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State Health Reform Assistance Network

Charting the Road to Coverage

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IHS, Tribal Programs and Medicaid
Overview of New CMS Guidance

Manatt Health
May 20, 2016

Focus of Today's Discussion

- Review CMS guidance expanding circumstances under which 100% FMAP is available for services "received through" IHS and Tribal health facilities, and highlight opportunities for states to increase scope of services for which IHS/Tribal health facilities may bill at IHS rate.
- Identify operational challenges and pathways states may pursue to maximize the benefits of the new guidance, and discuss strategy for informing and clarifying CMS position.

New Guidance (State Health Official Letter #16-002)
https://www.medicaid.gov/federal-policy-guidance/downloads/SHO022616.pdf

New Guidance Expands Definition of "Received Through"

100% FMAP is now available for all Medicaid services that are authorized under IHS rules. "Care coordination agreements" can extend 100% FMAP to non-IHS/Tribal providers offering services authorized under IHS rules, even if not considered facility services.

Services Authorized Under "IHS Rules" and Covered in State Plan	
Inpatient	Outpatient

Previous definition limited 100% FMAP to "facility services" offered and billed by an IHS/Tribal Provider

"Facility Services"
Services the referring IHS/Tribal facility is authorized to provide directly (defined by state)

Services Provided Directly by IHS/Tribal Provider

Services Provided by non-IHS/Tribal Provider

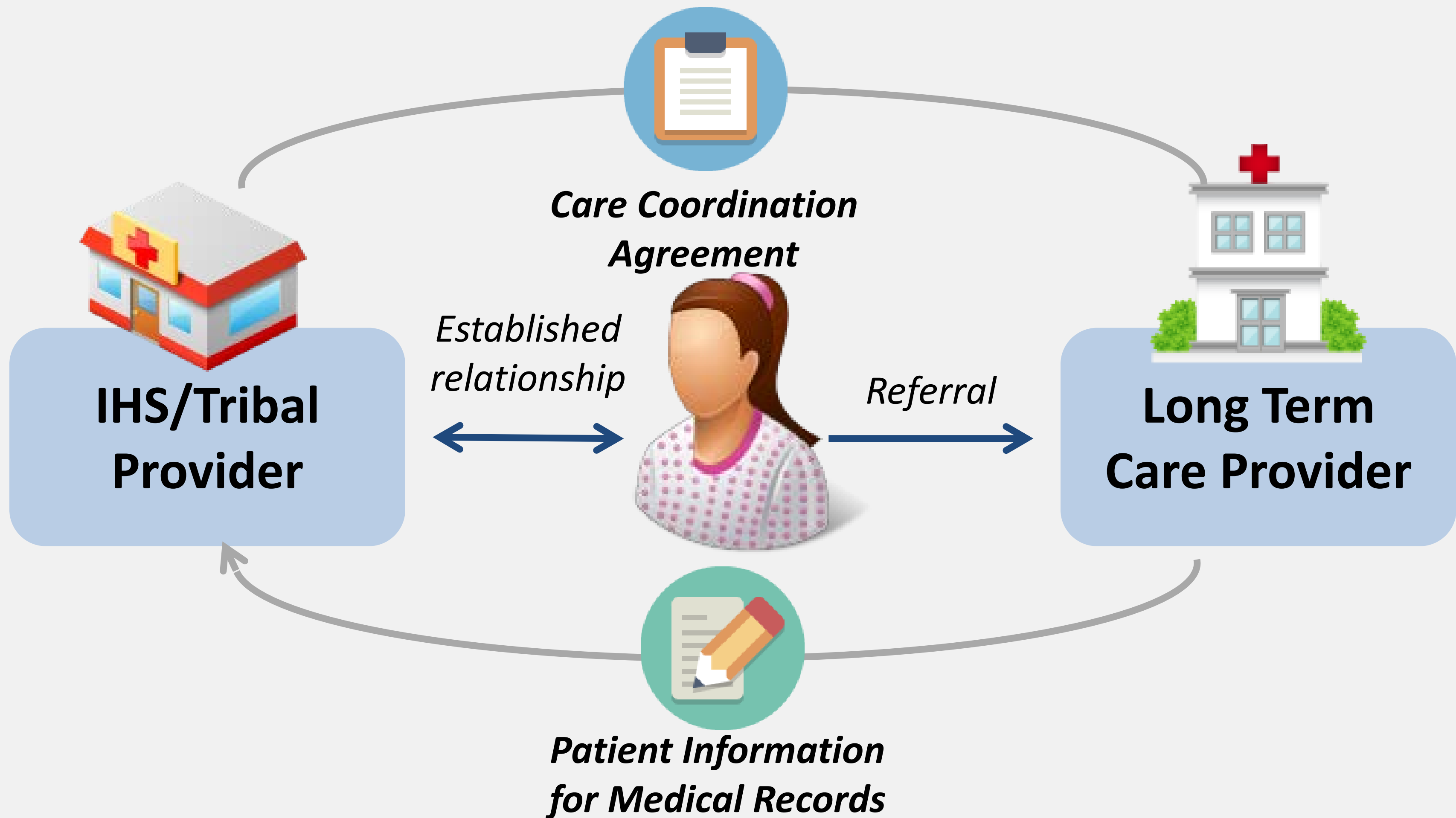
All services must be covered by Medicaid

Care Coordination Agreements Under New Guidance

Care coordination agreements must meet certain criteria:

- Agreement must be written; e.g. formal contract, provider agreement, or MOU
- Providers must be enrolled in Medicaid
- Patient must have an existing relationship with the IHS/Tribal facility
  - Relationship may be based on a visit, or through allowable telehealth procedures
- Practitioner at IHS/Tribal facility must request service through "verifiable means"
- Non-IHS/Tribal practitioner must transmit back to IHS/Tribal facility information on care provided to patient
- IHS/Tribal practitioner remains responsible for patient's care
  - Providing follow up care; updating medical record with information about visits to non-IHS/tribal provider

Care Coordination for Services "Received Through" IHS/Tribal Provider



Standards for Claiming 100% FMAP in FFS

State must ensure that:

- Claims include fields that document that the item or service was "received through" an IHS/Tribal facility
  - ✓ Service was furnished to AI/AN patient at request of practitioner at IHS/Tribal facility (NPI of requesting practitioner should be on claim)
  - ✓ Service was in scope of a care coordination agreement that meets all the requirements set forth in the guidance (see slide 6)
- Payment rate is authorized under State Plan and consistent with the guidance
- No duplicate billing for the same service to the same beneficiary

Standards for Claiming 100% FMAP in MMC

States may claim 100% FMAP for the portion of MMC capitation payment attributable to services provided AI/ANs, provided:

- AI/AN individual is enrolled in the managed care plan
- Service meets requirements to be considered "received through" IHS/Tribal facility
- Non-IHS/Tribal provider is in network and paid as any other in-network provider
- State remains compliant with federal law on IHS/Tribal provider reimbursement rates.

Billing for Services Under Care Coordination Agreement

- **If the non-IHS/Tribal provider bills the state directly for services:**
  - Provider receives its standard Medicaid reimbursement rate
- **If the IHS/Tribal provider bills the state for services provided by non-IHS/Tribal providers**:
  - For "facility services", the state pays the IHS per-visit rate
  - For "non-facility services", the state pays the non-IHS/Tribal provider's standard Medicaid rate
- **"Facility services"** are services that the referring IHS/Tribal facility could have provided as determined by state rules
  - Inpatient services furnished by non-IHS/Tribal providers are never "facility services"
  - For IHS facilities: services provided offsite "generally" are not facility services
  - For Tribal facilities: depending on state rules, a wider range of offsite services may be considered facility services

Both billing options preserve 100% FMAP

Financial Implications for States and Tribes

For States

- New guidance authorizes states to claim 100% FMAP for additional non-IHS/Tribal Medicaid spending:
  - In 2008, Medicaid spending on AI/AN populations was over $3 billion in 20 states (together, these states represented over 80% of total Medicaid AI/AN enrollment)
  - Most payments went to hospitals and specialists: only $680 million (20% of total spending) was paid to Indian Health Programs and was eligible for 100% match

For Tribal Facilities and their Patients

- The wider the range of services a state considers to be "facility services", the greater the opportunity for Tribes to increase both their reimbursement revenue and patient access through care coordination agreements.

Discussion

Thank you!

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