National Indian Health Board

Submitted via *regulations.gov*

February 26, 2016

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9936-N
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Comments on CMS-9936-N; Waivers for State Innovation

I write on behalf of the National Indian Health Board (NIHB) regarding the notice titled "Waivers for State Innovation" (CMS-9936-N) and published by CMS and the Department of the Treasury (Agencies) in the December 12, 2016, Federal Register. This notice, which relates to section 1332 of the Patient Protection and Affordable Care Act (ACA) and its implementing regulations, indicated that the Agencies would accept comments at any time from interested parties.

Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/AN). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

We appreciate the opportunity to provide comments on ACA section 1332, which provides the Secretaries of Health and Human Services (HHS) and the Treasury (Secretaries) with the

discretion to approve a state proposal to waive specific provisions of ACA (State Innovation Waiver), provided that the proposal meets certain requirements.

Specifically, these comments reiterate our ongoing concerns that a State Innovation Waiver could result in American Indians and Alaska Natives (AI/ANs) having higher cost-sharing or having greater premium payments than they would have had absent the waiver, potentially reducing their access to quality health care services. Though we acknowledge the previous efforts of the Agencies to respond to this issue, we believe they can take additional steps to protect AI/ANs.

In summary, to ensure that a State Innovation Waiver does not adversely affect AI/ANs, we recommend that representations made by a state and determinations made by the Secretaries pertaining to a state satisfying the requirements for granting waivers under ACA sections 1332(b)(1)(A), (B) and (C) should consider the specific impact on each individual AI/AN and not limit the representations to the overall, or average, impact on the population as a whole.

We also ask CMS to ensure that protections afforded to AI/ANs under section 1932 of the Balanced Budget Act of 1997 (BBA) and section 5006 of the American Recovery and Reinvestment Act of 2009 (ARRA) continue to apply under any State Innovation Waiver involving Medicaid beneficiaries.

Statutory Authority and Background

Under ACA section 1332, the Secretaries, as appropriate, can exercise their discretion to approve a request for a State Innovation Waiver only if they determine that the proposal meets the following four requirements:

(1) The proposal will provide coverage to at least a comparable number of state residents as would occur absent the waiver;
(2) The proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending at least as affordable for state residents as would occur absent the waiver;
(3) The proposal will provide coverage at least as comprehensive for state residents as would occur absent the waiver; and
(4) The proposal will not increase the Federal deficit.

The Secretaries retain their discretionary authority under Section 1332 to deny waivers when appropriate given consideration of the application as whole, including the four requirements. As under similar waiver authorities, the Secretaries reserve the right to suspend or terminate a waiver, in whole or in part, any time before the date of expiration, if they determine that the state materially failed to comply with the terms and conditions of the waiver.

Final regulations at 31 CFR part 33 and 45 CFR part 155, subpart N require a state to provide actuarial analyses and actuarial certifications, economic analyses, data and assumptions, targets, an implementation timeline, and other necessary information to support its estimates that the proposed waiver will comply with these requirements. CMS-9936-N provides additional guidance about the requirements that a state must meet, the application review procedures of the Secretaries, the amount of pass-through funding, certain analytical requirements, and operational considerations.

Discussion

Indian-Specific Protections Under ACA

On May 13, 2011, TTAG submitted comments to the Agencies in response to CMS-9987-P, Application, Review, and Reporting Process for Waivers for State Innovation, which set forth a procedural framework for submission and review of initial applications for a State Innovation Waiver, including processes to ensure opportunities for public input in the development of such applications by states and in the federal review of the applications. In those comments (see attached document), TTAG in its analysis noted that ACA contains a number of Indian-specific protections—some within the Section 1332 waiver authority of the Secretaries and some outside this authority—and outlined several scenarios under which a State Innovation Waiver could have a direct negative impact on AI/ANs and I/T/Us because of changes in Indian-specific and non-Indian specific provisions of the law.

To ensure that a State Innovation Waiver would not infringe on these protections, TTAG asked the Agencies to modify 45 CFR 155.1308 to require states with at least one I/T/U to provide in their waiver application, along with other data, an explanation of the impact that the waiver would have on AI/AN residents. TTAG specifically recommended that the Agencies add to 45 CFR 155.1308(a)(2)(iv)(D)(4) the following paragraph:

> (iii) A explanation of how the waiver will meet the requirements of sections 1332(b)(1)(A), (B) and (C) of the Affordable Care Act as they pertain to American Indian and Alaska Native residents of the State.

In CMS-9987-F, issued on February 27, 2012, the Agencies declined to add this language to the regulations. However, the Agencies indicated that they would consider this and other recommendations regarding the State Innovation Waiver approval process in the future.[1]

NIHB reiterates its previous recommendation in the comment and further asks the Agencies, either through regulation or guidance, to:

> Clarify that the four assurances and requirements indicated above as necessary predicates before approval is granted of a State Innovation Waiver are specific to each AI/AN.

Adoption of this clarification would ensure that no individual AI/AN would be, for instance, subject to greater premium payments or cost-sharing requirements under a State Innovation Waiver than would the individual AI/AN without implementation of such waiver.

Indian-Specific Protections Under BBA and ARRA

BBA and ARRA provide a number of Indian-specific protections associated with Medicaid and Medicaid managed care, and TTAG seeks to ensure that these protections remain in effect under any State Innovation Waiver approved by the Secretaries.

BBA established section 1932(a)(2)(C) of the Social Security Act, which provides that no state can require AI/ANs to enroll in a Medicaid managed care system, except in cases in which an I/T/U operates the system. This requirement protects AI/ANs and I/T/Us from the difficulties of participating in Medicaid managed care systems that lack experience or incentive to work with Indian health systems. In addition, this requirement ensures that AI/ANs and I/T/Us can continue to access Medicaid on a fee-for-service basis without having to go through a private managed care contractor as an intermediary.

[1] The Agencies also stated, "Further, we clarify that section 1332(a)(2) of the Affordable Care Act clearly defines the scope of authority under section 1332, and does not extend to subtitle A of title I of the Affordable Care Act, which includes the market reform provisions, or section 1557 of the Affordable Care Act, which includes the nondiscrimination provisions" (77 FR 11705).

To its credit, CMS has recognized the issues posed by mandating managed care in Indian country and to date has rejected every attempt by states to waive section 1932(a)(2)(C) through a section 1115 demonstration waiver, including waiver requests related to the optional Medicaid expansion under ACA. Accordingly, TTAG asks the Agencies, either through regulation or guidance, to:

> Emphasize the importance of maintaining the Indian-specific protections contained in section 1932(a)(2)(C) under a State Innovation Waiver.

As a supplement to section 1932(a)(2)(C), ARRA section 5006 provides a number of protections for AI/ANs who elect to enroll in Medicaid managed care. These protections include:

- A prohibition on the imposition on AI/ANs of any enrollment fee, premium, or similar charge and any deduction, copayment, cost-sharing, or similar charge with regard to services received at the Indian health system or through referral by the Indian health system;
- A prohibition on the reduction of payments to I/T/Us by the amount of any enrollment fee, premium, or similar charge and any deduction, copayment, cost-sharing, or similar charge that would otherwise apply;
- A provision that AI/AN Medicaid managed enrollees can choose an I/T/U as their primary health care provider;
- A provision that AI/ANs who elect to participate in Medicaid managed care can continue to use their I/T/U and that the I/T/U will receive payment; and
- A guarantee that if the MCO does not pay the I/T/U at the rate for I/T/Us in the State plan, the State must pay the I/T/U the difference between the applicable rate and the rate paid by the MCO, whether or not the I/T/U is in-network.

In new managed care regulations issued on June 1, 2015,[2] CMS proposed to codify section 5006, a policy supported by TTAG. Accordingly, we ask the Agencies, either through regulation or guidance, to:

> Emphasize the importance of maintaining the Indian-specific protections contained in section 5006 under a State Innovation Waiver.

[22] See CMS-2390-P, "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability" (80 FR 30098), at https://www.gpo.gov/fdsys/pkg/FR-2015-06-01/pdf/2015-12965.pdf.

National Indian Health Board

Conclusion

Thank you for the opportunity to provide these comments on the State Innovation Waiver approval process under ACA section 1332. We also appreciate the continuing efforts by the Agencies to help ensure that states electing to apply for a State Innovation Waiver maintain the Indian-specific cost-sharing protections contained in ACA, as well as the Indian-specific protections included in BBA and ARRA. NIHB remains willing to assist CMS in these endeavors. Please contact Devin Delrow, NIHB Federal Relations Director at ddelrow@nihb.org if you have any questions on the issues addressed in these comments.

Sincerely,

Lester Secatero
Chairman, National Indian Health Board

Cc: Kitty Marx, Director, CMS Division of Tribal Affairs