

**California Department of Health Care Services Comments**  
**Medicaid Services “Received Through” an Indian Health Service/Tribal Facility**

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**Background:** The Centers for Medicare and Medicaid Services (CMS) has requested feedback and comments regarding proposed changes to a policy that describes the circumstances whereby 100% federal funding is available for services furnished to Medicaid-eligible American Indian and Alaska Natives (AI/AN) through facilities of the Indian Health Services (IHS) or Tribes. The intent of the policy change which would apply to all states would be to improve access to care of AI/AN Medicaid beneficiaries.

**Medi-Cal AI/AN Services Overview:** California’s Medicaid program, known as Medi-Cal, provides comprehensive coverage for AI/ANs through fee-for-service and managed care delivery systems. Medi-Cal reimburses tribal health clinics (61), urban Indian health clinics (7), Indian Health Services youth regional treatment programs (5), fee-for service providers, and managed care plans for the services to this population. On average, monthly enrollment of self-identified American Indians is approximately 55,000 individuals. Quarterly, the California Area Federal Indian Health Service, the California Rural Indian Health Board, and two tribal health clinic Medi-Cal providers submit an average of 11,000 records of federally recognized AI/ANs enrolled in Medi-Cal through tribal clinics. This data allows DHCS to claim the 100 percent federal reimbursement for Medi-Cal services rendered to federally recognized AI/AN participants within the reporting period.

**100% Federal Matching Assistance Percentage (FMAP):** Medi-Cal claims 100% FMAP for services provided to federally recognized AI/ANs at tribal clinics that are enrolled as providers under the IHS-HCFA (CMS) Memorandum of Agreement (MOA). Medi-Cal only claims for the portion of the IHS-HCFA MOA visit rate not covered by a managed care plan contract with the clinic.

**Current CMS Policy:** The enhanced facility FMAP is based on section 1905 (b) of the Social Security Act, which provides for the federal government to assume 100% of the amounts paid for covered services received through an IHS facility whether operated by the IHS or by Tribes and tribal organizations. If a service is received through an IHS/Tribal facility, the FMAP is 100% and the state pays no share of the cost.

***Proposed Modification (Second Condition):*** *Under current CMS policy, to qualify for 100 percent FMAP, the service “received through” an IHS/Tribal facility must be a “facility service” (element 2). CMS is strongly considering an option under which a service “received through” an IHS/Tribal facility could be any service encompassed within a Medicaid state plan benefit category that the IHS/tribal facility is authorized to provide. Current Medicaid state plan benefit categories are described in section 1905(a), 1915(i),*

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*1915(j), 1915(k), 1945, and 1915 (c) of the Act, along with any other state plan authority established in the future as a state plan benefit. In order to be eligible, the services would have to be covered under the state’s approved Medicaid state plan. Among the covered services that could be considered “received through” an IHS/Tribal facility would be transportation services, as well as emergency transportation (EMT) services and non-emergency transportation (NEMT) services, including related travel expenses (such as meals, lodgings, and cost of an attendant pursuant to federal and state requirements). Transportation may be claimed as an optional medical service or as an administrative expense; however, arrangements claimed as an administrative expense are not eligible for the 100 percent FMAP.*

**DHCS Comment:** The phrase “authorized to provide” needs to be clarified. Is the “authority” referencing facility licensure, Medi-Cal provider type, IHS facility contract scope of responsibility, managed care plan contract scope, or all of these? Could this mean that when a tribal facility refers patients out of the clinic for inpatient services, pharmacy, specialty services, etc. that the referral provides “authority” for the service? States need the clarification in order to properly claim FMAP.

***Proposed Modification (Third Condition):*** *Under current CMS interpretation, to qualify for 100 percent FMAP, the service must be furnished in an IHS/Tribal facility or by its employees or contractual agents as part of the facility’s services. CMS is strongly considering an option that would expand the meaning of a contractual agent to include a qualified individual or entity that is enrolled as a Medicaid provider and who provides items or services not within the scope of a Medicaid “facility services” benefit but within the IHS/Tribal facility authority, pursuant to a written contract under which the services for the Medicaid beneficiary are arranged and overseen by the IHS/Tribal facility and the individuals served by the contractual agent are considered patients of the facility. The IHS/Tribal facility would need to retain responsibility for the provision of services, meaning that the IHS/Tribal facility must retain control of the medical records, including updating medical records with information from care provided by contractual agents and providing care coordination for the AI/AN individual. In sum, consistent with the changes described in element two, contractual agents would include those that furnish services that are “received through” the IHS/Tribal facility but are not necessarily furnished directly by the IHS/tribal facility. Urban Indian Health Programs could participate as contractual agents.*

**DHCS Comment:**

- This would be difficult/impossible to track as the Medi-Cal program would not have immediate access to all of the (60+) tribal facility fee-for-services contracts for

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services provided outside of the facility walls. Notably, some of those referral services are for a small number of patients which make tracking contracts between the facility and the referral provider even more administratively burdensome although the services are critical (i.e. long term care)

- This proposed change does not address the arrangements/agreements of managed care plans with network providers to cover services provided outside of the clinic facility walls to clinic facility AI/ANs participants.
- It would require the Medi-Cal program to monitor contracts between (7) urban Indian health clinics with (60+) tribal facilities operated by 109 tribes which would be administratively problematic.
- Lastly, it would be cost prohibitive for the Medi-Cal program to monitor tribal facility retention of control of medical records for services provided by other healthcare entities including urban Indian health clinics.

The proposed change could potentially increase FMAP for Medi-Cal by broadening the definition of services provided to qualified AI/ANs that the state could claim. However, the proposal includes conditions that are cost prohibitive to implement. Qualified AI/ANs registered at tribal facilities use the services as their medical homes. It is reasonable to assume that any care for these patients provided outside of the facility and reimbursed by Medi-Cal will impact services received at their medical homes and therefore be considered in planning ongoing care by the healthcare providers at the tribal facility. Hence, State Medicaid programs should be able to claim FMAP for those services if the qualified AI/AN is a registered patient of a tribal facility.

***Proposed Modification (Fourth Condition:*** *Under CMS’ current interpretation, the IHS/Tribal facility must maintain responsibility for the provision of the service and must bill the state Medicaid program directly for the service (element 4). CMS is strongly considering an option under which IHS/Tribal facilities would have a choice of specifying in the written contracts with contractual agents whether the facility would bill the state Medicaid program for the service (accepting assignment from contractual agents who are not providing a service within a Medicaid facility benefit category) or whether the contractual agent would bill the state Medicaid program directly.*

**DHCS Comment:** Referral providers that serve tribal clinic patients who are Medi-Cal eligible are either managed care network providers or bill Medi-Cal directly. To maximize the receipt of federal funding, the applicable funding associated with an AI/AN enrollee should follow him or her, wherever they are receiving covered benefits under Medicaid programs. It is unclear the extent to which such arrangements must be tracked for audit

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purposes but appears to impose a burdensome requirement on the Tribal/IHS facility and potentially the state. CMS clarification is needed on what is intended for this provision.

***Application to fee-for-service.*** Pursuant to each state’s Medicaid plan, IHS/Tribal facilities are typically reimbursed for facility services using an all-inclusive rate (AIR), or the Federally Qualified Health Center (FQHC) prospective payment system (PPS) rate or

FQHC alternate payment methodology (APM) rate. The practical impact of the changes proposed above on fee for service payments would be as follows:

*For services that are of the type that are encompassed within the applicable facility benefit, an IHS/Tribal facility would receive payment at the applicable IHS facility rate under the state plan whether provided by facility employees or contracted providers as a facility service.*

*If an IHS/Tribal facility chooses to provide Medicaid services that are of a type that could be funded through the IHS/Tribal authority but are not within the scope of the applicable facility benefit, such as personal care, home health, 1915(c) waiver services, etc., those services will be paid at the state plan rates applicable to those services. This includes non-emergency medical transportation. We note that states retain flexibility in establishing economic and efficient payment rates to sufficiently reimburse for the provision of services.*

**DHCS Comment:** This seems reasonable.

***Application to managed care.*** Current CMS policy was designed in the context of fee-for-service Medicaid program. To accommodate the widespread adoption of managed care by state Medicaid programs, CMS is strongly considering the following clarification with respect to services provided to AI/AN individuals enrolled in managed care plans. To the extent that services are furnished by an IHS/Tribal facility or its employees to AI/individuals enrolled in a managed care plan, the state would be able to claim the 100 percent FMAP for the portion of the capitation rate representing those services expended by the managed care plan. The portion of the capitation rate that would be eligible for 100 percent FMAP would be for services for which the following conditions are met:

1. *The service is furnished to a Medicaid-eligible, enrolled, AI/AN individual;*
2. *The IHS/Tribal facility provides the service, either directly or through a contractual agent, and maintains oversight responsibility as described above; and*

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3. *The service is payable under the managed care plan and is, in fact, paid by the managed care plan.*

*Under this clarified policy, states would be permitted to claim the 100 percent FMAP for a portion of the capitation payment for AI/AN individuals who are enrolled in managed care, even though the state itself may make no direct payment for IHS/Tribal facility services. The portion of the managed care payment eligible to be claimed at 100 percent FMAP must be based on actual expenditures incurred for IHS/tribal encounters. To inform future guidance and technical assistance to states, we are interested in obtaining more information regarding the methods states currently use to determine the portion of managed care claims reported on the CMS-64 at the 100 percent FMAP.*

**DHCS Comment:** The ability to claim the 100 percent FMAP as described could be labor intensive for states if they do not already identify the IHS/Tribal encounters as part of the rate development process. Because capitated rates are prospective, based on aggregated costs/encounter data that are two years old and subject to trending, efficiency adjustments, risk adjustments and administration costs to match the covered population (not just AI/AN individual's), it would be very labor intensive to apportion capitated rates by specific services provided to AI/ANs. In addition, it would be good for CMS to clarify that the statement “The portion of the managed care payment eligible to be claimed at 100 percent FMAP must be based on actual expenditures incurred for IHS/tribal encounters.” Does this mean that states would be able to claim for the portion of the monthly capitation payment that is related to these costs as developed would be able to be claimed at 100 percent FMAP based on the CMS established rate setting guidelines or that we would have to take an additional step to calculate the actual encounters for these services and develop a new methodology for claiming?

**DHCS General Summary:** While it is appreciated that CMS is looking to develop proposals to help states broaden the definition of conditions whereby states can fully claim 100 percent FMAP in more meaningful ways, the proposals presented create additional hurdles for states to address and are more cumbersome than existing processes. In order to achieve the intended goal of appropriately financing the delivery of health care services to the AI/AN population, it is recommended that CMS consider the ability for the financing to follow the individual while leveraging the role that Tribal facilities may play in terms of the provision of and/or the referral to such services.