Care Coordination Agreements Between Indian Health Service Facilities And Urban Indian Organizations

Background

- Federal Medicaid statute provides for 100% federal match (FMAP) of state expenditures for services "received through" IHS/Tribal facilities.

- On February 26, 2016, the Centers for Medicaid and Children's Health Insurance Plan (CHIP) services issued a State Health Official (SHO) letter to states and Tribes providing guidance to update their policy on when 100% federal funding would be available for services furnished to Medicaid-eligible American Indians and Alaska Natives (AI/AN) through facilities operated by IHS or Tribes.

- The update is intended to increase access to care, strengthen continuity of care, and improve population health.

- This presentation will address care coordination agreements between IHS and Urban Indian Organizations (UIOs).

Overview of New Interpretation

- CMS has moved to permit a wider scope of services beyond just facility services. The scope of services available include all services that an IHS/tribal facility is authorized to provide, according to IHS rules, and that are covered under the approved Medicaid State Plan in the state in which the IHS/Tribal facility is located.
- The end result is that some of the services that are available for the 100% FMAP include long-term services and supports and non-emergency medical transportation (based upon the state's claiming authority).
- CMS expanded the meaning of services "received through" and IHS/Tribal Facility. Under the expanded meaning, a non-IHS/Tribal provider could include an Urban Indian Organization.
- The request for services from an IHS/Tribal Facility practitioner is in accordance with a written care coordination agreement.
- Medicaid beneficiary and IHS facility participation is voluntary.

100-Percent FMAP Flow Chart

UIO works with the State to determine implementa-tion game plan

Care Coordination Agreement between an IHS facility and UIO Medicaid provider is executed

The IHS facility refers a Medicaid Enrolled AI/AN patient that is an IHS beneficiary to that UIO Medicaid provider using a Medicaid referral that is generated via RCIS

The UIO Medicaid provider treats the patient

The UIO Medicaid provider sends a copy of the medical record to the IHS facility that generated the referral

The referring IHS provider reviews the copy of the medical record sent to the IHS facility by the UIO Medicaid provider

The copy of the medical record is signed by the IHS referring provider. The record is then scanned and placed into the patients medical record

The IHS provider will follow up as necessary

Requirements for Implementation

- There must be an established relationship between the AI/AN Medicaid beneficiary and the IHS/Tribal facility practitioner.
- Both the IHS and UIO provider must be enrolled in the state's Medicaid program as rendering providers.
- There must be a written care coordination agreement between the IHS and UIO.
- The care coordination agreement is not limited to Medicaid-eligible beneficiaries only. The "care coordination" performed by the IHS primary care provider is a direct care service that IHS must offer to all IHS beneficiaries, regardless of coverage (see 25 USC 1641(b)). In order for the state to receive 100% FMAP for the coordinated care; however, the beneficiary must be Medicaid-eligible.

Written Care Coordination Agreements

Minimum requirements:

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

Medicaid Beneficiary and IHS 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 facilities.
- States and IHS facilities must not require beneficiaries to receive services from only those providers referred from the IHS facility.
- States may not require IHS facilities or UIO providers to enter into written care coordination agreements.

Medicaid Billing and Payment

- Medicaid rates paid to IHS facilities for services must be the same for services provided to AI/ANs and non-AI/ANs.

- Medicaid rates for services furnished by UIO providers must be the same for all beneficiaries served.

- IHS will not bill for the UIO provider except for contracts with a specialist (e.g., radiology, lab, dialysis). This is different than a contract with a specialist that comes in or provides a service in house and the read is done elsewhere. These are Federal Acquisition Regulation based.

- The UIO provider will bill directly at the State plan rate applicable to the service provided (e.g., physician consultation).

State Plan Requirements

- Payment methodologies for all services provided by IHS/Tribal facilities and UIO 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.

Billing, Compliance, and Documentation

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

Definition of Eligibility for Care Coordination Agreement

- There are different eligibility populations for IHS and UIOs. For example, UIOs can serve members of state-recognized Tribes because the Indian Health Care Improvement Act defines them as eligible Urban Indians. However, such persons are not eligible for direct care services at IHS.
- The definition of eligibility for the purposes of the Care Coordination Agreement is a person that is an "IHS Beneficiary", which means an American Indian or Alaska Native that is **eligible for direct care services at IHS** in accordance with 42 C.F.R. 136.12 **and is a registered user of the IHS**.
- UIOs cannot use their urban contract/grant money from IHS for any purpose other than serving eligible Urban Indians. Therefore, UIOs will need another source of funds to serve anyone who does not meet the IHCIA definition of Urban Indian.
- The next slide displays a comparison of the "Urban Indian" and "Indian" definitions of eligibility.

Comparison of "Urban Indian" and "Indian" Definitions/Eligibility

Eligibility Criteria	Urban Indian	Indian
Member of a Federally-recognized Tribe (including Alaska Natives)	✓	✓
Member of terminated Tribe or band	✓	✗
Member of State-recognized Tribe or band	✓	✗
Persons of Indian descent belonging to the Indian community served by the facility	✗	✓
Descendant in the first- or second-degree	✓	✗
Non-Indian women pregnant with an eligible Indian's child	✗	✓
Non-Indian members of an eligible Indian's household	✗	✓
California Indians	✓	✓

Questions

Thank You

Resources

- SHO#16-002, February 26, 2016- https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf
- Indian Health and Medicaid- https://www.medicaid.gov/medicaid/indian-health-and-medicaid/index.html
- Section 1905(b) of the Social Security Act- https://www.ssa.gov/OP_Home/ssact/title19/1905.htm