Alaska Native Health Board

THE VOICE OF ALASKA TRIBAL HEALTH SINCE 1968

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November 27, 2017

Sent Via E-Mail: Courtney.king@Alaska.gov

Courtney O'Byrne King, MS
Medicaid State Plan Coordinator
Division of Health Care Services
Alaska Department of Health and Social Services

Re: Tribal Recommendations on Proposed Changes to Long-Term Services and Supports Delivery System (new 1915(k) Community First Choice State Plan Option, new Targeted Case Management for individuals meeting institutional level of care, new 1915(c) Individualized Supports Waiver, and corresponding revisions to existing 1915(c) waivers).

Dear Ms. King:

Thank you for engaging us in tribal consultation on the Department's proposed changes and enhancements to the long-term services and supports (LTSS) delivery system.

Alaska Native Health Board (ANHB) was established in 1968 with the purpose of promoting the spiritual, physical, mental, social, and cultural well-being and pride of Alaska Native people. ANHB is the statewide voice on Alaska Native health issues and is the advocacy organization for the Alaska Tribal Health System (ATHS), which is comprised of tribal health programs that serve all of the 229 tribes and over 158,000 Alaska Natives and American Indians throughout the state. As the statewide tribal health advocacy organization, ANHB assists tribal partners, state and federal agencies with achieving effective communication and consultation with tribes and their tribal health programs.

In general, we support the Department's proposals, which we understand are principally a response to the State's fiscal woes, and intended to enhance federal financial support for services while ensuring they remain within the Department's budgetary constraints.

It has long been a declared priority of the Alaska Tribal Health System to ensure that our elders and other beneficiaries are able to receive culturally-competent health care services and supports throughout their lives and as close to home as possible, where they are near their families and supported by their cultural traditions and ties. Much remains to be done to fully achieve that goal. In the coming months and years, we look forward to working with the Department to envision and establish a regulatory framework and reimbursement methodology

that would allow tribal health organizations to deliver a full array of LTSS that meet the unique needs and life ways of the people and communities we serve. In the meantime, the Department's proposed changes appear to be a step in the right direction.

However, we have several recommendations for changes to the current proposal, to help make these vital services more available to our beneficiaries across the State.

1. Modify the conflict-free care management and care coordination requirements to ensure AI/ANs can receive both services from qualified THOs.

We urge the Department to make changes to all "conflict-free" care management/care coordination provisions to ensure that Alaska Native/American Indian beneficiaries (AN/AI) are able to receive both direct home-and-community-based services and care management/coordination from a Tribal Health Organization (THO). Currently and in the proposed new provisions, all provider agencies must choose between being direct service providers of home and community-based services, or coordinating and managing them. They may not provide both, unless they operate in a rural area, are the only willing and qualified entity to provide the services in their community, administratively separate the two types of services, and receive an exception from the Department. (See proposed Community First Choice State Plan Amendment Attachment 3.1-K, Pages 15 - 17, "Conflict of Interest Exception.")

These provisions are intended to ensure that recipients truly have a free choice of direct providers of home-and community-based services and are not unduly influenced to receive them from the same agency that employs their care coordinators/managers. But for many AI/ANs, rather than ensuring a free choice of providers, the provisions will have the opposite effect, making it impossible for them to choose a tribal health provider for both types of services. The provisions also prohibit THOs from offering Medicaid services that they are otherwise fully qualified to provide. The availability of an exception for rural areas may allow some AI/ANs to receive both kinds of services from their THO, but those living in urban centers would be forced to accept either their care management/coordination or direct care services from a non-tribal provider, simply because their THO would be prohibited from offering both kinds of service.[1]

Restricting the scope of THO services and the ability of AI/ANs to be served by THOs in this way is contrary to federal laws and policy addressing the interplay between Medicaid and the tribal health system. A host of Federal laws recognize the importance of ensuring AI/ANs have access to culturally appropriate services furnished by tribal health programs focused on their unique needs. The CMS Medicaid Managed Care rules, for example, require Managed Care entities to demonstrate that their networks include sufficient

[1] While it is not entirely clear, it appears that the Department's current regulations would not even allow a tribal provider to choose to deliver direct care services to one waiver population and care management services to a different waiver population, except with a waiver. We do not see how there could be a conflict of interest in providing these services to separate populations. We urge the Department to make any necessary changes to its proposals, and to current regulations, to clarify that separate populations may be served without a waiver.

numbers of Indian health care providers, and provide that Indian enrollees must be permitted to receive services from out-of-network Indian health care providers. 42 CFR 438.14.[2] Forcing THOs to choose between furnishing direct or care coordination/management services also violates the spirit, if not the letter, of Section 408 of the Indian Health Care Improvement Act, which requires State Medicaid agencies to enroll tribal organizations as Medicaid providers without a State license or other State "recognition," so long as the THO "meets generally applicable State or other requirements for participation as a provider of health care services under the program." [42 U.S.C.A. 1647a]. It may also be contrary to the Department's own regulation recognizing these federal laws and policies, 7 AAC 105.200(d), which makes facilities operated by tribal health programs exempt from any Medicaid requirement "that the provider be licensed or certified by this state to be eligible" as a Medicaid provider.

We recognize that the State's current and proposed restrictions reflect the current federal regulation for conflict-free home-and-community-based waiver services, 42 CFR 441.201. However, that federal regulation applies only to waiver services, and the State is not required to establish the same conflict-free rules for State Plan services like the Community First Choice Option. Further, given the federal laws and policies on the rights of AI/AN Medicaid recipients and tribal providers, we think the federal conflict-free regulation must be understood to allow THOs to furnish both care management and direct services to their AI/AN recipients (with appropriate administrative safeguards to help ensure recipients' free choice of providers), since THOs are the only "willing and qualified" providers capable of delivering culturally-appropriate services to AI/AN recipients living in their service areas.

We urge the Department to discuss the applicable federal laws and policies with CMS and to do everything it can to ensure that AI/ANs are free to receive both kinds of services from THOs that are otherwise willing and qualified to provide them. We would be pleased to meet with CMS, separately or jointly with the Department, to present the issue and identify the best possible solution.

2. Modify the Supervisory and Work Experience Requirements to Allow THOs to Establish their Own Standards or to Obtain Waivers from the Department's Requirements.

For the proposed new and revised programs, the Department plans to adopt essentially the same education, training, and experience requirements for program administrators and care coordinators that are now in place for existing home and community based programs. (See proposed Community First Choice State Plan Amendment, Attachment 3.1-K, Pages 20 – 22.)

Smaller programs and those located in rural areas may have difficulty hiring and retaining staff who meet the required standards, as we have observed in past comments on the current requirements. For example, program administrators would be required to have

[2] See also the December 14, 2016 CMCS Informational Bulletin, "Indian Provisions in the Final Medicaid & Children's Health Insurance Program Managed Care Regulations."

one to four years' experience supervising two or more staff who worked in a human services setting -- supervisory experience that may be impossible to acquire in smaller programs and communities. We urge the Department to work with us to establish more flexible and achievable standards for tribal programs. One option, which we favor, would be to allow tribal health programs to establish their own qualifications for these positions. Alternatively, or in addition, the Department should allow itself the option to modify the requirements in individual circumstances, as it does now with the conflict-free requirements and barrier crimes and conditions.

We also noticed two small but significant differences between the standards as stated in the draft SPA and in the draft Conditions of Participation for Care Coordination Services. In both cases the COPs state a more appropriate, flexible, and achievable standard. The SPA, but not the COPs, would require certain levels of "paid" and "full -time" work, while the COPs would allow full-time "or equivalent part-time" paid or unpaid work. We urge the Department to modify the proposed SPA and all other documents to follow the standards stated in the COPs (as well as allowing THOs to establish their own standards or to obtain waivers from the Department).

3. Recognize that Health Professionals Employed by THOs May be Licensed in Any State.

The proposed Community First Choice SPA, and we assume other materials the Department will be submitting to CMS, includes requirements that certain health professionals be licensed by the State of Alaska. (See, e.g., proposed Attachment 3.1-K, Page 10, regarding payment for emergency response systems.) We ask that all such references be modified to recognize the express exemption from State licensure afforded by Section 221 of the Indian Health Care Improvement Act (42 USC 1621t) for licensed professionals carrying out a THO's Self-Determination contract or compact. Section 221 provides:

> Licensed health professionals employed by a tribal health program shall be exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

See also 2012 Op. Alaska Att'y Gen (April 17), recognizing the preemptive effect of the provision with regard to pharmacists employed by THOs.

Please note that this exemption for employees of THOs is different than the separate exemption for federal employees assigned to work in tribal health programs, which the Department has is recognized in 7 AAC 105.200(c). We encourage the Department to modify that regulation to expressly recognize the Section 221 exemption for THO employees as well.

4. Allow CFC-PCA and other Services to Be Furnished in THO-Owned or Controlled Residential Settings.

Courtney O'Byrne King, MS
Medicaid State Plan Coordinator

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The proposed State Plan Amendment for the 1915(k) Community First Choice (CFC) option would cover the services "only in private residences and … not … in provider-owned or controlled settings. " (See proposed Attachment 3.1-K, Page 13, "Setting Types.") The CMS SPA pre-print for the service allows States to cover the services in additional settings: including "in private residences and in provider owned or controlled settings," and "settings that have been determined home and community-based through the heightened scrutiny process," but the Department has at least preliminarily opted against covering the services in those settings.

We do not know the reasons for the Department's initial choice, but we ask you to reconsider it, and to allow the services to be furnished in non-institutional settings that are owned or controlled by THOs. We agree that it is best to deliver services in a recipient's own home when that is feasible. But as a practical matter, that will not be an option in some remote communities, especially those that lack modern water and sewer systems. For some AI/AN elders and other beneficiaries, the next best option may be to receive services in a supported housing or other residential facility that is owned or controlled by a THO, designed and operated in a culturally-competent way to meet the unique needs of the AI/ANs we serve.

5. Establish Reimbursement Rates that Cover the Services' True Cost.

Finally, but equally important, we urge the Department to develop reimbursement methodologies and rates that would ensure these important services are available and sustainable State-wide, particularly in rural communities served exclusively by THOs. For example, we would like to discuss whether the services would appropriately be paid at a separate Department-determined, cost-based tribal encounter rate, and whether some services might qualify for reimbursement under the Department's new CHA/P encounter rate.

If it would be helpful to meet face-to-face to discuss these topics further, we would be more than happy to do so. We value our partnership with the State of Alaska and appreciate this opportunity to consult with you.

Sincerely,

Verné Boerner
President and CEO
Alaska Native Health Board

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November 27, 2017

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