

Medicaid Services “Received Through” an Indian Health Service/Tribal Facility: A Request for Comment

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services

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Introduction

The Centers for Medicare & Medicaid Services (CMS) is updating its policy regarding the circumstances in which 100 percent federal funding would be available for services furnished to Medicaid-eligible American Indian and Alaska Native (AI/AN) individuals through facilities of the Indian Health Service (IHS) or Tribes. The intent of this policy change, which would apply to all states, would be to improve access to care for AI/AN Medicaid beneficiaries. This paper describes the policy options under consideration and seeks feedback from states, Tribes, and other stakeholders.

Current Policy

In general, AI/AN Medicaid beneficiaries may choose to receive covered services from any provider that participates in a state's Medicaid program, including a hospital, clinic, or a qualified IHS/Tribal facility. (Different rules apply to AI/AN beneficiaries who enroll in Medicaid managed care plans). The rate at which the federal government will match the state's payment for the covered service – the Federal Medical Assistance Percentage (FMAP) – varies depending on the provider that furnishes the service to the eligible AI/AN individual. If the provider is not an IHS/Tribal facility, the FMAP is the state-specific FMAP, which in FY 2016 varies from 50 percent to 74 percent, and the state share varies from 50 percent to 26 percent (unless the service qualifies for a special FMAP rate). If the service is “received through” an IHS/Tribal facility, the FMAP is 100 percent and the state pays no share of the cost.

This enhanced IHS/Tribal facility FMAP is based on section 1905(b) of the Social Security Act (the Act), which provides for the federal government to assume 100 percent of amounts paid for covered services “received through an Indian Health Service [IHS] facility whether operated by the Indian Health Service or by a tribe or tribal organization.” (Tribal facilities include facilities that are owned or operated by Tribes and tribal organizations under the Indian Self-Determination and Education Assistance Act, P.L. 93-638.)

The current CMS interpretation of this statutory provision is that 100 percent FMAP is available in costs of covered services under the following conditions:

- (1) The service must be furnished to a Medicaid-eligible AI/AN individual;
- (2) The service must be a “facility service” – i.e., within the scope of services that a facility (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center, nursing facility) can offer under Medicaid law and regulation;

(3) The service must be furnished in an IHS or Tribal facility or by its employees or contractual agents as part of the facility's services; and

(4) The IHS or Tribal facility must maintain responsibility for the provision of the service and must bill the state Medicaid program directly for the service.

Policy Changes Under Consideration

State Medicaid programs, Tribes, and others have expressed concern that the current CMS interpretation of section 1905(b) of the Act is overly restrictive. In light of the federal government's traditional role in the delivery and financing of health care to the AI/AN population, states believe that the federal government should assume more of the cost of services provided to Medicaid AI/AN beneficiaries. Tribes believe that the current CMS interpretation does not fully reflect federal legal responsibility for health care for AI/AN individuals. Others have argued that current CMS policy undermines service delivery innovation and reform by IHS/Tribal facilities.

In response to these concerns and to update the policy regarding the availability of the 100 percent federal funding, CMS is strongly considering interpreting section 1905(b) of the Act in manner that would expand the circumstances in which state Medicaid payments for services furnished to AI/AN beneficiaries would be considered to be "received through" an IHS/Tribal facility and therefore qualify for 100 percent FMAP. More specifically, CMS is strongly considering changing the second, third, and fourth conditions of the current interpretation, as set forth above.

We are requesting comments from states, Tribes, and others on the parameters of the proposed change in the interpretation of section 1905(b) of the Act. We are particularly interested in comments regarding the following modifications of our proposed policy to expand the application of 100 percent FMAP:

1. *Modifying the 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), 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.

2. *Modifying the 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.
3. *Modifying the 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.
4. *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.

5. *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/AN 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
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.

Stakeholder Feedback and Comments

CMS is interested in the effect these changes will have in improving the health status of AI/AN Medicaid beneficiaries, as well as their feasibility. CMS invites states, Tribes, and other stakeholders to review and provide feedback on the parameters of the reinterpretation of section 1905(b) of the Act. Please send written comments by November 17, 2015 to TribalAffairs@cms.hhs.gov.