Medicaid Services "Received Through" an Indian Health Service/Tribal Facility:
A Request for Comment
Comments from South Dakota
November 13, 2015

These comments are submitted on behalf of the South Dakota Health Care Solutions Coalition, a broad stakeholder group convened by Governor Daugaard that includes representatives of tribes, legislators, providers, IHS and the executive branch. The goal of the Coalition is to increase access to health care services for Indian people who are dually eligible for Indian Health Service/Tribal Health Program (I/T) and Medicaid through a strategy whereby services for this population will be paid at 100% FMAP in order to offset state costs of expanding Medicaid to the entire expansion-eligible population.

The Coalition appreciates the changes proposed in the White Paper. To ensure greater access to healthcare, and greater access to care paid at 100% FMAP, it will be imperative that states have adequate flexibility to define processes that will accomplish the proposed changes in ways that will minimize unneeded bureaucracy and maximize health care options for individuals. We look forward to the release of final policy changes to implement 100% FMAP for services, and respectfully submit the following comments for consideration:

1. We are seeking clarification on what constitutes services being *"arranged and overseen"* by the IHS/Tribal facility. Many South Dakotans live in urban areas that are geographically distant from IHS or Tribal service programs. These individuals get primary and other care outside IHS today. For instance, Sioux Falls is the largest population center in our state, and it is located in the far southeastern corner of the state. The nearest IHS facility would be in Wagner, SD, which is 110 miles away, and has very limited capacity for services. The nearest tribally-operated facility is 45 miles away. There is no public transportation between cities. It would not make sense for Native Americans living in Sioux Falls or other cities that are not in close proximity to an IHS/tribal provider to have their care coordinated directly from the IHS facility based providers.

   Could the policy change include flexibility for what constitutes services being *"arranged and overseen"* in situations where the nearest provider is geographically removed from IHS or a tribal health program so states and tribes can develop strategies that work for their populations? One possible option is to allow IHS or Tribal Health Programs (I/T) to utilize Urban Indian Health Organizations (UIO) as contractual agents for care coordination and to provide care to an IHS eligible patient living within a designated geographic area. Should

the UIO need to make further referrals to non-Indian Health provider, on behalf of the I/T health program it has entered into an agreement with for care beyond its scope, the non-Indian Health provider could bill Medicaid directly, and be paid the state reimbursement rate. Both scenarios would ensure the 100% FMAP reimbursement for services provided on behalf of an IHS or Tribal Health Program.

Another option is to define *“arranged and overseen”* within the contractual arrangement and define specific I/T management of those services within the contract. We do not want to disrupt the existing care coordination that is happening outside the IHS system now, so we are seeking flexibility in the definition of “arranged and overseen” and the mechanisms used to manage this aspect of care.

Appropriate sharing of medical records should be defined in the agreement between I/T and non-Indian Health providers, and I/Ts should be able to use the state’s Health Information Exchange or other integrated EHR tools for sharing records. We are seeking clarification in the white paper that medical record management can be defined by an agreement between II/T and non-Indian Health providers. This would allow for a provision that would insure follow-up, but not require the I/T to actually control the record of the non-Indian Health provider. The general terms would be included in the state plan amendment.

2. We would like flexibility to define the contract mechanism between I/T and non-Indian health providers in the Medicaid State Plan. IHS is specifically seeking an ability to expedite the contracting process. We would like the white paper to acknowledge the appropriate contractual arrangement between I/T and non-Indian health providers may be a memorandum of agreement or a purchase of services agreement, depending on the way services will be provided. Federal procurement processes would not apply to certain arrangements, and we want to avoid unnecessary bureaucracy if possible. We are also seeking flexibility to use a master contracting or agreement within an IHS region to make the process consistent and efficient. We are also seeking flexibility to use a master contracting or agreement within an IHS region to make the process consistent and efficient. We request the white paper provide flexibility at the State/Indian Health Program (IHP) level to determine the terms of the contracting agreements and allow the state the opportunity to describe in the state plan amendment how it will meet the contracting standards for approval.

3. We are seeking clarification on reimbursement for “facility based services” in general. For all services that meet the other requirements of being coordinated by IHS (or a Tribal program) and provided through a contractual agreement between the I/T and a non-Indian health provider, we feel 100% FMAP should be available. For example, a woman receives her prenatal care from a provider at the Pine Ridge IHS service unit. She develops complications late in her pregnancy and needs perinatology care that is not available in the IHS service unit, and her IHS provider refers her to a non-IHS provider in Rapid City, SD. The woman gets the specialty care, and her IHS provider continues to coordinate her overall prenatal care. The woman delivers early, and her baby requires neonatal unit care which is not provided in the IHS facility. The baby is in the NICU in Rapid City for 10 days. IHS has a contract for the specialty provider care and the NICU services the IHS system does not provide. We are seeking clarification that 100% FMAP would be provided in this type of scenario for the specialty provider care and the NICU service. We are also seeking clarification that 100% FMAP would be available for all hospital and other facility-based services, such as nursing home and residential psychiatric treatment center services. In addition, we seek clarification that 100% FMAP would be available for services provided via telehealth by non-I/T providers, per the authority in the Medicaid state plan.

4. For all services that are provided outside the I/T system today, we strongly support the ability for providers to bill the Medicaid plan directly at 100% FMAP. We also want to be able to reimburse these services at the state plan (not IHS encounter) rates for non-IHS providers billing directly through the Medicaid program. Providers see Medicaid as a reliable funder and the rates in the Medicaid system are based on procedures and costs so they align better to actual service provision than the IHS encounter rate. To force non-IHS providers to have different rates based on participant IHS eligibility would be confusing for providers and seems like it could conflict with federal policy relative to participant choice and access to services, and have other unintended consequences relative to service delivery.

   For example, Medicaid pays $950 for Magnetic Resonance Imaging (MRI) for all Medicaid eligibles today. The IHS encounter rate is $350 for this same procedure. Conversely, Medicaid pays $1,053 for an inpatient stay that averages 3 days for a live birth for all Medicaid eligibles today. The IHS inpatient daily per diem rate for all inpatient procedures is $2,443 per day or $7,329 for a 3 day stay.

Overall, the extension of the all-inclusive rate to non-Indian Health providers would not be appropriate to the intent of federal policy. The all-inclusive rate is a provision provided to Indian Health providers as an extension of the federal trust responsibility unique to Tribes and the Indian Health Service, and should remain exclusive to Indian Health programs.