State Health Reform Assistance Network
Charting the Road to Coverage

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Medicaid and the Indian Health Service: New Guidance Explains How States May Secure Additional Federal Funds

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Introduction

States with a significant American Indian and Alaska Native (AI/AN) population stand to benefit from increased federal Medicaid funding under new guidance released in February 2016. When Medicaid-eligible AI/ANs receive services through a facility operated by the Indian Health Service (IHS), an Indian Tribe, or a Tribal Organization, the federal matching rate is 100 percent. The new policy announced by the Centers for Medicare & Medicaid Services (CMS) increases the range of Medicaid services and providers for which states may claim full federal funding, conditional upon states and health care providers fulfilling certain procedural requirements. These additional funds reduce the cost of Medicaid expansion for states, and remain in place over time even as the federal matching rate declines for other beneficiary populations. South Dakota Governor Dennis Daugaard, representing a state with a large American Indian population, has been a key proponent of the new policy.

This report is part of a series prepared by the Robert Wood Johnson Foundation's *State Health Reform Assistance Network* exploring the fiscal implications of expansion. Previous reports have explored state budget savings and revenue gains associated with expanding Medicaid,[1] including through specific lenses such as spending on uncompensated care[2] or criminal justice costs.[3] This report summarizes the new policy expanding federal funding for state Medicaid services provided to American Indians and Alaska Natives. This guidance was preceded by a Request for Comment in October 2015,[4] discussed in a prior report.[5]

Background: Federal funding in the Medicaid program

When states decide to expand their Medicaid programs under the Affordable Care Act (ACA), they receive 100 percent federal matching

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funds (FMAP) for the newly eligible population of adults with incomes below 138 percent of the federal poverty level (FPL). The matching rate starts to decrease in 2017 until it levels off at 90 percent in 2020.

The match rate does not decrease, however, for certain Medicaid services received by American Indians and Alaska Natives.[6] The federal government continues to cover 100 percent of those costs as long as the services are "received through" the Indian Health Service.[7] Eligible IHS facilities include those operated directly by the IHS, as well as those operated by an Indian Tribe or Tribal Organization (collectively referred to as "IHS/Tribal facilities").

Notably, the full federal match rate applies to IHS services for both the expansion and pre-expansion Medicaid populations, and does not decrease over time. The new guidance makes additional services eligible for the full federal match, thereby supporting the cost of state Medicaid program offerings to both newly eligible adults as well as previously eligible populations.

STATES WITH LARGE AMERICAN INDIAN AND ALASKA NATIVE POPULATIONS WILL REAP THE LARGEST BENEFIT

The increased federal funding is particularly helpful in states with a large number of Medicaid-eligible AI/AN people. The table below lists the fifteen states where the nonelderly population (ages 0–64) has the highest proportion of AI/AN individuals. Under Medicaid expansion, nonelderly people are eligible if their income falls below 138 percent of the federal poverty level.

State	% AI/AN
Alaska	14.5%
New Mexico	10.3%
South Dakota	9.1%
Oklahoma	7.3%
Montana	6.9%
North Dakota	5.2%
Arizona	4.5%
Wyoming	2.5%
Washington	1.4%
Oregon	1.4%
Idaho	1.3%
North Carolina	1.2%
Minnesota	1.2%
Utah	1.1%
Nevada	1.0%

(States highlighted in red have not yet expanded their Medicaid programs)

New CMS policy: Additional services and providers are now eligible for full federal funding

Under CMS's former policy, the 100 percent federal match rate only applied to "facility services," meaning the set of services that the IHS/Tribal facility was licensed to furnish directly. CMS's new guidance in February 2016[8] expanded the range of services eligible for full federal funding, allowed those services to be contracted out to non-IHS/Tribal facilities, and specified when services will be reimbursed at IHS rates as opposed to Medicaid state plan rates. The newly bolstered 100 percent federal match applies across traditional Medicaid fee-for-service (FFS), Section 1115 waiver programs, and also managed care plans (discussed in the next section).

All IHS/Tribal services are now potentially eligible for full federal funding. The 100 percent match is available for all services that meet two criteria: (1) an IHS/Tribal facility is authorized to provide that service under IHS rules; and (2) the service is covered by the state Medicaid plan. Unlike the previous policy, eligibility for the full federal match no longer depends on whether IHS/Tribal facilities are licensed to provide a particular service under state law. For example, long-term services and supports (LTSS) and transportation benefits were formerly ineligible for full federal funding because IHS/Tribal facilities are not licensed to provide those services directly. These benefits are now eligible because they are within the scope of IHS rules and may be covered by a state Medicaid plan.

IHS/Tribal facilities may establish care coordination agreements that involve referrals to non-IHS/Tribal providers. Services performed through a referral to a non-IHS/Tribal provider may count as being "received through" an IHS/Tribal facility, and therefore eligible for the 100 percent match, as long as certain criteria

are met. In order to qualify for the 100 percent match, certain relationships and agreements must be in place before a referral is made to a non-IHS/Tribal provider, and the referral itself must conform to federal guidelines (see sidebar). In addition, states must establish processes for documenting compliance with these criteria in order to prevent inaccurate or duplicative billing.

There are two ways to bill for services provided by non-IHS providers. Non-IHS/Tribal providers may bill the Medicaid agency directly for their services, or the IHS/Tribal facility may handle all billing on behalf of its contractual partners. The full federal match is available in both cases, although the billing rate may differ.

Option 1. The non-IHS/Tribal provider bills directly.

- Non-IHS/Tribal providers must receive the same billing rate for services under a care coordination agreement as they receive for services to non-AI/AN patients in the standard Medicaid program.
- In order to easily identify claims that are eligible for the enhanced federal match, the state must ensure that claims forms include a field to document whether the item or service was "received through" an IHS/Tribal facility.

Option 2. The IHS/Tribal facility handles all billing.

- The IHS/Tribal facility must differentiate between services that can be claimed as "IHS/Tribal facility services" and those that cannot. Both will receive the full federal match, but the two types of services are billed at different provider rates.
- Identifying IHS/Tribal facility services:
  - For IHS-operated facilities, most services provided outside the facility will not qualify as IHS/Tribal facility services.
  - Tribal Organizations may be able to claim a greater range of services as facility services, and will need to consult with their state to determine which services provided by non-IHS/Tribal providers may qualify as Tribal facility services. In general, a Tribal facility may claim as "facility services" any services that fit within the scope of practice for similar facilities in the state (e.g., inpatient or outpatient hospital, nursing facility, or Federally Qualified Health Center).
- Determining the proper billing rate:
  - For IHS/Tribal facility services, the IHS/Tribal facility will bill the state Medicaid agency at the applicable IHS/Tribal facility rate.

CARE COORDINATION AGREEMENTS WITH NON-IHS/TRIBAL PROVIDERS: CONDITIONS AND PROCEDURES

Conditions that must exist prior to a referral from an IHS/Tribal facility to a non-IHS/Tribal provider:

- Both the IHS/Tribal facility and the non-IHS/Tribal provider must be enrolled in the state's Medicaid program.
- All care must be provided pursuant to a written care coordination agreement between the IHS/Tribal facility and the non-IHS/Tribal provider.
- The patient must have an established relationship with a qualified practitioner at the IHS/Tribal facility.

Procedures for referral from an IHS/Tribal facility to a non-IHS/Tribal provider:

- The patient must be referred directly by the IHS/Tribal practitioner to the non-IHS/Tribal provider with a request for specific services.
- The non-IHS/Tribal provider must inform the IHS/Tribal practitioner about the care provided to the patient, including the results of diagnostic or treatment procedures.
- The IHS/Tribal practitioner is responsible for performing appropriate follow-up activities, including documenting new information in the patient's medical record and furnishing or requesting additional services, as necessary.

- For all other services, the IHS/Tribal facility may bill as an assigned claim by the non-IHS/Tribal provider, using the applicable state plan rate for that provider and that service.
- State Medicaid plans should specify payment methodologies for facility services that may be split between IHS/Tribal facilities and non-IHS/Tribal providers. States are not permitted to vary their rates based on the applicable federal match percentage.

Federal match methodology for managed care plans

The procedures and policies outlined above were designed for Medicaid fee-for-service. CMS recognizes, however, that some Medicaid-eligible American Indians and Alaska Natives may be enrolled in risk-based Medicaid managed care plans. The guidance permits states to claim 100 percent federal match for the portion of any capitation payment attributable to the cost of services "received through" an IHS/Tribal facility if the following conditions are met:

- The AI/AN beneficiary is enrolled in the managed care plan.
- The service received meets the same requirements described above to be considered "received through" an IHS/Tribal facility.
- The non-IHS/Tribal provider is part of the managed care plan's provider network, and is paid in conformance with the plan's contractual agreement for network providers.
- The state complies with federal law[9] and applicable guidance on managed care provider payments relating to AI/AN Medicaid services.

Conclusion

States receive 100 percent federal match for American Indians and Alaska Natives in the Medicaid program, whether they are enrolled in traditional Medicaid or in the expansion adult group. Under this guidance, CMS extends enhanced federal funding to a broader set of services and providers serving American Indians and Alaska Natives, contingent upon states adjusting their claims forms and providers complying with new procedures. This policy bolsters critical services for these populations and reduces states' costs as they maintain and expand their Medicaid programs.

End notes

[1] Bachrach D, Boozang P, Herring A, Glanz Reyneri D. "States Expanding Medicaid See Significant Budget Savings and Revenue Gains." (Princeton: Robert Wood Johnson Foundation, 2016). Accessed March 25, 2016, *http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf419097*.

[2] Bachrach D, Boozang P, Lipson M. "The Impact of Medicaid Expansion on Uncompensated Care Costs: Early Results and Policy Implications for States." (Princeton: Robert Wood Johnson Foundation, 2015). Accessed February 29, 2016, *http://statenetwork.org/wp-content/uploads/2015/06/State-Network-Manatt-Impact-of-Medicaid-Expansion-on-Uncompensated-Care-Costs-June-2015.pdf*.

[3] Guyer J, Bachrach D, Shine N. "Medicaid Expansion and Criminal Justice Costs: Pre-Expansion Studies and Emerging Practices Point Toward Opportunities for States." (Princeton: Robert Wood Johnson Foundation, 2015). Accessed February 29, 2016, *http://statenetwork.org/wp-content/uploads/2015/11/State-Network-Manatt-Medicaid-Expansion-and-Criminal-Justice-Costs-November-2015.pdf*.

[4] CMS & CMCS. "Medicaid Services 'Received Through' an Indian Health Service/Tribal Facility: A Request for Comment." (Washington, D.C.: U.S. Department of Health & Human Services, 2015). Accessed February 29, 2016, *http://www.medicaid.gov/medicaid-chip-program-information/by-topics/indian-health-and-medicaid/downloads/tribal-white-paper.pdf*.

[5] Bachrach D, Polaris J. "Medicaid and the Indian Health Service: States to Receive Additional Federal Funds." (Princeton: Robert Wood Johnson Foundation, 2015). Accessed February 29, 2016, *http://statenetwork.org/wp-content/uploads/2015/11/State-Network-Manatt-Medicaid-and-the-Indian-Health-Service-States-to-Receive-Additional-Federal-Funds-November-2015.pdf*.

[6] Indian Health Service eligibility also includes other groups, such as Indians of Canadian or Mexican origin, as well as non-Indians with certain Indian familial relationships. For full details, see "Indian Health Manual," Section 2-1.2, (Washington, D.C.: Indian Health Service). Accessed February 29, 2016, *http://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p2c1#2-1.2*.

[7] 42 U.S.C. § 1396d(b).

[8] CMS, Letter to State Health Officials re: Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives, SHO #16-002 (2016). Accessed February 29, 2016, *https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf*.

[9] 42 U.S.C. § 1396u–2(h)(2)(C)(ii).