CMS All Tribes Call
Medicaid Managed care ITU Addendum Webinar
November 9, 2016

Ms. Terwilliger: Good afternoon and welcome to today's All Tribes Call on the Medicaid Managed Care ITU Addendum sponsored by the Tribal Affairs Division Center for Medicaid and CHIP Services (CMCS). I am Lane Terwilliger, with the Division of Tribal Affairs, and joining me on today's call is my colleague Rachel Ryan. On April 25, 2016, CMS released a final rule on managed care in Medicaid and the Children's Health Insurance Program (CHIP). This rule incorporated the Indian protections in Section 5006 of the American Recovery and Reinvestment Act, otherwise referred to as ARRA. The Indian-specific provisions in the final managed care rule are located in the section, Standards for Contracts Involving Indians, Indian Health Care Providers, and Indian Managed Care Entities. In the final rule, CMS committed to developing sub-regulatory guidance through the consultation on the use of the Medicaid and CHIP Indian managed care ITU Addendum. The ITU Addendum is intended to help facilitate contracts between Indian health providers and managed care plans by identifying specific...several specific provisions established in federal law that apply when contracting with Indian health care providers. Per an October 5, 2016, CMS All Tribes Call, CMS obtained tribal input and advice on an informational bulletin that the Center for Medicare and Medicaid Services is developing that highlights the Indian-specific provisions of the final rule. We indicated on that call that we would hold a separate call on the ITU addendum. CMS will then release the informational bulletin and the ITU addendum as a single guidance, together. And after…following this call, the ITU...the link to the ITU Addendum will be sent out to everyone who participated. It's on our Spotlight page. At this time, I would like to provide an overview of the purpose of the ITU addendum and walk through key provisions. Purpose: similar to the

standardized contract addendum used for the Qualified Health Providers in the Medicare Part D program, this addendum has been developed for Medicaid managed care entities to use when contracting with Indian health care providers. Through the clearance process, this addendum was modified slightly from the model addendum for QHPs to be streamlined and consistent with the final Medicaid managed care rule. This addendum is not required, but CMS received several comments supporting the development and issuance of a model addendum for this purpose to assist Medicaid managed care entities in including Indian health care providers in their networks. We anticipate that the addendum will facilitate acceptance of network contracts by ITU providers. We also anticipate that offering contracts that include the addendum will provide managed care entities with an efficient way to establish contract relationships with ITU providers and ensure that American Indian and Alaska Natives can continue to be served by their Indian health care provider of choice. Indian tribes are entitled to special protections and provisions under this federal law, which are listed in the addendum. The addendum also identified several specific provisions that have been established in federal law that apply when contracting with ITU providers. The use of this addendum benefits both managed care entities and the ITU providers by lowering the perceived barriers to contracting, assuring managed care entities comply with key federal laws that apply when contracting with ITU providers, and minimizing potential disputes. Next, I'm going to walk through the key provisions in the addendum. First of all, we have defined both Indian…Indian health care provider managed care plan consistent with the regulatory definitions in the final rule. Next, we have the cost sharing exemption for Indians: no reductions in payment. In this section, we emphasize that American Indian and Alaska Natives are exempt from cost-sharing and explain that managed care entities are prohibited from reducing payments to Indian health care providers. These provisions were enacted with the

American Reinvestment and Recovery Act of 2009. The next section describes the enrollee option to select an Indian health care provider as a primary health care provider. We also emphasize American Indian and Alaska Natives' right to choose the Indian health care provider regardless of whether that provider is in the managed care entity's network. This provision was also enacted with the American Reinvestment and Recovery Act of 2009. Next, managed care entities' agreement to pay Indian health care providers: this provision requires managed care entities to pay Indian health care provider regardless of whether the provider is in the managed care entity's network. Next, contract assurance that allows Indian health care providers to limit who is eligible for items and services. This section identifies that an Indian health care provider can limit who it provides services to under the Indian Health Care Improvement Act. The next section, explanation of applicability of federal laws to Indian health care providers. This provision explains that certain federal laws are applicable to the Indian health care providers, but not others. Those laws are listed in Appendix A to the addendum. Next section is the explanation that Indian health care providers are nontaxable entities. This section explains that managed care entities may not collect or require Indian health care providers to remit taxes. The next section is an explanation that Indian health care providers are not subject to insurance requirements, including professional liability insurance. This provision of the addendum explains that Indian health care providers that are subject to Federal Tort Claims Act are exempt for insurance requirement. The next section is explanation concerning licensure accreditation exemption for Indian health care providers, including professional staff and the facility. This section explains that managed care entities may not subject Indian health care providers to state licensure and accreditation requirements. The next section talks about key resolution and binding arbitration. This section identifies that managed care entities may not subject Indian

health care providers to binding arbitration in the event of a dispute between the managed care entity and the Indian health care providers. The next section is a statement that federal law governs. Indian health care providers are not subject to state law and medical quality assurance requirements. These provisions explain that federal law governs in the event of a conflict and will prevail. It also explains that Section 805 of the Indian Health Care Improvement Act apply to medical quality assurance or requirement. The next section explains the claims format. The section requires managed care entities to process claims in accordance with Section 206H of the Indian Health Care Improvement Act. Next we talked about the payment of claims. This provision requires managed care entities to pay the applicable payment rate, whichever is higher. Hours and days of service: this section of the addendum explains that the Indian health care provider may set its own hours and dates of operation. Next section is purchased and referred care requirement. This section explains that the requirements for purchase and referred care prevail over the managed care entity's requirement when purchase and referred care are used. The next section discusses sovereign immunity. This section advises that by contracting with the managed care entity, the Indian health care provider has not waived sovereign immunity. The last section discusses endorsements. The final provision of the addendum advises against using Indian health care provider names used to suggest official endorsements or preferential treatment of a specific managed care entity. At this time, I would like to open up the call for any questions and comments. Joanne, operator, could you ask if there are any questions or comments?

Operator: No worries, Ms. Terwilliger. Ladies and gentlemen, at this time I would like to remind everyone, in order to ask a question or make a comment, please press star and the number one on your telephone keypad. We will pause for just a moment to take a pause ***. *(Unclear - 9:35.) (Pause.)* Once again, if you would like to ask a question or make a comment, please

press Star One, Star One on your telephone keypad. Your first question or comment comes from the line of Ms. Melanie Fortilis *(spelled phonetically)* from Choctaw Nation. Your line is open. Go ahead with your question and comment.

Ms. Fortilis: Thank you, and thanks, Lane and Rachel, for holding this call. I just wanted to put on the record that we appreciate the work that has gone into this draft addendum and we did... We had a discussion with you all last week during TTAG, the committee, and a strike reversion was then, uh…recommended changes was presented, and I just want to say, for the record, the Choctaw Nation endorses that strike-through. And we wanted that on the record. But one of the items I wanted to mention specifically was with regard to FTCA coverage, the section that refers to that. Um, in the current draft, there is a paragraph related to Indian health service and a paragraph related to FTCA coverage for tribal organizations, and I just wanted to... Um, we've made some suggested comments or changes to that section and the reason that we have is because we want to be clear that the coverage for FTCA related to either IHS or tribes—it should be the same and it should be stated as equally, as strongly in the tribal paragraph as it did the federal paragraph. So, just wanted to put that comment on the record, and we've made a suggested change for that. We understand that the...that one of the differences is that we have a self-determination or self-government agreement to abstain *(unclear - 11:44)* those services from the Indian Health Service, and that's how we get FTCA coverage. But we do believe the definitions at the beginning of the addendum would cover the definition of a tribal organization for purposes of that. So, thank you again, for having...hosting this call, and thank you for receiving my comments.

Ms. Terwilliger: Thank you, Melanie.

Ms. Ryan: Hey Melanie, this is Rachel. Um, I received a copy of the redline version, but you have not submitted your recommended comments yet, right? We didn't miss that?

Ms. Fortilis: I'm not specific to Choctaw Nation. I just want to say that we support the red line.

Ms. Ryan: Okay. Do you know...

Ms. Fortilis: Okay. Great.

Ms. Ryan: Okay. Thanks. Thank you. Yeah.

Operator: Once again, I would like to remind everyone, in order to ask a question or make a comment please press star and then the number one on your telephone keypad. *(Pause.)* There are no further questions or comments from the phone lines at this time. I would now like to hand the conference back to today's presenter. Please continue.

Ms. Terwilliger: I'm... This is Lane Terwilliger. I was going to wrap up since I don't hear any more questions, and we do appreciate the red line and the support for the red line version from Melanie. Thank you. So, as a final reminder, Tribal Affairs is seeking written comments on the ITU addendum, and those comments are due by close of business November 16, 2016. Please submit written comments to the tribalaffairs@cms.hhs.gov. Again, please submit written comments to tribalaffairs – that's one word – @cms.hhs.gov. Thank you, again, for your participation.

Operator: If I can interrupt, Ms. Terwilliger?

Ms. Terwilliger: Yes.

Operator: Yes, ma'am, we do have additional participants who are going to make a comment or ask a question. You would like to take them?

Ms. Terwilliger: Yes. Thank you.

Operator: All right. Thank you. So, your next question or comment comes from the line of Devon Delro from National Indian Health. Your line is open. Go ahead with your question or comment.

Mr. Delro: Thank you. Hi, Lane. Hi, Rachel. I just want to echo Melanie's comments and really thank CMS for taking the comments submitted by TTAG and tribes to heart in creating this managed care addendum. And I just want to recommend that you continue to work with the TTAG and tribes in finalizing this. Um, hopefully, at the end of this comment period, um… NIHB will be submitting some formal written recommendations, but at the end of the comment period, if you could also, uh, if any additions or edits you make to the addendum—you share those edits with TTAG, with tribes before the product is actually finalized. Thank you.

Ms. Terwilliger: Thank you, Devon.

Operator: Your next question or comment comes from the line of Elliott *** *(unclear - 15:04)* from *** *(unclear - 15:05.)* Your line is open. Go ahead with your question or comment.

Male: Uh, hi, Lane, Rachel. Um, again, to echo Devon and Melanie's comments, thank you to CMS for working on this addendum and for issuing the sub-regulatory guidance. I think that the managed care addendum will be a primary important tool for the IHS, tribes, tribal organizations, and urban programs in contracting with and entering into provider's networks in managed care settings. I would like to ask...make one comment and ask one clarifying question, if I could. Um, on the managed care addendum there is a section entitled, "Purchase Referred Care Requirement" that's been, uh… states, I think, very positively that the provider may make, uh, the provider, which is really the Indian health care provider, may make referrals to other in-network providers, and such referrals shall be deemed to meet any coordination of care and referral obligations to the managed care plan. And that's consistent with what CMS put out in its

new managed care regulations. And I think that will be, uh, that will go a long way to avoiding scenarios in which an individual, Indian Medicaid and managed care enrollee, would have to seek primary care, for example, at an Indian health care provider, and then go seek the same primary care at a managed care provider...in-network managed care provider simply in order to be referred up or to a specialist. That would create a burden on the individual Medicaid enrollee and also a burden on the Medicaid system in unnecessary duplication of care. So, we think that first sentence is very important. I think that the second two sentences, uh, the second or third sentences there are really designed to kind of assist with purchase referred care issues to the extent that… You know, just kind of looking at this again, uh, the tribal comments are graphed managed care addendum that was provided to CMS entitled, the section, "Purchase Referred Care," and I think that, you know, on further reflection, really, it should just be...it should just reference referral requirements as, you know, purchase referred care programs or payer of last resort and should not really be implicated in referrals in managed care settings. So, it may be neater to simply remove those second and third sentences to that paragraph and simply have a paragraph reiterate the, uh, the deemed to meet, uh, deemed to meet provisions in the first sentence. Um, that's my comment/my question and, you know, I think that tribes will be submitting written comments. And thank you very much for the reminder to do so and the information about how they can do so. One question I had was, there was, in at least the draft that some tribes had submitted to CMS that included a provision, which would have laid out the requirement that is set out in the ARRA stimulus bill, which states that certain trust-related income from things like forestry or fisheries or other types of trust-related income are not to count for the purposes of determining how much income somebody has for Medicaid eligibility purposes. So, there was a provision that was included there in the tribal version that was initially

submitted to CMS, and that was omitted from the final draft. It may have been omitted because of the sense that the managed care entities never have a role in making eligibility determinations. We were not sure whether that was the case or not. And so, I guess that's our question to CMS. Have you been able to confirm whether that's the case, because, to the extent they are assisting in enrollment, um, they'll obviously be working with the state, but to the extent that they're assisting in the enrollment process, that's an important provision, which really opens up Medicaid to a larger number of individuals, particularly in certain areas of the country.

Ms. Terwilliger: Thank you, Elliot, for that question, and you are actually correct. Managed care entities don't play any role in the Medicaid eligibility process, and so that was the genesis behind removing that particular provision. Um, individuals that are enrolled in Medicaid and CHIP—that is a state function, a single state agency function. And then, after they're enrolled in Medicaid, then they're either assigned or opting into the plan. And so, that was the genesis of why that provision was taken out, but I really appreciate your question.

Mr. Delro: Thank you. I think we'll be submitting further comments in writing, as well.

Ms. Terwilliger: Thank you. We're looking forward to receiving those.

Operator: We have your next question or comment coming from the line of Sarah *** *(unclear - 20:58)* from National Indian. Go ahead with your question or comment. Your line is open.

Female: Hi; thank you, Lane and Rachel. This is Sarah with NIHB. I just wanted to add a, kind of, minor terminology, uh, additional comment. I'm sure we'll be including them in our written comments that are due the 16th, as well. Thank you for all the information. It definitely clarified a few of our questions, but with regards to change in the terminology for an Indian health care provider that you have with, you know, in the crux of the addendum that relates it. So, I guess we're just trying to figure out, you know, which are the facilities that include IHS and

tribally operated facilities, but it just seems to not be clear what a network Indian health care provider agreement is. This reflects to terminology and we want to make sure everyone is on the same board.

Ms. Terwilliger: Sarah, this is Lane. Could you step back and repeat your question? I want to make sure I understand it.

Female: Yeah. Sorry about that. Um, so just regards to... It's not a question or a question for a comment, but with regards to the terminology of the Indian health care providers that have been replaced Indians—sorry—have replaced provider, I think we need a clarification on what a network Indian health care provider agreement is.

Ms. Ryan: So... This is Rachel. I can... This might help. So, when we were reviewing the addendum at TTAG, somebody actually pointed out that we had somewhere along in the edit process, someone had done a word replace for a provider, IHCP. So, what happened is that there were some places where it should have just said, "network provider" in reference to a provider that was in the managed care network, and it got replaced with "network IHCP provider." So we've tracked those down in the addendum and I think we've corrected them. Does that fix your problem or am I not... Does that not address it?

Female: Yes, it does. Thank you, Rachel. I wanted to make sure that that was the case there. Thank you.

Ms. Ryan: Yeah. And it was a really good catch. It was only on a couple of places, but it was very consistent.

Ms. Terwilliger: And when we do—this is Lane—we really do appreciate all of your willingness to respond to this quickly, the TTAG's participation in this, and that we are looking for a quick response. But, we really are trying to get this guidance out so we can have the

informational bulletin and the ITU addendum, kind of, go out as a pair. And, you know, now that we have a different administration, it's really incumbent that we work to get these out as fast as possible. I think that there will be one more little round of clearance internally. So, I just wanted to inform you about that. So, we really appreciate the willingness to turn this around and fairly quickly. Thank you.

Operator: Your next question or comment comes from the line of Angela Wilson from Pit River Tribe. Your line is open. Go ahead with your question or comment.

Ms. Wilson: Hi, Lane and Rachel. Thanks for holding the call, as well. I certainly agree with all of the comments that we're hearing on the phone from our colleagues out in Indian Country. Also, we do appreciate the work of TTAG, as well. Just a quick comment really, one of the significant barriers that we run into here in California, you know, Pit River averages about 27,000 miles in months *(unclear - 24:41)* in transporting our patient to specialty care outside of managed care entity that we primarily work with, which is partnership and when that happens and we cross over to the boundaries of another managed care entity. Part of the problems that we're running into is the credentialing process. So, when we all become, all of us, ITUs become... Um, we enroll with the state Medicaid program, we have to credential at that time and, I guess, you know, my comment would be that that tribe should be able to credential with the state Medicaid program and have that credentialing carry throughout all of the Medicaid process, whether it's on the managed care entity side or on the fee-for-service side. The reason that this is such an issue is, when we're forced to do separate credentialing for every single or different managed care entity, that process covered significant barriers in third-party reimbursement in a timely manner and also access to care in certain cases when we're really trying to work hard to educate the managed care entities about these referrals from the primary

care provider. So, it is an administrative burden on the ITUs to have to separately credential with each managed care entity. So that's just a comment on my end.

Ms. Terwilliger: Hi, and this is Lane. I would like to respond to that, because, right now, I know you're in California. It always seems to be our pool of problem areas. We are actually looking into that issue now and going over it with our General Counsel in getting clarification. So, I think it's kind of a two-pronged problem. Not only is it happening to you on the ground there, and we agree with you that it shouldn't, but we've got to get the clarification and internally educate CMS internally and also within our regional offices. So, we've got a little bit of work cut out for us, but we have heard about that issue, and a lot of times, we're also hearing from different regions that sometimes tribes are disagreeing to do things just to get into the network. And so, we're trying to get, kind of, a feel for how widespread this program is, I mean this issue is and whether it's not just in California or it's in other areas. And maybe when Kitty Marx gets back, we might have a discussion on may be releasing some guidance to the states to remind them what the rules are, because we're hearing that a lot. We're also hearing that some managed care organizations in California are doing, like, site visits and things, too. So, we've learned an alarming number of issues going along with the credentialing and licensing, and I think that there's a general confusion on what the requirement is for fee-for-service and whether or not the managed care entities can apply an additional requirement on top of fee-for-service. So, we're on that and I hope that we can get that resolved in your region soon. So, more to come on that. But never stop bringing us...

Ms. Wilson: Thank you. All right, thanks, Lane. I appreciate it.

Operator: Your next question or comment comes from the line of Carolyn Gougeau *(spelled phonetically)* from Red Cliff Indian. Go ahead with your question or comment. Your line is open.

Ms. Gougeau: Good afternoon. Yes, this is Carolyn Gougeau with the Red Cliff Band of Lake Superior Ojibway in Wisconsin, and I work within the purchase referred care department. And our health center is going through some transitions. And so, when I look at this, the Medicaid and CHIP managed care entities with this addendum for contracting, I need to be able to find... I need to get a 101 on this. First off, our health center: I believe we have contracts with the state and we do have work with Medicaid/Medicare, so I'm not quite sure if I'm able to...I'm following you as far as the purchase referred care. We do need referrals for those that are referred outside of the facility. So, I'm trying to see... From my experience is, when we do applications up with individuals for Medicaid, the state will automatically put those individuals in an HMO or a managed care entity, and it's up to the people then to go exempt themselves out of that managed care. So, is this... Am I following this? Is this what's happening? Is this where...what the focus of the group is?

Ms. Terwilliger: Let me just... A coup... You have a couple of questions in there. Let me address that. In our final rule and also, um, as part of our guidance that we're hoping to release with this ITU addendum, we want to, kind of, point out some options and for states and tribes to work together, or even CMS states and tribes to liaison together to figure out, you know, if they're going to mandate Indian individuals into managed care, then maybe there's some things that they could do better. And we talked a little bit in our rule about algorithms and all, and that's, kind of, like a foreign object; but we're thinking, like, on the ground we've heard some practices. I heard some from the California Rural Indian Health Board that maybe you could put

all the Indian health care programs into the plan, and maybe the individual could be assigned by a ZIP code, and maybe that would eliminate the individual's wrong assignment to the wrong provider. And there's been some other, kind of, strategies. So, we would be happy to work with you in your particular state with your tribes to figure out a strategy, and that maybe we can facilitate a discussion how they can do that better, because we do understand that it's a burden to be enrolled into a managed care plan when you're already using an Indian health care provider as your primary care provider. So, we do understand that. We would like to have a discussion off-line with you and would like to hear, you know, any, kind of, best practices you can think of, because when we roll all of these provisions out, we want to be able to suggest to states strategies for making this better.

Ms. Wilson: I appreciate that and, yes, I would like to have further dialogue with you on how we can do best practices and where it best works for the people that we serve within our areas. So, I guess I could email you and then try to start collaborating and coordinating some of these efforts. Because I can understand, too. As I mentioned, we're going through transitions at our health center, and I work with *** *(unclear due to background noise - 32:11.)* So, I know that this is something that would just ***.

Ms. Terwilliger: Would you like me to provide my email now?

Ms. Wilson: Yes. That would be great.

Ms. Terwilliger: I'm just going to spell it out. Just phonetic. Lane.terwilliger@CMS.HHS.gov.

Ms. Wilson: All right. Well, thank you, Lane.

Ms. Terwilliger: You're welcome. We really do look forward to getting some strategies for this, because we've been hearing about it at all of the consultations across the nation.

Operator: There are no further questions or comments from the phone lines at this time. I would like to now hand the conference back to the presenter. Please continue.

Ms. Terwilliger: Thank you for, everyone, for taking time to participate in this call. We really look forward to receiving your comments, and, again, thank you for your willingness to submit them on such a short turnaround track, but we really are trying to get this guidance out now that we're in a new administration, you know, fresh, not even 20-hours old. We want to get as many things as possible, we've been working hard on with you, out as soon as possible. So, we look forward to receiving them. Thank you.

(End of webinar - 33:43.)