



Federal Funding for Services “Received Through” an IHS/Tribal Facility and Furnished to Medicaid Eligible American Indians and Alaska Natives

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Centers for Medicaid & CHIP Services

Background

- Update is intended to help states increase access to care, strengthen continuity of care, and improve population health
- The Indian Health Service (IHS) provides culturally-appropriate health services to almost 2.2 million American Indians and Alaska Natives (AI/AN)

Background

- Federal Medicaid statute provides for 100% federal match (FMAP) for services “received through” IHS/Tribal facilities
- Previous interpretation did not generally extend to services provided outside of IHS/Tribal facilities
- In 2015, CMS announced its intent to re-interpret the statute

Overview of New Interpretation

- Permitting a wider scope of services
- Request for services in accordance with a written care coordination agreement
- Medicaid billing and payments to non-IHS/Tribal providers
- Medicaid beneficiary and IHS/Tribal Facility participation is voluntary

Overview of New Interpretation

- Managed care
- Compliance and documentation
- Applicability to 1115 demonstrations
- Relationship between matching rates

Permitting a 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
- Service highlights:
 - Long-term services and supports
 - Transportation

Request for Services Under a Written Care Coordination Agreement

- There must be an established relationship between the AI/AN Medicaid beneficiary and the IHS/Tribal facility practitioner
- Both the IHS/Tribal facility and non-IHS/Tribal provider must be enrolled in the state's Medicaid program as rendering providers
- There must be a written care coordination agreement between the IHS/Tribal facility and the non-IHS/Tribal provider



Written Care Coordination Agreements

- Minimum requirements:
 - The IHS/Tribal facility practitioner provides the request for specific services and relevant information about the patient to the non-IHS/Tribal provider;
 - The non-IHS/Tribal provider sends information about the care provided to the patient to the IHS/Tribal facility practitioner;
 - The IHS/Tribal facility practitioner continue to assume responsibility for the patient's care by assessing the information and taking appropriate action; and
 - The IHS/Tribal facility incorporates the patient's information in his/her medical record.

Medicaid Billing and Payment

- 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
- Two billing options
 - Selected option should be reflected in written care coordination agreement

Option 1 - Non-IHS/Tribal Provider Bills Directly

- A non-IHS/Tribal provider may bill directly at the State plan rate applicable to the service provided (e.g., physician consultation)
- The claim must include field(s) such as a code or check-box that document that the service was “received through” an IHS/Tribal facility to ensure proper FMAP

Option 2 - IHS/Tribal Facility Bills Directly

- The IHS/Tribal facility must separately identify services provided by non-IHS/Tribal providers from those that are provided by the IHS/Tribal facility itself
- **IHS Facilities** - Services provided by non-IHS providers outside of IHS facilities generally may not be claimed at the facility rate
- **Tribal Facilities** – Generally have more flexibility than IHS and should consult with their state Medicaid agency

IHS/Tribal Facility Bills Directly

- **Tribal facilities** - can only bill the Tribal facility rate for services provided by non Tribal providers if the State permits other non-Tribal facilities of the same type to do the same
 - For example, if State Medicaid rules permit non-Tribal FQHCs to bill the PPS rate for services provided outside the FQHC, then Tribal FQHCs may do the same using the Tribal facility rate

IHS/Tribal Facility Bills Directly

- A Tribal/IHS facility may also bill for services of a non-IHS tribal provider, such as a physician, as an assigned claim.
- In that case, the claim will be paid at the state plan rate applicable to that physician service, and not at the IHS/Tribal facility rate

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

Medicaid Beneficiary and IHS/Tribal Facility Participation is Voluntary

- 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

Managed Care

- States may claim the 100% match for a portion of a capitation payment if the following conditions are met:
 1. The service is furnished to a managed care enrolled AI/AN Medicaid beneficiary;
 2. The service meets the fee-for-service “received through” requirements with supporting documentation;
 3. The non-IHS/Tribal provider is a network provider of the enrollee’s managed care plan;
 4. The managed care plan pays the non-IHS/Tribal provider consistent with the network provider’s contractual agreement; and
 5. Consistent with CMS guidance, the state has complied with federal law regarding the provision of supplemental payments to IHS/Tribal providers that are not federally qualified health centers.

Compliance and Documentation

- In states where IHS/Tribal facilities implement the policy described in the SHO, the Medicaid agency must establish a process for documenting claims for expenditures for items or services “received through” an IHS or Tribal facility.

Compliance and Documentation (cont.)

- The documentation must be sufficient to establish that:
 - 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

Applicability to Section 1115

- State expenditures for services covered under section 1115 demonstration authority are eligible for 100 percent FMAP as long as all of the elements of being “received through” an IHS or Tribal facility are present



Relationship Between 100 percent FMAP for Tribal Services and Other Federal Matching Rates

- The 100 percent FMAP for services pursuant to this payment change is applicable instead of:
 - The regular FMAP rate described in section 1905(b)
 - The newly eligible FMAP rate described in section 1905(y)
 - The enhanced FMAP rate for breast and cervical cancer
 - The enhanced rate for Community First Choice services.

Questions

Thank you

The CMS team is always available to assist with any questions.

Please direct questions to TribalAffairs@cms.hhs.gov

Resources

- SHO#16-002, February 26, 2016- <https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf>
- Request for Comment- <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/indian-health-and-medicaid/request-for-comment.html>
- Indian Health and Medicaid- <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/indian-health-and-medicaid/indian-health-medicaid.html>