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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JAN 1 1 2016

The Honorable Dennis Daugaard
500 East Capitol Street
Pierre, SD 57501

Dear Governor Daugaard:

Thank you for your thoughtful comments on the proposed change that the Centers for Medicare & Medicaid Services (CMS) is considering regarding the circumstances in which 100 percent federal funding would be available for services furnished to Medicaid-eligible American Indians and Alaska Natives (AI/AN) originating through facilities of the Indian Health Service (IHS), including facilities owned and operated by IHS or a Tribe under the Indian Self-Determination and Education Assistance Act, P.L. 93-638 (IHS/Tribal facility). CMS is continuing to review comments that we received from other stakeholders in response to our October 27, 2015, Request for Comment, entitled "Medicaid Services 'Received Through' an Indian Health Service/Tribal Facility."

We also appreciate the constructive input we received from the South Dakota Health Care Coalition. We share the Coalition's goal of improving access to health care services for Medicaid-eligible AI/ANs. We hope that the proposed change to our policies will help the state further support initiatives underway in South Dakota that are aimed at improving care coordination and quality of care for AI/AN Medicaid beneficiaries.

I am writing to provide an interim response to issues raised in your comments as well as those from the Coalition, based on CMS' review of comments to date. CMS' final policy determination will be reflected in a State Health Official letter, which we will issue shortly.

Defining Services "Arranged and Overseen" by IHS/Tribal Facilities

The Coalition asked for clarification on what constitutes services "arranged and overseen" by an IHS/Tribal facility. The Coalition also asked about options for serving AI/ANs who live in areas that are geographically distant from IHS/Tribal facilities.

CMS intends to make 100 percent federal funding available to states for services furnished to AI/AN Medicaid beneficiaries by a non-IHS/Tribal provider when those services are requested by an IHS/Tribal facility for its patient, provided certain conditions are met, including that the services are furnished in accordance with a written care coordination arrangement between the IHS/Tribal facility and the non-IHS/Tribal provider. First, the IHS/Tribal facility and the non-IHS/Tribal provider must both be enrolled in the state's Medicaid program as providers. Second, there must be an established relationship between the patient and a qualified practitioner at an IHS/Tribal facility. (Such a relationship could be established, for example, through an initial

visit, which could occur via telehealth if the IHS/Tribal facility has that capacity.) Third, care must be provided pursuant to a care coordination arrangement, under which the IHS/Tribal facility coordinates the care of its patient by the non-IHS/Tribal provider and retains control of the patient's medical record.

CMS will develop additional details around requirements for care coordination, but anticipates that care coordination will build upon an established relationship between the patient and a provider at the IHS/Tribal facility.

We intend that the 100 percent federal funding would apply on a permanent basis to all services "received through" an IHS/Tribal facility by an AI/AN Medicaid beneficiary who is a patient of that facility, regardless of whether the beneficiary is eligible under a Medicaid traditional eligibility category or is a newly eligible adult under the Medicaid expansion. We note that this policy would only affect the availability of the 100 percent federal funding for the state, and would not limit the ability of an IHS/Tribal provider to refer individuals to any qualified Medicaid provider, or limit the ability of any AI/AN beneficiary to obtain services from any participating Medicaid provider.

We understand the challenge of ensuring access for AI/AN individuals who live in areas that are geographically distant from IHS/Tribal facilities. CMS intends to make the 100 percent federal funding available for care both in cases where an IHS/Tribal facility is either providing services directly or is requesting care and undertaking care coordination (or both) where the other conditions described above are met. IHS/tribal facility involvement can be through telehealth to the extent that the providers have the capacity and meet state standards for recognition of telehealth services.

Defining Arrangements Between IHS/Tribal Facilities and Providers

The Coalition, in its comments, asked for flexibility at the State/Indian Health Program (IHP) level to establish the mechanisms and terms of agreements between IHS facilities and providers, such as a memorandum of agreement or a purchase of services agreements rather than establishing formal contracts that are governed by federal procurement rules. In addition, the Coalition requested that the state be given the opportunity to describe in the Medicaid state plan how it will meet the standards for approval of agreements between IHS facilities and providers. The Coalition also sought clarification as to whether medical record management can be defined by an agreement between the IHS/Tribal facility and non-IHS/Tribal providers.

CMS intends to consider a service "received through" an IHS/Tribal facility if it is requested by the IHS/tribal facility practitioner; furnished to an AI/AN patient of that practitioner, who remains responsible for overseeing the patient's care; and furnished by a non-IHS/Tribal provider with which the IHS/Tribal facility has established a written agreement that makes clear the responsibilities of both the facility and the provider with respect to care coordination and medical record management. Such an agreement could take various forms, including but not limited to a formal contract, a provider agreement, or a memorandum of understanding and would not be governed by federal procurement rules, to the extent it is consistent with IHS

authority. CMS does not intend to require a state to describe in its Medicaid state plan what the standards for a written agreement are or how it will ensure that those standards are met.

Defining the Scope of Medicaid Services Eligible for 100 Percent Federal Funding

In its comments, the Coalition seeks clarification on reimbursement for "facility-based" services, including whether 100 percent federal funding would apply to state expenditures for the cost of services provided by non-IHS/Tribal providers under contract with IHS, such as perinatology specialty care, neonatal hospital care, nursing home care, residential psychiatric treatment center services, and telehealth.

CMS intends to adopt the option under which the state can obtain 100 percent federal funding for services that meet all of the requirements above as long as they are within the scope of the services that the IHS/Tribal facility is authorized to provide, and that are covered under the approved Medicaid state plan. This includes services that are provided to AI/AN Medicaid beneficiaries who are patients of an IHS/Tribal facility and who have been referred to a non-IHS provider (who is also a participating Medicaid provider) by the IHS/Tribal facility under the care coordination arrangement described above. These services, could, for example, include inpatient hospital care, nursing home care, or specialty physician services like perinatology, to the extent that such services are covered under South Dakota's Medicaid state plan, and are services that could be offered by the IHS/Tribal facility at issue under governing law and, if applicable, the compact or contract between the Tribe and IHS.

Defining Billing and Payment Arrangements

In its comments, the Coalition strongly supported the option for non-IHS/Tribal providers under care coordination arrangements with IHS/Tribal facilities to bill the Medicaid program directly and sought clarification that, when non-IHS providers bill directly, the state Medicaid program is able to reimburse for these services at the state plan rates otherwise applicable for the service.

While operational and reporting requirements are still under development, CMS intends to adopt this option, with the clarification that the billing arrangement must be specified in the written agreements between IHS/Tribal facilities and non-IHS/Tribal providers. As discussed above, these written agreements need not be formal contracts. Under this option, the IHS/Tribal facility has flexibility to bill the state Medicaid program directly for facility services furnished by the non-IHS/Tribal provider under the care coordination arrangement, to the extent consistent with IHS authority, or to require the non-IHS/Tribal provider to bill directly. If the non-IHS/Tribal provider who is also a Medicaid provider bills the state Medicaid program directly, the provider would be reimbursed at the rate under the Medicaid state plan for that provider's services. If the IHS/Tribal facility bills the state Medicaid program directly, the reimbursement rate would depend on whether the service was within the scope of the facility benefit (e.g., inpatient or outpatient hospital, nursing facility, Federally Qualified Health Center, etc.). For services that are within the scope of the facility benefit, the facility would be paid at the applicable facility rate under the Medicaid state plan. For services like non-emergency transportation or personal care services that are not within the scope of the facility benefit, the facility would be paid at the

state plan rate for that non-facility service. States would retain flexibility in establishing economic and efficient payment rates to sufficiently reimburse for the provision of services consistent with access to care.

Technical Assistance in Implementing the Revised Policies

HHS is committed to assisting you and your staff as you move forward in improving access and quality of services for the AI/AN population. We are aware of the interest from South Dakota's Tribes to provide technical assistance as the state and the Tribes work towards implementing the changes we intend to make to our tribal policy. CMS, IHS, and HHS officials would like to meet with your staff and the Tribes in South Dakota for a day-long session to discuss operationalizing this policy in a manner that best supports access to care for AI/AN individuals.

This meeting is a first step in our commitment to assisting your staff and the Tribes in operationalizing this policy, and we are prepared to provide additional assistance as we work towards our shared goal of improving access to care for AI/AN individuals. Specifically, we are developing a new position in IHS that will serve as the primary IHS and CMS point of contact for South Dakota to help resolve federal policy and operational issues that arise during implementation. In addition, IHS intends to send an implementation team to the Great Plains Area to provide technical assistance on implementation as well as to work closely with the newly created liaison staff and with IHS and CMS headquarters staff. We also expect to be able to use existing funding to invest in telehealth resources to facilitate access to services for AI/AN individuals who live in areas that are geographically distant from IHS facilities but would benefit from IHS care.

Our revised policy will improve care coordination and quality of care for over 40,000 South Dakota AI/ANs who are already Medicaid eligible and receive IHS services, as well as for thousands more South Dakota AI/AN residents who might choose to begin utilizing IHS services or who could gain access to health care through Medicaid expansion. We stand ready to assist as the state continues to work to improve the health of South Dakotans.

Sincerely,

Sylvia M. Burwell