State of Utah

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November 17, 2015

Ms. Victoria Wachino
Director, Center for Medicaid & CHIP Services
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Attn: Comments on Medicaid Services "Received Through" an Indian Health Service/Tribal Facility: A Request for Comment

Dear Ms. Wachino:

Utah Medicaid appreciates the opportunity to comment on the policy change you are considering regarding these services for American Indians and Alaska Natives (AI/AN).

There are eight federally recognized tribes and one Urban Indian Organization in Utah. Approximately 1.5 percent of Utah's population (48,500) is AI/AN. Almost half of AI/AN in Utah live in an urban environment. The AI/AN have the highest rates of overall poverty (29%) and childhood poverty (35%) in Utah. Medicaid programs are extremely important to accessing health care and in providing additional resources for the Tribal health programs across the state. As of October 31, 2015, approximately 58 percent of those AI/AN living at or below poverty were enrolled in Utah Medicaid.

Overall, the Utah Department of Health (Department) supports the proposed changes that would allow 100 percent Federal Medical Assistance Percentage (FMAP) to be paid for certain services. The change will help support the Department's ongoing efforts to ensure access to services for its AI/AN members. The Department's comments on these changes include input from the Department's Office of AI/AN Health Affairs and some Utah Indian Health Advisory Board representatives.

UTAH DEPARTMENT OF HEALTH

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1. *Modifying the second condition – reconsidering the requirement that "received through" an IHS/Tribal facility must be a "facility service"*. Utah tribes and reservations are located in some of the most rural and frontier parts of the state. Currently, Utah Medicaid has several contracts with Tribes to provide transportation of Medicaid clients who need services but are not able to get to these locations themselves. However, the state receives only the regular FMAP for these services, even though the transportation is provided to AI/AN individuals. The Department supports the proposed policy to allow 100 percent FMAP for these types of services.

2. *Modifying the third condition – expanding the meaning of a contractual agent to include an individual or entity that is enrolled as a Medicaid provider, or services furnished through the IHS/Tribal facility, but are not necessarily furnished directly by the IHS/Tribal facility; including Urban Indian Health programs*. Expanding the definition of contractual agent will improve the Tribes' ability to work more effectively with contractual agents and more easily provide services the Tribes are not able to provide in their own facilities.

   The stipulation that the records and care coordination are retained and controlled by the IHS/Tribal facility and that the individuals are considered patients of the IHS/Tribal facilities, provides an opportunity for improved case management and patient outcomes. However, the Department requests that CMS allow some flexibility in its requirement that IHS/Tribal facilities retain responsibility for these services—in particular, the statement that "the IHS/Tribal facility must retain control of the medical records." Currently, several Tribal programs have contracts for services and specialty providers outside of their facilities. The Department is looking into how those contracts address the responsibility for medical records and case management. We hope the CMS policy will be flexible enough to support existing arrangements and not require a significant process shift for these Tribes or their contractual agents.

   Providing opportunity for the Tribes to include Urban Indian Programs as a contractual agent would improve access to culturally appropriate services for tribal members who normally utilize the IHS/Tribal facilities on the reservation but who are not currently residing at the reservation. The Urban Indian Program and the IHS/Tribal facility will need to coordinate records retention and case management to prevent unnecessary tension between IHS/Tribal/Urban facilities. Again, the Department requests that CMS allow flexibility in its definition of retaining responsibility in order to allow for these entities to work out appropriate solutions to their coordination issues.

3. *Modifying the fourth condition – IHS/Tribal facilities would have the choice to bill for the services or have the contractual agent bill for the services*. This proposal could benefit the IHS/Tribal facilities that have the capacity to manage the increased billing. In addition, the potential for additional resources could improve capacity for the health programs overall. However, if smaller Tribal facilities with smaller capacity to manage the increased billing allow the contractual agent to bill Medicaid, the smaller facilities could stand to lose additional resources to improve their health programs and overall health in their communities. The Department requests that the policy support Tribal options in operationalizing their contracts with their agents in a way that maintains the Tribes' right to self-determination.

4. *Application to fee for service – impact of proposed changes on payments*. The two bullets in the Request for Comment document match how reimbursement in Utah is currently managed. However, it is unclear how contracted agents would be reimbursed if they see an AI/AN individual and then bill Medicaid directly. In Utah, Medicaid pays the All Inclusive Rate (AIR) based on the identification of a facility as an IHS/Tribal facility. The Department requests that states be given the option to pay state plan rates rather than the AIR to contractual agents that bill Medicaid directly.

5. *Application to managed care – allowing states to collect 100 percent FMAP for certain services provided to AI/AN individuals enrolled in managed care plans*. Currently, IHS/Tribal facilities are carved out of Utah Medicaid's managed care contracts. The IHS/Tribal facilities bill Utah Medicaid directly and are paid the AIR. The Department is supportive of the CMS proposed change, even though Utah Medicaid will likely continue to carve out these facilities from its managed care contracts.

Sincerely,

[redacted]

Michael Hales
Deputy Director, Department of Health
Director, Medicaid and Health Financing