CMS State Health Official Letter #16-002
Federal Medicaid Funding “Received Through” IHS and Tribally-operated health programs

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- Social Security Act statute provides for 100% FMAP for services “received through” Indian Health Service (IHS) & Tribal facilities
- Previous CMS interpretation did not generally extend to services provided outside the “four walls” of IHS/Tribal facilities
- HHS Departmental Appeals Board decisions and court cases in North Dakota, South Dakota, Arizona, and Alaska affirmed CMS/HHS interpretations
- In 2015, CMS announced its intent to re-interpret the statute and began Tribal consultation and discussion with the States
State Health Official Letter on 100% FMAP

- SHO letter, February 26, 2016, regarding new CMS interpretation on 100% FMAP delivered “through IHS and Tribal health programs”
- CMS interpretation Permit a wider scope of services
- Referrals or request for services must be in accordance with a written care coordination agreement
- New policy provides Medicaid billing and payments to non-IHS/Tribal providers at 100% FMAP
- Medicaid beneficiary and IHS/Tribal Facility participation is voluntary
States/Tribes can collaborate to provide a wider scope of services

- New FMAP policy allows wider scope of services to include:
  - All services that an IHS/Tribal facility are authorized to provide pursuant to their IHS funding agreement and federal rules
  - All services that are covered in the Medicaid program
- Authorization for Long Term Care, HCBS related services, Transportation, and Accommodation support
- Can help to assist those States to justify and carry out Medicaid Expansion
  - Cost savings through 100% FMAP
  - Waiver authority for uncompensated care programs through IHS/Tribal health programs
Permitting Wider Scope of Services

• Scope of services now includes:
  – All services the IHS/Tribal facility is authorized to provide according to IHS rules and
  – Covered under the approved Medicaid State Plan
  – There will be variation in how this is carried out in those Areas that IHS operates a health program compared to those Areas operating health programs under the Indian Self-Determination Act

• Examples to highlight:
  – Long-term services and supports
  – Transportation
  – Behavioral health
SHO Letter Requirements

• There must be a written “Care Coordination Agreement” between IHS/Tribal facility and the non-Tribal provider

• There must be an established relationship between the AI/AN Medicaid beneficiary and the IHS/Tribal facility practitioner
  – Telehealth is allowed

• Both the IHS/Tribal facility and non-IHS/Tribal provider must be enrolled in the state’s Medicaid program as rendering providers
Requirements of Care Coordination Agreements

1. The IHS/Tribal facility practitioner provides the request for specific services and relevant information about the patient to the non-IHS/Tribal provider;

2. The non-IHS/Tribal provider sends information about the care provided to the patient to the IHS/Tribal facility practitioner;

3. The IHS/Tribal facility practitioner continue to assume responsibility for the patient’s care by assessing the information and taking appropriate action; and

4. The IHS/Tribal facility incorporates the patient’s information in his/her medical record.
Medicaid Billing & Payments

• Two Options: Non-Tribal Provider bills; or the IHS/Tribal program bills
  – In later case, the claim will be paid at the state plan rate applicable to that physician service, and not at the IHS/Tribal facility rate

• Medicaid rates paid to IHS/Tribal facilities for services must be the same for services provided to AI/ANs and non-AI/ANs.

• Medicaid rates for services furnished by non IHS/Tribal providers must be the same for all beneficiaries served
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.
Freedom of Choice Continues

• 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
• State may not require IHS/Tribal facilities or non-IHS/Tribal providers to enter into written care coordination agreements
State Documentation Requirements

- States must establish a process for documenting claims for expenditures for services “received through” an IHS/Tribal facility as follows:
  - 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
New 100% FMAP Policy saves State Medicaid general funds that can be reinvested

- States can achieve significant cost-savings to provide a wider range of Medicaid services under care coordination arrangements with IHS/Tribal health programs
- Lifting the restriction on where services are provided allows States great flexibility
- This is very important for States with large AI/AN populations like AZ, CA, NM, OK, WA, AK and others
- Shifts costs away from the State and cost savings can be reinvested in the Medicaid program
New policy can facilitate improved relationships between Managed Care Plans & Tribes

- Tribes are exempt from auto-assignment in managed care plans under waiver authority
- Challenges due to payment, contracting issues, referrals, and cultural competent care all affect timely access to care
- States/Tribes and managed care plans now have an incentive to collaborate to enter into care coordination arrangements that can save State Medicaid programs resources
- This can help to improve access to care for AI/AN beneficiaries
- Can generate additional Medicaid collections for IHS/Tribal programs and managed care plans
Summary

• CMS’ new interpretation of the 100% FMAP provision provides opportunity for States/Tribes to collaborate on providing a wider scope of services
• Provides States an opportunity to collaborate with Tribes to increase their capacity for provide health services and access for eligible American Indian/Alaska Natives
• Can help to facilitate access to care issues that many Tribes experience with Medicaid managed care
• Assist states to save funding in their health care programs that can be allocated to other expenses in carrying out the Medicaid program
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Alaska Native people are the healthiest people in the world.