**Oregon-Washington Tribal Clinic Benefit Project**

**Draft Policy Issues**

**Project Objective:**

In collaboration and consultation with Oregon and Washington’s Tribes, the Oregon Health Authority (OHA) and Washington Health Care Authority (HCA) will obtain approval from the Center for Medicare and Medicaid Services (CMS) to make Medicaid payments to Indian Health Services (IHS) operated and 638 contract/compact Tribal programs (hereafter referred to as I/T facilities) for certain services that are not otherwise available to Medicaid beneficiaries.[[1]](#footnote-1)

These payments are to cover I/T facilities’ “uncompensated care costs” associated with Medicaid reductions. The payments are intended to support the viability of these facilities, which are the essential providers of health care for the states’ Native American populations.

The project will provide OHA and HCA with a CMS approved concept paper that would allow OHA to amend its Oregon Health Plan 1115 demonstration waiver to make Medicaid payments for these services, and for HCA to either obtain a Medicaid State Plan amendment (SPA) or new demonstration waiver to make these payments.

**Policy Issues:**

Following is a list of policy issues that will need to be addressed for Oregon and Washington to make payments to I/T facilities for certain Medicaid services. The issues are based on state conference calls with CMS, review of Arizona Medicaid program’s implementation of a tribal supplemental payment program, discussions with Northwest Portland Area Indian Health Board (NPAIHB) staff and consultants, and discussions with OHA and HCA staff. This list should not be viewed as complete. As an initial task, Oregon and Washington will need to meet with Tribal representatives to determine other policies issues that need to be addressed by the project.

1. **Waiver Request**
2. **Medicaid Waiver or Uncompensated Care Payment Option.**

Under the existing Medicaid categorically needy (CN) program, states’ Medicaid benefits must comport with comparability of service, state-wideness and amount, duration and scope requirements. Comparability of service requires that CN beneficiaries are eligible for the same benefit package/services, except as allowed in 42 CFR 440.250, 431.54 and 431.55. State-wideness requires that the services be available throughout the entire state. States have flexibility to define the amount, duration, and scope of the Medicaid services they cover. However, federal law requires that coverage of each mandatory and optional service be “sufficient in amount, duration, and scope to reasonably achieve its purpose.”

Oregon and Washington could elect to seek a “comparability of service” or “amount, scope and duration” exemption in order to make Medicaid payments to I/T facilities for certain services. This option may likely be difficult to obtain because neither 42 CFR 440.250 limitations nor existing 1915 waiver provisions appear to allow services or payments based on a “provider type.” Instead, an 1115 demonstration waiver would be required.

CMS has indicated a willingness to support state’s efforts to provide care to American Indian (AI) and Alaska Native (AN) people. However, they may have policy and political constraints granting a comparability of service waiver based on an “I/T provider” designation. While federal treaty and law recognizes that government-to-government relationship between Tribes and the federal government and Title XIX of the Social Security Act has specific Indian provisions (e.g., cost-sharing prohibitions and managed care enrollment), CMS has otherwise limited this special relationship to payment rate options (e.g., use of the IHS encounter rate). Except for federal law provisions for cost-sharing, CMS has not granted waivers for Medicaid AI/AN specific benefit designs.

Arizona was able to resolve benefit package restrictions through an “IHS/tribal 638 facilities uncompensated care l payment” program. Under their approved waiver, Arizona’s Medicaid program makes payments that take into account their uncompensated costs for specified types of services furnished by I/T facilities. These payments are made for both AI/AN and non-native beneficiaries. The Arizona program did not waive any existing Medicaid provisions in order to make these uncompensated care payments.

It is recommended that OHA and HCA seek early guidance from CMS on the specific type of approach (i.e., waiver of service comparability and possibly state wideness, or compensated care payments) they would support. This guidance will reduce the time and resources needed to complete the project.

1. **Non-Native Coverage**

Oregon and Washington’s I/T facilities serve tribal members, other eligible AI/AN people and non-natives. For example, some 10,300 (34%) of the 30,480 Medicaid beneficiaries served by I/T facilities in state fiscal year (SFY) 2011 were non-natives.

Based on preliminary discussions with CMS and the Arizona waiver, CMS does not appear willing to grant waivers or uncompensated care payments for only AI/AN beneficiaries. In part, this may be due to HHS Office of Civil Rights concerns over discriminatory practices. OHA, HCA and the Tribes will need to decide whether to take this issue on in order to avoid non-federal share payments for non-natives.

1. **2014 Medicaid Expansion Group.**

The Patient Protection and Affordable Care Act (ACA) will expand mandatory Medicaid coverage to 138 percent of the federal poverty level (FPL), effective January 2014. The expansion will include all adults under age 65 who are not currently eligible for Medicaid and who are U.S. citizens or lawful legal residents. Except for benefit design and cost-sharing, the existing Medicaid program rules and policies would apply to this new eligibility group. OHA, HCA and Tribes will need to make a policy decision on whether the tribal clinic benefit design or uncompensated care payments would also apply to the new coverage group.

1. **Participating Tribal Programs.**

Oregon and Washington’s tribal clinics operate under 638 self-determination status or as IHS operated programs. In each case, the clinics are located on federally recognized tribal lands. Oregon has one urban tribal program that operates as a regular Federally Qualified Health Centers (FQHC) and Washington has two urban tribal programs that operate as regular FQHCs.

Based on available information, it appears that the other States working with Tribes on a tribal clinic benefit option have limited the option to IHS and 638 clinics located on reservation land. For example, Arizona’s uncompensated care l payment program is limited I/T facilities. Urban Indian health programs, which operated under FQHC designation, are not included.

Consideration will need to be given as to whether urban tribal programs should have access to the tribal clinic benefit or supplemental payments. Including urban tribal clinics creates non-federal fiscal exposure because services provided by these clinics are reimbursed at the state’s “regular” Federal Medical Assistance Percentage (FMAP), 62.91% for Oregon and 50.00% for Washington, and not the 1905(b) 100% FMAP for AI/AN beneficiaries served by tribal clinics.

It is recommended that OHA and HCA seek early guidance from CMS on whether they would allow urban Indian health programs to be covered. While these programs are considered FQHCs in the Medicaid program, they also are recognized in the IHCIA as tribal providers.

1. **Tribal Benefit Design Options for Waiver**
2. **Health Benefit Design.**

The concept of a tribal clinic benefit or uncompensated care payments results from States having to reduce their Medicaid optional benefits. As noted above, certain states have sought to exempt AI/AN beneficiaries from these reductions. If this is the approach that OHA and HCA elect to embrace, CMS may ask the states to define the “base year” that benefits began to be reduced and that define the new services covered under the tribal clinic benefit design.

Another option could be to propose that tribal programs, as deemed under Title XIX as FQHCs, have the same opportunity to provide FQHC core benefits. However, based on an initial review of FQHC and rural health center (RHC) services, their “core” services may not cover key services that tribal clinics would want to provide, such dental, pharmacy, therapies, mental health and chemical dependency services. CMS may also have concerns with this approach because of the FQHC linkage to non tribal providers.

A third option would be to look to IHS for guidance on a tribal benefit design. Under the Indian Health Care Improvement Act (IHCIA), Tribes receive “direct service” funding for services provided by their tribal programs and contract health services (CHS) funds to purchase other medical services (e.g., inpatient hospital care) for Tribal members and other AI/AN eligible persons. While IHS operations manual provides a general direct services chart of accounts, it does not specify a specific benefit package. In further discussions with NPAIHB staff, it was affirmed that there is not a specific IHS benefit design.

Given the absence of a model benefit design for I/T facilities programs, it is recommended that the design be based on the array of services that were provided by I/T facilities at a specific date before Oregon and Washington’s Medicaid programs began to reduce benefits. Examples of these services are found in Washington’s “*Medicaid Provider Guide – Tribal Health Program*” document.

1. **Behavioral Health & Long-Term Care Services.**

Based on a preliminary review of Arizona and California’s proposed tribal benefit design, benefit coverage has focused on medically related services including dental coverage. Oregon and Washington tribal clinics also provide mental health and chemical dependency services, and several programs also provide nursing facility and home and community-based long-term care (LTC) services.

It is recommended that Medicaid behavioral health services be included in the benefit or uncompensated care payment program covered in this project. Unless there has been a reduction in home and community-based services provided by I/T facilities, it is recommended that LTC services not be included in the scope of this project.

1. **Finance Issues**
2. **FMAP Rate for Non-Natives**

Section 1905(b) of the Social Security Act authorizes the federal government to reimburse states at 100% FMAP for Medicaid covered services provided by IHS or tribal facilities. While the law is silent on whether 100% FMAP applies to services to AI/AN or non-natives beneficiaries, CMS has long held that the higher match rate only applies to services to AI/AN beneficiaries.

Based on discussions with Arizona’s Medicaid staff, they sought a waiver to employ the 100% FMAP for non-natives. However, CMS said that would not grant such a waiver and that state’s regular match would be applied to the uncompensated care payments for non-natives. OHA, HCA and the Tribes will need to decide whether they should take on this long standing policy.

1. **Non-Federal Share Requirements**

According to Arizona waiver documents, CMS required the state to pay I/T facilities for the uncovered waiver services to non-natives (see discussion above). CMS also required the state to pay the non-federal share for the non-natives. After completing a more detailed claims analysis of services to non-natives, Arizona decided to pay the non-federal share in order obtain the waiver approval for their IHS/tribal 638 facilities uncompensated care payment program. [[2]](#footnote-2)

Based on claims analysis, Oregon and Washington will need to decide if the state is prepared to provide the non-federal share amount for those certain services provided by I/T facilities to non-natives. As a reference, Washington paid I/T facilities approximately $52 million in state fiscal year (SFY) 2011, with $11.3 million (22%) for non-natives. An estimated $630,000 was associated with adult services (e.g., dental) that have been eliminated.

If they are not prepared to pay the non-federal share, the states will need to address the non-federal share issue early in the project. The project will need to obtain an early read from CMS on whether they would approve a change in their 1905(b) 100% FMAP policy or CPE or IGT options (see below).

1. **Tribal Non-Federal Share Options**

There are two options available for Tribes to pay the non-federal share for the services provided to non-natives. Under federal law, public entities including Tribes may provide the non-federal share through a certification of public expenditures (CPE). The funds must be “… certified by the contributing public agency as representing expenditures eligible for FFP under this section.” [[3]](#footnote-3) The certified funds also must not be “public funds” that are federal funds, or they re federal funds authorized by federal law to be used to match other federal funds. California was reportedly considering a CPE option.

The second option is intergovernmental transfers (IGT). Medicaid IGTs are the transfer of funds from one governmental entity to another government entity for the purpose of providing that entity with the non-federal share for Medicaid reimbursement. [[4]](#footnote-4) Public providers that are governmental entities are able to make IGT payments to the state Medicaid program for reimbursement of services provided by that provider so-long as they meet the test as a “bona fide donation.” [[5]](#footnote-5)

Tribes may be willing to provide the non-federal share for the exempted services (e.g., adult dental services) provided by I/T facilities to non-natives. However, they may favor a CPE option because it is perceived to be administratively simpler and places fewer limit on their cash-flow (e.g., funds do not need to be transferred to the state Medicaid program). It also would likely be administratively simpler for the state Medicaid agencies.

Washington has adopted a IGT program with Tribes. Participating Tribes provide the non-federal share for chemical dependency services they provide to non-natives. CMS Region X approved this option under the condition that the financing would be through an IGT. They required this approach based on their experience with CPE administrative match programs.

1. **Reimbursement Rates**

Tribal health programs are reimbursed for most of their services at either FQHC payment rates for Oregon’s tribal clinics or the IHS encounter rate for Washington’s tribal programs. Other services such as prescription drugs and therapies are reimbursed like other Medicaid provider types.

OHA and HCA will need to determine whether there should be a change in existing reimbursement policies for those tribal clinic benefits that are no longer covered under the Medicaid program. The preliminary review of other states efforts to adopt a tribal benefit did not indicate that the state was altering its existing reimbursement policies. For example, Arizona’s IHS/tribal 638 facilities uncompensated care payment Option 1 payment methodology uses the existing IHS encounter rate as the basis for the uncompensated care payment.

It is recommended that Oregon and Washington’s Medicaid program employ their existing payment policies or the policy that was in effect at the time of the service termination to reimburse the I/T facilities. In addition to reducing payment complexity it also reduces information system revisions.

1. **Other Policy Issues**
2. **Tribal Program Capacity.**

CMS has indicated a willingness to allow state Medicaid programs to exempt tribal clinics from benefit reductions that apply to other provider types. However, they have required states to address whether tribal clinics have the capacity to serve non-tribal members who are AI/AN or non-natives. CMS has expressed concern that tribal clinics may not have the capacity to meet the demand for Medicaid services that are only available at tribal clinics.

Arizona responded to this issue by saying that non-native Medicaid beneficiaries are required through their waiver to obtain services through managed care organizations (MCO). Under Arizona’s model, IHS and 638 clinics are not part of MCOs’ provider networks. It should be noted that AI beneficiaries who voluntarily enroll in an MCO can also receive Medicaid services at a tribal clinic. Arizona also argued that tribal clinics are located in geographic areas that are not readily available to non-natives. Given that relatively few non-natives are obtaining services at tribal clinics, they believe that non-natives will not seek limited services at a tribal clinic.

Oregon and Washington’s Medicaid programs will need to conduct an analysis of the number of existing I/T medical and behavioral health programs and their current service utilization. For example, Washington’s I/T facilities served 30,480 persons in state fiscal year (SFY) 2011, 21,180 (66%) were AI/AN people and 10,300 (34%) were non-natives. The employment of an uncompensated payment model could assist both the States and CMS in needing to address a capacity issue because there is no assumption that I/T facilities would be expected to serve a significant number of Medicaid beneficiaries under uncompensated care.

1. **Tribal Sovereignty.**

Under Washington’s government-to-government accord with the 29 federally recognized Tribes, Washington’s Medicaid program has not imposed any requirements on Medicaid beneficiaries they will serve. Oregon may have similar relationships with its 9 Tribes.

Based on a review of Arizona and California’s proposals, it is not clear whether CMS would require tribal facilities to provide the additional uncovered benefits to non-natives or AI/AN beneficiaries who were not members of that Tribe. Arizona stated in a response to CMS that AIs who are members of federally recognized Tribes are a “… political classification as they are members of sovereign nations, and not a racial classification.” Therefore, the 14th Amendment and other racial discrimination provisions are not applicable. Whether or not Oregon and Washington will need to address this matter with CMS remains to be seen.

1. **Waiver Budget Neutrality**

Like Arizona, Oregon will need to amend its Oregon Health Plan demonstration waiver to adopt a tribal clinic benefit that is not in the Oregon Health Plan’s (OHP) Prioritized List of Health Services. One challenge in obtaining the approved amendment may be the ability to continue to demonstrate 1115 budget neutrality. Washington will also have to address this issue if it needs to implement a new demonstration waiver for the benefit.

1. **SPA Implementation Option**

In order to reduce administrative burden and implement the option in a timely manner, Washington may want to adopt the tribal clinic benefit through a SPA. As with the CPE/IGT policy issue (see above discussion), Washington will need to obtain an early read from CMS on whether they would accept a SPA for the benefit.

1. **Information Technology (IT) Issues.**

While not a policy issue, OHA and HCA will need to consider necessary information system changes and administrative support for benefit coverage changes or supplemental payments. It should be noted that Arizona’s approved waiver allows for a manual billing and payment process for their compensated care payment program.

1. On April 6, 2012, Arizona’s Medicaid program obtained an 1115 waiver amendment that allows their program to make uncompensated care payments for non-covered services provided by I/T facilities. Based on available information, California, New Mexico and Utah are also considering waiver options to support tribal programs. [↑](#footnote-ref-1)
2. Arizona’s Medicaid program estimated that the tribal clinic services to non-natives were under $2.0 million for state fiscal year (SFY) 2011. This was down from a previous $12.0 million per-year estimate. [↑](#footnote-ref-2)
3. See 42 CFR 433.51. [↑](#footnote-ref-3)
4. See Section 1903(w)(6)(A) of the Social Security Act. [↑](#footnote-ref-4)
5. See 42 CFR 433.54. [↑](#footnote-ref-5)