

**INDIAN HEALTH SERVICE
CARE COORDINATION AGREEMENT BETWEEN THE IHS AND UIO
Frequently Asked Questions**

Question 1: Will Indian Health Service (IHS) have to be consulted before prescriptions can be given or filled? See Section V(a).

This section describes the elements of a care coordination arrangement under this Agreement. As described in the State Health Official Letter 16-002 (February 26, 2016), the intent of this care coordination arrangement is to ensure that IHS practitioners will remain responsible for a patient's care and be able to coordinate and manage the care furnished to a patient of the IHS facility upon a Request for Services, so that an individual will receive appropriate care regardless of whether or not the rendering provider is an IHS employee. Care coordination means that the IHS practitioner will be responsible for determining the patient's needs and course of care and for coordinating and managing the patient's care; that all such care, including diagnosis, treatment, and prescriptions, will be recorded in the IHS facility medical records for the patient; and that such records will be available to inform the IHS facility practitioner's ongoing management of the course of care for the IHS facility patient.

Answer 1: No, IHS will not need to be consulted before prescriptions can be given or filled. The IHS practitioner, however, is responsible for care coordination as defined in Section V(a), including prescriptions.

Question 2: In Section VI(c), the Care Coordination Agreement (CCA) states that providers are responsible for billing services for Medicaid or non-Medicaid beneficiaries. What are the circumstances in which the beneficiary is not Medicaid? I thought the CCA states that the services have to be covered under Medicaid. If this is so, wouldn't that mean all patients were Medicaid beneficiaries?

PROVIDER is responsible for billing for all services furnished, regardless of whether the IHS Beneficiary is enrolled in Medicaid or covered by another alternate resource. For Medicaid claims, the PROVIDER's claim must contain the information specified by the [name of State] Medicaid program to document the care coordination arrangement under this Agreement.

Answer 2: No, the beneficiary is not required to be covered by Medicaid. In the case of individuals who are Medicaid-eligible, however, there are instances where Medicaid beneficiaries also have another alternate resource such as private insurance. In states that have expanded Medicaid, a beneficiary can have private insurance coverage from their employment and still qualify for Medicaid. In that instance, the private insurance is primary and must be billed prior to Medicaid. This section of the CCA is stating that when the Medicaid beneficiary has additional coverage, the provider must bill that coverage.

Question 3: In Section VI(e), the CCA states that the provider shall maintain malpractice insurance and that services pursuant to this agreement are not covered by Federal Tort Claims Act (FTCA). Does this mean that services provided pursuant to this agreement by Urban Indian

Organizations (UIOs) who already have FTCA protection would not be covered? If so, why are they not covered?

PROVIDER shall maintain malpractice insurance in the form and minimum amount required by the State in which the services are performed, and shall keep and maintain all required records of care, referrals, invoices, and billing documents. Services provided by PROVIDER pursuant to this Agreement are not covered by the Federal Tort Claims Act.

Answer 3: Although some UIOs may also be Federally Qualified Health Centers (FQHCs) and may attain deemed status for purposes of FTCA, it is a determination separate from this CCA. The FTCA coverage would only extend to the activities carried out under the Health Resources and Services Administration (HRSA) health center grant, and not to activities under the IHS CCA. (FTCA coverage also does not extend to activities carried out under an Urban Indian Organization's contract/grant with IHS for the provision of services to Urban Indians.)

Question 4: The CCA is based upon the South Dakota Agreement so they are IHS patients. Who owns the chart? This impacts GPRA (Government Performance and Results Act).

Answer 4: The Urban Indian Organization owns the medical record. However, IHS must receive a copy of the medical record from the Urban Indian Organization in order to provide primary care and care coordination. If GPRA measures were performed at the Urban Indian Organization, that would be indicated on the records sent to IHS and they could document the patient's results as well as the Urban Indian Organization.

Question 5: The IHS referring for specialty services does not work for us. We are not specialty providers, so this does not fit us. IHS provides the same services we do. We provide primary care and behavioral health.

Answer 5: Establishing a CCA may not work for every IHS Area/Service Unit and Urban Indian Organization. In addition, the types of services needed for IHS patients may vary locally dependent on the patient, IHS Area/Service Unit services needed, and the types of services an Urban Indian Organization has available. IHS Areas/Service Units will need to make the determination on whether or not to enter into a CCA.

Question 6: We are concerned with the administrative burden. The state benefits from 100% FMAP (Federal Medical Assistance Percentages) and this requires IHS to take on an administrative burden. Arizona was exploring the possibility of a waiver to reimburse IHS.

Answer 6: There is additional administrative burden for IHS Areas/Service Units to consider when making a determination to enter into a CCA. At the forefront of decision making is whether the arrangement will increase access to care, strengthen continuity of care, and improve health outcomes.

IHS facilities may bill Medicaid programs for covered health care services described in the respective Medicaid State Plans and approved waivers. Covered services may include case

management and/or care coordination. However, the IHS is unable to bill for and/or accept incentives which may be funded through shared savings arrangements, Delivery System Reform Incentive Payment Program, or other initiatives for providing referrals (and not care coordination). The federal Anti-Kickback Statute is a criminal statute that prohibits the exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) the referral of federal health care program business. See 42 U.S.C. § 1320a-7b.

Question 7: Who is eligible for services under the CCA?

Answer 7: The definition of eligibility for the purposes of the CCA 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 (registered in the IHS Resource and Patient Management System (RPMS)).

IHS regulations provide that the following individuals will be eligible for services at facilities operated by IHS:

- Persons of Indian descent belonging to the Indian community served by the facilities and program.
- Non-Indian women pregnant with an eligible Indian’s child, during the period of her pregnancy through post-partum.
- Non-Indian members of an eligible Indian’s household, if necessary to control acute infectious disease or a public health hazard.

It is important to note that there are different eligibility populations for IHS and UIOs. For example, UIOs can serve members of state-recognized tribes. However, such persons are not eligible for direct care services at IHS. The Indian Health Care Improvement Act (IHCIA) definition of eligible Urban Indian, 25 U.S.C. 1603(28) requires that, in addition to residing in an urban center, an individual must meet one or more of the criteria identified in 25 U.S.C. 1603(13)(A)-(D). In Section VIII(d), the CCA states that UIOs cannot use their urban contract or 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.