Compilation of Tribal Comments on Proposed Cost Containment SPA

#	Comments Taken from Tribal Written Submissions	State Response
1	(ANTHC and ANHB) is providing these comments as part of the tribal consultation process on the proposed State Plan Amendment (SPA) on cost containment. While we appreciate the Department of Health and Social Services (DHSS or Department) extending the written comment deadline to August 8, we want to make our position clear that we believe the process the Department has used to institute these changes has not constituted meaningful consultation, we strongly oppose this SPA, and we recommend the Department immediately abandon this effort in its current form.	The Department thanks ANTHC and ANHB for the comments contained here, and the rest of the document. The Department has met the consultation requirements and is moving forward with submission of the cost containment SPA. See also response to comment numbers 2, 4, 6, 13 and 15.
2	(ANTHC and ANHB) Tribal Health Organizations (THOs) have expressed serious concern with the State's process for moving these rate reductions and inflation freezes forward. On July 1, 2019, DHSS simultaneously announced its intent to submit a SPA to reduce payment rates and to freeze inflation increases for FY2020, while at the same time issuing emergency regulations to implement these exact same proposed changes to the Medicaid State Plan. These changes are contradictory to the existing and active State Plan. The implementation occurred even though DHSS had not yet completed federally required tribal consultation on the SPA. Crucially, this also occurred prior to approval of the change by the Centers for Medicare and Medicaid Services (CMS). The United States Court of Appeals for the Ninth Circuit has repeatedly confirmed that States may not lawfully implement SPAs prior to CMS approval. See, e.g., Arc of Cal. v. Douglas, 757 F.3d 975, 984 n.4 (9th Cir. 2014).	CMS will determine whether the state has complied with federal law with respect to the submission of the SPA in their role as the federal agency overseeing this process. *See Armstrong v. Exceptional Child Center, Inc.* 135 S. Ct. 1378, 1385 (2015). The process utilized emergency regulations, with immediate notification to the public that we intended to make these regulations permanent. By taking this step we must comply with the full array of public process and comment before the regulations become final. This process, which includes tribal consultation, is ongoing. As noted in this document, the Department has met the requirement of tribal consultation and will be moving forward with submission of the SPA. See also response to comment numbers 1, 4, 6, 13 and 15.
3	(ANTHC and ANHB) The Department could have and should have engaged us much earlier on possible rate reductions and inflation freezes, which it was discussing with the Legislature as early as March during the Legislative budget making process. Had it done so, there would have been ample time to consider these proposed changes through a regular process which first engaged tribes in Tribal Consultation and then secured CMS approval before being implemented. The Department's failure to do so is a violation of law which, as you know, is now being challenged in court by the Alaska State Hospital and Nursing Home Association, along with the substance of the cuts.	The Department initiated, and complied with, the tribal consultation process approved by CMS as outlined in section 1.4 of the state plan. Tribal providers were included in the legislative process both by participation in, and submission of, comments related to the budgetary process. While the Department understands the concern stated on the timing of these decisions, due to the timing of the budgetary process and the various decisions that needed to be made related to these regulations, the Department worked and generated these regulations as quickly as possible. The Department is in compliance with the statutory requirements for making these regulations permanent and complying with other CMS rules, including tribal consultation. Although this process may have been expedited, the department must still follow the process including submission of the SPA to CMS for their approval.

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4	(ANTHC and ANHB) Tribal consultation is required by statute prior to the submitting a SPA to CMS. Section 5006(e) of the American Recovery and Reinvestment Act of 2009 (ARRA) requires that states with Indian health programs solicit advice from them "prior to submission of any plan amendments…likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations." 42 U.S.C. § 1396a(a)(73). Additionally, CMS's Tribal Consultation Policy requires states to "seek advice from Indian health providers, which includes…tribal health programs…prior to submission of SPAs."	The Department complied with the tribal consultation policy, which was deemed by CMS in 2012 to be in compliance with the cited authorities. The Department has not submitted the SPA prior to tribal consultation. See also response to comment numbers 1, 2, 6, 13 and 15.
5	(ANTHC and ANHB) The DHSS held what they considered to be a tribal consultation on this proposed change on July 24—three and half weeks after implementing the change. During in-person tribal consultation, the Department asserted that it implemented the emergency regulations based on a directive received from the State Administration, but when we asked to see it, we were told that there was no directive and that DHSS was moving forward based on the FY2020 Enacted Budget signed by the governor. A budget does not constitute an emergency. Alaska law clearly states that emergency regulations may only be issued "for the immediate preservation of the public peace, health, safety, or general welfare." AS 44.62.250(a).	The Department initiated the consultation process on July 1, 2019, the date of publication of the emergency regulations on which the proposed amendment is based. The tribal consultation process is not the appropriate venue in which to argue the legality of the use of the emergency regulations process under the Administrative Procedures Act.
6	(ANTHC and ANHB) The effective implementation of this SPA through emergency regulations beginning on July 1 deprived THOs of the opportunity to provide the Department with the impacts and alternative recommendations through meaningful consultation. Moreover, when we requested the Department's analysis and rationale for the SPA, to allow us to better understand how the Department decided on the size of the cuts and how to apportion them, the Department refused to provide it, citing the pending litigation.	The Department initiated the consultation process on July 1, 2019, the date of publication of the emergency regulations on which the proposed amendment is based. Tribal consultation requires the department "solicit advice, review, seek clarification, and utilize the aforementioned as appropriate from the federally recognized tribal health programs in the Indian Health Service (IHS) to ensure that their inclusion in the decision making prior to changes in programs that are likely to have a direct effect on American Indians or Alaska Natives (AI/ANs), tribal health programs or IHS, while preserving the right of the Department to make appropriate decisions." Department staff members were unable to respond to certain specific questions during the consultation, but were not prevented from listening to and considering the concerns and suggestions of the tribal health organizations. The Department recognizes that there was some confusion as to what could be shared due to ongoing litigation during our original meeting. ANHB was provided with the state opposition and cross-motion filed with the Superior Court on August 30, 2019, which provided detail on the Department's decision. No additional consultations are necessary at this time. See also response to comment numbers 1, 2, 4, 13 and 15.

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7	(ANTHC and ANHB) There is no indication that the State has considered the adverse impacts to quality of care and equal access to care that the proposed SPA will have on Alaska Natives and American Indians. Consideration of these effects is required by both federal and state law. The Medicaid statute requires state plans "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such are and services are available to the general population." 42 U.S.C. § 1396a(a)(30(A). Alaska law requires rates be set in accordance with the Medicaid statute, AS 47.07.070(a), thus requiring assessment on impact to quality of care and equal access to care. Alaska law further requires the State consider the "reasonable costs related to patient care" in setting Medicaid reimbursement rates." AS 47.07.070(b).	The Department did consider all of the requirements of 1396a(a)(30)(A) in implementing the emergency regulations. It also considered a myriad of other federal authority and guidance on this issue including but not limited to (1) how Alaska rates compare to Medicare rates; (2) the fact that a 5% reduction or cost of living freeze is not a *per se* violation of the statute (see CMS guidance SMD 17-004); and (3) the information that was included in our 2016 federally required Access Monitoring Review Plan (AMRP). We also considered how the same level of rate reduction and inflationary freeze impacted quality of care and access in 2018 and concluded that there was no net loss in providers and no issue in the quality of care. The state additionally considered the 2019 "snap back" of provider rates to 2017 levels with corresponding inflation adjustments and noted that the recent rate reductions were not cumulative, and that providers and recipients were not at risk. Finally, the Department considered the fact that primary care providers, FQHC and critical access hospitals would be held harmless so as to ensure that primary care was not impacted by the rate reductions. For a fuller response on the state's consideration of these factors, please see the state opposition and cross- motion filed with the superior court on August 30, 2019, which will be made available upon request.
8	(ANTHC and ANHB) During our in-person meeting on July 24, we asked a series of clarifying questions related to the cost containment, and we requested that all tribal services be exempt from the cuts. The department indicated that it could not answer some of those questions without further review. We still seek an answer to all the outstanding questions. *(questions an comments included in letters are listed below*)	See Department responses to the eight items below.
	8.1. Ambulatory Surgical Center Services. The Alaska Native Medical Center estimates that these rate cuts would result in a nearly $2 million loss to the ANMC alone.	Thank you for providing this information. Based on comments made during the in-person meeting, the state believes there may be some confusion surrounding the mechanism of reimbursement for these services in the tribal health system. Ambulatory surgery center claims are reimbursed at the "Grouper" rate set by the Office of Rate Review (ORR) regardless of tribal or non-tribal status.

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	8.2. Transportation and Accommodation Services. We seek clarification whether the cuts apply to patient accommodations operated by tribal health programs, which are reimbursed at federal per diem rates according to the State Plan (Attachment 4.19-B, Page 11b). In our in-person meeting the Department indicated the rate reductions would apply to these services, but the July 1, 2019 Dear Tribal Leader letter stated the cuts will only affect "services with rates set by divisions/departments within the State of Alaska."	The rate reductions apply to patient accommodations operated by tribal health programs reimbursed at federal per diem rates.
	8.3. Laboratory Services Not Billed by Independent Lab Providers. We seek further clarification whether these cuts apply to laboratory services furnished by tribal hospitals. The Department stated that these services can be billed under health professional provider types. Those billed under labs are not affected, but those billed under provider type will be affected if not listed as primary care provider. The Department indicated that specialty providers not related to the hospital would be affected. It also stated that there was a difference between a specialist and specialty provider and that there are eight specialist types which have been exempted from the rate reductions. ANMC has 175,000 specialty clinic visits a year. It is important for us to have clarification on which providers and specialties are subject to cuts as they stand now and going forward.	Services through provider type 080 - Independent Laboratory - are exempt from the rate reductions and inflation freeze. Laboratory services billed by provider types 020 Physician, 021 Health Professional Group, and 034 Advanced Practice Registered Nurse are exempt only for the following rendering provider specialties: 001 General Practice, 008 Family Practice, 009 Gynecology, 016 Obstetrics and Gynecology, 049 Pediatrics, 054 Obstetrics, 125 Adult Health, 126 Nurse Midwife, 127 Women's Health/OB/Gyn, 128 Family Health, 129 Pediatric, and 130 Gerontological are exempt. Laboratory services billed outside of an Independent Laboratory by rendering provider types not listed above will be subject to the rate reduction and inflation freeze.
	8.4. Outpatient Drugs Not Billed by Pharmacy Providers. We seek further clarification as to the specifics of how the 5% rate reduction applies to outpatient drugs that are not billed under the Pharmacy provider type. THO's typically don't / can't bill Medicaid for outpatient drugs that are not billed through the Pharmacy provider type. The Department indicated that any medicines billed through the pharmacy system (typical outpatient prescriptions) are not impacted. We are requesting that this be confirmed. It also indicated that medicines billed as a J-code which are part of an encounter and the encounter rate are not impacted. This is somewhat confusing, as medicines billed to Medicaid using a J-code as part of an encounter rate are not separately reimbursed; they are "rolled into" the encounter rate itself. The Department stated it would need to know if a billing was done by an HC group, not at the encounter rate if outside of primary care.	1) Covered outpatient drugs dispensed by entities enrolled as pharmacies (provider type - 70) are not included in the 5% rate reduction. 2) Covered outpatient drugs administered by physicians, physicians assistants, and nurse practitioners (physician administered drugs, 42 CFR 447.520; State Plan: Prescribed Drugs (G)) billed using a HCPCS code (commonly 'JCode') that previously were directly reimbursed at WAC+1% under Fee For Service (outside of any tribal encounter or bundled rate) are subject to the 5% rate reduction. Entities impacted are providers who are enrolled as Health Professional Groups (without one of the specialty designations listed below) billing on a Professional Claim type (CMS-1500). Excluded HPG provider specialty types: general practice [001], family practice [008], gynecology [009], obstetrics and gynecology [016], pediatrics [049], obstetrics, adult health [125], nurse midwife [126], women's health/OB/Gyn [127], family health [128], pediatric [129], and gerontological [130].
	8.5. Tribal Targeted Case Management. Thank you for confirming that these rates will not be impacted.	The Department made every effort to provide exemptions where feasible and is pleased to include tribal targeted case management in those exemptions.

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	8.6. Professional Services of Specialty Physicians. We seek an exemption for the professional fees of specialty physicians working for tribal health programs. We noted that most professional services for primary care providers would not be impacted. However, fees for most specialist services have been cut. These cuts have a big impact on tribal hospitals, and especially on ANMC. Physician services are not included in the IHS encounter rate for inpatient hospital services, and tribal hospitals are separately reimbursed for them. At ANMC, professional services are also reimbursed separately from a reduced outpatient IHS encounter rate. These specialty services are very expensive and difficult to secure, and the cuts will adversely impact services. As we estimate, ANMC estimates that it will lose $2.5 million from the cut here, yet because most of these services are reimbursed by the federal government at 100% FMAP, the State would save very little money ($2000-3000 per month), and all costs will be shifted to tribes. We request that tribes be exempt from this cut.	The Department is not able to meet this request because of the nature of the budget considerations the department is facing and until our requirements under (30)(A) are met. See also response to comment number 8 above. In addition, specialty physicians are being paid at 113% of the Medicare rates and received an inflationary increase in FY 19.
	8.7. Home and Community-Based Services. The Department stated that home and community-based services will not be impacted because they are provided through a separate waiver program.	The Department stated the HCBS rates are not impacted in this specific package; changes to waivers occur through a different CMS mechanism. This process will also include federally required tribal consultation.
	8.8. Applied Behavioral Health Analysis Services. We understand that these service rates will be subject to the cuts. Tribal facilities have only recently begun providing this service. Currently, without the cuts, the rates for this are very modest and inadequate. Cuts to these rates will make the services provided unaffordable. We noted that these rates were not included in the increase provided for in January 2019.	Aside from the facilities and providers that were held harmless to meet primary care considerations, cost containment strategies were applied equally across all provider types.
9	(ANTHC and ANHB) Finally, we would like to note that these rate reductions and inflation freezes also put in jeopardy the treatment of rural populations, not just Alaska Natives and American Indians. Under federal law, tribal health programs may serve non-IHS beneficiaries (i.e., individuals who would not otherwise be eligible for IHS services) only if they determine that serving them will not result in a denial or diminution of care to eligible IHS beneficiaries. In many rural communities across Alaska, Tribal Health Organizations are the only healthcare providers. If Medicaid rates are reduced and inflation freezes instituted, Tribal health providers who treat non-tribal beneficiaries in rural locations may have to stop providing services to non-IHS beneficiaries, in order to ensure that services to IHS beneficiaries are not diminished.	The Department recognizes the concerns over how these regulations will impact funding for tribal providers in FY 20. However, the Department also notes that over the past few years a number of initiatives have been implemented to improve the Tribal Medicaid program, including but not limited to the Behavioral Health Aide (BHA), Community Health Aide (CHA) and tribal transportation programs. If tribal entities are no longer able to serve non-AI/AN beneficiaries in rural and remote areas where other services do not exist, the Department requests a transition plan for which regions will be diverting services to non-tribal providers so we can anticipate the volume and target areas.

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10	(ANTHC and ANHB) We recommend that the Department exempt tribal facilities from the rate reductions and inflation freeze. We believe that this will bring maximum benefit to the State, Tribes and Tribal Health Organizations, and the patients we serve. Holding tribal providers harmless will allow the State to maximize access to 100% FMAP funding, while continuing to allow Alaska Native and American Indian Medicaid beneficiaries access to the care they need.	Tribal facilities are exempt from the rate cuts for multiple provider types for which the rates are set by the Indian Health Services (IHS) and published in the federal register. These include but are not limited to: tribal clinic and hospital services paid under the IHS rate. Rates for tribal providers not set by IHS will be treated like non-IHS providers for those provider types. For example non-primary care professional services for IHS providers who have opted out of the IHS rate will be affected by the rate cuts, just like non tribal providers.
11	(ANTHC and ANHB) Additionally, we believe federal law allows States to pay tribal and non-tribal providers at different rates. Some services are already paid differently for tribal and non-tribal providers. (For example, only tribal hospitals are paid at IHS encounter rates, CMS will allow States to pay tribal and non-tribal FQHCs at IHS rates, and tribal pharmacies are reimbursed at lower rates than non-tribal pharmacies for covered outpatient drugs.) We recommend that the Department consider expanding this to allow tribal facilities to be as little impacted by rate reductions and inflation freezes as possible.	To the extent ANTHC and ANHB are seeking to create a third tier of payment for services reimbursed by the Department for tribal providers not subject to the encounter rate, this recommendation cannot be implemented at this time. This is a complex effort to implement and manage in the Enterprise system and the Department is not able to add a new tier of reimbursements while we manage all of the other changes required this fiscal year. However, we are willing to talk to you further about this idea during regularly scheduled meetings during this fiscal year.
12	(ANTHC and ANHB) We hope the Department will consider these recommendations, and we remind you that Tribes and Tribal Health Organizations have already collaborated with the State to lower Medicaid costs overall, such as through the expansion of Care Coordination Agreements. It is in our best interest as well as the State’s to keep costs as low as feasible so that we can provide more care to more people.	The Department agrees with this comment and appreciates the efforts that the Tribal Health Organizations have undertaken to maximize federal claiming for services provided to tribal beneficiaries. There is more work to be done and we look forward to continuing this collaboration in the coming year. These costs savings will assist the Department in meeting its budget goals so as to mitigate further reductions to the program as a whole and to tribes and tribal health providers.
13	(NSHC, MA, APIA) submit these comments to oppose the State of Alaska's proposal to submit a state plan amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) to implement cost containment measures. We request tribal consultation, which as discussed [below] has not yet occurred due to the State's unwillingness to discuss any aspect of its rationale for implementing the cuts.	The department complied with the tribal consultation policy, which was deemed by CMS in 2012 to be in compliance with the cited authorities. See also response to comment numbers 1, 2, 4, 6 and 15.

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14	(NSHC, MA, APIA) has serious concerns about how the proposed SP A will affect both quality of care and equal access to care for Alaska Native/American Indian Beneficiaries. In your July 1, 2019 letter, you stated that you did not anticipate that the proposed rate reductions would have any negative impact on the Alaska Tribal Health System (ATHS) or the Medicaid beneficiaries we serve. This may be due to the assumption that because the rate cuts do not affect reimbursement at the IHS 0MB rate, the cuts will not affect the ATHS or its beneficiaries. Yet as discussed below, and as made clear during the initial call between the State and tribal representatives last week, many services provided by the ATHS are billed under the various fee schedules the State proposes to cut. These services are largely reimbursed by CMS to the State at 100 percent FMAP, so there would be no impact to the State budget if the ATHS would be exempt from the cuts. We urge the State to engage in tribal consultation to discuss these concerns prior to submitting a SPA to CMS.	The Department implemented cost containment across the board for both tribal and non-tribal providers to create equanimity across the system. The Tribal rates set by IHS for tribal clinic and hospital services are not included in cost containment as answered above.
15	(NSHC, MA, APIA) Tribal consultation is required by statute prior to submitting a SP A to the Centers for Medicare & Medicaid Services (CMS). Section 5006(e) of the American Recovery and Reinvestment Act of 2009 (ARRA) requires that states with Indian health programs solicit advice from them "prior to submission of any plan amendments ... likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations." 42 U.S.C. § 1396a(a)(73). Additionally, CMS's Tribal Consultation Policy requires states to "seek advice from Indian health providers, which includes ... tribal health programs ... prior to submission of SP As." CMS Tribal Consultation Policy§ 6.3 (Dec. 10, 2015). To date, the State has not engaged in tribal consultation. On a recent call with tribal representatives, the State refused to discuss any aspect of its reasons for the proposed Medicaid rate cuts because of pending litigation. The only explanation provided was the "budget policy," but when requested, the State declined to provide it. Consultation requires - at a bare minimum - for the State to provide a reason for the changes it is proposing to make to the Medicaid program. The State has provided none. It must do so in order to satisfy its federal obligation to consult with tribes. Until it does so, it cannot submit the SPA to CMS. As discussed below, we have serious concerns about the impact the proposed SPA would have on [NSHC] and our patients, and we urgently request that the State fulfill its tribal consultation obligations.	The Department complied with the tribal consultation policy, which was deemed by CMS in 2012 to be in compliance with the cited authorities. The Department has not submitted the SPA prior to tribal consultation. See also response to comment numbers 1, 2, 4, 6 and 13.

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16	(NSHC, MA, APIA) [...] is deeply concerned about the impact the proposed SPA will have on quality of care and access to care. The Medicaid statute provides that state plans for medical assistance must: provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan ... as may be necessary ... to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlists enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. 42 U.S.C. § 1396a(a)(30)(A). To implement section 30(A)'s requirements regarding efficiency and economy, CMS established the upper payment limit (UPL) by regulation, capping aggregate Medicaid reimbursements to a state at what the Medicare program would have paid facilities for services. 42 C.F.R. § 447.272. CMS explicitly exempts Indian Health Service (IHS) and tribal facilities from the UPL: (c) Exceptions- (1) Indian Health Service and tribal facilities. The limitation in paragraph (b) of this section [i.e., the upper payment limit] does not apply to Indian Health Service facilities and tribal facilities that are funded through the Indian Self-determination and Education Assistance Act (Pub. L. 93-638).	See response to comment number 7.

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<tr><th>#</th><th>Comments Taken from Tribal Written Submissions</th><th>State Response</th></tr>
<tr><td>15</td><td>(NSHC, MA, APIA) Id. § 447.272(c)(l). CMS, therefore, has provided the State with the ability to exempt tribal health programs from rate cuts without exceeding the UPL.
In addition to this federal framework, Alaska law requires that rates be set in accordance with the Medicaid statute. AS § 47.07.070(a). This requires an assessment of whether the rate decreases will impact quality of care and equal access to care. Alaska law also goes further than federal law in also requiring the State to consider the "reasonable costs related to patient care" in setting Medicaid reimbursement rates. AS§ 47.07.070(b). There is no indication the State has taken any of this into consideration, as it has not provided any reason at all for the rate cuts, other than budget cuts. The State may not lawfully implement these rate cuts without assessing their potential impact on quality of care and access to care.
The proposed SPA contains across-the-board inflation freezes and rate reductions that will impact skilled nursing facilities, long term services and supports targeted case management, specialist services, and other critical services. It remains unclear how the proposed SPA will impact tribal health programs, which bill under a variety of payment systems, and whether the State has considered the costs of patient care. For example, even if the IHS OMB rates are not impacted, a reduction in rates under which providers who work at NSHC facilities bill may impact those providers' ability to serve NSHC's Medicaid patients.
Additionally, under section 813(c) of the Indian Health Care Improvement Act (IHCIA), tribes can only serve non-Indian Medicaid beneficiaries if doing so would not result in diminution of services to Indians. 25 U.S.C. § 1680c(c). If the rate cuts affect tribal health care providers' ability to continue to provide services to Indians, then they may have to stop serving non-Indians. In many parts of the State, the only providers are Indian health care providers. This would mean that many non-Indian Medicaid beneficiaries could lose all access to care if the State implemented the rate cuts and Indian health care providers stopped serving non-Indians.</td><td>The Department agrees that the Upper Payment Limit (UPL) reductions for Nursing Homes do not apply to tribes or Tribal Health Organizations. Please note that the reductions contemplated by this regulation process and SPA do not relate to an UPL calculation. The Department will be submitting an updated Access Review Monitoring Plan (AMRP) as part of the state plan amendment submission. Additionally the state will be submitting addendums to the AMRP for the time period affected by the rate adjustments after a retro-active claim review.</td></tr>
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ANHB - Alaska Native Health Board
ANTHC - Alaska Native Tribal Health Consortium
APIA - Aleutian Pribilof Islands Association
NSHC - Norton Sound Health Corporation