

December 5, 2016

The Honorable Don Shooter  
Chairman, Joint Legislative Budget Committee  
Arizona State Senate  
1700 West Washington  
Phoenix, Arizona 85007

**SUBJECT: AHCCCS Healthcare Services for Native Americans Report**

Dear Senator Shooter:

Laws 2016, Chapter 122, Section 29, requires the Arizona Health Care Cost Containment System to report on Healthcare Services for Native Americans, including information on the following items:

1. An estimate of State and Total Fund expenditures for Native Americans, broken out by fee-for-service and capitated expenditures.
2. An assessment of the state fiscal implications of federal guidance regarding claiming 100% federal funds for certain expenditures:
  - a. Services furnished by non-Indian Health Services (IHS) or tribally-operated "638" providers through a written care coordination agreement
  - b. Services by IHS or 638 providers that previously did not qualify for 100% federal funds.
3. Strategies to encourage written care coordination agreements.
4. An analysis of the impacts of the federal guidance on access to care, continuity of care and population health for Native Americans in Arizona.

**Introduction and Background**

American Indians and Alaska Natives (AI/AN) enrolled in AHCCCS may choose to receive their coverage through the AHCCCS American Indian Health Program (AIHP) on a Fee-for-Service basis, or through one of the AHCCCS contracted managed care organizations (MCOs) on a capitated basis. AI/AN members have a unique program choice in that they can switch their enrollment between AHCCCS AIHP and an AHCCCS managed care health care plan and back again at any time. All AI/AN members enrolled in AHCCCS (whether it be in AIHP or MCOs) may receive health care services from Indian Health Facilities (IHS, tribally-operated "638" health programs, urban Indian health clinics). AIHP members can also receive services from any other AHCCCS-registered providers, while MCO-enrolled members receive services through their MCO's network providers.

The Indian Health Care Improvement Act provided states with a 100% Federal Medical Assistance Percentage (FMAP) for Medicaid services provided at IHS facilities and tribal health

programs under P.L. 93-638 (hereafter referred to as "638" facilities). Services provided within the facilities as an inpatient or outpatient hospital service are reimbursed at the IHS all-inclusive rate (AIR) at the 100% federal match. In 2011, CMS provided AHCCCS with additional guidance which expanded the 100% federal match to services provided by an agent, employee, or contracted provider of the IHS or 638 facility, so long as the IHS or 638 facility bills for the services directly. These additional services can be provided outside of the facility and are reimbursed at the rate defined in the Medicaid State Plan. In totality, Fee-for-Service expenditures which are eligible for the 100% federal matching rate are identified in the AHCCCS Budget Submittal and Appropriations Status Report expenditure detail as "IHS Facilities"

To ensure equal access to state, local, and federal programs, to which other citizens are entitled (in accordance with Medicaid Payment Policy and the Indian Health Care Act), if IHS/638 facilities are unable to provide the necessary treatment, Medicaid-eligible American Indians who enroll with AIHP may use non-IHS/Tribal providers for services. These services are matched at the regular FMAP (currently 69.24% for categorical populations and 89.85%-100% for expansion adults) and reimbursed at the rates defined in the Medicaid State Plan. In totality, FFS expenditures for AI/AN members which are eligible for the regular FMAP are identified in the AHCCCS Budget Submittal and Appropriations Status Report expenditure detail as "IHS Referrals" or "IHS Non-Facility". This report refers to FFS expenditures matches at regular FMAP as "non-IHS/Tribal providers".

In a February 26, 2016, State Health Official Letter (#16-002), CMS provided new guidance that expands the scope of Medicaid services provided to AI/AN members that **may** qualify for 100% federal match if certain criteria (which will be outlined further in this report) are met. This guidance is positive step forward in that the expansion of services that can qualify for 100% federal match may help improve access to care for AI/AN members, increase support for IHS services, and provide fiscal savings to the states. However, the letter is unclear in a number of areas and the additional guidance promised by CMS has not yet been provided. There are a number of implementation challenges, most notably, the requirement for written care coordination agreements which are completely voluntary for the IHS/638 Facility, the non-IHS/638 facility provider, and the AI/AN member. There is no financial incentive for participation.

Please note that this guidance primarily applies to AI/AN members enrolled in the AHCCCS AIHP and Tribal ALTCS members. It does not apply to the Title XXI populations (KidsCare or MCHIP), nor does it apply to other Fee-for-Service populations including: Federal Emergency Services, non-American Indian fee-for-service, prior quarter, or hospital presumptive eligibility.

1. ***"An estimate of the Administration's annual total fund expenditures on acute care, long-term care and behavioral health services for Native Americans in this state, including an estimate of total state expenditures on such services. The Administration shall provide separate estimates of total Medicaid fee-for-service expenditures and total Medicaid capitation expenditures for services furnished to Native Americans in this state."***

As of November 1, 2016, there are 116,352 Acute Title XIX members in the AIHP and 2,523 ALTCS EPD Title XIX Tribal members. State Fiscal Year 2016 Fee-for-Service expenditures associated with these members are shown in Table 1 below.

Expenditure information for Native Americans enrolled in contracted managed care health plans is estimated based on a self-reported ethnic origin code within the AHCCCS PMMIS recipient demographic system. There is no documentation required to self-report as Native American (except to exempt from KidsCare or Freedom to Work premiums) and therefore the estimates may be over or understated. As of November 1, 2016 there are 57,151 Acute members and 1,920 ALTCS (413 EPD and 1,507 DDD) members enrolled with the Native American indicator. Table 2 on the following page shows the State Fiscal Year 2016 estimated capitated expenditures for those members identifying as Native American.

<b>Acute</b>	<b>State</b>	<b>Federal</b>	<b>Total</b>
IHS/638 Facility	-	546,337,322	546,337,322
Non-IHS/Tribal Provider	67,781,061	225,153,998	292,935,059
	<b>67,781,061</b>	<b>771,491,320</b>	<b>839,272,381</b>
<b>ALTCS</b>			
IHS/638 Facility	-	13,657,047	13,657,047
Non-IHS/Tribal Provider	33,212,312	73,262,604	106,474,916
	<b>33,212,312</b>	<b>86,919,651</b>	<b>120,131,963</b>
<b>Behavioral Health</b>			
IHS/638 Facility <sup>(Note)</sup>	-	-	-
Non-IHS/Tribal Provider	21,121,603	47,733,365	68,854,968
	<b>21,121,603</b>	<b>47,733,365</b>	<b>68,854,968</b>
<b>Grand Total</b>			
IHS/638 Facility	-	559,994,369	559,994,369
Non-IHS/Tribal Provider	122,114,976	346,149,967	468,264,943
	<b>122,114,976</b>	<b>906,144,336</b>	<b>1,028,259,312</b>

Note: BH IHS Facility expenditures are included in the Acute above.

Program	State	Federal	Total
Traditional Acute	55,648,167	122,745,581	178,393,748
Prop 204 Acute	16,994,850	88,295,001	105,289,851
Newly Eligible Adult	-	13,084,606	13,084,606
Title XXI	382,789	6,551,789	6,934,577
LTC EPD	5,605,653	12,364,063	17,969,715
LTC DDD	18,007,437	39,717,959	57,725,396
<b>TOTAL</b>	<b>96,638,895</b>	<b>282,758,999</b>	<b>379,397,894</b>

2. ***“An assessment of the state fiscal implications associated with federal policy guidance issued by CMS in the state health official letter #16-002 dated February 26, 2016. The assessment shall include an estimate of the state fiscal impact of the following policies addressed in the letter:***

***(a) The one hundred percent federal matching assistance percentage for services furnished by non-Indian health service providers to Native Americans in this state through a written care coordination agreement.”***

To qualify for the 100% federal match, services must meet the following conditions:

- Both the IHS/Tribal facility and non-IHS/Tribal provider must be registered Medicaid providers.
- The service must be requested by a practitioner at an IHS/Tribal facility; it may not be self-requested by the beneficiary or requested by the non-IHS/Tribal provider.
- The patient must have an established relationship with a provider at the IHS/Tribal facility. This relationship can be based on visits, including the initial visit, conducted using telehealth procedures.
- The care must be provided pursuant to a written care coordination agreement between the IHS/Tribal facility and the non-IHS/Tribal provider, under which the IHS/Tribal facility remains responsible for overseeing the patient’s care and retains control of the patient’s medical record. These written agreements must include the following:
  - The IHS/Tribal facility provides a request for specific services and relevant information about the patient to the non-IHS/Tribal provider.
  - The non-IHS/Tribal provider sends information about the care it provides to the patient and results of any procedures to the IHS/Tribal facility;
  - The IHS/Tribal facility continues to assume responsibility for the patient’s care by assessing the information and taking appropriate action, including furnishing or requesting additional services, when necessary; and
  - The IHS/Tribal facility incorporates the patient’s information into the medical record through the Health Information Exchange or other agreed-upon means.

These extensive requirements create a tremendous administrative burden for the IHS/Tribal facility, the non-IHS/Tribal provider, and AHCCCS, which must validate compliance and documentation before claiming the 100% federal match. Again, there is no financial incentive for the providers to take on this additional work so the State can benefit from the additional federal funds. Therefore, it should not be initially assumed that a high percentage of existing non-IHS/Tribal provider claims will be eligible for the higher federal match under this guidance.

It is also not clear that all services will benefit from this guidance. There has been conflicting information as to whether or not inpatient services are eligible for the increased match under this guidance. AHCCCS staff has participated in a number of conference calls and seminars on this issue and the messages from various CMS staff have been mixed and conflicting. AHCCCS is pursuing a more formal discussion with CMS leadership on this point.

Table 3 below provides a breakdown by service category of the non-IHS/Tribal providers for State Fiscal Year 2016.

Professional Services	28.4%
Transportation	27.9%
Inpatient Hospital	24.6%
Outpatient Facility	13.0%
Pharmacy	4.8%
Dental	1.3%
	100.0%

AHCCCS believes that care coordination agreements for transportation and pharmacy claims will only be possible in very rare situations. In particular, pharmacy claims which are paid through the AHCCCS Pharmacy TPA to the major retail pharmacies are not likely to include care coordination agreements with a Tribal facility.

If inpatient hospital, pharmacy, and transportation are not likely to benefit from this guidance, that would eliminate approximately 57% of the existing non-facility spend as feasible for the 100% match. The most likely categories for successful care coordination agreements are for professional services and outpatient facility services, which represent about 41% of the total spend.

It is important to note that AIHP members can go to any registered AHCCCS provider at any time for services. Many of these providers will not have any relationship with an IHS/Tribal facility and thus no ability to initiate a written care coordination agreement even if they were motivated to do so. As noted in a later section of this report, AHCCCS cannot delay providing

coverage to initiate a written care coordination agreement. Thus, it is infeasible to assume that even a low percentage of non-IHS/Tribal provider expenditures will be converted to the 100% match in the current environment.

***2(b) "The one hundred percent federal matching assistance percentage for services furnished by an Indian health service facility or tribal facility that did not previously qualify for a one hundred percent federal matching assistance percentage, including home and community-based services, transportation services and other nonfacility-based services."***

Again, the SHO letter guidance on these additional services has been unclear. In 2011, CMS informed AHCCCS that the state could claim 100% match for any service covered under the State's Medicaid Plan (or 1115 waiver) so long as the services are provided by an IHS/638 facility or by an agent, employee, or contracted provider of the facility. This included services provided outside of the facility so long as the IHS/638 facility bills for the service directly. Based on that older guidance, AHCCCS has already been claiming transportation (both emergency and non-emergency) as well as other services at the 100% FFP so long as those conditions are met.

In terms of the potential savings associated with capitation, currently AHCCCS health plans are prohibited from encountering or contracting for services performed by IHS/Tribal facilities. AHCCCS has special payment authority within the waiver to pay for those services on a fee-for-service basis so that the existing 100% match can be claimed for those expenses. Therefore, AHCCCS is already maximizing its claiming of the 100% match. Additionally, how to determine what portion of the capitation payment would require significant actuarial analysis and CMS has yet to provide any additional guidance on how that should be calculated.

***3. "A report on the Administration's strategies to encourage written care coordination agreements, as prescribed in the state health official letter #16-002 dated February 26, 2016, between Indian Health Service providers and non-Indian Health Service providers."***

As discussed above, there is no financial or other incentive for IHS/Tribal facility and the non-IHS/Tribal provider enter into a written care coordination agreement and take on the administrative burden required by the guidance. The guidance is clear that such activities are completely voluntary participation for both the member and the provider:

- Medicaid beneficiaries must have freedom of choice of qualified providers.
- States may not require beneficiaries to receive services through an IHS/Tribal facility or non-IHS/Tribal provider that has established a care coordination agreement with an IHS/Tribal provider.
- States may not delay providing Medicaid coverage by requiring beneficiaries to initiate or continue a relationship with an IHS/Tribal facility.
- State may not require IHS/Tribal facilities or non-IHS/Tribal providers to enter into written care coordination agreements

In order to improve quality of care and access to care for the AIHP population, and provide some incentive to facilitate the written care coordination agreements necessary for the 100% match, AHCCCS, in consultation with Tribes and IHS, made a proposal to CMS to institute an American Indian Medical Home initiative for the AIHP membership.<sup>1</sup> Under this model, IHS/638 facilities (Urban Indian health programs are not eligible) can achieve a medical home status by meeting certain criteria related to care coordination, patient-centered care models, enhanced access to services, evidenced-based care, collaborative care management, secure data exchange, and quality improvement.

Under the proposal, the medical homes would be reimbursed a PMPM (per member per month) payment based on the levels and attributes of services that they provide. Services will include: Primary care case management; 24 hour call line; After-hospital care coordination; Participation in the AZ HIE, participation in a regional Care Management Collaborative (CMC), and Diabetes education. Prioritization and execution of care coordination agreements between IHS/Tribal providers and non-IHS/Tribal providers would occur through participation in regional CMCs. Payment to the American Indian medical home will be 100% federal match and AHCCCS is hopeful that this will provide a roadmap for the development of the written care coordination agreements necessary to obtain the 100% federal match for non-facility services.

AHCCCS is currently in discussions with CMS to gain approval for this initiative. For more information, a link to the AI Medical Home waiver submittal is included here:

<https://www.azahcccs.gov/AmericanIndians/Downloads/Consultations/Meetings/2016/RevisedAIMedHomeProposalFinal.pdf>

**4. *“An analysis of the impact of the federal policy guidance issued by CMS in the state health official letter #16-002 dated February 26, 2016 on access to care, continuity of care and population health for Native Americans in this state.”***

CMS has indicated that the proposed changes are intended to “help states, the IHS, and Tribes to improve delivery systems for AI/ANs by increasing access to care, strengthening continuity of care, and improving population health.” It is hoped that the changes may create new incentives for IHS and Tribal providers to develop arrangements with other providers to expand their patients’ access to specialty services and supportive services. In Arizona, AI/AN members can already go to any AHCCCS registered provider to receive services, so it is not anticipated it will increase access to care. However, care coordination agreements could result in better coordinated care, which may lead to improved outcomes.

On multiple occasions, tribal partners have expressed that there could be additional benefits to Native American health care in Arizona if the state is willing to reinvest a portion of any savings realized from the 100% FFP back into IHS/Tribal facilities to provide additional support to expand and enhance service delivery within their facilities.

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<sup>1</sup> Initially submitted as part of the Arizona Delivery System Reform Incentive Payment (DSRIP) proposal, this proposal is now separate from the DSRIP.

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### **Conclusion**

The CMS SHO letter #16-002 includes some promising opportunities for states to work with IHS/Tribal facilities as well as non-tribal providers to increase access to care and improve delivery systems for the AI/AN population while also potentially reducing state funding. However, both because AHCCCS has already maximized claiming of the 100% federal match and due to the significant administrative burden required by the guidance, it is unlikely to result in a significant shift in non-IHS/Tribal provider spending to the federal government. There is additional clarification from CMS required on a number of points and there is a great deal of work necessary to create an infrastructure whereby the use of the written care coordination agreements can be achieved and documented.

AHCCCS believes that the approval by CMS of the American Indian Medical Home will be an important first step in building that infrastructure. However, at this time, there are far too many variables and uncertainties to project a potential state match savings against the current budget.

If you have any questions about this report, please do not hesitate to call Jeffery Tegen at (602) 417-4705 or Elizabeth Carpio at (602) 417-4616.

Sincerely,

A handwritten signature in black ink, appearing to read 'T. Betlach', with a horizontal line extending to the right.

Thomas J. Betlach  
Director

CC: Lorenzo Romero, Director, Governor's Office of Strategic Planning and Budgeting  
Richard Stavneak, Director, Joint Legislative Budget Committee