ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

SENT VIA EMAIL: *jetta.whittaker@alaska.gov*
courtney.king@alaska.gov

November 27, 2017

Ms. Jetta Whittaker
Ms. Courtney King
Alaska Department of Health and Social Services
P.O. Box 110680
Juneau, AK 99811-0680

Re: Proposed Regulation Changes on Medicaid Coverage and Payment for Various Long-Term Services and Supports (LTSS)

Dear Ms. Whittaker & Ms. King:

The Alaska Native Tribal Health Consortium (ANTHC) is a statewide tribal health organization that serves all 229 tribes and more than 158,000 Alaska Native and American Indian (AN/AI) individuals in Alaska. ANTHC and Southcentral Foundation co-manage the Alaska Native Medical Center, the tertiary care hospital for all AN/AIs in Alaska. ANTHC also provides a wide range of statewide public health, community health, environmental health and other programs and services for Alaska Native people and their communities.

We are pleased to provide comment on the Department of Health & Social Services (DHSS) proposed waiver changes and regulations on Medicaid coverage that establish a Community First Choice program, related Targeted Case Management services, and related Medicaid payment rates. Our recommendations broadly describe several recommended policy and program changes that would make it more feasible for tribal health organizations (THOs) to deliver these vital services. However, we recommend additional consultation through face-to-face or teleconference meetings to discuss these topics further, and answer questions that the Department may have concerning our recommendations, so that THOs are able to deliver the full array of long-term services and supports under the proposed waivers and regulations.

7 AAC 105.200. Eligible Medicaid providers.

The proposed regulations refer to 7 AAC 105.200(c), which the department has not specifically identified for amendment. However, we request the Department to review all the relevant proposed and current regulations in their entirety and make any further changes to the regulations, Conditions of Participation, application forms, and related materials that maybe needed to fully-implement our recommendations. As drafted 7 AAC 105.200(c) only applies to a health care provider who is an employee of the federal government assigned to a tribal health program, is exempt from state licensing requirements. We request that 7 AAC 105.200(c) be amended 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:

Alaska Native Tribal Health Consortium
4000 Ambassador Drive, Anchorage, Alaska 99508
Main: (907) 729-1900 | Fax: (907) 729-1901 | anthc.org

> 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.).

We underline our recommended new language at 7 AAC 105.200(c).

(c) Notwithstanding any other provision of 7 AAC 105 – 7 AAC 160, and if the employee has an active license from a jurisdiction in the United States, a health care provider who is an employee of a tribal health program as defined in 7 AAC 160.990, or who is an employee of the federal government assigned to a tribal health program, is exempt from any requirement in 7 AAC 105 – 7 AAC 160 that the provider be licensed, certified, or registered by this state to be eligible under this section.

7 AAC 127.020. Community First Choice Services Long Term Services and Supports case management.

We urge the Department to make changes to all "conflict-free" care management/care coordination provisions to ensure that AN/AI beneficiaries are able to receive both direct home-and-community-based services and care management/coordination from a 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 AN/AIs, 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 AN/AIs 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 AN/AIs to be served by THOs in this way is contrary to federal laws and policy addressing the interplay between Medicaid and the tribal health

[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.

system. Federal laws recognize the importance of ensuring AN/AIs 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 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 AN/AI 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 AN/AI 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 AN/AI 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 AN/AIs 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.

We underline our recommended new language at 7 AAC 127.020(b).

(b) A provider of Personal Care Services under 7 AAC Chapter 125 or Home and Community-based Waiver Services Under 7 AAC Chapter 130, or those who have an interest in or are employed by a provider of Personal Care Services or Home and Community-Based Waiver Services, may not provide services under this section for an individual unless the provider has been granted an exception under 7 AAC 130.220(j) or is a tribal health program as defined in 7 AAC 160.990.

7 AAC 127.075. Community First Choice personal care services place of service.

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-

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

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 AN/AI 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 AN/AIs we serve.

We underline our recommended new language at 7 AAC 127.075(a).

(a) Community First Choice personal care services may be provided only to a recipient who is living in the recipient's personal residence or in a residential facility, not excluded under (b) of this section, that is owned or controlled by a tribal health program as defined in 7 AAC 160.990.

7 AAC 130.220 Provider certification.

We reiterate our request that the Department review all the relevant proposed and current regulations in their entirety and make any further changes to the regulations, Conditions of Participation, application forms, and related materials that maybe needed to fully-implement our recommendations. 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 one to four years' experience supervising two or more staff who worked in a human service setting -- supervisory experience that may be impossible to acquire in smaller programs and communities. ANTHC recommends the Department to work with THOs to establish more flexible and achievable standards for tribal programs. One option 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).

We underline our recommended new language at 7 AAC 130.220(a).

(a) Unless the department grants an exception under (j) of this section or the provider agency is a tribal health program as defined in 7 AAC 160.990, the department will only certify a provider agency, with respect to each eligible category of home-and-community based waiver recipients, as either a provider of one or more home and community-based waiver services under (1) or (3) of this subsection or as a provider of care coordination services for those same categories of recipients under (2) of this subsection, as follows: …"

We thank you for the opportunity to provide our comment and recommendations to establish the Community First Choice waiver and related Targeted Case Management services. If you should have any questions, please contact me directly at (907) 729-1908 or at gmoses@anthc.org.

Sincerely,

Gerald Moses
Senior Director of Intergovernmental Affairs