Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid Eligible American Indians and Alaska Natives

Center for Medicaid & CHIP Services

Background

- On February 26, 2016, CMS issued a State Health Official (SHO) letter.
- Federal Medicaid statute provides for 100% federal match (FMAP) for services "received through" IHS/Tribal facilities
- Previous interpretation did not generally extend to services provided outside of IHS/Tribal facilities.
- In 2015, CMS announced its intent to re-interpret the policy and held consultation with Tribes and Tribal organizations and received input from State Medicaid agencies.

Overview of New Policy

- Permits a wider scope of services
- Request for services must be in accordance with a written care coordination agreement
- Medicaid billing and payments to non-IHS/Tribal providers
- Medicaid beneficiary and IHS/Tribal Facility participation is voluntary

Permitting a Wider Scope of Services

- Scope of services now includes:
  - All services the IHS/Tribal facility is authorized to provide according to IHS rules, **and**
  - Services covered under the approved Medicaid State Plan
- Service highlights:
  - Long-term services and supports
  - Transportation
    - Including non-emergency medical transportation (NEMT)

Request for Services Under a Written Care Coordination Agreement

- There must be an established relationship between the AI/AN Medicaid beneficiary and the IHS/Tribal facility practitioner.
- Both the IHS/Tribal facility and non-IHS/Tribal provider must be enrolled in the state's Medicaid program as rendering providers.
- There must be a written care coordination agreement between the IHS/Tribal facility and the non-IHS/Tribal provider.
- An Urban Indian Organization is considered a non-IHS/Tribal provider for purposes of a care coordination agreement.

Written Care Coordination Agreements

- Minimum requirements:
  - The IHS/Tribal facility practitioner provides the request for specific services and relevant information about the patient to the non-IHS/Tribal provider;
  - The non-IHS/Tribal provider sends information about the care provided to the patient to the IHS/Tribal facility practitioner;
  - The IHS/Tribal facility practitioner continue to assume responsibility for the patient's care by assessing the information and taking appropriate action; and
  - The IHS/Tribal facility incorporates the patient's information in his/her medical record.

Medicaid Billing and Payment

- Medicaid rates for services furnished by non IHS/Tribal providers must be the same for all beneficiaries served.
- A non-IHS/Tribal provider bills directly at the State plan rate applicable to the service provided (e.g., physician consultation).

State Plan Requirements

- Payment methodologies for all services provided by IHS/Tribal facilities and non-IHS/Tribal providers must be set forth in an approved Medicaid state plan
- Payment rates cannot vary based on the applicable FMAP
- However, states can set rates that address unique needs in particular geographic areas or encourage provider participation in underserved areas
- States should review existing state plans to ensure compliance

Medicaid Beneficiary and IHS/Tribal Facility Participation is Voluntary

- Medicaid beneficiaries must have freedom of choice of qualified providers
- States must not directly or indirectly require beneficiaries to receive covered services from IHS/Tribal facilities
- States and IHS/Tribal facilities must not require beneficiaries to receive services from only those providers referred from the IHS/Tribal facility
- States may not require IHS/Tribal facilities or non-IHS/Tribal providers to enter into written care coordination agreements

Managed Care

States may claim the 100% FMAP for a portion of a capitation payment if the following conditions are met:

1. The service is furnished to a managed care enrolled AI/AN Medicaid beneficiary;
2. The service meets the fee-for-service "received through" requirements with supporting documentation;
3. The non-IHS/Tribal provider is a network provider of the enrollee's managed care plan;
4. The managed care plan pays the non-IHS/Tribal provider consistent with the network provider's contractual agreement; and,
5. The state pays a supplemental payment to IHS/Tribal providers consistent with the Medicaid managed care regulations.

Compliance and Documentation

In states where IHS/Tribal facilities implement the policy described in the SHO, the Medicaid agency must establish a process for documenting claims for expenditures for items or services "received through" an IHS or Tribal facility.

The documentation must be sufficient to establish that:

- The service was furnished to an IHS/Tribal facility patient pursuant to a request for services from the IHS/Tribal practitioner;
- The requested service was within the scope of a written care coordination agreement;
- The rate of payment is authorized under the state plan; and
- No duplicate billing for the same service and beneficiary by both the facility and the provider

Albuquerque Service Unit, CMS, University of New Mexico and State of New Mexico Pilot Project

- On 11/3/2016 meeting is to discuss how to implement 100% FMAP at UNMH. The goal is to improve the collaboration between UNMH, IHS and 638's in order to make sure this is the most effective that we can make it
- This will help the State save money as well as help tribes to build up services. It also gives tribes the capacity to provide these services and have the federal government pay for it.
- Since no one has completed this type of process at the national level, we are building the model as we start to move forward

Major points to take into consideration

- There needs to be a practical way to exchange patient information.
- There needs to be a Case Management and Care Coordination Agreement in place between IHS providers and non-HIS providers
- The State needs to assign a modifier number for medical billing. This will identify the patient claims that fall under 100% FMAP.

Major points to take into consideration(cont.)

- Various systems to deal with IHS RPMS and tribal considerations as well.
  - Systems needed to be more compatible, sharing software, new software, portal access or alternate forms of system modifications?
- UNMH used Cerner and within the system there is a way to share information between referring providers. This portal access is a potential way for the various entities to communicate and share information.
- A specific way to identify patient eligibility will need to be determined, along with other administrative reporting requirements.
- Discuss the boundaries of information sharing with a HIPAA compliance officer.

Initiation of Process

- Regular Meetings to continue collaboration efforts.
- State of New Mexico started to submit claims for 100% reimbursement.

CMS Review August 2017

- CMS focused on the referrals from the second quarter of Federal Fiscal Year 2017 which was January 1, 2017 to March 31, 2017.
- (CMS) findings were that referrals were being sent from IHS but medical records regarding the visit weren't coming back to IHS
- However charts reviewed came off the list of claims that CMS received from the state
- Not all the charts reviewed had a referral in our system (meaning they were self-referrals or possibly referred from someone else), and if we (ASU), are not sending the referral, we are not looking for documents to come back
- The only referrals reviewed were from UNM
- Key recommendation made: NAS is the middleman/gatekeeper for all referrals and appointments GOING to UNMH, they should also be the middleman/gatekeeper for all information that we require BACK from UNMH

Outcomes

- Additional meetings 100% FMAP Operational Workgroup, decide on a 100% FMAP Strategic Planning bi-weekly location and occurrence timeframe.
- Create a Work Flow Document to present to HSD for approval.
- After the Initial 100% FMAP Operational Workgroup, set-Up first 100% FMAP Monthly Overview meeting to keep all stakeholders involved.
- Obtain a list of areas that are willing to participate in the developmental and implementation process. So far the Alpha test will include ASU, Isleta and UNMH.
- Provider listings will have to be given to UNMH to identify our providers to allow for Cerner Messaging and access to notes for referrals

Outcomes

- Created additional work
  - Service Unit had to add staff, monitoring
  - For nurses processes to pull off notes, for those not identified through new system.
- Gained access to UNM system to pull off notes using M Page
  - Notification are sent but still have issues determining providers
  - 40-50% successful at the beginning

August 208 Reevaluation by CMS

- Representatives from NM State Medicaid, CMS, UNM and IHS Headquarters.
- Tremendous progress was made with regard to developing and learning the process, monitoring referrals and closing the loop.
- CMS, gave the green light for the State to submit all eligible claims. This will potentially result in millions of dollars for the State of New Mexico,

Albuquerque Service Unit, CMS, University of New Mexico and State of New Mexico

- Lessons Learned
  - What is working now?
    - Data Exchange
    - Better quality of care for our patients
    - Continued collaboration with all
  - What still needs to improve?
    - Data Exchange still at about 50-60%
    - Providers work multiple places
- Collaboration is key

100-Percent FMAP Flow Chart

UIO, Tribal Program and/or IHS works with the State to determine implementa-tion game plan

Care Coordination Agreement between an IHS facility or Tribal Program and non IHS/Tribal (including UIO) Eligible Medicaid provider is executed

The IHS facility or Tribal Program refers a Medicaid Enrolled AI/AN patient that is an eligible beneficiary to that non IHS/Tribal Medicaid provider using a Medicaid referral that is generated via RCIS

The non IHS/Tribal (including UIO) Medicaid provider treats the patient

The non IHS/Tribal (including UIO) Medicaid provider sends a copy of the medical record to the IHS facility that generated the referral

The referring IHS facility or Tribal Program provider reviews the copy of the medical record sent to the IHS facility by the non IHS/Tribal (including UIO) Medicaid provider

The copy of the medical record is signed by the IHS facility or Tribal Program referring provider. The record is then scanned and placed into the patients medical record

The IHS facility or Tribal Program provider will follow up as necessary

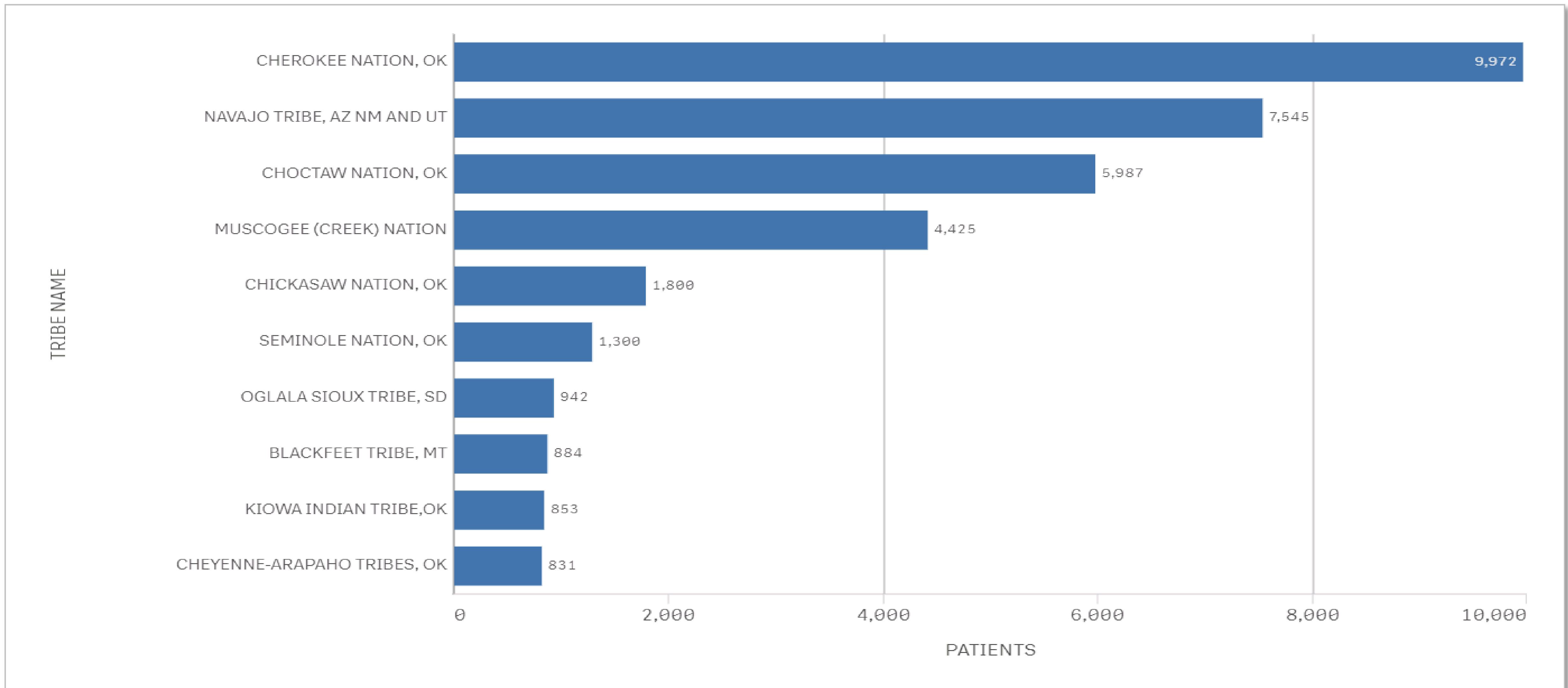
Care Coordination Agreements between IHS/Tribal Facilities and Urban Indian Organizations

- CMS and the IHS have also been meeting with the National Council of Urban Indian Health (NCUIH) to address operationalizing care coordination agreements with Urban Indian Organizations (UIOs).
- The OUIHP and the IHS Office of Resource Access and Partnerships have revised a care coordination agreement template that may be used by IHS Areas to establish care coordination agreements with UIOs at the IHS Area level.

Care Coordination Agreements between IHS/Tribal Facilities and Urban Indian Organizations

- The IHS Office of Urban Indian Health Programs (OUIHP) works in partnership with 41 Urban Indian Organizations in 22 states.
- Provide unique access to culturally appropriate and quality health and behavioral health care services.
- Integral part of the Indian health care system and serve as resources to both tribal and urban communities.
- Urban Indian Organization program sizes and services vary from full ambulatory care, limited ambulatory care, outreach and referral, and residential and outpatient substance abuse treatment programs.

Top 10 Tribes Served
Number of AI/AN Patients – Calendar Year 2018



San Diego American Indian Health Center

United American Indian Involvement, Inc.

Resources

- SHO#16-002, February 26, 2016- https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf
- Indian Health and Medicaid- https://www.medicaid.gov/medicaid/indian-health-and-medicaid/index.html
- Section 1905(b) of the Social Security Act- https://www.ssa.gov/OP_Home/ssact/title19/1905.htm
- 100% FMAP – Care Coordination Agreement Templates- https://www.ihs.gov/businessoffice/100-percent-fmap/

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