Inter Tribal Association of Arizona

The Implications of the Proposed Policy Change by the Centers for Medicare & Medicaid Service (CMS) Policy on the Availability of Federal Funds to Assume 100 Percent of Amounts Paid for Medicaid Covered Services Received through an Indian Health Service (IHS) or Tribal Facility

The twenty one member Tribes of the Inter Tribal Association of Arizona (ITAA) appreciate that the Centers for Medicare and Medicaid Services (CMS) is seeking to update its policy on section 1905 (b) of the Social Security Act that allows an enhanced Federal Medical Assistance Percentage (FMAP) for the payment of services provided to Medicaid eligible American Indian/Alaska Native individuals that receive covered services at an IHS or Tribal health care facility. CMS distributed a white paper on October 15, 2015, and announced it is seeking comments on the policy that allows states to receive a federal reimbursement to pay the claims submitted by Indian Health Service (IHS) and P.L. 93-638, Title I and Title III tribal providers. It entails that if the Medicaid service is provided in an IHS or Tribal facility, the FMAP is 100 percent and the states pay no share of the costs. The rationale for updating the policy is that the current interpretation of section 1905 (b) is too restrictive.

Position: ITAA endorses the updated policy interpretation that would authorize the enhanced 100 percent FMAP (federal reimbursement) to be applicable to additional conditions. This would benefit the Indian health care system in Arizona and the working relationship that the Indian Health Service (IHS) and Tribes have with the Arizona Health Care Cost Containment System (AHCCCS).

1. Currently the 100 percent FMAP applies to services that are within the scope of service of the IHS/Tribal facility. The proposed policy change would apply the 100 percent federal reimbursement to any service received through an IHS/Tribal facility that's included in a Medicaid State Plan now or in the future. This would include coverage of Emergency Medical Transportation (EMT) and Non-Emergency Medical Transportation (NEMT), although travel expenses (such as meals, lodging, and costs of an attendant) claimed as an administrative expense would not be eligible for the 100 percent FMAP.

2. Under current CMS interpretation, to qualify for the 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. The proposed policy change expands the meaning of a contractual agent to include a registered Medicaid provider who provides covered items or services per the authority of an IHS or Tribal facility. A written contract would have to be arranged by the IHS/Tribal facility and it may include services that are received through the IHS/Tribal facility, but not necessarily furnished directly by the IHS/Tribal facility. Urban Indian Health Programs could participate as contractual agents. ITAA agrees that this policy change is needed.

3. At the present time, an IHS/Tribal facility must bill the state Medicaid program directly for a service. CMS proposes to allow two billing options for contractual agents. The IHS/Tribal facility may continue the current process of billing the state Medicaid program for the service or choose to allow the contractual agent to bill the state Medicaid program directly. It is hoped that this policy change will incentivize providers in the private sector to contract with IHS and Tribes to provide Medicaid benefits, particularly, specialty care services that are not directly available in our facilities. This is especially important in terms of access to care and reducing health disparities, as Medicaid eligible beneficiaries, will be assisted in the Purchased Referred Care process to make appointments with external providers.

4. CMS states that the practical effect of applying the 100 percent FMAP to a service categorized as a facility benefit, is that an IHS/Tribal facility would receive payment at the applicable IHS facility rate, such as the

all-inclusive rate (AIR), identified in the State Medicaid Plan. The AIR is negotiated annually with the most recent inpatient and outpatient rates published in the Federal Register on April 7, 2015. The proposed policy states that the rate published in the state plan would apply to either facility employees or contracted providers. At the present time providers that Medicaid patients are referred to through the Purchased Referred Care (PRC) program are reimbursed with a combination of state and federal matching funds. Making available the 100 percent federal reimbursement may result in incentivizing more providers to enroll as Medicaid providers, thereby increasing access to care for our patients.

CMS states that if an IHS/Tribal authority chooses to provide a service that is not within the scope of the applicable facility benefit, the services will be paid at state plan rates. The examples of personal care and home health are noted. CMS reiterates that states retain the flexibility in establishing payment rates. New authorities in the Indian Health Care Improvement Act of 2010 include assisted living, home and community based services, hospice care, long term care and convenient care services. Despite no IHS appropriations to date for these new authorities, some Tribes have instituted these services with 638 resources. For these Tribes, ITAA seeks that CMS clarify if the new authorized services would be considered a facility benefit of the tribally operated health care system. In terms of the proposed policy, should these Tribes and Tribes that establish these services in the future expect that state plan rates would apply?

5. CMS is seeking to add that a state may claim Federal reimbursement for a portion of the capitation payment for AI/AN individuals who are enrolled in managed care, as long as they receive the service at the IHS/Tribal facility or through a contracted provider that the IHS/Tribal facility maintains oversight responsibility of. ITAA agrees that this policy change is appropriate. In Arizona, while the majority of AI/AN enroll in the Medicaid American Indian Health Program (AIHP) plan receive their health care at IHS/Tribal facilities, a large number of AI/AN have opted to enroll in managed care plans. Many of these individuals obtain their basic health care at an IHS or Tribal facility, but access their health plan provider network for other types of care.

Background: The Tribes in Arizona have long sought to resolve interpretations of the application of the 100 percent FMAP. The Health Care Financing Administration (HCFA), as it was known prior to the name change and reorganization of the agency, now called CMS, provided guidance in the form of the Memorandum of Agreement (MOA) between the Indian Health Service and the Health Care Financing Administration in 1996. It clarified that services provided *through* health care facilities owned and operated by Tribes and Tribal organizations meeting all conditions and requirements were eligible for the 100 percent Federal reimbursement. The MOA did not address the referrals by IHS and Tribes and payment for services to contracted providers for AI/AN Medicaid eligible individuals.

An impetus for the Arizona Health Care Cost Containment System (AHCCCS), to examine claiming 100 percent federal reimbursement for state plan services or in terms of its Section 1115 Demonstration began after AHCCCS was faced with legislatively mandated reductions of optional benefits in 2010. AHCCCS had received clarification by U.S. HHS Region 9 officials in 2011 that Medicaid covered services may be claimed at 100 percent FMAP when they are provided by an IHS/tribal facility or by an employee or contracted agent of the facility regardless of the place of service. The letter clarified that the 100 percent rate is available for services outside the boundaries of an IHS/Tribal facility.

AHCCCS began to work with a Tribal Committee to examine reimbursement methodologies for IHS/Tribal facilities. The result was a proposed State Plan Amendment (SPA) 12-003 of March 1, 2012, which indicated "AHCCCS will provide an option to reimburse IHS and 638 tribal facilities for Medicaid inpatient hospital services in accordance with the OMB all-inclusive rate **or the inpatient cost from the most recent cost**

report as a per diem." It did not amend the section that reimbursement for inpatient professional services and tribal nursing facilities at the Navajo Nation and the Gila River Indian Community would be based on the AHCCCS capped fee-for-service schedule. On March 15, 2012, AHCCCS issued a Notice of Public Information relating to the SPA. It states that to take into account regional cost variation "beginning on 7/1/12, IHS and Tribally operated facilities will have an option to choose among the available reimbursement methodologies for inpatient and outpatient services and that the option should be selected no later than December 15th of that year…" The notice indicated that reimbursement for the all-inclusive rate for up to 5 visits per recipient per day would be instituted on 7/1/2012. It further clarified that IHS/Tribal facilities may submit claims and receive reimbursement for services provided outside of their boundaries when services are provided by contracted entities or their employees.

Uncompensated Care Payments to IHS/Tribes: ITAA requests that CMS include in the definition of an applicable facility benefit, any of the optional Medicaid benefits that states, such as Arizona, eliminated during the recession. ITAA recently provided comments to AHCCCS on the Arizona Section 1115 Demonstration renewal, requesting the permanent renewal of uncompensated care payments to IHS and Tribes for optional benefits no longer covered in the state plan. At the present time, these include services of a podiatrist and emergency dental care for adults. In 2015, the Arizona State Legislature restored coverage of orthotics, but eliminated coverage of non-emergency medical transportation (NEMT). ITAA had recommended that claims for NEMT be added to the list of eliminated services that qualify for uncompensated care payments.

ITAA submitted letters to Thomas Betlach, AHCCCS Director, on July 24, 2015, and August 17, 2015, addressing the need to re-evaluate the payment methodology for uncompensated care payments. ITAA requested that an interim workgroup be created to study the formula and associated values (i.e., user population, historical payments, provider rates, etc.) used to calculate a Per Member/Per Month (PM/PM) rate of reimbursement. AHCCCS utilizes the 100 percent FMAP to pay these claims, but concerns were noted that the payments have not kept in pace with the costs of care. . This became evident after AHCCCS adjusted the payment methodology on January 1, 2014, citing a high administrative burden of the prior claims methodology option that the agency indicated it could no longer maintain.

Conclusion: ITAA is mindful of CMS and AHCCCS Tribal Consultation requirements. The 100% FMAP policy change is beneficial, but it also calls upon the states to continue to consult with IHS, Tribes and Urban Indian health care providers on payment methodologies and rates. This includes delineating payment methodologies in the State Plan and exploring reasonable changes to reflect the cost of services, especially for "non-facility" services.

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