Center on Budget and Policy Priorities

820 First Street, NE, Suite 510 Washington, DC 20002
202-408-1080 Fax: 202-408-1056 center@cbpp.org www.cbpp.org

November 17, 2015

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

Re: Medicaid Services "Received Through" an Indian Health Service/Tribal Facility

Dear Sir or Madam:

The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, DC. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes. We appreciate the opportunity to comment on the white paper explaining CMS' intent to update its policy regarding the availability of 100 percent federal funding for services provided to American Indian and Alaska Native (AI/AN) Medicaid beneficiaries.

We agree that the current interpretation of the statutory provision that limits 100 percent federal match to services "received through" Indian Health Service (IHS) facilities is too restrictive particularly given the federal government's responsibility for delivering and financing services to the AI/AN population. We support the change that CMS intends to make that would extend the scope of services to include all services covered under the state's Medicaid plan and that would encompass services provided by health care providers contracting with the IHS or tribal facility.

In finalizing the policy, CMS should provide clear guidance on what it means to be "received through" an IHS facility and make sure that the final definition encompasses all services covered in the state regardless of whether they are part of the facility services. Similarly, services provided through contractual agents should also encompass a broader scope of services. We urge CMS to be as flexible as possible in defining how referrals and contractual arrangements between IHS and tribal facilities and outside providers are carried out so as not to impose undue administrative burdens on the IHS and tribal facilities.

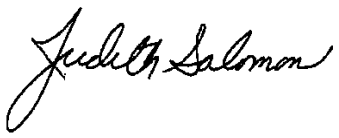
The intent to change the policy has already been instrumental in moving Alaska to expand Medicaid, and it appears that it may have a similar affect in South Dakota. We hope that the new policy leads other states to move in this direction. Besides providing a positive impact on state budgets, the new policy should also provide new opportunities for IHS and tribal facilities to provide a full package of coordinated services and increase their capacity to provide health care to tribal members. The inclusion of emergency and non-emergency transportation in the scope of services

received through IHS facilities is especially important in this regard. It is also important that the clarification of what it means to be received through an IHS facility advances the ability of IHS and tribal facilities to coordinate care by providing case management.

Finally, section 1932(h) of the Social Security Act requires that AI/AN beneficiaries enrolled in managed care plans be able to select an Indian health provider as their primary care provider. It also requires that managed care plans that enroll AI/AN beneficiaries provide access to Indian health care providers. The white paper proposes to allow states to claim 100 percent federal match for services provided to enrolled AI/AN beneficiaries by Indian health care providers. In finalizing this policy, CMS should ensure that it furthers the goal of allowing AI/AN beneficiaries to be treated by Indian health providers reflected in section 1932(h) without creating burdensome paperwork requirements. CMS should also monitor the managed care plans to make sure that they have adequate networks and are not putting barriers in the way of the freedom to choose an Indian health provider even when the provider is outside the managed care organization's network.

Thank you for considering our comments.

Sincerely yours,



Judith Solomon
Vice President, Health Policy