Alaska Native Health Board

THE VOICE OF ALASKA TRIBAL HEALTH SINCE 1968

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April 26, 2022

Courtney O'Byrne King, Medicaid State Plan Coordinator
Alaska Department of Health & Social Services
3601 C Street, Suite 902
Anchorage, AK 99503

RE: Proposed Medicaid State Plan on Third-Party Liability

Dear Ms. King,

The Alaska Native Health Board (ANHB)[1] submits these written comments and questions in the Tribal Consultation on the proposed Medicaid State Plan Amendment (SPA) on Third-Party Liability (TPL). This letter supplements our exchange during the in-person tribal consultation held last week. We thank you for that informative and helpful meeting, and for being so open to considering the interests, needs, advice, and requests of the Alaska Tribal Health System.

1. **Tribal providers are exempt from TPL requirements because they are "payers of last resort" even as to Medicaid.**

As we discussed during our in-person meeting, our principal request and strong recommendation is that the Department formally recognize, and memorialize in the language of the SPA, that because the Indian health system is the ultimate "payer of last resort," secondary even to Medicaid, tribal health programs have no obligation to bill other potentially liable third parties before Medicaid, and enjoy a complete exemption from the "third party liability" requirements that would otherwise apply under the proposed SPA.[2]

We recognize that this is a new request, and that tribal providers have not previously raised any formal objection to the Department's past practice of applying the same TPL requirements to tribal and non-tribal providers alike. But with TPL requirements about to be applied to previously-waived services, it is time to revisit and reconsider that past practice, which we believe is contrary to federal law.

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[1] 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 180,000 Alaska Native and American Indian people throughout the state. The ATHS administers clinical and public health programs for AI/AN people throughout the state of Alaska. As the statewide tribal health advocacy organization, ANHB supports Alaska's Tribes and Tribal programs achieve effective consultation and communication with state and federal agencies on matters of concern.

[2] We recognize that the State is required to amend its State plan to meet the statutory requirements of the Bipartisan Budget Act (BBA) of 2018 and the Medicaid Services Investment and Accountability Act (MSIAA) of 2019, given Centers for Medicare & Medicaid Services' (CMS) decision to stop waiving those requirements.

As you know, and as the Department has recognized in other contexts, federal law makes the IHS and tribal health programs "payers of last resort," secondary even to Medicaid. This is most clearly stated in the Indian Health Care Improvement Act (IHCIA), which states:

> Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations […] shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, *notwithstanding any Federal, State, or local law to the contrary.*[3]

As we see it, because tribal programs are the payers of last resort *after Medicaid*, they cannot legally be required to bill any other payer ahead of Medicaid, as would otherwise be required under the proposed SPA. Rather, they should be entitled to rely on their "last resort" status to bill Medicaid *in the first instance,* and leave it to the Medicaid program to pursue reimbursement from any other potentially liable third parties. Put differently, we believe the Medicaid program must follow a "pay and chase" practice for all services furnished by Alaska Tribal Health organizations, regardless of whether those services are also covered by Medicare or other payers to which Medicaid is secondary.

We believe that exemption from TPL requirements is inherent in "payer of last resort" status and in the very meaning of that phrase. Our interpretation is supported by several statements in CMS's "Coordination of Benefits and Third-Party Liability in Medicaid (COB/TPL)" handbook (2020), even though the handbook does not address the issue squarely. The handbook explains that Medicaid's Third Party Liability rules flow from Medicaid's usual status as the payer of last resort, and notes that "there are a few exceptions to the general rule that Medicaid is the payer of last resort[,]" including for IHS programs.[4] It states that "IHS is a secondary payer to Medicaid," and instructs that State Medicaid Agencies "will pay for medical expenses that would otherwise be covered by an IHS program," and notes that "IHS will stand behind Medicaid to pay for services that … Medicaid does not cover."[5]

We think the law is clear that tribal programs, as the ultimate payers of last resort, are exempt from complying with Medicaid TPL requirements. But even if the law is ambiguous, we note that federal Indian laws, like the IHCIA, are required to be interpreted liberally in favor of the Indian person or entity.[6] Liberal interpretation in favor of tribal interests is also required by the Indian Self-Determination and Education Assistance Act (ISDEAA), the federal law that authorizes Alaska tribal health organizations to operate their health programs in the IHS's place. "[7]

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[3] 25 U.S.C. 1623(b) [emphasis added].

[4] CMS, Coordination of Benefits and Third Party Liability (COB/TPL) In Medicaid 2020, (https://www.medicaid.gov/medicaid/eligibility/downloads/cob-tpl-handbook.pdf) at p. 20

[5] *Ibid.*, page 70.

[6] Statutes concerned with Indian affairs "are to be construed liberally in favor of the Indians, with ambiguous provisions interpreted to their benefit[.]" *Montana v. Blackfeet Tribe of Indians*, 471 U.S. 759, 766 (1985) (citations omitted); see also *Swinomish Indian Tribal Community v. BNSF Railway,* 951 F.3d 1143 at 1156 (9th Cir. 2020).

[7] "[E]ach provision of this chapter and each provision of a contract or funding agreement shall be liberally construed for the benefit of the Indian Tribe participating in self-determination, and any ambiguity shall be resolved in favor of the Indian Tribe." 25 U.S.C. § 5321(g). This well-established rule of interpretation is also reflected in CMS's tribal consultation policy, which provides that, "[t]o the extent permitted by law, when undertaking to formulate and implement policies that have tribal implications, CMS shall [e]ncourage Indian tribes to develop their own policies to achieve program objectives; … defer to Indian tribes to establish

Consequently, we hereby formally advise and request the Department to include language in the SPA that recognizes a TPL exemption for tribal health programs. We respectfully suggest some wording to accomplish this, based on the draft SPA you generously provided for our review. We provide four options:

- Add the underlined language to the proposed language in Paragraph I: "Exceptions exist for Tribal Health Organizations, claims specified in 42 C.F.R. 433.139(b)(3)(i) and (ii), and any approved cost avoidance waivers." To us, this is the clearest and simplest option.
- Alternatively, instead of expressly referring to tribal health providers, substitute the statutory authority that makes them payers of last resort, by adding the underlined language to Paragraph I: "Exceptions exist for providers that are payers of last resort under the authority of 25 U.S.C. 1623(b), claims specified in 42 C.F.R. 433.139(b)(3)(i) and (ii), and any approved cost avoidance waivers."
- To more broadly recognize an exception for all programs that pay second to Medicaid under federal law, add the underlined language to Paragraph I; "Exceptions exist for programs and providers that under federal law pay second to Medicaid, claims specified in 42 C.F.R. 433.139(b)(3)(i) and (ii), and any approved cost avoidance waivers."
- Finally, it may be possible to make no changes to the current draft language, *if the Department and CMS confirm in writing* that the following italicized language in the draft provides an exception for tribal health programs pursuant to 25 U.S.C. 1623. *"Unless federal law excludes claims for medical services,* claims are cost-avoided when a third-party liability policy exists within the claims payment system."

If the Department is not confident of its authority or duty to recognize a TPL exception for tribal health programs, we would be pleased, if the Department would find it helpful, to raise the issue with CMS or to engage with the Department in a joint consultation with CMS on the subject.

2. Similarly, Tribal Self Insurance Plans are "payers of last resort" after Medicaid, and are also exempt from Medicaid TPL requirements

For similar reasons, we ask the Department to recognize a TPL exception for "tribal self-insurance plans (TSIPs)" which are recognized under federal law as payers of last resort secondary not only to Medicaid, but even to the IHS itself. Although we do not know whether there are any such plans in Alaska now, it would be prudent for the SPA to anticipate the possibility that they will be established in the future, and to make clear that they are not subject to Medicaid's TPL requirements.

As you may know, the Indian Health Service operates a "Purchased and Referred Care Program (PRC), formerly known as "contract health services," which authorizes and pays for services furnished by no-IHS/tribal providers to IHS beneficiaries, subject to certain limitations and the availability of funds. The PRC program has TPL and Coordination of Benefit Rules TPL rules that are similar to Medicaid's: if a patient has an "alternate resource" that could cover the cost of the

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standards; and …consult with tribal officials as to the need for federal standards and any alternatives that would limit the scope of federal standards or otherwise preserve the prerogatives and authority of Indian tribes." Centers for Medicare & Medicaid Services, Tribal Consultation Policy § 5.6 (2015), (https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSTribalConsultationPolicy2015.pdf).

care, that resource must be exhausted before the PRC program will pay anything for the patient's care.

The applicable federal regulation, 42 C.F.R. 136.61, treats virtually all other State, federal, local, and private insurance programs as "alternate resources," specifically including Medicaid.[8] But as the IHS interprets the rule, TSIPs are not an "alternate resource." Rather, they are the payer of absolute last resort, secondary not only to Medicaid, but even to the IHS itself. [9]

As defined by IHS, a TSIP is:

> A plan that is funded solely by a Tribe or Tribal organization and for which the Tribe or Tribal organization assumes the burden of payment for health services covered under the plan either directly or through an administrator. Any portion of the cost of care that is the responsibility of a reinsurer or stop loss plan will not be considered Tribal Self-Insurance. [10]

That is to say, a TSIP is a tribally-funded health insurance plan (usually established to cover tribal members, families, and/or employees) that pays directly for its beneficiaries' health care services, up to any amount above which the tribe holds re-insurance or stop-loss coverage, and thus bears the financial risk of that care. The IHS recognizes that it would be contrary to the federal trust responsibility for Indian Health to shift onto TSIPs the cost of health care services furnished to IHS beneficiaries.

We submit that this is equally true with respect to the Medicaid program as with respect to the PRC program. As evidenced by the 100% FMAP rate Congress specified for services furnished to IHS beneficiaries by tribal health programs, the Medicaid program plays an important role in helping fulfill the federal trust responsibility for Indian health. Just as the IHS PRC program must not shift onto tribally-funded TSIPs the cost of health services furnished to IHS beneficiaries, neither should Medicaid. TSIPs should be fully exempt from both PRC and Medicaid TPL rules.

We thus ask that the Department include language in the SPA that exempts both Tribal health programs and TSIPs from the Medicaid TPL requirements. This could be done, for example, by

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[8] 42 C.F.R. § 136.61 Payor of last resort.
(a) The Indian Health Service is the payor of last resort for persons defined as eligible for contract health services under the regulations in this part, notwithstanding any State or local law or regulation to the contrary.
(b) Accordingly, the Indian Health Service will not be responsible for or authorize payment for contract health services to the extent that:
(1) The Indian is eligible for alternate resources, as defined in paragraph (c) of this section, or
(2) The Indian would be eligible for alternate resources if he or she were to apply for them, or
(3) The Indian would be eligible for alternate resources under State or local law or regulation but for the Indian's eligibility for contract health services, or other health services, from the Indian Health Service or Indian Health Service funded programs.
(c) Alternate resources means health care resources other than those of the Indian Health Service. Such resources include health care providers and institutions, and health care programs for the payment of health services including but not limited to programs under titles XVIII or XIX of the Social Security Act (i.e., Medicare, Medicaid), State or local health care programs, and private insurance.

[9] Indian Health Service, Indian Health Manual, Chapter 3, "Purchased and Referred Care," 2.3-8(H), (https://www.ihs.gov/ihm/pc/part-2/chapter-3-purchased-referred-care/#2-3.8H).

[10] Indian Health Service, Indian Health Manual, Chapter 3, "Purchased and Referred Care," § 2-3.1F(30), https://www.ihs.gov/ihm/pc/part-2/chapter-3-purchased-referred-care/#2-3.1F

adding the underlined language to the proposed language in Paragraph I: "Exceptions exist for Tribal Health Organizations, Tribal Self-Insurance Plans, claims specified in 42 C.F.R. 433.139(b)(3)(i) and (ii), and any approved cost avoidance waivers." If the Department is not confident of its authority or duty to recognize a TPL exception for TSIPs we would be pleased to raise the issue with CMS or to engage with the Department in a joint consultation with CMS on the subject.

3. Other Issues.

We have several questions and concerns that will be fully resolved if, as we have urged, the Department confirms that Tribal Health Organizations and TSIPs are not subject to the TPL requirements. But in case that does not occur, or if it cannot occur without CMS consultation, we request clarification on the following topics.

3.1. Opting out of Medicare.

During our in-person consultation (and in our separate discussions on the Tribal Clinic "four walls" issue and the "Tribal FQHC" option), the Department confirmed that Tribal programs may elect to be Tribal FQHCs for Medicaid only, and they are not required to enroll in Medicare. Further, you confirmed that the decision not to enroll the FQHC in Medicare would not adversely affect the amount Medicaid would pay for the FQHC's covered services.

Kindly confirm in writing that this is also the case with respect to other provider types and services. Our understanding has been that Tribal Health Organizations are *never* required to enroll in Medicare as a condition of billing Medicaid for their services, even if Medicare would cover some or all of its services if the tribal organization did enroll in Medicare. Rather, as payers of last resort, tribal health organizations may always choose to be Medicaid-only providers, and that choice does not mean they cannot bill Medicaid for services they furnish to patients who are dually eligible for both Medicare and Medicaid, or reduce the amount they will be reimbursed by Medicaid for those services.

We note that tribal health organizations may decide not to enroll in Medicare for any number of reasons, for example: because most of their patients are not eligible or enrolled in Medicare, few or none of their services are covered by Medicare, Medicare coverage for their services is limited or Medicare reimbursement rates are too low, they lack the resources to comply with Medicare's administrative requirements or have decided those resources should be used to address other needs, or the cost of participating in Medicare exceeds its benefits. Although any category of provider might reasonably opt against enrolling in Medicare, that choice might be particularly sensible for tribal providers of children's services, behavioral health services, and home- and community-based services.

3.2. Services furnished to "Dually Eligible" Beneficiaries.

For tribal health organizations that are enrolled providers in both Medicaid and Medicare, kindly clarify whether the TPL rules would apply to them for services they furnish to dually eligible patients. As payers of last resort, are tribal health organizations free to bill Medicaid promptly and without first billing Medicare or waiting 90 days, regardless of whether Medicare also covers the service?

What if the service is one that Medicare does not cover, but it is not on the "never covered list" because some other insurance plan does cover it? Could the Department publish a separate list of "Medicare Never Covers" codes, or clearly identify in its "never covered" which services, if any Medicare covers?[11]

3.3. VA Benefits and application of Medicaid TPL Requirements.

VHA eligible individuals may pose a unique question as part of the implementation of the new TPL requirements. There are some beneficiaries who are dually or triply eligible as VA/Medicaid or VA/Medicare/Medicaid beneficiaries, and some of these beneficiaries are free to choose which benefits apply, as explained in the Alaska Medicaid Tribal Billing Manual.[12] For such beneficiaries who are able to elect their benefit of choice between VA or Medicaid, Tribes asked if there would be a need to provide a VA denial to bill Medicaid. During our in-person consultation, the Department shared that the election process would continue as it does now. Can the Department confirm this in writing, including that if a beneficiary, identified as code "N" per the Billing Manual, will not need to provide a VA denial of benefits to submit a claim to Medicaid in the first instance?

Further, beneficiaries marked with resource code "N2" already require letter of denial from the VA to submit a VA denial letter to bill Medicaid. However, some veterans can elect either Medicare or VA benefits as their primary coverage, but once paid, either the VA or Medicare will not pay above the Medicare rate. Our question for this class of beneficiaries, is whether the provider will need to submit a denial of benefits from both Medicare and VA in order to submit claims to Medicaid. During our in-person consultation, the Department confirmed that once VA or Medicare has reimbursed, the other will not provide reimbursement for the service, and that only a confirmation of payment by one of these entities is necessary to follow up and submit claims for the second instance for beneficiaries who are triply eligible. Can the Department confirm this in writing?

3.4. Transportation and Accommodation Services.

In our in-person consultation, you confirmed that transportation and accommodation services, with one exception, are not covered by payers other than Medicaid, and will thus be included on the initial list of "Never Covered Codes." We appreciate the confirmation, especially given how vital these services are to Medicaid beneficiaries who live or work in rural or remote communities, most of whom are Alaska Natives and American Indians. However, we also encourage the Department to increase Medicaid payment rates for these providers, especially for hotels and particularly during the tourist season. These providers are in scarce supply, and we believe that rates must be substantially increased to ensure all Alaska Medicaid beneficiaries have adequate access to services.

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[11] We note that CMS's COB/TPL Handbook says this about services to dually eligible beneficiaries: "For dually eligible beneficiaries, Medicare is generally liable for claims, and thus SMAs [State Medicaid Agencies] are required to cost-avoid claims for dually eligible beneficiaries. Some Medicaid benefits, however, are not covered by Medicare, meaning that Medicare has no legal obligation to pay for the service. Accordingly, SMAs are not required to cost-avoid claims for services provided to dually eligible beneficiaries that are only covered by Medicaid." CMS, Coordination of Benefits and Third Party Liability (COB/TPL) In Medicaid 2020, (https://www.medicaid.gov/medicaid/eligibility/downloads/cob-tpl-handbook.pdf) at p. 46.

[12] Alaska Dept. of Health & Social Services, Alaska Medicaid Tribal Billing Manual, accessed April 26, 2022 (https://manuals.medicaidalaska.com/tribal/tribal.htm), sec. "Billign Third-Party Liability", "Payer of Last Resort".

3.5. CHA/P, BHA/P, and DHA/T Services.

Thank you for confirming in our in-person consultation that, because other payers do not cover them, services furnished by certified Community ~~Behavioral~~ Health Aides and Practitioners and by Behavioral Health Aides and Practitioners will not be subject to the TPL requirements (nor have they ever been), and tribal health programs may bill Medicaid for their services without waiting or first (fruitlessly) billing Medicare or other payers. We would appreciate receiving this assurance in writing.

Please also confirm that the same is true for services furnished by Dental Health Aides and Therapists.

We understand that some other state's Medicaid programs cover, or will soon cover, services furnished by other provider types that are unique to the Indian health system, such as Traditional Healers and Community Health Representatives. Assuming no other changes to applicable law or the Medicaid State Plan, are we correct that, if Alaska Medicaid extends coverage to services furnished by additional tribal provider types, the TPL requirements would not apply to those services, provided no other payers cover them?

4. Our thanks.

Finally, some words of thanks.

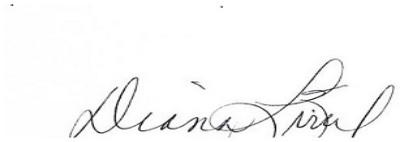
First, we would like to thank and acknowledge the Department for the work it has done to try to minimize the adverse impact the changes will have on Medicaid providers that will be subject to the TPL requirements. We especially appreciate the decision to publish a list of "Never Covered Codes," and to update the list for each calendar year.

Second, thank you for extending the deadline for these written comments several days, to accommodate our busy schedules last week.

Last, but by no means least, thank you for what has again been a very positive consultative experience – for listening carefully to our concerns, and for being open to our suggestions and requests. By continuing to work together in this constructive and respectful fashion, we can best serve the individuals and communities that depend upon the Alaska Medicaid Program and the Alaska Tribal Health System.

Should the Department or CMS have any questions regarding our recommendations and comments in this letter, you may contact ANHB at anhb@anhb.org or via telephone at (907) 729-7510.

Duk'idli (Respectfully),



Diana L. Zirul
Chair, Alaska Native Health Board
Tribally-Elected Leader of the Kenaitze Tribal Council