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MEMORANDUM

March 4, 2016

TO: Tribal Health Clients

FROM: Hobbs, Straus, Dean & Walker, LLP

Re: *Making CMS's New 100% FMAP Policy Work for Tribal Health Programs*

As we reported earlier this week, CMS just issued its much-anticipated State Health Official (SHO) Letter announcing that 100% FMAP will be extended to services rendered by non-IHS/Tribal providers to an American Indian/Alaska Native (AI/AN) enrolled in Medicaid when a referral¹ is made by the IHS or a tribe pursuant to a written coordinated care agreement. This significant change in policy was widely supported by Tribes and represents an enormous opportunity for the IHS and tribal health providers to work with their States to improve access to Medicaid services and resources for American Indians and Alaska Natives.

At the outset, it is important to remember that FMAP reimbursement is about CMS reimbursing the State, not CMS or the State reimbursing Tribes. As a result, the new CMS 100 percent FMAP policy only directly benefits States. Tribes and tribal health programs will have to work with their State to make the new 100 percent FMAP policy benefit them as well.

The new policy provides an important incentive for States to work with Tribes, however, as new 100 percent FMAP dollars will only be made available to States if Tribes and non-Tribal providers enter into the kind of coordinated care arrangements called for in the SHO Letter. The key for Tribes and Tribal health programs will be to work with States to obtain something in return for setting up such arrangements, such as the ability to bill for new services or include new populations, including Medicaid Expansion.

¹ Such referrals are for Medicaid enrolled individuals only. As discussed below, such referrals need not be Purchased/Referred Care referrals in order for the service rendered to qualify for 100 percent FMAP reimbursement to the State. However, coordinated care arrangements should address the impact on Purchased/Referred Care in the event Medicaid legitimately denies payment on a claim due to limitations in the scope of covered services.

Following is a brief outline of the different ways the new FMAP policy can potentially be used to benefit Tribal health care programs, and some of the steps Tribes can take to benefit from the policy. We also discuss the new policy's implications for managed care. As discussed below, making the policy work for Tribes will largely have to occur on a case by case, state by state basis. Please let us know if you would like additional information about the SHO Letter or to discuss how to best implement it for your health program.

I. Negotiating Increased Access to Medicaid Services through Coordinated Care Arrangements

CMS's new 100 percent FMAP policy will allow States to claim 100 percent FMAP for services rendered by non-IHS/Tribal providers if the patient is referred to that provider by an IHS/tribal facility under a written care coordination agreement. This provides the States an incentive to work with Tribes to set up such networks so that the State can claim additional FMAP reimbursement from CMS. However, the creation of such a network does not provide Tribes with any benefit standing on its own – it only increases reimbursement to the States.

Tribes can benefit from the 100 percent FMAP policy, however, if they use the incentive structure it creates to get the State to make additional services available for Medicaid reimbursement through such coordinated care arrangements. Both Tribes and the non-IHS/Tribal providers will need some incentive from the State to enter into such arrangements. Ideally, the new policy will create an incentive for the State to provide incentives for both Tribes and non-IHS/Tribal providers. The SHO Letter makes it clear that States will not be permitted to make reimbursement rates dependent on the FMAP reimbursement rate. This means States will not be allowed to incent Tribes and non-IHS/Tribal providers to enter into arrangements that will provide the States increased 100 percent FMAP reimbursements by making reimbursement rates higher for such services. However, there are other ways States could do so.

For example, States could use the creation of such networks to increase eligibility for services. In South Dakota, for example, the State has expressed interest in expanding Medicaid if this policy went forward, as it would provide significant new resources available to the State. The IHS and Tribal facilities in that State would in turn benefit by being able to bill Medicaid for services provided to American Indians and Alaska Natives in the new adult group.

States could also pave the way for Tribes to take advantage of the new policy by making other services eligible for reimbursement if rendered pursuant to coordinated care arrangements. The States could, for example, add a service not otherwise eligible for reimbursement to be reimbursed through such arrangements, particularly if combined with other authorities such as 1915(b)/(c) waivers or 1115 demonstration waivers. The SHO Letter specifically notes that it is applicable to 1915 and 1115 waivers, which reflects comments made by Tribes.

There are several different models that could be used in the construction of such coordinated care arrangements. First, as noted in the SHO Letter, the IHS and Tribes already have the authority to enter into sharing arrangements with outside providers under the demonstration projects authorized by Section 307 of the Indian Health Care Improvement Act, 25 U.S.C. § 1637. This authority has not been fully implemented to date due to lack of appropriations, but given the increased Medicaid billing possibilities made available through the SHO Letter, this mechanism should be available to be used in connection with a coordinated care agreement.

Second, Tribes could use the opportunities provided by the SHO Letter coordinated care arrangements to design their own Tribal Managed Care Networks, as authorized by Section 1932 of the Social Security Act. Such networks could be used to enroll Indian beneficiaries into a network of providers with the IHS/Tribal provider making referrals to outside providers through a coordinated care network. Like other forms of managed care, such networks might be able to offer additional services not otherwise available in the State plan. Such a Tribal Managed Care Network could allow Tribes to manage much of the Medicaid program for their members, while coordinating and increasing access to care through a network of coordinated care providers, and saving purchased/referred care dollars.

In addition, as set out in the SHO Letter, regardless of the model they choose to implement a coordinated care agreement, Tribal health programs will have the choice of either allowing outside providers to independently bill Medicaid for the services they provide, or bill up through the Tribal health facility. Billing up through the IHS/Tribal facility may have its advantages, but also poses several complications. First, as set out in the SHO Letter, only “facility” services provided by outside providers could be billed at the IHS encounter rate. Other facilities would be reimbursed at the regular State plan rate. Another complication is how to pass along the reimbursement for such care back out to the non-IHS/Tribal provider, and at what rate. Such reimbursement arrangements will also have to be examined for compliance with Medicaid’s general Stark physician referral and Anti-Kickback Statute requirements.

Finally, any coordinated care arrangement should also address potential impacts on Purchased/Referred Care (PRC). The referrals addressed in these agreements will be Medicaid only referrals for Medicaid eligible AI/AN, and as a result, the payor of last resort rule will apply and the PRC program will not be liable for the cost of the service being referred. This should be spelled out in any agreement. In addition, such agreements should also spell out what will occur if Medicaid should deny any claim for any reason (i.e., for being outside the scope of services covered in the State plan). Will the PRC program cover the cost of such services? Will the provider?

These are just some of the issues that will have to be worked through in building any such network. Overall, however, the new policy presents a significant opportunity

for Tribal health care providers to work with their non-Tribal partners and their States to build networks that will increase care provided to AI/AN Medicaid beneficiaries.

II. Implications for Managed Care

The SHO Letter also has very positive implications for Tribes negotiating and managed care proposals made by their State plans. The SHO Letter clarifies that States can claim 100 percent FMAP for that portion of a managed care capitated payment that is attributable to services “received through” an IHS/Tribal health facility, including services provided by outside providers under a coordinated care arrangement that meets the requirements of the SHO Letter. Importantly, the SHO Letter states that States may only do so if it has complied with the requirements of Section 1932(h)(2)(C)(ii) of the Social Security Act. This is the provision that guarantees that Tribal health care programs be paid a wraparound payment by the State if a managed care entity fails to pay what the Tribal health care program would otherwise be paid under the State plan (usually the IHS encounter rate). As a result, if a State wanted to claim 100 percent FMAP for that portion of the capitated payment it makes to its managed care entities for care received through an IHS/Tribal health facility, it would have to first guarantee that Tribes were being fully paid by the State for managed care services. This is an important incentive that may be helpful for many Tribes having difficulty getting paid the full encounter rate for managed care services.

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The new 100 percent FMAP policy represents a significant opportunity for Tribal health programs to increase access to care and strengthen care coordination. If you would like any further information about any of the items discussed in this memorandum, please contact Elliott Milhollin (emilhollin@hobbsstrauss.com or 202-822-8282) or Geoff Strommer (gstrommer@hobbsstrauss.com or 503-242-1745).