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BILL ANOATUBBY
GOVERNOR

November 17, 2015

Ms. Kitty Marx, Director
Center for Medicare and Medicaid Services
Division of Tribal Affairs
Intergovernmental External Affairs Group
Centers for Medicaid and CHIP Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Marx:

On behalf of the Chickasaw Nation we are pleased to provide the Center for Medicare and Medicaid Services (CMS) Division of Tribal Affairs with comments in response to its Tribal White Paper titled, Medicaid Services "Received Through" an Indian Health Service/Tribal Facility: A Request for Comment.

The Chickasaw Nation wants to extend our gratitude to CMS for developing this white paper which will improve the health status of AI/AN Medicaid beneficiaries and strengthen our government-to-government relationship.

We welcome the opportunity to provide feedback on the parameters of the reinterpretation of section 1905(b) of the Social Security Act and offer our comments included with this letter.

If you have any questions, please contact Dr. Judy Goforth Parker, secretary of the Chickasaw Nation Department of Health, at (580) 436-3980 or at Judy.Parker@chickasaw.net.

Sincerely,

Bill Anoatubby

Bill Anoatubby, Governor
The Chickasaw Nation

Enclosure

COMMENTS OF THE CHICKASAW NATION
CENTERS FOR MEDICARE AND MEDICAID SERVICES, DIVISION OF TRIBAL AFFAIRS, INTERGOVERNMENTL EXTERNAL AFFAIRS GROUP, CENTERS FOR MEDICAID AND CHIP SERVICES
IN RESPONSE TO ITS TRIBAL WHITE PAPER TITLED: MEDICAID SERVICES "RECEIVED THROUGH" AN INDIAN HEALTH SERVICE/TRIBAL FACILITY: A REQUEST FOR COMMENTS

The Chickasaw Nation appreciates CMS' efforts in updating its policy regarding the circumstances in which 100 percent federal funding would be available for services furnished to Medicaid-eligible American Indian and Alaska Native (AI/AN) individuals through facilities of the Indian Health Service (IHS) or tribes.

The Chickasaw Nation supports an interpretation of section 1905(b) of the Social Security Act that would expand the circumstances in which state Medicaid payments for services furnished to AI/AN beneficiaries would be considered to be "received through" an IHS/tribal facility and therefore qualify for 100 percent Federal Medical Assistance Percentage (FMAP). The following are specific comments on each of the conditions mentioned in the CMS Tribal White Paper:

Modifying the second condition. The Chickasaw Nation is supportive of the option under which a service "received through" an IHS/tribal facility could be any service encompassed within a Medicaid state plan benefit category that the IHS/tribal facility is authorized to provide. This support comes with the understanding of this language to be inclusive of authorized to provide in the Indian Health Care Improvement Act and other authorizing legislation. We also support the inclusion of emergency transportation (EMT) and non-emergency transportation (NEMT) services, including related travel expenses.

Modifying the third condition. The Chickasaw Nation supports CMS' consideration of the option that would expand the meaning of a contractual agent to include a qualified individual or entity that is enrolled as a Medicaid provider and who provides items or services not within the scope of a Medicaid "facility services" benefit but within the IHS/tribal facility authority. Our comments are concerning the written contract requirement, as many of our health care providers we refer patients to do not have written contracts/agreements with us, but rather non-written arrangements. We would recommend this language be clarified to say "contract or agreement arrangement" rather than "written contact requirement." We also support that the individuals served must have some type of relationship with the IHS/tribal facility. The requirement that "IHS/Tribal facilities 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" could be very problematic. Currently in these type of relationships, the outside provider sends the referring provider a copy of the visit report with any recommendations or plans of care, which are then filed in the patients' medical record. Any requirement above that interaction is not necessary, nor enforceable. It is also

recommended that a clarification be inserted to say "any service that is authorized to be provided by IHS/tribal facility would be eligible for Medicaid reimbursement."

Modifying the fourth condition. No comments.

Application to fee-for-service. This section needs some clarification. It is our recommendation that the provision of services which are eligible for the OMB AIR are not limited to the Medicaid facility based services, but rather any service provided in an IHS/tribal facility. This type of limitation does not relate to the 100% federal matching issue, but rather reaches into the reimbursement rate, which we recommend not be a part of this policy guidance. Mainly because the only limitation of services reimbursed at the OMB AIR is that the service is authorized to be provided by an IHS/tribal facility through the Indian Health Care Improvement Act and other authorizing legislation.

Application to managed care. This section is more difficult to provide comments because it is unclear how states currently are reimbursed at 100% FMAP for managed care services. We assume that states already receive 100% FMAP for managed care services. We also believe that tribes have the right to be paid by managed care plans at the OMB AIR, which should already be eligible for reimbursement at 100% FMAP. Other concerns are any requirements on "what types of documentation will be needed for application of the 100% FMAP?" The managed care plans won't have an incentive to track the service back to the IHS/tribal facility because the 100% FMAP is the state getting reimbursed, and the managed care plan won't have any incentive to do anything extra for the state. A consideration should be given by CMS to allow states to incentivize the managed care plans in some way, through an administrative fee or otherwise, to ensure a tracking system is going to work. There needs to also be further clarification on how this would work. For example, will the match be at the regular rate and then adjusted at the end of the year?

Conclusion

Thank you for considering these comments. These policy considerations are very important to Indian Country and to support the federal responsibility to provide health care to our citizenry and to ensure that Indian health programs continue to be able to provide health services to Indian communities.