery.html> (advertising estate recovery avoidance services) (last visited Oct. 20, 2014).

<sup>11</sup> 42 U.S.C. § 1396p(b)(3)(A); see also MEDICAID ESTATE RECOVERY at 7-8.



must include protections against State recovery of “income, resources, and property” that the Department of Health and Human Services (HHS) determines should be exempt “because of the Federal responsibility for Indian Tribes and Alaska Native Villages.”<sup>12</sup>

The minimum AI/AN protections are set out as follows in the Centers for Medicare and Medicaid Services (CMS) State Medicaid Manual:

Medicaid Estate Recovery.--The following AI/AN income, resources, and property are exempt from Medicaid estate recovery:

1. Certain AI/AN income and resources (such as interests in and income derived from Tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;
2. Ownership interest in trust or non-trust property, including real property and improvements:
  - a. Located on a reservation (any federally recognized Indian Tribe’s reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established by Alaska Native Claims Settlement Act and Indian allotments) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or
  - b. For any federally -recognized Tribe not described in (a), located within the most recent boundaries of a prior Federal reservation.
  - c. Protection of non-trust property described in (a) and (b) is limited to circumstances when it passes from an Indian (as defined in section 4 of the Indian Health Care Improvement Act) to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a Tribe and non-Indians, such as spouses and step-children, that their culture would nevertheless protect as family members; to a Tribe or Tribal organization; and/or to one or more Indians;
3. Income left as a remainder in an estate derived from property protected in 2 above, that was either collected by an Indian, or by a Tribe or Tribal organization and distributed to Indian(s), as long as the individual can clearly trace it as coming from the protected property.
4. Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of Federally-protected rights, and income either collected by an Indian,

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<sup>12</sup> 42 U.S.C. § 1396p(b)(3)(B). This provision also notes that “[n]othing in this subparagraph shall be construed as preventing the Secretary from providing additional estate recovery exemptions under this subchapter for Indians.” *Id.*

- or by a Tribe or Tribal organization and distributed to Indian(s) derived from these sources as long as the individual can clearly trace it as coming from protected sources; and
5. Ownership interests in or usage rights to items not covered by 1-4 above that have unique religious, spiritual, traditional, and/or cultural significance or rights that support subsistence or a traditional life style according to applicable Tribal law or custom.

American Indians and Alaska Natives Income, Resources and Property Not Exempt from Medicaid Estate Recovery.--You may recover the following income, resources and property from the estates of American Indians and Alaska Natives:

1. Ownership interests in assets and property, both real and personal, that are not described in . . . items 1-5 above.
2. Any income and assets left as a remainder in an estate that do not derive from protected property or sources in . . . items 1-5.

As CMS further noted in a 2014 Dear State Medicaid Director Letter, “[i]n addition to complying with these manual provisions, states may also . . . take into consideration other situations in which estate recovery would present undue hardship to the AI/AN population when establishing exemptions.”<sup>13</sup>

*Current Concerns for AI/ANs.* The California Rural Indian Health Board (CRIHB)’s member Tribes and clinics have noted three important ways in which estate recovery negatively affects AI/AN Medicaid enrollment: (1) estate recovery primarily affects beneficiaries of very modest means who, like many AI/ANs, rely upon Medicaid for long term care services, are often uninsured, and often lack the resources for comprehensive estate planning;<sup>14</sup> (2) estate recovery undercuts widely held AI/AN cultural beliefs about intergenerational legacies, an especially complex and historically charged issue for AI/AN people (particularly in California); (3) Medicaid-eligible individuals cite the fear of estate recovery as a factor against enrolling in Medicaid, thus leaving them uninsured and more likely to forego preventive care or otherwise require uncompensated care; and (4), patients are not given adequate information concerning the rules governing estate recovery at the time they seek to apply for or enroll in Medicaid. In addition, the fact that applicants for ACA Marketplaces are simultaneously screened for Medicaid eligibility<sup>15</sup> similarly discourages AI/ANs from applying for Marketplace coverage for fear of

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<sup>13</sup> CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEAR STATE MEDICAID DIRECTOR LETTER #14-01, RE: APPLICATION OF LIENS, ADJUSTMENTS AND RECOVERIES, TRANSFER-OF-ASSET RULES AND POST-ELIGIBILITY INCOME RULES TO MAGI INDIVIDUALS 3 (Feb. 21, 2014).

<sup>14</sup> As noted *supra*, estate recovery avoidance requires obtaining complex legal and financial advice concerning, among other matters, probate, taxation, and Medicaid recovery, and may be practically unattainable for individuals who qualify for Medicaid. Impoverished AI/ANs who cannot rely on IHS-funded services for care may have little choice other than to agree to accept Medicaid benefits or forego health services altogether. They also may not know the dangers of estate recovery until they are informed about their obligations after the passing of a loved one.

<sup>15</sup> 42 U.S.C. § 18083.

being enrolled in Medicaid and involuntarily subject to estate recovery, thus cutting off yet another avenue for health insurance.

This dissuasion from Medicaid actively undercuts federal laws designed to address the high rates of AI/AN poverty and lack of insurance<sup>16</sup> and the significant health disparities between AI/ANs and the general population.<sup>17</sup> For example, in the American Recovery and Reinvestment Act (ARRA), Congress specifically encouraged AI/AN Medicaid enrollment by prohibiting the application of cost-sharing to AI/AN Medicaid beneficiaries, guaranteeing AI/AN access to Tribal health facilities within a managed care entity, and requiring Tribal consultation prior to amendments to Medicaid state plans that directly affect Indians or Tribal health programs.<sup>18</sup> Similarly, the ACA's expansion of Medicaid eligibility to up to 138% of the Federal Poverty Level for parents and childless adults<sup>19</sup> was "a key component" of the ACA's overall "goal of filling in gaps in the availability of affordable health coverage in the United States"<sup>20</sup> for underserved populations like AI/ANs. None of these objectives are served if AI/ANs refuse to enroll in Medicaid due to the specter of estate recovery.

A related issue arises in the context of information distributed to AI/ANs at the time they seek to enroll in Medicaid. It is our understanding that in most States, Medicaid applicants are usually not told about estate recovery unless they are already over fifty-five years old and seeking the long-term care services that trigger the recovery process. If not, the applicant is more or less individually responsible for becoming aware of the recovery program and tracking down State or federal websites and brochures discussing both estate recovery generally and specific AI/AN protections. Even if they manage to do so, the information is not specific to the individual applicant and does not provide any assurances as to whether or not that person might ultimately be subject to estate recovery, leading to uncertainty at best or, after the beneficiary is deceased, a surprise letter of recovery directed at his or her family.

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<sup>16</sup> See generally SAMANTHA ARTIGA ET AL., HENRY J. KAISER FAMILY FOUNDATION, HEALTH COVERAGE AND CARE FOR AMERICAN INDIANS AND ALASKA NATIVES (2013).

<sup>17</sup> NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP'S RECOMMENDATIONS ON THE INDIAN HEALTH SERVICE FISCAL YEAR 2015 BUDGET 2 (2013) [hereinafter 2015 BUDGET]; see also Indian Health Service, Indian Health Disparities (Jan. 2013), available at [http://www.ihs.gov/factsheets/index.cfm?module=dsp\\_fact\\_disparities](http://www.ihs.gov/factsheets/index.cfm?module=dsp_fact_disparities).

<sup>18</sup> See generally ARRA § 5006.

<sup>19</sup> 42 U.S.C. § 1396a(10)(A)(i)(VIII).

<sup>20</sup> THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, THE COVERAGE GAP: UNINSURED POOR ADULTS IN STATES THAT DO NOT EXPAND MEDICAID 7 (Mar. 2014). See also 25 U.S.C. § 1601(2) (IHCA provision recognizing the "major national goal of the United States . . . to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States").

*Effectiveness of Estate Recovery.* In addition to the policy considerations listed above, estate recovery is only questionably effective. In 2011 the Medicaid program paid \$114.3 billion in Medicaid long-term care costs (of which \$72.2 billion was federal).<sup>21</sup> This amounted to approximately 26% of the \$432.4 billion in total Medicaid spending,<sup>22</sup> despite the fact that long-term care users only constitute approximately 6% of the total Medicaid population.<sup>23</sup> However, in 2005, HHS reported that estate recovery nationwide amounted to \$330 million, which was only 0.13% of the annual Medicaid budget. Individual state collections ranged from 0% to 0.64% of total Medicaid spending,<sup>24</sup> with collections as a percentage of total long-term care spending ranging from 0% to 6.9% in 2004.<sup>25</sup>

In light of the federal government's trust responsibility towards AI/ANs, the goals of the Medicaid program, ACA, ARRA, and IHCA, and the significant barrier that estate recovery poses towards maximizing AI/AN Medicaid enrollment, AI/ANs should be categorically exempt from Medicaid estate recovery.<sup>26</sup> Given the overall low collection levels within the estate recovery program, the financial effects of such an exclusion would likely be negligible for CMS while still removing a significant barrier to AI/AN enrollment.

#### Vehicles for Expanding an AI/AN Estate recovery Exemption.

Various exemption mechanisms could protect AI/ANs from estate recovery. These include the following avenues:

- A legislative amendment to the Social Security Act that would acknowledge the federal government's fundamental trust responsibility to provide health services to AI/ANs and exempt AI/AN Medicaid beneficiaries from estate recovery outright. This legislative fix could be achieved through an amendment to 42

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<sup>21</sup> CHRISTOPHER J. TRUFFER ET AL., DEPARTMENT OF HEALTH AND HUMAN SERVICES, 2012 ACTUARIAL REPORT OF THE FINANCIAL OUTLOOK FOR MEDICAID 13 tbl. 1.

<sup>22</sup> *Id.*

<sup>23</sup> KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID'S LONG-TERM CARE USERS: SPENDING PATTERNS ACROSS INSTITUTIONAL AND COMMUNITY-BASED SETTINGS 1 (Oct. 2011).

<sup>24</sup> MEDICAID ESTATE RECOVERY at 5.

<sup>25</sup> ERICA F. WOOD & ELLEN M. KLEM, AMERICAN BAR ASSOCIATION COMMISSION ON LAW AND AGING, PROTECTIONS IN MEDICAID ESTATE RECOVERY: FINDINGS, PROMISING PRACTICES, AND MODEL NOTICES 38 tbl. 2 (May 2007). For the purposes of this statistic, "long-term care expenditures" include nursing home, intermediate care facilities for the mentally retarded, and total home care expenditures. *Id.* at 61 n.130.

<sup>26</sup> For the purposes of any such exemption, applicability should be determined according to the definition of Indian used in the AI/AN Medicaid cost-sharing prohibition at 42 C.F.R. § 447.51.

U.S.C. § 1396p(b)(3)(B) and modeled on the ACA's AI/AN hardship exemption from the individual mandate.<sup>27</sup>

- “Section 1917(b)(3) of the Social Security Act gives the Secretary authority to establish standards for hardship. This includes exemptions from estate recovery for certain assets and resources,”<sup>28</sup> as well as specific statutory authorization to provide “additional estate recovery exemptions . . . for Indians.”<sup>29</sup> CMS could use this authority to either (1) issue a regulatory hardship exemption from Medicaid estate recovery for AI/AN beneficiaries or (2) amend the Medicaid State Manual’s current list of AI/AN property exemptions to generally exempt AI/ANs from estate recovery. This hardship exemption could similarly be modeled from the current AI/AN exemption from the individual mandate.
- CMS could work with the Tribal Technical Advisory Group (TTAG) and Tribal Health programs to encourage and facilitate State-specific laws and regulations to exempt AI/ANs from estate recovery. The ad hoc basis of this third approach makes it less desirable than a top-down legislative or administrative fix.
- At the very least, CMS should require, or otherwise strongly encourage, States to adopt Minnesota’s practice of adjudicating potential AI/AN exemption from (and liability for) Medicaid estate recovery as part of the Medicaid application process, and to provide written declarations where the individual is found to be exempt.<sup>30</sup> This will provide the individual AI/AN and his or her family with more definitive guidance that, for the exempt, will allay the confusion and uncertainty that currently clouds the application process, and, for the non-exempt, ensure that applicants make their enrollment decisions with full knowledge that they might potentially face estate recovery in the future.

A statutory fix would provide the strongest protection for AI/ANs, as it could withstand staff changes and policy shifts between administrations at both the State and federal levels and would avoid having to implement exemptions on a State-by-State basis. A blanket AI/AN exemption from estate recovery would further be consistent with both the ACA’s AI/AN exemption from tax

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<sup>27</sup> See 45 C.F.R. § 155.605(g)(6)(i) (extending individual mandate exemption to any “Indian eligible for services through an Indian health care provider, as defined in 42 CFR 447.50 . . . or an individual eligible for services through the Indian Health Service in accordance with 25 USC 1680c(a), (b), or (d)(3)”).

<sup>28</sup> State Medicaid Manual § 3810(7).

<sup>29</sup> 42 U.S.C. § 1396p(b)(3)(B).

<sup>30</sup> We understand that AI/ANs can receive a written exemption letter from Medicaid estate recovery at the time they apply for Medicaid if they are living on current or previous Tribal lands. While this potentially would not work as well in States like California and Alaska due to issues related to Tribal land status, CMS could consult with the TTAG to establish a mutually-acceptable process for claims concerning California Indians and Alaska Natives.

penalties<sup>31</sup> and the “major national goal of the United States . . . to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.”<sup>32</sup>

### Conclusion

In 1851, the United States government signed eighteen treaties with California Indians, in which California Indians were promised health, education, and welfare in exchange for millions of acres of land. These treaties were never ratified, nor were the millions of acres of land returned to Tribal control.<sup>33</sup> The unjust nature of this history means that estate recovery today adds insult to injury in the eyes of California’s AI/AN population, who view the system as requiring AI/ANs to give the federal government additional land or other resources in exchange for the health care to which they are already entitled. And California Indians are not alone: health care that was promised in exchange for cessions of millions of acres of lands should not be contingent upon AI/ANs nationwide being forced to cede even more land, assets, or possessions.

CRIHB believes that a blanket legislative or administrative exemption for AI/ANs is necessary to properly effectuate the United States’ trust responsibility towards Tribes. In the absence of such an exemption, and at the very least, CRIHB recommends further research to determine the current impact of estate recovery on AI/AN Medicaid enrollment, as well as to develop successful strategies through which AI/ANs can retain assets while still participating in Medicaid (such as implementation of the Minnesota model and other approaches). This should be done in conjunction with Tribal consultation between CMS, the TTAG, and Tribes and Tribal organizations with the ultimate goal of developing a mechanism through which to obtain a statutory or regulatory AI/AN estate recovery exemption.



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<sup>31</sup> 26 U.S.C. § 5000A(e)(1)(3).

<sup>32</sup> 25 U.S.C. § 1601(3).

<sup>33</sup> See generally United States Bureau of Indian Affairs, Pacific Regional Office, Who We Are, available at <http://www.bia.gov/WhoWeAre/RegionalOffices/Pacific/WeAre/> (last visited September 17, 2014).