November 13, 2019

Sue Birch, Director
State of Washington Health Care Authority
626 8th Avenue, SE
PO Box 45502
Olympia, WA 98504-5502

RE: AIHC Proposed Revisions State-MCO Contract

Dear Director Birch:

In July of 2019, the American Indian Health Commission for Washington State (Commission), advocating on behalf of the twenty-nine tribes and two urban Indian health programs, submitted proposed revisions to the Health Care Authority's Model Washington Apple Health-Fully Integrated Medicaid Managed Care (State-MCO Contract). We understand that HCA will be submitting a new contract for tribes to review that will be quite different from the model contract we reviewed. In the interim, the Commission requests HCA consider the Commission's proposed changes. Attached is the Commission's October 31, 2019 revisions to the State-MCO Contract. This document amends our prior submission from July 2019. We also request that HCA (1) prohibit MCOs from requiring IHCPs to contract for non-native enrollees by incorporating amendments to the Tribal Billing Guide and the State-MCO Contract; and (2) provide a timeline for consultation and engagement on the requested changes submitted by tribes, IHCPs, and the Commission.

**1. Prohibiting MCOs from Requiring IHCPs to Contract for Non-Native Enrollees**

At the HCA's Tribal Compliance and Operation Workgroup meeting on October 9, 2019, the HCA provided a handout with the following statement: ***"For nonAI/AN clients, contracts with the managed care plans will be required."*** (emphasis added). The HCA argued that the following language from WAC 284-170-200(9) requires IHCP-MCO contracts for non-natives:

> To provide adequate choice to enrollees who are American Indians/Alaska Natives, each health issuer must maintain arrangements that ensure that American Indians/Alaska Natives who are enrollees have access to covered medical and behavioral health services provided by Indian health care providers. Issuers must ensure that such enrollees may obtain covered medical and behavioral health services from the Indian health care provider at no greater cost to the enrollee than if the service were obtained from network providers and facilities, even if the Indian health care provider is not a contracted provider.

The Commission disagrees. Nothing in federal nor state law, including WAC 284-170-200(9), requires an IHCP enter into a contract for services provided to a non-native client. WAC 284-170-200(9) does not create an exception to the rule that IHCPs must be reimbursed for their services regardless of their contracting status.[1] Rather, the purpose of WAC 284-170-200(9) is to ensure American Indian/Alaska Natives (AI/AN) are not financially penalized if their IHCP does not have a contract and that "AI/AN enrollees" have access to their IHCP as the WAC section title, "Network Adequacy" suggests.

To infer from the AI/AN protection in WAC 284-170-200(9) that IHCPs must enter into contracts for the small percentage of non-native patients conflicts with the plain language of 25 U.S.C. § 1621e(a) and circumvents an IHCP's statutory right of recovery. 25 U.S.C. § 1621e(a), which provides protections to the IHCP for reimbursement of health services, does not condition this requirement based upon the native status of the IHCP patient:

> (a) **Right of recovery**. Except as provided in subsection (f), the United States, an Indian tribe, or tribal organization shall have the right to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges billed by the Secretary, an Indian tribe, or tribal organization in providing health services through the Service, an Indian tribe, or tribal organization, or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities, to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such charges or expenses if—
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> (1) such services had been provided by a nongovernmental provider; and
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> (2) such individual had been required to pay such charges or expenses and did pay such charges or expenses. (emphasis added).[2]

The statute requires MCOs reimburse IHCPs for providing health services.[3] The statute is unambiguous in its protection of IHCPs and includes an express preemption of state law in preventing this right of recovery.[4]

The Commission found no federal law, federal guidance, or other state billing guides which suggests that IHCPs must contract for non-native patients. For example, the Medicaid managed care rules found in 42 C.F.R. § 438.14(c)(1)-(2) do not provide an exception to the right of recovery rule based on the fact that the beneficiary is non-native, nor does the CMS suggested contract language for state-MCO contracts provide such an exception.[5] To do so would be illogical and impractical to implement since federal law not only

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[1] 42 C.F.R. § 438.14(c)(1)-(2).

[2] 25 U.S.C. § 1621e(a).

[3] 25 U.S.C. § 1621e(a).

[4] 25 U.S.C. § 1621e(c).

[5] State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval, Section 1.D.5.02-03, p.27, January 20, 2017.

permits IHCPs to serve non-natives, but in some cases, actually requires it.[6] IHCPs, unlike stand-alone providers, are part of a complex system of care heavily regulated by federal law. IHCPs already have extensive processes in place such as establishing medical necessity for purchased and referred care. Requiring that MCOs serve as another layer of oversight when federal law specifically provides IHCPs with the choice to be exempt from contracting is not in line with the spirit and intent of 42 C.F.R. § 438.14(c)(1)-(2) and the IHCP's statutory right of recovery.

Crafting an exception to an IHCP's right of recovery will create several unintentional consequences. One is that some IHCPs may discontinue serving non-natives when faced with the administrative burden of contracting with MCOs. Many of these non-native patients are individuals who would otherwise be unable to access care given the limited number of providers. Tribal clinics across this state serve a significant number of non-natives who live in rural areas that experience significant barriers to accessing care. For example, Shoalwater Bay Tribal Clinic is just one of two providers in Pacific County. If not for this clinic, many non-natives would have to travel long distances just to access primary care. Second, if the HCA enforces such a rule for Medicaid, private issuers such as qualified health plans may also require contracts for non-natives even though IHCPs Affordable Care Act are considered essential community providers with the same protections for reimbursement regardless of a contract. Lastly and most significantly, requiring IHCPs to contract for non-natives would essentially force IHCPs to contract for AI/AN enrollees given the administrative burden of separating out a patient population for contracting purposes. This result would run afoul of the Congressional intent to protect the IHCP's right of recovery.[7]

The right of recovery under the Affordable Care Act is of critical importance to tribes both inside and outside the Medicaid context. Tribes routinely bill private insurance companies an in-network providers absent a contractual relationship, as tribes are entitled to do under 25 U.S.C. § 1621e(a). Importantly, the statutory right of recovery is based not on the identity of the *patient* but on the identity of the *provider* as an IHCP. Tribes like the Swinomish Indian Tribal Community have been educating private insurers about the right of recovery for a number of years and have developed working relationships with those providers to ensure proper payments. As we all know, the Indian Health Service has historically underfunded tribal health programs, and this key federal statute helps enable IHCPs to devote scarce resources to the provision of health services rather than to administratively burdensome bureaucracy endemic in the private insurance system. For this reason, the State should not attempt to erode the Tribes' statutory protections under the ACA by imposing a requirement to contract with MCOs.

In conclusion, federal law provides two separate protections: (1) access for the AI/AN enrollee to the IHCP/network adequacy; and (2) reimbursement to the IHCP for the provision of health services. The two protections should not be conflated to result in requiring an IHCP to contract with an MCO. The Commission requests the HCA amend the Tribal Billing Guide and the State-MCO Contract to include a provision prohibiting MCOs from requiring IHCPs to contract for non-native patients. The Commission's revisions (see section 5.20.8) also contain a proposal to operationalize efficient reimbursement to Tribes as

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[6] 42 C.F.R. § 136.12: "Services will also be made available, as medically indicated, to a non-Indian woman pregnant with an eligible Indian's child but only during the period of her pregnancy through postpartum (generally about 6 weeks after delivery)."

[7] 25 U.S.C. § 1621e(c).

non-contracted entities. This proposal would create an Indian health plan under each MCO with specific Recipient Aid Categories (RACs) codes that would contain each of the applicable IHCP protections provided in federal law.

**2. Timeline for Consultation and Engagement on the Tribes, IHCPs, and Commission's Requested Changes to State-MCO Contracts**

We understand that a new State-MCO contract will take effect in January 2020. The Tribes were not invited to engage in consultation with the State on that contract. Unfortunately, the implementation of the January 2020 contract coincides with the dissolution of the Behavioral Health Organizations (BHOs) and HCA's apparent target date to migrate related billing processes for managed care enrollees from the ProviderOne system to the MCOs. Tribes that operate substance use disorder (SUD) programs, in particular, are greatly concerned about the uncertainty of their operations beginning January 2020. Because Tribes were not given an opportunity to consult on the State-MCO contract that goes into effect in January 2020, we believe the State must maintain the status quo using the ProviderOne billing system for SUD services, at least until tribes have the opportunity to engage in consultation with the State. We ask that HCA expressly commit to maintaining payment on billings submitted by IHCPs via ProviderOne for SUD services at present.

As a result of the feedback we have received from its member tribes, the Commission requests that HCA commit to the following:

1. modify the next State-MCO contract to explicitly prohibit MCOs from imposing contracts on IHCPs for any reason (including as a condition of reimbursement at the appropriate encounter rate), regardless of the native status of their patients;
2. delay changes to any reimbursement process to IHCPs in the transition from behavioral health organizations to MCOs until the State has held a consultation with the tribes on the new contract;
3. immediately send Tribes a copy of the January 2020 State-MCO contract for review; and
4. conduct a consultation in January of 2020 on the State-MCO contract.

We look forward to working in partnership in improving the current state-MCO contracts to better serve AI/ANs and IHCPs. Should you have any questions, please contact Vicki Lowe, Executive Director for the Commission, at vicki.lowe.aihc@outlook.com.

Thank you,

Stephen Kutz, BSN, MPH
Chair, American Indian Health Commission

cc: Tribal Chairs
AIHC Delegates
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