State of Alaska
Department of Health and Social Services
Medicaid Services "Received Through" an Indian Health Service/Tribal Facility: Comments

Introduction

The State of Alaska (State) appreciates the opportunity to respond to CMS's proposed changes, "Medicaid Services "Received Through" an Indian Health Service (IHS)/Tribal Facility: A Request for Comment" (October 2015). The State is in strong support of CMS's intent to revise interpretation of Section 1905(b) of the Social Security Act. The concepts under consideration have the potential to improve access to necessary care and care coordination for American Indians and Alaska Natives (AI/AN).

Background

In Alaska, under current policies the Medicaid program expends more funds for services to AI/ANs provided outside the tribal health system than within the tribal health system. The State is in full support of reversing this trend. We are convinced the proposed expansion of the application of the 100 percent Federal Medical Assistance Percentage (FMAP) will create many more opportunities for our State to work with the tribal health programs to further expand their direct services and to develop additional mechanisms for coordination of care.

When a Medicaid beneficiary is also an IHS beneficiary and is seen in an IHS facility (including Alaska's tribally operated facilities), Alaska is reimbursed at 100% FMAP. However, under the current FMAP policy, transportation and accommodation services for IHS beneficiary referrals to IHS facilities are only reimbursed at regular FMAP rates. With Alaska's size and distance between an individual's home community and nearest location of medically necessary services, travel becomes a critical access to care issue.

The Alaska Tribal health system depends upon referrals to other care facilities. In a state as vast as Alaska, with a small population, economies of scale do not allow tribal providers to offer a full range of specialized services. Referrals for AI/ANs from a tribal health facility to a non-tribal facility should be 100% FMAP. Alaska's Medicaid program has a strong and collaborative relationship with the Tribal Health System in Alaska. The two systems are jointly responsible for providing necessary access and services across the state. It is critical that the two work together to achieve the best possible performance.

In order to maximize access to care, the State encourages flexibility for the state and the tribal health system to develop the terms required to establish the relationship between the referring provider and tribal health organization. This might mean that care outside (or through) the Tribal health program requires a service-by-service referral, a referral for an episode of care, or a general referral for Medicaid covered service, depending on the capacity and array of services the respective tribal health program.

A full range of possibilities and flexibility is needed to assure that State Medicaid policy does not inadvertently encourage AI/AN beneficiaries to seek care outside the Tribal health programs when they are able to provide or manage the care, but also does not impose administrative and care management burdens that are unreasonable in communities where the tribal health system is extremely limited, sometimes even entirely purchased/referred care dependent.

In Alaska, as across the nation, there is wide variation of service delivery from one site to another. Thus, it is necessary to have the policy, which CMS indicates will be published in a State Health Official letter, be extremely flexible and allow funds to follow the AI/AN individual with requirements closer to those found in federal cost sharing policy exempting AI/AN beneficiaries (42 CFR 447.56 (a)(1)(x)) than in the current policy. This will allow for tribal health system to work directly with their state to craft models that will work best in their state and for each Indian health program in a manner that strengthens tribal programs rather create any unintended results that weaken the programs. The State supports and recognizes that support from tribes is necessary to move this policy forward and sustaining it in future federal administrations.

Policy

The policy changes under consideration are addressed in five sections.

Modification of the second condition:
The State fully supports CMS's proposed change to modify this policy. All tribal health services included in a state's Medicaid State Plan or under any waivers should qualify for 100 percent FMAP. As the "Day-to-Day Life of an AI/AN Medicaid Beneficiary" section at the end of these comments illustrate, transportation is critical access to care for tribal members. Alaska firmly believes that because of the crucial access needs, all tribal transportation and accommodation services, emergency and non-emergency, should qualify for 100 percent FMAP. As noted above, tribal beneficiaries in Alaska simply do not have access to the full spectrum of health services without transportation, and in many communities, travel is required for health care services more than the most routine of primary care needs.

Modification of the third condition:
The State agrees that CMS should modify the third condition. We also agree that the change should apply to both facility and non-facility services. The State also supports the concept that non-tribal providers covered by this policy must comply with Medicaid standards defined in conditions of enrollment and any necessary changes be addressed through the State Plan process, which we believe is implicit in CMS's proposal.

However, we have questions and concerns regarding the proposed policy regarding contractual agents and requests modification. As stated, the policy appears to require that the service be provided under IHS/Tribal facility authority; be pursuant to a written contract under which services are arranged and overseen by the IHS tribal facility; the individuals served are considered patients of the facility; the facility would need to retain responsibility for the

provision of services—i.e., the facility must retain control of the medical records, including updating records with information from care provided by contractual agents; and must provide care coordination.

We acknowledge that this proposed policy is formative, and we may not fully understand CMS's intention, but these provisions as currently stated have the potential to be administratively burdensome; they may not work programmatically and could undermine the intent of expanding access and coordination of care. In Alaska the tribal health system is a consortium of tribal health organizations, almost all operating multiple facilities. These organizations have complex relationships with each other, but without doubt function as a health system with a strong referral and response relationship among them. We do not believe direct contractual relationships among the tribal health programs are contemplated by this guidance, but would find it helpful to have that clarified. We also are concerned that the type of contractual relationship described by CMS could create logistical barriers, around credentialing providers or establishing formal record sharing protocols in situations where prompt access to care is critical.

The State urges flexible and broad definition so non-facility services provided by non-Tribal providers that are Medicaid enrolled providers not be excluded from services for which 100% FMAP can be claimed if the other conditions are satisfied.

The State proposes that a documented referral from an enrolled provider be sufficient to satisfy the requirement for application of 100% FMAP. The State would accept referral to constitute a contracted relationship. CMS will need to take into consideration those circumstances where contracting is not practicable, such as emergency circumstances, specialty care of limited volume or duration, or when care is flowing from one tribal organization to another or to a non-tribal provider for services as described in the "Day-to-Day Life of an AI/AN Medicaid Beneficiary" section at the end of these comments.

If CMS allows a referral to represent a contractual arrangement then the administrative burden of managing the Electronic Health Records (EHRs), payments, and certification requirements is alleviated. For example, EHRs may not be required for all services, the amount of information transferred should be limited to the type of service provided (i.e., lab). We believe that CMS has broad latitude to define what constitutes "through a facility. In addressing the issue of what constituted a connection to a tribal facility for purposed of defining the exemption to beneficiary cost sharing, CMS took a very expansive position in 42 CFR 447.56 (a)(1)(x). The State recommends CMS consider a similar approach when defining what constitutes "through a facility."

If CMS determines that a referral alone is not sufficient, the State believes that the most relevant criteria listed in the proposed modification is care coordination. If a referral is made and the individual is receiving care coordination from a tribal health organization, the service should be eligible for 100 percent FMAP.

The State is aware that not all states are similar with regard to the structure of their IHS/tribal health systems. We believe that CMS should allow states, in consultation with the IHS and tribal health providers, to define the requirements for contractual relationships, medical records, patient

relationships, and care coordination. We would also note that as primary care, behavioral health, and long term support services become increasingly integrated, CMS may need to provide clarity that care coordination of services within the tribal system is allowable even when services are subject to conflict free case management requirements. Otherwise, CMS would be imposing conflicting requirements on providers.

Modification to the fourth condition:
The State supports modifying the fourth condition and recommends including both options: billing through the IHS/tribal facility and allowing the non-tribal provider to bill directly. This would allow tribal health providers to work with the other providers to find the alternative that works best for both Parties. The latter option would allow a tribal health provider to simplify its relationship with the providers they refer patients to.

States should have flexibility to allow tribes and providers to determine when Fee-for-Service (FFS) is appropriate. FFS should be used when it is appropriate to the service, based on the relationship with the provider. The State would compare state plan reimbursement to encounter rate because either can be an underpayment or an overpayment depending on the circumstance (such as specialty care, neonatal, nursing home care, etc.).

The State believes that to the extent that CMS requires contractual relationships, they must build a functional reimbursement in order to pay for the administrative duties/new business to cover that relationship beyond the encounter. The State requests flexibility in reimbursement structure for the tribal health providers and the state to develop an agreement through the consultation process. This agreement could be part of the overall reform with reform incentives such as value based purchasing. This flexibility could extend to developing new (tribal) provider types for tribal-only providers to support 1902(a)(30) cost based tribal rates.

Impacts to Fee-for-Service:
The State supports this proposal. As noted above, we believe that states would benefit from flexibility to experiment with new payment methodologies as health care systems move toward value-based purchasing. Also, depending on the final requirements, CMS policy should provide states the flexibility to reimburse for care coordination and new administrative activities that have not been historically included in encounter rates.

Application to Managed Care:
The State does not have any comments since we do not have managed care.

Day-to-Day Life of an AI/AN Medicaid Beneficiary

The Alaska Tribal Health System in Alaska is comprised of 25 Tribal Health Organizations that compact with Indian Health Services as a consortium. Members of 229 federally-recognized tribes receive healthcare through this system. The flow of patients is often from village clinic to sub regional clinic to the hub clinic or hospital outpatient setting and then on to tertiary care in Anchorage or out of state, which could be provided by Tribal or Non-tribal providers. With Alaska's size and distance between an individual's home community and nearest location of

medically necessary services, travel becomes a critical access to care issue. Families are already riding on snow mobiles, boats, all-terrain vehicles, small planes, ferries, and larger airplanes simply to get the level of health care they need. It is only in the largest hubs that jet service is available, and many villages are served only by charter or infrequently scheduled small aircraft.

To offer a few real life examples, in a region like the Yukon Kuskokwim area, which is the size of the state of Oregon, there are 52 village clinics, four sub-regional clinics, with inpatient and outpatient hospital services provided in the main hub, Bethel. There is a variety of provider types and levels of health care providers depending on location of service delivery. Patients in the villages may get referred to the regional hub, or they may get referred to providers in Anchorage or out of state, either tribal or non-tribal for additional services that are not available in that region. Bethel also has services at various non-traditional facilities, such as the McCann Treatment Center for kids with behavioral health issues, a pre-maternal home for expectant mothers from outlying communities to reside until they give birth and then return to the village, and a Long Term Care facility for elders. When these patients are referred out of the region or facility, they go to a Medicaid enrolled provider that would conceivably be a "contracting agency."

The referral and divert pattern within Alaska is large and complicated. The referrals occur across tribal and non-tribal health facilities and services. For example, a Bethel OB patient may be referred to Anchorage or out of state, due to a high risk diagnosis, or a Ketchikan child with behavioral health issues may be referred to a treatment center in Sitka or Juneau. These services are referred internally within the tribal health system whenever possible but the patient may be referred to a non-tribal setting due to a variety of circumstances.

A few more examples to illustrate the complexity: A 4 year old girl in Shishmaref has meningitis. She has to be non-emergently sent to Nome to be stabilized. She is then either non-emergently traveled or medevaced to Alaska Native Medical Center (ANMC) in Anchorage as she is too sick to care for in Nome. She spends several weeks in Anchorage. Due to her chronic health care needs after her initial diagnosis, she has to be medevaced many times to both Nome and ANMC for respiratory problems, intractable seizures, and other health needs if she is not transported with non-emergent travel soon enough. This is a common occurrence for children with chronic healthcare needs in rural Alaska.

In another example, a child in Noatak is diagnosed with chronic otitis media and intermittent tympanic membrane perforation. She typically has hearing loss with possible speech delay. The child takes non-emergent flight(s) to Kotzebue to see the ANMC specialty doctor while they are in Kotzebue and to also see the audiologist, speech therapist, and ENT to see if she needs ear tubes. Each of these flights also requires an escort. The child and escort are flown non-emergent on Alaska Airlines to ANMC for ear tube surgery. For follow-up, the child is flown commercially to see audiology, ENT, speech, and the specialty doctor while in Kotzebue to make sure the ear tubes are functioning properly. Eventually, the child will outgrow this issue, but until then, there are numerous non-emergent flights for the family to ensure she is getting the proper care.

These are examples of the very common and complex referrals that occur every day in Alaska. It is absolutely essential that this policy allow maximum flexibility to states to allow them to meet this very real need in our respective states and regions.

We appreciate your consideration of our comments and recommendations and encourage you to continue to consult with states on the feasibility of the proposed changes. If you have any questions regarding our comments, please contact Jon Sherwood, Deputy Commissioner, (907.465.5830 or jon.sherwood@alaska.gov) or Renee Gayhart, Tribal Health Manager (907.465.1619 or renee.gayhart@alaska.gov).