Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

Tribal Best Practices and Critical Issues

June 21, 2017

Tribal Self-Governance Advisory Committee

TribalSelfGov.org

Tribal Best Practices and Critical Issues

Today's Webinar will focus on:

TRIBAL BEST PRACTICES:

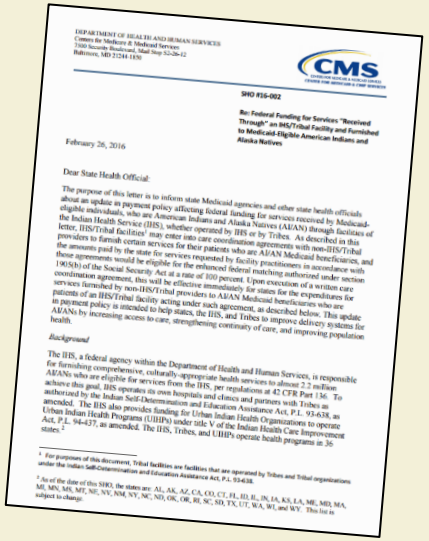
- Medicaid Pharmacy Reimbursement for Tribal Programs.

CRITICAL ISSUES:

- Maintaining Ability to Bill for Services Provided Outside Clinic Walls: Coordination with State Medicaid Officials.
- Congressional health legislation and related activities.

CMS FAQ: Background

- On February 26, 2016, CMS issued SHO Letter expanding 100% FMAP policy.


DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS

SHO #16-002

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

February 26, 2016

Dear State Health Official:

The purpose of this letter is to inform state Medicaid agencies and other state health officials about an update in payment policy affecting federal funding for services received by Medicaid-eligible individuals, who are American Indians and Alaska Natives (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes. As described in this letter, IHS/Tribal facilities[1] may enter into care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with these agreements would be eligible for the enhanced federal matching authorized under section 1905(b) of the Social Security Act at a rate of 100 percent. Upon execution of a written care coordination agreement, this will be effective immediately for states for the expenditures for services furnished by non-IHS/Tribal providers to AI/AN Medicaid beneficiaries who are patients of an IHS/Tribal facility acting under such agreement, as described below. This update in payment policy is intended to help states, the IHS, and Tribes to improve delivery systems for AI/ANs by increasing access to care, strengthening continuity of care, and improving population health.

Background

The IHS, a federal agency within the Department of Health and Human Services, is responsible for furnishing comprehensive, culturally-appropriate health services to almost 2.2 million AI/ANs who are eligible for services from the IHS, per regulations at 42 CFR Part 136. To achieve this goal, IHS operates its own hospitals and clinics and partners with Tribes as authorized by the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended. The IHS also provides funding for Urban Indian Health Organizations to operate Urban Indian Health Programs (UIHPs) under title V of the Indian Health Care Improvement Act, P.L. 94-437, as amended. The IHS, Tribes, and UIHPs operate health programs in 36 states.[2]

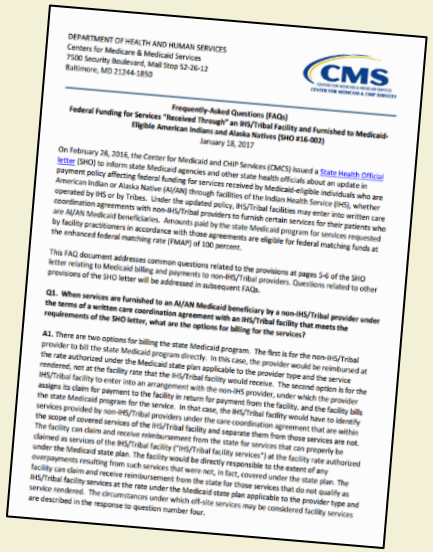
[1] For purposes of this document, Tribal facilities are facilities that are operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act, P.L. 93-638.

[2] As of the date of this SHO, the states are: AL, AK, AZ, CA, CO, CT, FL, ID, IL, IN, IA, KS, LA, ME, MD, MA, MI, MN, MS, MT, NE, NV, NM, NY, NC, ND, OK, OR, RI, SC, SD, TX, UT, WA, WI, and WY. This list is subject to change.

- Under the SHO there were <u>two options</u> for tribal health programs to bill Medicaid for clinic services:
    1. The outside provider bills Medicaid directly at the applicable rate; or
    2. The tribal program processes all billing at either the: (a) OMB rate for services within a facility's "four walls"; or (b) applicable state plan rate for services outside the four walls.
- In implementing the SHO Letter, CMS realized some IHS/tribal facilities have been billing Medicaid for clinic services provided outside their "four walls."

CMS FAQ: Background

- On January 18, 2017, CMS issued an FAQ addressing Medicaid reimbursement for clinic services provided outside the four walls.
- The FAQ formalizes its interpretation that IHS/tribal facilities enrolled as clinics may not bill Medicaid for services provided outside their four walls.
- The policy is based on CMS's interpretation of Section 1905(a)(9) of the Social Security Act and federal regulations codified at 42 C.F.R. § 440.90.



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Frequently-Asked Questions (FAQs)
Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives (SHO #16-002)
January 18, 2017

On February 26, 2016, the Center for Medicaid and CHIP Services (CMCS) issued a State Health Official letter (SHO) to inform state Medicaid agencies and other state health officials about an update in payment policy affecting federal funding for services received by Medicaid-eligible individuals who are American Indian or Alaska Native (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes. Under the updated policy, IHS/Tribal facilities may enter into written care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries. Amounts paid by the state Medicaid program for services requested by facility practitioners in accordance with those agreements are eligible for federal matching funds at the enhanced federal matching rate (FMAP) of 100 percent.

This FAQ document addresses common questions related to the provisions at pages 5-6 of the SHO letter relating to Medicaid billing and payments to non-IHS/Tribal providers. Questions related to other provisions of the SHO letter will be addressed in subsequent FAQs.

Q1. When services are furnished to an AI/AN Medicaid beneficiary by a non-IHS/Tribal provider under the terms of a written care coordination agreement with an IHS/Tribal facility that meets the requirements of the SHO letter, what are the options for billing for the services?

A1. There are two options for billing the state Medicaid program. The first is for the non-IHS/Tribal provider to bill the state Medicaid program directly. In this case, the provider would be reimbursed at the rate authorized under the Medicaid state plan applicable to the provider type and the service rendered, not at the facility rate that the IHS/Tribal facility would receive. The second option is for the IHS/Tribal facility to enter into an arrangement with the non-IHS provider, under which the provider assigns its claim for payment to the facility in return for payment from the facility, and the facility bills the state Medicaid program for the service. In that case, the IHS/Tribal facility would have to identify services provided by non-IHS/Tribal providers under the care coordination agreement that are within the scope of covered services of the IHS/Tribal facility and separate them from those services are not. The facility can claim and receive reimbursement from the state for services that can properly be claimed as services of the IHS/Tribal facility ("IHS/Tribal facility services") at the facility rate authorized under the Medicaid state plan. The facility would be directly responsible to the extent of any overpayments resulting from such services that were not, in fact, covered under the state plan. The facility can claim and receive reimbursement from the state for those services that do not qualify as IHS/Tribal facility services at the rate under the Medicaid state plan applicable to the provider type and service rendered. The circumstances under which off-site services may be considered facility services are described in the response to question number four.

CMS FAQ: Background

- Section 1905(a)(9) provides Medicaid coverage for:

  > [C]linic services furnished under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

- Regulations at 42 C.F.R. § 440.90 provide:

  > *Clinic services* means … services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes …: (a) Services furnished at the clinic …; and (b) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

Who does the rule apply to?

- Under the policy, IHS/tribal facilities enrolled as clinics may not bill Medicaid for any services provided outside their facilities' four walls.
- Services provided outside the four walls might include:
  - Community Health Aides
  - Nursing/immunization
  - Care to homebound individuals
- The rule does not apply to:
  - Clinic services provided within the four walls of a facility;
  - Clinic services provided outside the four walls to homeless persons;
  - Tribal hospital-based services;
  - Services provided by outside providers billed as an assigned claim.

CMS's Proposed Solution

- CMS's FAQ suggests that tribal facilities enrolled in Medicaid as clinics should ask States to redesignate them as Medicaid Federally Qualified Health Centers (FQHCs).
- Medicaid FQHCs are not subject to the "four walls" limitation.
- The FAQ says that under § 1905(*l*)(2)(B) of the Social Security Act, tribal outpatient health programs are by definition FQHCs.
  - FQHCs for purposes of Medicaid do not generally have to meet requirements to enroll as a Medicare FQHC.
- Medicaid FQHCs do not necessarily have to meet the requirements for Medicare FQHCs (i.e., cost reporting and governance requirements) – but States may impose additional requirements (see below)

CMS's Proposed Solution

- Medicaid FQHCs are generally paid based on the Prospective Payment System (PPS) rather than at the OMB rate.
- The FAQ says that states may use an Alternative Payment Methodology (APM) that establishes that tribal Medicaid FQHCs may bill at the OMB rate instead of the PPS rate.
- The state would need to amend its state plan to allow tribal Medicaid FQHCs to bill at the OMB rate through an APM.

Short Grace Period

- Recognizing that it may take time to transition to being enrolled in Medicaid as an FQHC and being reimbursed under the state plan at the OMB rate, the FAQ provides a grace period.

- The FAQ says CMS does not intend to review claims for clinic services furnished outside the four walls of a tribal facility before **January 30, 2021**.

- CMS says, however, that tribal facilities that wish to transition to being an FQHC should notify the state of their intention within one year of the FAQ, or by **January 18, 2018**.

We bill as a clinic. What should we do?

- If you bill for services provided outside the four walls of your clinic, or ever wish to, you should begin discussions with your State as soon as possible.
- Review existing State Law to determine whether it imposes any additional requirements on Medicaid FQHCs
  - If your State does impose additional requirements on Medicaid FQHCs, can you meet them?
  - If not, work with the State to exempt Tribal Medicaid FQHCs from these requirements.
- Work with State to develop a State Plan Amendment (SPA) that allows Tribal Medicaid FQHCs to bill at the OMB rate under an Alternate Payment Methodology (APM).
- Once Tribal Medicaid FQHC APM is in place, and you can meet the requirements of a Tribal Medicaid FQHC, ask State to redesignate you as a Tribal Medicaid FQHC.