



November 17, 2015

Ms. Vikki Wachino
Director, Center for Medicaid & CHIP Services
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
Sent via email: tribalaffairs@cms.hhs.gov

Attn: Comments on Medicaid Services “Received Through” an Indian Health Service/Tribal Facility: A Request for Comment

Dear Ms. Wachino:

The National Association of Medicaid Directors (NAMD) appreciates the opportunity to respond to the proposed changes included in the CMS paper, “Medicaid Services ‘Received Through’ an Indian Health Service/Tribal Facility: A Request for Comment” (October 2015).

NAMD supports CMS’ intent to revise interpretation of Section 1905 (b) of the Act to move towards parity in the federal matching rate for services furnished through Indian Health Services (IHS) or “638” tribally-operated health facilities. We believe the concepts under consideration carry potential to improve access to services, care coordination and health-related outcomes for American Indians and Alaska Natives.

American Indians and Alaska Natives (AI/AN) have for too long been marginalized and poorly served under existing health care programs. While admittedly not the only factor contributing to these disparities, CMS’ current interpretation of federal financing obligations for services received by American Indians and Alaska Natives undermines the ability to provide access to a continuum of high quality services. Specifically, if a Medicaid-eligible AI/AN receives covered services from a non-IHS or non-tribal provider, the federal government reimburses states according to their regular state matching rate. This is in contrast to the 100 percent federal matching rate when Medicaid-eligible American Indians and Alaska Natives use Indian Health Services or “638” tribally-operated health facilities. Further, tying the enhanced match rate solely

to IHS/Tribal facilities undermines the opportunity for AI/AN individuals to access services and care delivery systems that have progressed over many decades.

We also encourage CMS to take its proposal a step further. We ask the agency to use the full extent of its authority to pursue a person-centered approach -- rather than a facility-centric approach -- to delivery and payment as it modifies 1905(b) conditions. Doing so is consistent with states' and CMS' core principle of person-centeredness, which is increasingly applied to system-wide innovation for other Medicaid-eligible individuals.

Based on consultation with our members, we believe CMS should strive to do the following through its guidance:

- Improve access to high quality services for tribal members in the most efficient manner possible.
- Ensure that all states can operationalize the proposals given different delivery system, payment and service relationships and capacities at the local level.
- Support state initiatives to build relationships for Medicaid enrollees through systems of care, rather than a facility based approach.
- Minimize the burden on states and tribal health providers.
- Advance updated policy interpretations that allow states to continue to innovate and extend delivery system improvements to all populations.

With respect to the current proposals, there are several outstanding operational and administrative provisions that require clarification. Additionally, CMS should clarify questions about the scope of state authority in order for states to make a final determination as to the feasibility and benefit of implementation. States also note that the timeline for comment on these concepts did not afford sufficient time for robust consultation with tribes.

Below we provide comments on each of CMS' proposed policy changes to section 1905(b):

Modification of the second condition regarding relevant services:

- States support interpreting a "service received through an IHS/Tribal facility" as any services within the Medicaid State Plan benefit category and services covered through an 1115 waiver.

Modification of the third condition regarding the meaning of contractual agent:

- States support expanding the meaning of a contractual agent. However, we strongly urge CMS to provide states flexibility to work with facilities/systems on the best way to ensure responsibility for the provision of services rather than specifying the state's role in these types of arrangements. This will maximize the potential for states and facilities/systems

to develop relationships that balance the needs of Medicaid eligible tribal members and the capacity of the local delivery system.

- For example, language in the concept paper requires a “...written contract under which the services for the Medicaid beneficiary are arranged and overseen by the IHS/Tribal facility and the individuals served by the contractual agent are considered patients of the facility.” States are concerned that this “arranged and overseen by” language could be overly restrictive (i.e. inadvertently limiting access to services in certain geographic areas). CMS should provide states flexibility to define, in the state plan or waiver, the parameters for what qualifies as “arranged and overseen by.”
- States are similarly concerned with potential limitations posed by the language, “...contractual agents would include those that furnish services that are received through the IHS/Tribal facility but not necessarily furnished directly by the IHS/Tribal facility.” Again, we ask CMS to provide states flexibility to consult with IHS/Tribal facilities on feasible contracting approaches and the delegation of responsibilities within those contractual arrangements. For example, we ask that CMS provide states flexibility to utilize Memoranda of Understanding, referrals and other tools which can facilitate and simplify complex operational changes.

Modification to the fourth condition regarding billing for services:

- States support additional flexibility to determine how the provision of services will be billed. However, states want to ensure that the options afforded are manageable for both facilities and states who administer payments. Similar to the proposed modification to the third condition, states need flexibility to structure the relationships to fit the particular health care community, and these will differ by state.

Impact to FFS payments:

- States are pursuing value-based purchasing (VBP) arrangements in fee-for-service and managed care programs. NAMD is undertaking a comprehensive assessment of states’ VBP initiatives, and we encourage CMS to use our forthcoming paper to further inform any federal level VBP policy work. In the meantime, we request that CMS ensure its IHS/Tribal-specific policy changes do not foreclose the opportunity to be part of VBP arrangements that drive value for Medicaid-eligible individuals and achieve system-wide efficiencies.
- States support additional flexibility to determine how the provision of services will be billed.

Application to Managed Care:

- States support CMS’ proposal to extend the 100 percent FMAP for the portion of the capitation payment expended for services furnished by an IHS/Tribal facility or employee.



We appreciate your consideration of our recommendations and encourage you to continue to consult with states on the feasibility of the proposed changes.

Sincerely,



Matt Salo
Executive Director