BACKGROUND:

Medicaid Administrative Claiming (MAC) is a program through which contracted government agencies may receive partial reimbursement for performing administrative activities, such as outreach and referral activities, that support the goals of the Medicaid State Plan. Currently, the Health Care Authority (HCA) contracts with school districts, local health jurisdictions, tribes and public hospitals for MAC. The Centers for Medicare & Medicaid Services (CMS) must review and approve the final claiming methodology.

For the past eight years HCA has worked in coordination with the Washington State Tribes and CMS to develop a Tribal MAC claiming methodology. Through this joint effort, HCA hoped to develop a plan that respects tribal sovereignty while minimizing administrative burdens associated with time study and claiming processes. Currently, 12 tribes participate in a paper based, random week time study each quarter. Participating tribal staff document 100% of the activities they perform in fifteen minute increments per their normal schedule during this randomly selected week.

The following is a brief timeline of key events related to the Tribal MAC program over the past 12 months:

January, 2013

HCA met with tribal leadership on January 17, 2013 to propose the development of a statistically valid stratified random moment time study (RMTS) that would operate in partnership with HCA's vendor, the University of Massachusetts Medical School (UMSS).

The proposed RMTS methodology quantifies outreach and linkage activities of time study participants and polls employees at random moments during their normal work day over a quarter. It then calculates the results. This method determines what portion of staff time is spent performing activities that are reimbursable by Medicaid, and is designed to be as quick and user friendly to participants.

Participants only complete the time study for randomly selected moments during their normal work day.

RMTS procedures are the same for all participants. For each randomly selected moment, the participant will select or provide a response to each of the following questions:

1. What type of activity were you doing?
2. What were you doing?
3. Who were you with?
4. Why were you performing this activity?

Tribes will submit quarterly claims to HCA for reimbursable MAC activities. The reimbursements are calculated based on results of staff participation in the time study.

February, 2013

On February 7, 2013 the stratified RMTS proposal was presented to the American Indian Health Commission (AIHC).

March, 2013

After careful consideration, on March 11, 2013, tribal representatives recommended that HCA move forward with the proposed stratified RMTS.

April – June, 2013

CMS reviewed the proposed RMTS.

July, 2013

HCA received notice from CMS on July 11, 2013 to move forward with the proposed stratified RMTS and to submit an official Cost Allocation Plan (CAP).

August – September, 2013

HCA, UMMS, and Washington State Tribes work to develop a CAP for submission to CMS.

Similar to the current process to determine the Medicaid Eligibility Rate (MER), the CAP proposed that each participating Tribe track both the total unduplicated number of clients eligible for Medicaid during the quarter, and the total number of unduplicated clients provided with services during the quarter. The MER would be calculated for each individual Tribe via a data match by comparing the Tribe's client list with HCA's Medicaid eligibility list.

The MER would be calculated according to the following formula:

$$\frac{\text{Total number of unduplicated clients eligible for Medicaid}}{\text{Total number of unduplicated clients provided with services}}$$

October, 2013

The Tribal CAP was submitted to CMS Region X on October 21, 2013.

March, 2014

Per CMS, the final obstacle to overcome in the tribal claiming methodology is the process used to determine the tribal Medicaid Eligibility Rate (MER).

The MER calculation determines the proportional share of Medicaid individuals to the total number of individuals within the target population. Participating Tribes must calculate the Medicaid Eligibility Rate (MER) for the total population served each billing quarter.

The MER is currently calculated according to the following formula:

$$\frac{\text{Total number of unduplicated clients eligible for Medicaid}}{\text{Total number of unduplicated clients provided with services}}$$

To determine if individuals being served are Medicaid eligible, contractors cross match their eligibility lists with enrollment eligibility information via ProviderOne.

Along with the MER percentage, Tribes enter the time study data from each participant into an HCA excel workbook system which calculates the percent of reimbursable time and generates an invoice.

CMS notified HCA that the proposed MER calculation is a clinic based MER and determined that the MER rate calculation should be based on Tribal enrollment.

CURRENT ISSUE:

CMS determined that the MER rate calculation should be based on Tribal enrollment. As a result the Tribal enrollment MER would be calculated according to the following formula:

$$\frac{\text{Total number of unduplicated enrolled tribal members eligible for Medicaid}}{\text{Total number of unduplicated enrolled tribal members provided with services}}$$

HCA supports Tribes in asking CMS to reconsider their recommendation concerning the MER.

The Tribal enrollment MER does not consider:

1. The uniqueness of the Tribes.

   MAC activities may take place anywhere Medicaid eligible tribal members, non-tribal members, families and/or children and contracted tribal personnel may interact. This could be in an office, clinic, and/or center, or during a home visit, as well as by telephone or at a meeting.

Tribes may offer a variety of programs other than those located in a clinic where staff may perform activities eligible for MAC claiming, including but not limited to:

- Elder/Senior services programs
- Childcare programs
- First Steps maternity support services (pregnancy outreach, education, and nutrition services)
- Food assistance programs
- Diabetes programs
- Indian Child Welfare
- Indian Health Service "Contract Health Services" program
- Social services

2. Requiring Tribal Health programs to submit data based on Tribal membership only is burdensome, and inconsistent with the 2003 CMS Medicaid School Based Administrative Claiming Guide concerning the MER calculation process The guide states:
   " The *development of the proportional Medicaid share, sometimes referred to as the Medicaid eligibility rate (MER), Medicaid percentage, allocable share, or discount rate, should relate to and be based on the claiming unit (the entity submitting the claim). For example, claims may be developed on the basis of an individual school, a school district, or a specific unit of government, such as a county or statewide, as determined by the claiming unit. The calculation of the MER must be based on verifiable data."*

   Each participating tribe contracts separately with the HCA and is responsible for the submission of claims related to Medicaid activities performed by their organization. Based on this information each contracted tribe is the "claiming unit" and should develop one MER per unit for the purposes of allocating costs to the Medicaid program.

   This definition of the claiming unit is reiterated in the proposed CAP which states:

   "Each participating Tribe will track both the total unduplicated number of clients eligible for Medicaid during the quarter, and the total number of unduplicated clients provided with services during the quarter. The MER will be calculated for each individual Tribe via a data match by comparing the Tribe's client list with HCA's Medicaid eligibility list."

3. Using Contract Health Service Delivery Areas (CHSDA) (now known as Purchased & Referred Care or PRC) to develop the MER calculation for a specific tribe creates several concerns potentially impacting tribal sovereignty:

   a. Does not capture the population being served.
   b. Overlapping CHSDAS: For example, one county may be included in multiple CHSDAs for more than one tribe, and one Tribe has a 10 county CHSDA that stretches along the I-5 corridor.
   c. No uniform policy – Tribes set their own policy on who is eligible.
   d. CHSDA's do not include all AI/ANs. In FY2013, IHS reported 49,153 active PRC users, but yet the IHS User Population was 67,152, leaving ~17,000 AI/AN people out of the denominator of the MER.

<u>RECOMMENDATIONS:</u>

Each Tribe will calculate the MER based on how they deliver services. This will respect tribal sovereignty, and account for each tribe's unique health delivery system.

a) "Clinic" based MER utilizing Indian Health Services (IHS) user population data. This MER calculation is based on native and nonnative populations that enter the clinic for services.

b) "Social Services" based MER. This MER calculation is program specific and based on caseload and Tribal enrolled/membership.