November 16, 2015

The Honorable Sylvia Mathews Burwell, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Burwell,

The Georgetown University Center for Children and Families writes in response to the Center for Medicaid and CHIP Services Request for Comment regarding Medicaid Services "Received Through" an Indian Health Service/Tribal (IHS) facility. We write in support of CMS' proposal to update the circumstances in which state Medicaid payments for services furnished to American Indian and Alaska Native beneficiaries would be considered to be "received through" an IHS facility and therefore qualify for 100 percent federal match. The proposed revisions would make federal reimbursement policy more consistent with the way Medicaid-eligible American Indians and Alaska Natives receive care, and lead to improved access and quality of care for American Indian and Alaska Native Medicaid beneficiaries.

Improving access to care for American Indians and Alaskan Natives

Extending the 100 percent Federal Medical Assistance Percentage (FMAP) rate for services *contracted* by Indian Health Services, in addition to those already provided directly by IHS, would improve access to care for the American Indian and Alaska Native population that faces persistent disparities in health and health care, barriers to obtaining care, and poor health status.[1] Continued underfunding of IHS limits access to care for the population that it serves. Indeed, the appropriated IHS budget is only sufficient to provide about half the services its constituents require.[2] Further, because most IHS facilities are on reservations, they are inaccessible to American Indians and Alaskan Natives who reside outside reservations. In 2009, 43 percent of American Indians/Alaska Natives lived outside of areas served by IHS.[3]

Because health services unavailable at IHS facilities are provided via the Contract Health Services (CHS) program, it is sensible that CMS is considering providing the same FMAP to these facilities that often serve as a source of care for many essential services for American Indians and Alaskan Natives, such as mental health services.

Extending the 100 percent FMAP would also simplify the way in which contracted facilities that provide care to American Indians and Alaska Natives are reimbursed. Currently, the nature of IHS contracting is complicated, and the Government Accountability Office (GAO) has reported on issues with the timeliness of payments to CHS due to the complexity of these arrangements.[4]

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[1] S. Artiga and R. Arguello, "Health Coverage and Care for American Indians and Alaskan Natives," Kaiser Commission on Medicaid and the Uninsured," October 2015.
[2] Centers for Medicare and Medicaid Services, "Health Care Reform: Tracking Tribal, Federal, and State Implementation," May 20, 2011.
[3] C. James et al, "Race, Ethnicity & Health Care: A Profile of American Indians and Alaska Natives and Their Health Care," Kaiser Family Foundation, September 2009.
[4] Government Accountability Office, "Indian Health Service: Opportunities May Exist to Improve the Contract Health Services Program," December 2013.

Because IHS facilities serve mainly as sources of primary care, even those American Indian and Alaska Native beneficiaries that live near IHS facilities have to seek care for specialty services through additional facilities that contract with IHS. However, due to limits on funding and capacity, those seeking care from specialists often have trouble obtaining that care.[5] For example, the demand for mental health services outstrips the capacity at some IHS and tribal facilities as American Indians and Alaska Natives experience a disproportionate rate of mental and behavioral health challenges.[6] The GAO has also found that funding for contracted health services is frequently insufficient to pay for eligible services, and at some facilities funding was only adequate to cover emergency services and urgent care.[7]

Medicaid already plays an important role in financing Indian Health Services

Addressing these issues by making these contracted services eligible for full federal matching funds makes sense given the large role that Medicaid plays in financing care provided through the IHS system. Medicaid is a key source of financing for IHS providers and is the largest third-party payer into the system, providing 70 percent in FY 2013.[8] This is especially the case for children, as 54 percent of American Indian/Alaska Native children are eligible for Medicaid. Further, Medicaid already includes special financing rules and protections for American Indians and Alaska Natives.

Expanding the services that are eligible for the full federal match would remove the constraint on IHS contracted services. Currently, IHS must approve contracted services on a case-by-case basis. Because identifying potential payers constitutes an important step in the IHS process for approving contracted services, expanding the facilities that are eligible for the 100 percent FMAP would allow IHS to simplify their process for approving and paying for contracted services for Medicaid eligible American Indians and Alaska Natives.[9]

In addition, as Managed Care has become more prevalent as a model for administering Medicaid, we support the proposal to allow states to claim the 100 percent FMAP for the portion of the capitation rate representing those services expended by the managed care plan.

CMS' proposal would be especially helpful for states that have expanded Medicaid. Indeed, in states that have expanded the population of American Indians and Alaska Natives that are eligible for Medicaid to 138% of the FPL, the share of patients served by IHS with Medicaid will grow, which will result in more savings that can be used to improve IHS capacity.

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Sean Miskell (Sean.Miskell@georgetown.edu).

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[5] For example the Per Charitable Trusts reports that two thirds of these referral claims are rejects. See C. Vestel, "New Options for Native Americans Under Health Law," *Stateline*, October 14, 2013.

[6] Department of Health and Human Services Office of the Inspector General, "Access to Mental Health Services at Indian Health Services and Tribal Facilities," September 2011.

[7] Government Accountability Office, "Health Care Services are Not Always Available to Native Americans," August 31, 2005.

[8] Artiga and Arguello, 2013.

[9] Government Accountability Office, "Opportunities May Exist to Improve the Contract Health Services Program," December 2013.