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Submitted via email to:
TribalAffairs@cms.hhs.gov

Ms. Kitty Marx
CMCS Division of Tribal Affairs
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicaid Services "Received Through" and Indian Health Services/Tribal Facility White Paper: A Request for Tribal Comment

Dear Ms. Marx,

The United South and Eastern Tribes, Inc. continues to express its strong support for the Centers for Medicare and Medicaid Services' (CMS) proposal to expand and modify the criteria used to determine services eligible for the 100% Indian Federal Medical Assistance Percentage (FMAP) rule. Expanding CMS' current interpretation of the 100% FMAP will incent states to work with Tribal Nations to increase Medicaid and CHIP enrollment, increase access to care for American Indian and Alaska Native (AI/AN) patients, reduce expenditure of limited Indian Health Service (IHS) appropriation dollars and provide a more equitable application of the federal trust responsibility.

USET is a non-profit, inter-tribal organization representing 26 federally recognized Tribal Nations from Texas across to Florida and up to Maine[1]. Both individually, as well as collectively through USET, our member Tribal Nation work to improve health care services for American Indians. Our member Tribal Nations operate in the Nashville Area of the IHS, which contains 36 IHS and Tribally Operated facilities. Our members receive health care services both directly at IHS facilities, as well as in Tribally-operated facilities operated under contracts with IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638.

Background:

USET is encouraged by CMS's desire to reexamine the federal government's role in financing and delivering health care to Medicaid-eligible AI/AN. Medicaid plays a critically important role in expanding access to care for low-income IHS beneficiaries. The program has helped increase resources available for these patients both by

[1] USET member Tribes include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME), Catawba Indian Nation (SC), Cayuga Nation (NY), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

facilitating savings in Purchased/Referred Care budgets and bringing in additional revenue to the IHS/Tribally operated facility (Indian Health System) through 3rd party billing. These additional resources help Tribes continue to address the unmet needs of their patients as a result of Congress' failure to fully fund the IHS. 100% FMAP is an important mechanism to ensure Tribes can continue to access the Medicaid program, the Federal Government meets its trust responsibility to Tribes, and States are not burdened with the cost of caring for a population who should otherwise have their care delivered and financed by IHS. For the 16 USET member Tribes that reside across 8 States where Medicaid has not been expanded, this proposal would provide an additional avenue to encourage States to expand Medicaid and increase services to AI/AN Patients.

In a letter to CMS on September 30th, USET asserted our position that CMS' historical analysis of the 100% FMAP rule has been overly narrow and that the agency is within their legal authority to expand their interpretation. We are grateful that CMS has addressed many of these concerns in their October 27th White Paper. We appreciate CMS' work to delineate their current 4-criteria model for determining 100% FMAP eligibly and allow the opportunity to provide suggestions on ways to expand the application of these conditions. We offer the following comments to address CMS' proposal to modify the conditions that determine eligibility for 100% FMAP.

Support for broadening criteria for the types of services eligible for 100% FMAP by modification of the 2nd condition.

One of the more restrictive criteria that CMS had been applying with its historic interpretation was limitations on the types of services eligible for 100% FMAP. CMS' historic interpretation limited services eligible for 100% FMAP to "facility services' or within the scope of services that a IHS/Tribal Facility (e.g. inpatient hospital, outpatient hospital, clinic, Federal Qualified Health Center, Nursing facility) can offer under Medicaid's facility based rules.

CMS' White Paper proposal would expand the types of services eligible for 100% FMAP to any services that could be "encompassed within a Medicaid State plan benefit category that the IHS/Tribal Facility is authorized to provide". USET agrees that increasing the types of services for which States can claim 100% FMAP will provide incentive to offer more comprehensive benefits and allow Tribes to bill for these services. The rule should clarify that all services an IHS/ Tribal Facility (I/T) is authorized to provide under the Snyder Act, Transfer Act, the Indian Health Care Improvement Act and other applicable law will be eligible. Additionally, other eligible services should include those authorized under Section 1915 and 1115 waivers. We support the inclusion of emergency transportation, non-emergency transportation and other travel related expenses in the modified rule. Ultimately these modifications will increase services available to Medicaid eligible AI/AN patients and bring resources into the Indian Health System.

Support for broadening the interpretation of provider arrangements that constitute a service being "received through an IHS facility" by modifying the third condition.

USET supports the proposal to include services received through an I/T, provided by contractual agents, as eligible under the 100% FMAP. These providers are often considered part of the Indian Health System, as they fill critical gaps and fulfill the unmet needs of patients. The statute allows for 100% FMAP for services "received through an IHS facility," which Tribes have always interpreted to include services rendered both inside and out of their hospital or clinic. In rural areas, where many USET member Tribes resides, many have existing agreements with special groups of outside providers to ensure patients may receive services not currently offered at the clinic level. This can include services such as physical therapy and rehab or cancer screening and cardiology. Where a contract exists, these outside providers should be viewed as extensions of the IHS or Tribally Operated Facility and eligible for 100% FMAP.

Similarly, services provided to Medicaid-eligible AI/AN patients, under referral or where a relationship exists between the patient and the I/T Facility should be eligible for 100% FMAP. In some cases, Tribes will not have a formal contract with an outside provider but rather an informal arrangement, offering medical referrals for patients to seek necessary care. For some USET Tribes, these referrals are also issued for primary care services. In these cases, acceptance of a referral should meet the requirements of being "received through" the Indian Health System. Including these providers in the rule will be essential to ensuring network adequacy in managed care settings and access to care for AI/AN on Medicaid. It will also encourage better care-coordination between all involved parties.

Although we are encouraged by CMS' willingness to consider the variety of provider arrangements that exist in the Indian Health System, we are concerned by a proposal to implement additional requirements, which could be administratively burdensome. The White Paper states that, "The IHS/Tribal Facility 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." We believe that these requirements go above and beyond the current arrangements that exist between Tribes and their providers and would be very difficult to implement if made a condition of claiming 100% FMAP. These restrictive requirements would have the unintended effect of limiting the number of outside providers Tribes are able to work with, rather than increasing access to care for AI/AN Medicaid patients. We suggest that CMS extend the rule without imposing additional requirements, which are not required by statute and could harm important provider arrangements.

<u>Support for flexible Medicaid billing options to account for various provider arrangements through modification of condition 4.</u>

USET supports CMS's proposal to modify the 4th condition of the current criteria to allow more flexibility in how contractual agents of I/T facilities bill the Medicaid program. Traditionally, States would only be reimbursed for 100% FMAP if the contractual agent billed "up through" the IHS or Tribally-operated Facility. While this works well for some providers with formal contracts with the I/T, this adds additional administrative barriers and can be difficult for providers providing care on a referral-by-referral basis. Acknowledging the different types of provider relationships by offering two billing pathways would reduce administrative challenges and confusion regarding reimbursement rates. These providers should also be able to bill for any services authorized under Snyder Act, Transfer Act, the Indian Health Care Improvement Act and under Section 1915 and 1115 waivers. Allowing for this flexibility will be an important feature of the rule and important to their continued participation in the Indian Health System.

Although we support the proposal on the whole, CMS will need to clarify how States will claim 100% FMAP for services billed directly by contractual agents of the IHS/ or Tribally Operated clinic. To date, there has not adequate information about how States currently claim 100% FMAP for services provided to AI/AN Medicaid beneficiaries. This guidance will be important to clarify so States can continue to be reimbursed at 100% FMAP when AI/AN patients wish to be seen in Fee-For-Service (FFS) setting by outside providers rather than in a Managed Care setting. Managed Care does not work well for most Tribes, so ensuring mechanisms exist for claiming 100% FMAP for "contractual" providers seeing AI/AN patients in FFS and billing Medicaid directly will be very important for States, Tribes and contractual agents. The easier it is for States to pay for care provided to AI/AN patients in FFS settings the less likely they will be to attempt to auto-enroll Indians into Managed Care and impose network restrictions harmful to their access to care.

Application to Fee for Service: Distinguishing Reimbursement Rates.

CMS' proposal clarifies that I/T facilities will continue to be reimbursed for facility services at the rate established with their State, whether the all-inclusive rate or through other payment methodologies such as the Federally Qualified Health Center Prospective Payment System. We support CMS's proposal to honor established rates for facility benefit services. We also appreciate CMS' efforts to ensure that "States retain the flexibility to establish economic and efficient payment rates to sufficiently reimburse for the provision of services." This language is important so that services outside of a traditional facility benefit can still be billed by Tribes and reimbursed at rates established by the State. This will help ensure that Tribes will be reimbursed for transportation services, home health and other services provided outside of the 4 walls of the I/T.

Application to Managed Care: Support for clarifying the criteria under which States that operate Medicaid Managed Care can claim 100% FMAP for health expenditures.

USET appreciates the efforts CMS has made to update and clarify that States may claim 100% FMAP when operating Medicaid Managed Care. In 8[2] of the 12 States where USET member Tribes reside States deliver their Medicaid benefits through Managed Care Organizations (MCOs). Of the 17 Tribes that reside in these States, some must navigate working with anywhere from 2 Medicaid MCOs in Mississippi, to 19 MCOs in Florida and Texas. In most cases, these MCOs have never worked with Tribes and are completely unfamiliar with the way the Indian Health System works. This leads to several challenges, especially with respect to reimbursement despite the Managed Care protections authorized through the American Reinvestment and Recovery Act (ARRA). For the reasons stated above, we are grateful that CMS makes a clear effort to clarify how States can claim 100% FMAP for care delivered to Medicaid-eligible patients through MCOs.

As noted earlier in the document, it is currently unclear how States go about claiming 100% FMAP for services provided to AI/AN Medicaid beneficiaries Managed Care settings. However, CMS' proposal establishes the condition that States can "claim the 100% FMAP for the portion of the capitation rate representing those services expended by the managed care plan." USET supports this requirement to ensure that funding from the federal government to States for AI/AN is, in fact, being expended on the health care for this population. There was no indication from CMS whether States were claiming 100% FMAP for full capitation payments regardless of actual expenditure on services prior to the clarification of the rule. This will be a great first step to setting up a more transparent system for States to claim 100% FMAP on care provided to AI/AN beneficiaries in managed care.

USET is concerned, however, that there will need to be a significant investment in creating infrastructure by which States can track actual expenditures made on AI/AN health care by MCOs. Managed care plans have very little incentive to create a tracking system for States, and this could pose an administrative burden for States to comply with the conditions of the 100% FMAP reimbursement. We urge CMS to establish a flexible guidance for States to be able to track actual expenditures and claim 100% FMAP for these services.

Another critically important aspect of how the Indian Health System interacts with MCOs are the payment protections in ARRA. One very important component of these protections is that States are required to make wrap-around payments when a MCO pays a lower rate than that negotiated in the State plan (usually the all-inclusive or encounter rate). In most cases, particularly when I/Ts are not listed as "in network" they are denied payment, or will receive payments lower than the rate established in the State plan. When Tribes seek the difference from their State, it can take weeks to months to recover, as significant revenues are lost or delayed. We

[2] Florida, Louisiana, Massachusetts, Mississippi, New York, Rhode Island, South Carolina and Texas all utilize Managed Care Organizations to deliver Medicaid benefits.

urge CMS to ensure that ARRA-mandated wrap-around payments are included in the 100% FMAP rule to ensure timely and proper payment to I/Ts participating in Medicaid Managed Care.

Conclusion

Thank you for considering these comments on the CMS White Paper proposal to modify the conditions that determine services eligible for the 100% FMAP. USET believes that the broader interpretation of this rule will lead to more productive relationships between Tribes and their State Medicaid departments and ultimately lead to greater access to care for AI/AN patients enrolled in Medicaid.

USET appreciates this opportunity to provide comments on the expanded interpretation of the 100% FMAP rule. Should you have any questions or require additional information, please do not hesitate to contact Ms. Liz Malerba, USET Director of Policy and Legislative Affairs, at (202) 624-3550 or by e-mail at lmalerba@usetinc.org.

Sincerely,

[redacted]

Brian Patterson
President

[redacted]

Kitcki A. Carroll
Executive Director

CC: USET member Tribes
Wanda James, USET Deputy Director
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"Because there is strength in Unity"