Kitty Marx, Director Tribal Affairs

Center for Medicare and Medicaid Services

7500 Security Blvd, Mailstop S1 13 23

Baltimore, MD 21244

October 12, 2015

Dear Director Marx;

RE: Services Provided Through an IHS/Tribal Facility

As a member of the Cherokee Nation with thirty years' experience working in the field of health service delivery in Indian Country I am pleased to see and enthusiastically support the proposed changes in criteria for determining what will be considered a service *provided through* an IHS or Tribal Facility. This policy could have far reaching effects on the provision of care to IHS eligible beneficiaries who are also Medicaid enrollees. The proposed changes clarify the status of IHS operated and Tribally operated facilities and creates a greater equality between those two sometimes dispirit modes of care provision. This new clarity of role should also have positive effects nationwide on state IHS/Tribal relations which are often stalemated by confusions over the unique status of IHS and Tribal providers and self-imposed limitations of state policy. Even more importantly these criteria will foster greater movement within the IHS and Tribal provider systems towards innovative approaches to care including increased utilization of case management and other techniques of patient centered care. It will reawaken the dream of IHS/Tribal facilities to provide community based patient centered care by providing a clear path to asserting their right to manage patients who previously were often lost to an uncooperative local health care system. This change will strengthen the ties of a significant number of patients to their IHS/Tribal provider. Research done by Carol Kornbrot Ph.D. on behalf of the CMS Tribal Technical Advisory Group indicates that almost a third of the known IHS enrollees with Medicaid coverage who received care in the most previous year have not been seen at an IHS/Tribal facility within the past three years. Most of this care was for specialty care and high end diagnostics although the largest costs were for inpatient hospitalizations. The proposed changes could end this systematic alienation of these IHS/Tribal clients from their putative medical homes and the culturally competent care that is their birthright. There could also be

positive secondary benefits for the mostly rural health care providers who are located nearby IHS/Tribal providers from strengthened referral patterns and improved collaboration.

The key to this expanded role and improved future is modification of the current second condition allowing for the provision of any state plan established service by an IHS/Tribal provider. At the end of this paragraph is language which makes specific reference to three types of transportation services that could be provided through an IHS/Tribal facility. I would suggest that this useful clarification be specifically expanded to list enrollment assisting which is also frequently reimbursed through administrative matching and is an important part of IHS/Tribal servicing of their clients.

The proposed language modifying the third condition is the corollary to the earlier change in that it establishes rules necessary to implement the new expanded definition within the context of the local provider network. This part of the change expands the provision of care through case management and defined contractual relationships. In California this will bolster the role of Tribal Health Programs within their local provider communities and foster greater patient satisfaction. It would be helpful if this paragraph also made a specific reference to the provision of face to face services through video connection commonly referred to as telemedicine.

The proposed language modifying the fourth condition is interesting and may find some resistance within the Tribal communities. It has the possible impact of freeing the IHS/Tribal facility from the rigors of complex billing practices associated with services they have not historically provided and reducing the number of vendors with whom they would have to maintain accounts. This section might be strengthened if there was a requirement for an annual accounting back to the IHS/Tribal provider for all assigned billings and an affirmation of the provision of all relevant protected patient information for all directly billed services for which 100% FMP had been invoked.

California is nearly a 100% Medicaid Managed Care state in which almost all IHS funded care which is Medicaid reimbursed care is provided through tribally operated organized primary care clinics. Over the years to achieve economies of scale almost all these Tribal Health Programs have opened their doors to non-Indian Medicaid beneficiaries. To address this situation the Medi-Cal program has developed an elaborate system of billing that meets the twin goals of reimbursing Tribal Health Programs fully for the established All Inclusive Rate and only claiming federal funding participation at 100% Federal Matching Percentage for those services provided to individuals who are IHS eligible beneficiaries. The expansion of 100% FMP to California's network of Managed Care Organizations for all services provided through the network to American Indian MCO enrollees would be detrimental without the further requirement that these beneficiaries be case managed by the appropriate and proximal network providing Tribal Health Program which the individual IHS beneficiary has selected as their medial home. This limitation and selection process is necessary to maintain the central role of the IHS/Tribal providers in medically managing their clients while facilitating easy referral to other providers within the MCO network for whom no specific contractual relationship is established. It would also be helpful if the current practice of not considering MCO incentive payments to the IHS/Tribal providers as a fee and thereby excluding these payments from the of

the calculation of the reimbursement of All Inclusive Rate was specifically addressed in the final policy. Although this would reduce the types of costs covered by 100% FMAP it is important to continue a practice that appropriately incentivizes all providers to address data collection and quality issues within their practice.

Thank you for your consideration of these comments.

Respectfully

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James Allen Crouch MPH