CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.

November 16, 2015

Vikki Wachino, Director
Center for Medicaid and CHIP Services
Department of Health and Human Services
Attn: CMS-2327-FC
P.O. Box 8016
Baltimore, MD 21244-8016

Sent via email to Tribal.Affairs@cms.hhs.gov

Dear Ms. Wachino:

Today I write on behalf of the California Rural Indian Health Board (CRIHB), a network of 12 tribal health programs that provide health care services to members of 33 tribes throughout California, to provide official comment on proposed changes to CMS's interpretation of its 100% FMAP policy. We appreciate the efforts CMS has made to revisit its overly narrow interpretation of 1905(b) of the Social Security Act, which requires 100% FMAP for services provided to Medicaid patients "received through" IHS and tribal facilities. This change will help to ensure better access to a full range of health care services for American Indians and Alaska Native (AI/AN) patients throughout the United States.

We fully support the proposals for changes to the policy made by South Dakota and Alaska, including Alaska's request for purchased/referred care-related transportation to be reimbursed at 100% of FMAP. Up until now, eligibility for 100% FMAP reimbursement has been tied to the facility rather than the patient, limiting full reimbursement for services provided to AI/AN Medicaid patients to IHS and tribal health program facilities. These new proposals would shift 100% FMAP eligibility to the status of the patient as AI/AN as they receive health care services through the purchased/referred care process. This is consistent with the federal trust obligation to provide health care to AI/AN patients as well as with existing special provisions for AI/AN in the Social Security Act and the Affordable Care Act, including cost-sharing protections and certain limited protections from Medicaid estate recovery. CRIHB therefore takes the position that the 100% FMAP rule should apply to purchased/referred care services.

This interpretation of Section 1905(b) is reasonable because it refers to services "received through" the IHS or tribal health program facilities and purchased/referred care services are a major component of the health care provided to AI/AN by tribal health programs. This is particularly true in California, which has no IHS facilities to provide a broad range of services normally provided by IHS hospitals, including everything from hospitalization to a number of outpatient services, like x-rays and blood tests. As a result, the California IHS Area is called "purchased/referred care-dependent."

Expanding CMS's current interpretation to include purchased/referred care services will benefit IHS and tribal health programs by allowing states to expand services for AI/ANs, either by covering additional population groups or additional services at no cost to the state. This could result in significant savings to purchased/referred care budgets for tribal health programs, which are significantly underfunded.

For these reasons, CRIHB respectfully requests that CMS interpret "received through" to include 100% FMAP eligibility for purchased/referred care services regardless of where they are received. This new interpretation would be especially helpful in ensuring access to health care services for AI/AN in purchased/referred care "dependent" areas like California. We respectfully request CMS to consider the following recommendations related to the new, proposed interpretation of 100% FMAP eligibility:

1. Extend 100% FMAP for purchased/referred care services throughout the entire Indian health system. It should follow the AI/AN patient, not the facility. This is consistent with both the trust duty to AI/AN patients and the decentralized way in which specialty health care services are provided today, through networks and referrals rather than one large facility.

2. Link the application for 100% FMAP to a purchased/referred care referral from any IHS or tribal health program facility with a "638" or Indian Self Determination, Education, and Assistance Act contract. This will create an incentive for states to work with the tribes and CMS to implement the new policy. The required participation of the tribal health programs may also prevent states from attempting to force AI/ANs into managed care plans.

3. Continue to protect the fee-for-service status option for AI/ANs to the maximum extent possible. This is critically important for rural tribal health programs in California. Fee-for-service status often creates better access to providers than managed care membership in rural areas, which limits AI/AN patients to networks that may not have providers within hundreds of miles. CRIHB supports the changes CMS has proposed, which would make services provided to fee-for-service users eligible for 100% FMAP if they are included in the facility benefits of an IHS or tribal health program facility, even if they are provided by a purchased/referred care contractor.

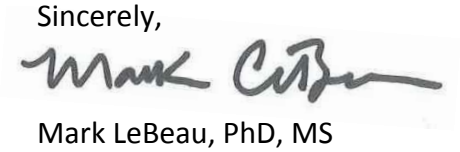
4. As the new policy is developed, encourage new contractual relationships based on advances in technology, like telehealth, that will both expand access to care and allow IHS and tribal health program facilities to conserve scarce purchased/referred care funding. This will require CMS to build some flexibility into the new policy with regards to kinds of providers and locations where services are provided.

5. Revise the extension of 100% FMAP to urban Indian programs to reflect the operation of the Indian health care delivery system. Urban Indian clinics generally refer patients to non-Indian facilities in close proximity for specialty care, not to tribal health programs

located hundreds of miles away. The "contractual agent" model is therefore not likely to help urban Indian clinics to utilize FMAP for services provided to their patients. CRIHB supports the extension of 100% FMAP to urban Indian health programs so long as its application is limited to IHS beneficiaries and it will not result in a reduction of 100% FMAP eligibility for purchased/referred care services.

Thank you for your willingness to revisit the current interpretation of Section 1905(b) of the Social Security Act and for this opportunity to provide comments. If you have any questions or concerns, please contact me at Mark.LeBeau@crihb.org or (916) 929-9761.

Sincerely,



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