ALASKA NATIVE
TRIBAL HEALTH
CONSORTIUM

Submitted via email to *TribalAffairs@cms.hhs.gov*

November 17, 2015

Division of Tribal Affairs
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington DC 20201

Re: Comments in Support of 100 Percent FMAP Proposal

Dear Division of Tribal Affairs:

Thank you for the opportunity to comment on the white paper exploring the option of a national policy change that would significantly improve the ability of the United States to fulfill its special trust responsibility to provide health care services to Alaska Natives and American Indians (AN/AIs). By expanding the circumstances in which the Centers for Medicare and Medicaid Services (CMS) pays a Federal Medical Assistance Percentage (FMAP) at the 100% level for services provided by or through an Indian Health Service or tribal facility, CMS can effect both an immediate and sustained improvement in the availability of health care services to one of the most underserved population in the nation. The Alaska Native Tribal Health Consortium (ANTHC) fully supports the proposal and offers several comments to assist in clarifying and refining the proposal to help maximize its positive impact.

Background

ANTHC is a tribal organization, created pursuant to Section 325 of Pub. L. 105-83 to carry-out statewide programs of the Indian Health Service (IHS) pursuant to the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, codified at 25 U.S.C. § 450 *et seq*. It is the largest tribal health compactor in the United States.

ANTHC co-manages the Alaska Native Medical Center (ANMC), a tertiary care hospital and level II trauma center in Anchorage, Alaska, that serves more than 150,000 AN/AIs throughout Alaska. ANTHC also provides a wide range of public health, community health, and environmental health programs and services for Alaska Natives and their communities throughout the State. ANTHC's Environmental Health and Engineering programs provide Alaska Native Villages with planning, design, and construction and operations support for clean water and sanitation projects statewide.

ANTHC and ANMC can fairly be considered the central hub of a very organized, but widely dispersed tribally controlled health system operated by 28 different Tribes and tribal organizations who work collaboratively to coordinate medical, dental and behavioral health care from the most remote villages, to sub-regional and regional hubs, and finally to ANMC. But, no

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

matter how closely these programs work together and support each other, ultimately services provided only "by" the programs are insufficient to support access to all necessary health care. There is no individual health provider, or even health system, that can directly meet all the health care needs of its patients or beneficiaries. The Alaska Tribal Health System (ATHS) is no different. Even with ANMC as a tertiary care hospital, there are some patient care needs that are beyond the capability or capacity of ATHS. But Tribal health programs want to ensure that they are able to continue to coordinate that care when the patient must receive care from more than one provider.

In many small communities, individuals have access to health care, if at all, only through community health aides (including behavioral health and dental health aides and therapists), unless they are able to travel hundreds, if not thousands, of air miles to a larger community. Limitations on funding for travel and related costs create a very real barrier to accessing basic health care most people in the rest of the United States take for granted. Transportation and related housing and meals are essential to access; without them Medicaid is often an illusory benefit. Non-emergency transportation is critical. Waiting for emergencies before authorizing travel jeopardizes lives and increases costs – not only for the transportation itself, but also for treating the emergent condition since often the condition would never have progressed to that stage had earlier diagnosis and treatment occurred on a planned basis. While all the proposed changes are important, coverage for transportation and related services is especially so in Alaska.

1. Comments on Paragraph 1 – Modifying the Second Condition

The Consortium strongly supports CMS's proposal to apply the 100 percent FMAP reimbursement to all "services" "received through" an IHS or tribally operated facility. 42 U.S.C. § 1396d(b). The current policy of applying 100 percent FMAP only to services provided in the facility, so-called "facility services," creates an inadvertent but significant barrier to providing access to care, particularly for services beyond the current capability or capacity of an IHS or tribal provider. ANTHC strongly supports removing this unnecessary barrier through the proposed policy change. Since, by its terms, the 100 percent FMAP rule is not limited by Medicaid's facility-based service rules, but rather applies to any service that may be provided in an IHS or tribally-operated facility, we believe this change is more consistent with federal law as well.

CMS's current policy to limit applicability of 100 percent FMAP to a "facility benefit" is inconsistent with Congressional intent to make 100 percent FMAP available to all "services" that are received through an IHS or tribally-operated facility. As a result, we strongly support CMS's proposal to change its existing policy such that any service the IHS or tribal facility is authorized by law to provide could qualify as a service "received through" an IHS/tribal facility. In implementing this change in policy, we urge CMS to clarify that it includes any service authorized under the Snyder Act, the Transfer Act, the Indian Health Care Improvement Act, the Indian Self-Determination and Education Assistance Act, and other applicable federal law.

We also believe it would be beneficial for CMS to clarify that although the service would have to be encompassed within a Medicaid state plan benefit category and covered under the State's approved Medicaid state plan, a service authorized pursuant to Section 1915 and 1115 waiver authorities would similarly qualify for 100 percent FMAP under this new policy revision.

Finally, although we understand that this revision would not be limited to these services, we strongly support the inclusion of "transportation services, as well as emergency transportation services and non-emergency transportation, including related travel expenses (such as meals, lodgings, and cost of an attendant pursuant to federal and state requirements)" as specific examples of covered services. Transportation and associated lodging expenses are a necessary predicate to accessing care throughout Indian country and an integral component in the provision of services in many areas of Indian country. This is even more true in Alaska than perhaps any other region of the country, since a significant number of Alaska Natives live in rural areas and remote villages over vast land masses with low population density, no road systems, extreme weather conditions, and a very high cost of living. We cannot over-emphasize the importance of CMS including transportation and lodging and related services as eligible for reimbursement at 100 percent FMAP as a service "received through" and IHS/tribal facility.

Recommendation:

- *We support this proposal.*
- *CMS should clarify that a service the IHS/Tribal facility is authorized to provide is any service authorized under the Snyder Act, the Transfer Act, the Indian Health Care Improvement Act, the Indian Self-Determination and Education Assistance Act, or other applicable federal law.*
- *CMS should clarify that services provided pursuant to Section 1915 waivers and 1115 demonstrations would also qualify under this proposal.*
- *CMS should retain and highlight that services covered include "transportation services, as well as emergency transportation services and non-emergency transportation, including related travel expenses (such as meals, lodgings, and cost of an attendant pursuant to federal and state requirements)."*

2. Comments in Response to Paragraph 2 – Modifying the Third Condition

We also strongly support CMS's proposal to modify the third condition so that referral services would be eligible for reimbursement at 100 percent FMAP even if provided by contractual agents outside the four walls of the IHS/Tribal facility so long as there is a connection to the IHS/tribal facility. Doing so will increase access to needed care while increasing coordination of care through the Indian health system.

Referrals are a necessary and integral part of the services received through Indian health system, which often either lacks the capability to provide specialty services, or lacks the capacity to provide such services for various reasons, such as lack of sufficient volume to allow for

reasonable economies of scale. Accordingly, referral services should be covered by 100 percent FMAP to the same extent as direct care services.

CMS's interpretation of the 100 percent FMAP rule has been overly restrictive to date, particularly with regard to referrals. The 100 percent FMAP rule provides:

> "the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization…."

42 U.S.C. § 1396d(b).

When it enacted the rule, Congress stated it would apply to all services "received through" an IHS or tribally-operated facility. Congress did not limit it to all services "provided in" an IHS or tribally-operated facility, although it certainly could have done so. (*Compare, e.g.*, 42 U.S.C. § 1396(c)). Instead, Congress clearly intended the phrase "received through" to require that a service have some connection to an IHS or tribally-operated facility. It is a limitation designed to prevent application of the 100 percent FMAP rule for services received by a Medicaid enrolled IHS beneficiary at a non-IHS provider when there is no connection to an IHS or tribally-operated provider.

As a result, we strongly support CMS's proposal to modify the third condition to expand its policy to more fully encompass the intent of § 1396d(b), especially since it could significantly increase access and coordination of care for IHS beneficiaries across the country. It would allow Tribes and tribal organizations to work with their States on a State-by-State basis to make additional Medicaid services available, or reduce limits on existing Medicaid benefits, through referrals or other arrangements.

Every new Medicaid service made available through referral through an IHS or tribally-operated facility due to the revised application of the 100 percent FMAP rule will result in significant savings to IHS and tribal providers that already struggle with stretched and inadequate purchased/referred care budgets. Those savings could then be put to immediate use by increasing priority levels of care that can be provided through the purchased/referred care program, and result in greater access to care for our beneficiaries. This will not only better serve AN/AI patients, but also help make the delivery of health care more efficient by freeing up resources to provide other services, including lower cost preventative services.

While the statute dictates that a service must have a connection to an IHS or tribal program, we recommend CMS implement this requirement in a manner that allows for maximum flexibility for tribes to work out the particulars of the necessary arrangements with their States on a State by State basis. This flexibility is needed so that the availability of 100 percent FMAP for services, whether provided through referral or other appropriate arrangements, genuinely enhances access

to existing services. It is also needed to enable States to work with IHS and tribal providers to find the best ways not only to maintain continuity of coordinated care, but also to ensure the continuum of available care is adequate to meet the needs of AN/AI patients.

While we recognize the need for a service to be connected to the IHS or tribal program to qualify for 100 percent FMAP, we urge CMS not to impose a host of specific requirements dictating how that connection must be made and maintained since they may inadvertently limit a variety of helpful alternatives. To address this concern, we believe that CMS's draft proposal should be clarified in several ways.

First, the policy (currently and as being proposed) uses the phrase "contractual agent," but there is no definition for the term "contractual agent" in the white paper. This phrase, and a closely related one "contractual arrangement," however are used frequently in Title 42. We are concerned there is risk that the phrase "contractual agent" will be prone to interpretations from these other provisions that may be laden with requirements and restrictions. For example, it would be unfortunate if all contracted agents were subject to the condition of participation related to "contracted services," even if they are not providing services in a hospital facility. (*See* 42 CFR § 482.12(e).) Since it seems unlikely that CMS intended imposing otherwise inapplicable provisions, we recommend that the guidance either clarify the term, as we discuss below, or select another term that is less formal.

Second, the proposal states that a contractual agent could include an enrolled Medicaid provider "who provides items or services not within the scope of a Medicaid "facilities services" benefit but within the IHS/Tribal facility authority...." We believe CMS's intent in this clause is to clarify that the services that could be provided by the contractual agent would not be limited by the Medicaid "facilities services" rule, as CMS has proposed in Paragraph 1, but would include any service the IHS/tribal facility is authorized to provide. However, this clause could also be read to mean that it does not include services within the scope of a Medicaid "facilities services" benefit, which would preclude hospital, nursing home, residential psychiatric treatment centers and other facilities from qualifying. Again, we do not believe this was CMS' intent, as it would be inconsistent with the proposal in Paragraph 1, and would defeat the goals sought to be achieved by CMS's proposal. CMS should clarify this when it finalizes its proposal.

Third, the proposal would require a "written contract" between the IHS/tribal facility and "contractual agents." While a written contract is one mechanism to ensure the requisite connection between the IHS/tribal facility and the contractual agent, it is unrealistic to believe that IHS/tribal providers could obtain written contracts with every provider to whom they refer patients or with whom they work to extend their capacity to provide services. Our concern is that many providers or provider groups simply will not enter into such contracts in circumstances in which there would be no incentive for them to do so. This will lessen the incentive for States to expand services. In addition, many IHS and small tribal health facilities lack the administrative capacity to negotiate and enter into such agreements in a timely manner. A better approach, in our view, would be to require only that the IHS/tribal facility provide a documented

referral and to require the rendering provider, as a condition of payment, to provide materials and records back to the referring IHS/tribal facility. Finally, we believe that the form of documented referral must be flexible. Examples of situations that would appropriately be treated differently include allowing for general referrals when the IHS/Tribal health program has extremely limited services (such as in purchased/referred care dependent areas), more focused referrals when the beneficiary has been a patient of the referring IHS/Tribal health program, and even deemed referrals delivered after the care was provided in cases of urgent or emergency situations.

Fourth, the proposal would require that the contract provide that the Medicaid services be "arranged and overseen" by the IHS/Tribal facility, and the individuals served by the contractual agent would have to be considered patients of the IHS/tribal facility. It goes on to state that "[t]he IHS/Tribal facility would need to retain responsibility for the provision of services, meaning that the IHS/Tribal facility must retain control of the medical records, including updating medical records with information from care provided by contractual agents and providing care coordination for the AI/AN individual." While we appreciate the reasoning behind these conditions, we are concerned that the requirement that the IHS/Tribal facility must retain responsibility for the provision of services, including compliance with certain conditions of participation in Medicaid and Medicare cannot practically be fulfilled during episodes of care provided outside the facility, by providers who have their own duty of care to patient. We also are concerned that the examples listed as required for IHS/Tribal facilities to retain responsibility for the provision of services are impractical for the same reasons. If read literally these could impose such administrative burdens and programmatic difficulties as to be unworkable in practice, and could defeat the purpose of CMS's proposal to increase access to care and coordination of services.

We are also concerned that the use of the phrase "arranged" might be interpreted to require a patient to seek primary care services within the IHS/Tribal system in order for the 100 percent FMAP rule to attach to any resulting referrals or other care arrangements. This would significantly undermine efforts to expand the availability of primary care services.

In addition, it could be interpreted to require that the referral be treated like a "consultation," where the patient would have to be re-seen at the IHS/tribal facility before receiving actual care. While this may be appropriate in some cases, in others, a return visit to the IHS/Tribal health facility may not be medically warranted and would likely merely increase the cost of the care.

A better approach, in our view, would be to implement this requirement in a manner that allows for the off-site providers to be considered an extension of the IHS/tribal provider with respect to those the IHS/Tribal provider considers to be its patients. It is extremely important that CMS not implement the rule in a manner that could be interpreted as requiring a primary care visit within the four walls of an IHS/Tribal facility before a referral could qualify for 100 percent FMAP. CMS should instead adopt an approach that would allow Tribes and States to define the parameters and recordkeeping and reporting requirements referral providers would need to make back to the IHS/Tribal facility on a State-by-State basis. These parameters defined

collaboratively by the State and Indian health programs will be far more likely to foster coordination and continuity of care than more prescriptive requirements.

These comments address specific language in the draft that we reviewed. At bottom, we believe that flexibility about the implementation of the requirements for contractual relationships, medical records, patient relationships, and care coordination is extremely important. We understand the interest underlying these proposed requirements is that Indian health programs have an ongoing relationship with their AI/AN beneficiaries and support it. The best way to achieve it is to allow tribal health programs to provide care coordination for their beneficiaries without limitations typically applied to case management rules, *i.e.* we need tribal providers to be able to provide a full range of care coordination even when the services the tribal health program provides would otherwise be subject to rules that treat service providers as having a conflict when they want to provide case management. It is critical that both tribal programs be able to do both in order to fulfill their multiple responsibilities for AI/AN beneficiaries.

Recommendation:

- *We support this proposal, with clarification.*
- *CMS should revise the phrase "who provides items or services not within the scope of a Medicaid "facilities services" benefit but within the IHS/Tribal facility authority...." so that it is not susceptible to an interpretation that it is intended to disqualify Medicaid facilities services benefits, but rather to express clearly that it is intended to be consistent with the policy change proposed in Paragraph 1.*
- *Rather than requiring a written contract in all cases, CMS should allow a documented referral that would provide that as a condition of accepting the referral, the provider would have to provide materials and records back to the referring IHS/tribal facility. CMS should not include the phrase "[t]he IHS/Tribal facility would need to retain responsibility for the provision of services, meaning that the IHS/Tribal facility must retain control of the medical records, including updating medical records with information from care provided by contractual agents and providing care coordination for the AI/AN individual" or similar such conditions. It should be enough that an AI/AN is considered a "patient" of the IHS/Tribal facility.*
- *CMS should clarify that "arranging" for the provision of services does not necessarily require the patient be first seen at and then referred from an IHS/Tribal facility for a specific referral or episode of care. Rather, recognizing more flexibility to make arrangements that are appropriate to the IHS/tribal program and type of service will enhance the effectiveness of this policy change.*
- *CMS should clarify that a referral to a contractual agent may be made for a specific treatment, an episode or care, or be a standing referral.*
- *CMS should adopt an approach that gives tribes in each State the opportunity to work with their States to develop the type of referral or other arrangements and requirements that best suit the relationship between the IHS/Tribal facilities in the State and outside providers.*

3. Comments in Response to Paragraph 3 – Modifying the Fourth Condition

We strongly support CMS's proposal to allow IHS/Tribal facilities the choice of whether they will bill the State Medicaid program directly for services referred to outside contractual agents, or allowing the contractual agent to bill the State Medicaid program directly for the service. Many tribal health programs have already entered into arrangements with outside providers in which they accept assignment from those outside providers and then bill Medicaid directly for those services. Any change in policy must be careful to allow tribal health programs to maintain such arrangements if they elect to do so. It is equally important, however, to allow contractual agents to bill Medicaid programs directly, as doing so may often be the most administratively simple mechanism, and will avoid complications due to differences in rates applicable to the provision of services within an IHS/Tribal facility and those applicable to non-IHS/Tribal providers under the State plan. Allowing IHS/Tribal facilities the choice between these two options will allow them to work with the other providers in their area to find the alternative that works best for both parties.

Recommendation:

- *We strongly support this proposal.*

4. Comments in Response to Paragraph 4 – Application to Fee-for-Service

CMS's proposal clarifies that services that are of the type encompassed within the applicable (Medicaid) facility benefit, an IHS/Tribal facility would receive payment at the rate applicable for IHS facilities in the State plan. Services that could be furnished pursuant to IHS/Tribal authority but that are not within the applicable facility benefit would be paid at the State plan rates applicable to those services. Examples provided include personal care, home health, § 1915(c) waiver services and non-emergency medical transportation. However, CMS notes that "states retain flexibility in establishing economic and efficient payment rates to sufficiently reimburse for the provision of services." This last sentence is critically important, as it recognizes the authority of States to establish payment rates that sufficiently reimburse for the provision of services to ensure patients have adequate access, and allows States continued flexibility in setting those rates. We support this proposal, and strongly recommend that CMS retain this language in the document it finalizes.

Recommendation:

- *We strongly support this proposal.*
- *CMS should retain and highlight the language it used in its proposal that "states retain flexibility in establishing economic and efficient payment rates to sufficiently reimburse for the provision of services."*

5. Comments in Response to Paragraph 5 – Application to Managed Care

The Consortium appreciates CMS's effort to clarify that states may claim 100 percent FMAP for that portion of any capitation rate they pay to a managed care plan that represent services provided to AI/AN individuals enrolled in a managed care plan. It is our understanding that states may already do so, and as a result we appreciate CMS clarifying this point. Under CMS's clarified policy, "states would be permitted to claim the 100 percent FMAP for a portion of the capitation payment for AI/AN individuals who are enrolled in managed care, even if the State itself makes no direct payment for IHS/Tribal facility services." We strongly endorse this approach. While AI/AN are exempt from mandatory enrollment in managed care systems, States are increasingly seeking to adopt managed care for all or parts of their Medicaid and CHIP programs, and in some circumstances it may be advantageous for AI/AN to enroll in managed care to obtain enhanced benefits. As a result, we strongly support this clarification, but recommend that CMS further clarify that it applies to managed care systems adopted either by state plan amendment or through a demonstration waiver.

CMS proposes to condition receipt of 100 percent FMAP to only the portion of the capitation rate for which the following conditions are met:

1. The service is furnished to a Medicaid-eligible, enrolled, AI/AN individual;

2. The IHS/Tribal facility provides the service, either directly or through a contractual agent, and maintains oversight responsibility as discussed elsewhere in the proposal; and

3. The service is payable under the managed care plan and is, in fact, paid by the managed care plan.

The Consortium appreciates that these conditions are designed to ensure that 100 percent FMAP payments would be conditioned on (1) it being a service "received through" the IHS/Tribal facility in a manner consistent with CMS's revised policy; and (2) the Managed Care plans actually making a payment for the service. These conditions ensure that 100 percent FMAP reimbursement is made for services "received through" the IHS/Tribal facility, and are designed to provide an incentive to the States to ensure that managed care plans make payments for services provided to AI/AN. While we support this goal, we have some concern about how it would be operationalized. The proposal goes on to state "that the portion of the managed care payment eligible to be claimed at 100 percent FMAP must be based on actual expenditures incurred for IHS/Tribal encounters." We are somewhat concerned that imposing a tracking requirement on both the managed care plans and the States as a condition of 100 percent FMAP applying could serve as a disincentive to including expanded services for IHS/Tribal facilities through managed care systems. The managed care plans will have little or no incentive to track payments made for services provided to AI/AN, unless the States provide them with one. As a result, if CMS retains these conditions, we believe it will be helpful to clarify that States will retain the flexibility to design managed care plans (through waivers or otherwise) in a manner

that allows them to incentivize managed care plans through administrative claiming mechanisms or otherwise to provide the information States would need to claim 100 percent FMAP for those portions of the capitation payments they make for such services.

It will also be equally important to ensure that any policy provides States with sufficient flexibility so that they can claim 100 percent FMAP without having to meet burdensome tracking and reporting requirements on a case by case or referral by referral basis. In order for this policy to properly incentivize States, the States must be given the flexibility to account for care provided to AI/AN on an annual or quarterly basis based on metrics such as the AI/AN service population enrolled in managed care and average encounter data, rather than requiring tracking and reporting on an a per encounter or per referral basis.

Finally, we strongly encourage that CMS remain vigilant regarding all forms of managed care to ensure that nothing in the design interferes with the relationship AN/AIs have with their Indian health program or payment to Indian health programs for the services they provide to AN/AI beneficiaries who use their program (whether the Indian health program is a member of a preferred network or not; and that the policies of the managed care plan neither encourage duplicative medical services, which can occur when managed care plans only allow certain kinds of care if their own providers authorize the need, even when other fully qualified health providers have justified the care and made the medical records available. These requirements may or may not need to be addressed in this guidance, but they do need to be monitored wherever any form of managed care is expanding

Recommendation:

- *We strongly support this proposal, with clarification.*
- *CMS should clarify that the 100 percent FMAP reimbursement applies to capitation payments made for services "received through" IHS/Tribal facilities in managed care systems established by state plan amendment or waiver authority*
- *CMS should allow States flexibility in ensuring that services are in fact paid by the managed care plans by allowing them continued flexibility to provide managed care plans incentives they need to provide information back to the State to assist them in claiming 100 percent FMAP, and flexibility in determining the total estimate of payments made for services "received through" IHS/Tribal facilities based on aggregated, rather than per referral or per encounter data.*

Conclusion

The Consortium very much appreciates CMS's thoughtful approach and attention to finding ways to improve the access to health care services Alaska Natives so desperately need. This level of commitment has been critical to our efforts to improve access to care, especially for those living in very remote locations, who otherwise would be forced to go without care all

together. We do encourage CMS and the State to reserve sufficient flexibility to respond to variations in tribal health situations and infrastructure so that unanticipated issues do not impede full implementation or disable them from fully supporting the vitality of Indian health programs as the home for care for Alaska Natives and American Indians.

Thank you for your consideration of our comments and suggestions.

Sincerely,

Gerald Moses
Senior Director of Intergovernmental Affairs