



Third-Party Billing at Urban Indian Organizations: Medicaid, Telehealth, and Pandemic Response

National Council of Urban Indian Health





Welcome!

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Learning Objectives

1. Learn about NCUIH's 2020-2021 project, which collected and analyzed data on UIO billing practices with a focus on telehealth and Medicaid.
2. Learn about national UIO billing trends, especially overall third-party revenue, Medicaid reimbursement, and provider losses.
3. Learn about telehealth policies relevant to UIOs before and after the pandemic.
4. Identify opportunities for enhanced billing and enrollment capacity in urban areas, moving past emergency orders.



PURPOSE OF ANALYSIS

- To provide an overview of how Urban Indian Organizations (UIOs) bill third-party resources
- To share data insights on Medicaid, including information such as the percentages of amounts billed and collected along with identifying best practices that facilitate successful third-party reimbursement policies.
- To describe impact of telehealth policy changes.
- To address the impact of the 2019 Coronavirus Public Health Emergency on (a) provider losses of expected revenue and (b) local telehealth capacity.



ROADMAP

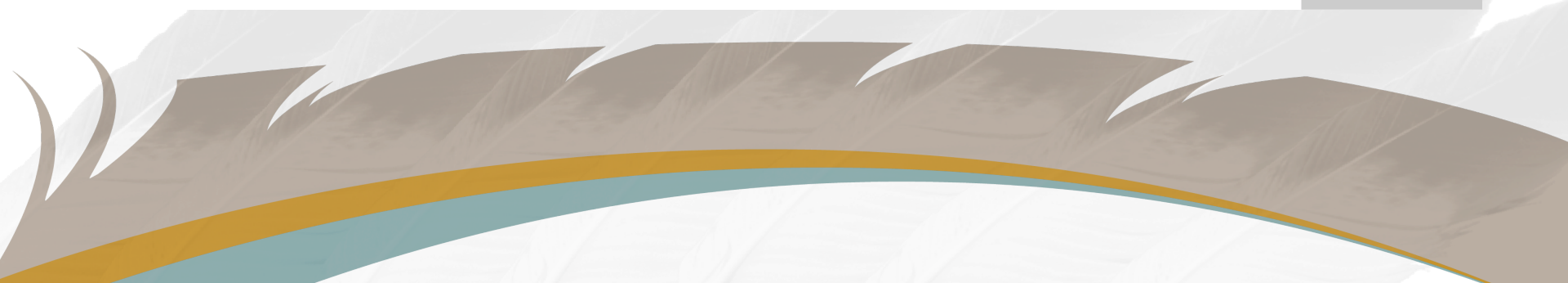
- Introduction to Urban Indian Organizations
- Relevant Third-Party Payers
- Methods
- Data Sources
- Findings
- Impact of Coronavirus
- Conclusions & Recommendations



Introduction to Urban Indian Organizations



NCUIH represents 41 Urban Indian Organizations (UIOs) at over 70 facilities throughout the United States.





FULL AMBULATORY PROGRAMS

- First Nations Community Healthsource (Albuquerque, NM)
- Denver Indian Health & Family Services (Denver, CO)
- American Indian Health & Family Services of SE Michigan (Detroit, MI)
- Gerald L. Ignace Indian Health Center (Milwaukee, WI)
- Indian Health Board of Minneapolis (Minneapolis, MN)
- Native American Development Corporation (Billings, MT)
- Helena Indian Alliance (Helena, MT)
- Native American Health Center (Oakland, CA)
- American Indian Health & Services (Santa Barbara, CA)
- San Diego American Indian Health Center (San Diego, CA)
- Indian Health Center of Santa Clara Valley (San Jose, CA)
- Sacramento Native American Health Center (Sacramento, CA)
- Nebraska Urban Indian Health Coalition (Omaha, NE)
- South Dakota Urban Indian Health (Sioux Falls, SD)
- Native Americans for Community Action (Flagstaff, AZ)
- Urban Inter-Tribal Center of Texas (Dallas, TX)
- Hunter Health Clinic (Wichita, KS)
- Native American Community Health Center (NATIVE Health) (Phoenix, AZ)
- NARA of the Northwest (Portland, OR)
- Seattle Indian Health Board (Seattle, WA)
- NATIVE Project (Spokane, WA)



LIMITED AMBULATORY PROGRAMS

- American Indian Health Services of Chicago (Chicago, IL)
- North American Indian Alliance (Butte, MT)
- Indian Family Health Clinic (Great Falls, MT)
- United American Indian Involvement (Los Angeles, CA)
- Nevada Urban Indians (Reno, NV)
- Urban Indian Center of Salt Lake City (Salt Lake City, UT)
- All Nations Health Center (formerly Missoula Urban Indian Health Center) (Missoula, MT)



OUTREACH AND REFERRAL PROGRAMS

- Bakersfield American Indian Health Project (Bakersfield, CA)
- Fresno American Indian Health Project (Fresno, CA)
- Native American Lifelines of Baltimore/Boston (Baltimore, MD/West Roxbury, MA)
- Tucson Indian Center (Tucson, AZ)



OUTPATIENT AND RESIDENTIAL SUBSTANCE ABUSE TREATMENT PROGRAMS

- American Indian Council on Alcoholism (Milwaukee, WI)
- Juel Fairbanks Chemical Dependency Services (St. Paul, MN)
- Native Directions (Manteca, CA)
- Friendship House Association of American Indians (San Francisco, CA)
- Kansas City Indian Center (Kansas City, MO)
- Native American Connections (Phoenix, AZ)



Relevant Third-Party Payers



Payers Covered in Previous Project Year

- CHIP
- Medicare Part B (Medical Insurance)
- Medicare Part D (Prescription Drug Coverage)
- Medicare Advantage Plans
- Medicare Prospective Payment System (PPS) for FQHCs
- Marketplace



Image source: "Important Facts About CHIP" Fact Sheet, available at: <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Outreach-and-Education/pdf/important-facts-about-chip.pdf>



2020 Third-Party Billing Report

- Downloadable via [our website](#).



National Council of
Urban Indian Health



EXCELLENCE, EQUITY, EFFECTIVENESS.

Recent Trends in Third-Party Billing at Urban Indian Organizations

Executive Summary

The report provides an overview of billing methods and payment methodologies that Urban Indian Organizations use for third-party reimbursement, data insights, and related policies and issues relevant both in the recent past and in the age of coronavirus.



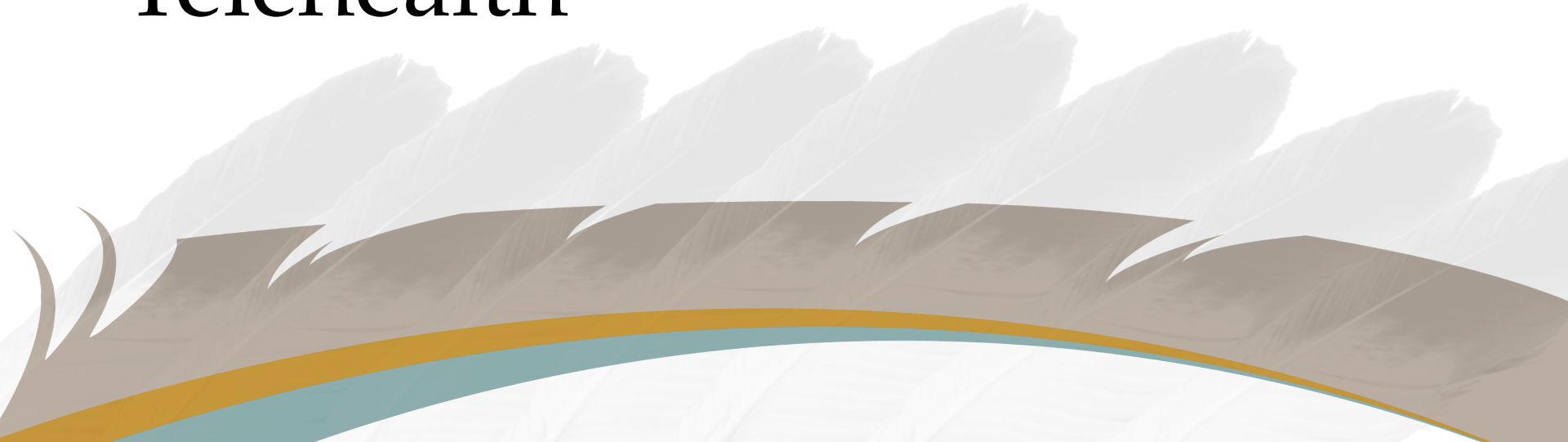
A Focus on Medicaid

- Fee-for-Service
- Managed Care*





Telehealth



Types of Telehealth

- Live Video
- Remote Patient Monitoring (RPM)
- Store-and-Forward (S&F)
- Mobile Health (mHealth)





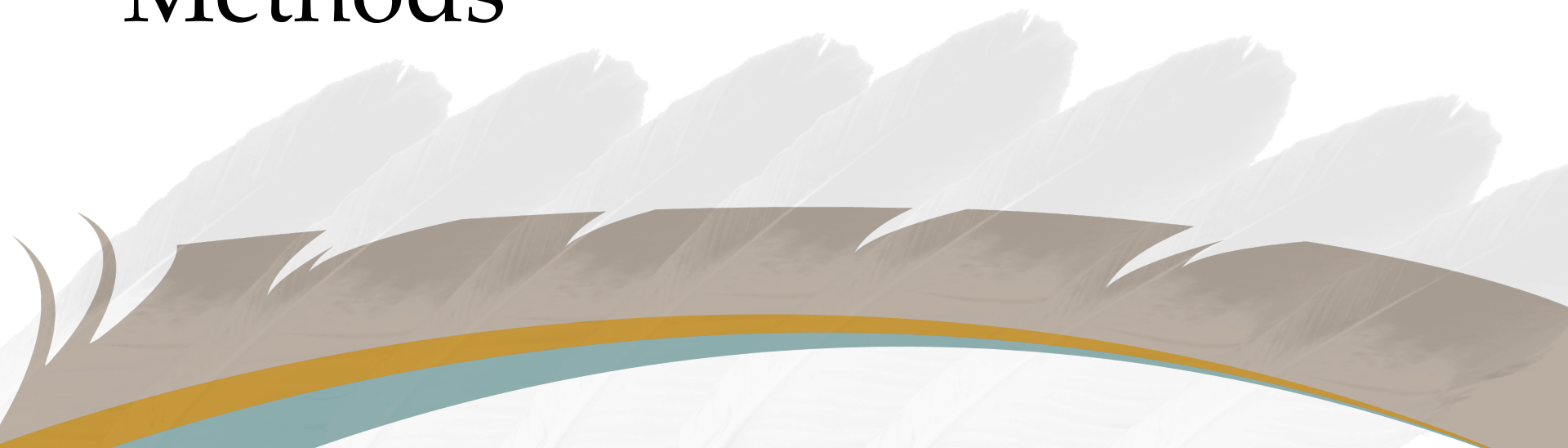
Telehealth after the Pandemic – Challenges and Opportunities



- During the COVID-19 crisis, telehealth was playing a critical role in the provision of health care services to AI/AN people
- Rate Considerations and Other Flexibilities
- Interstate Telehealth



Methods





Research Plan

2019-2020 Data

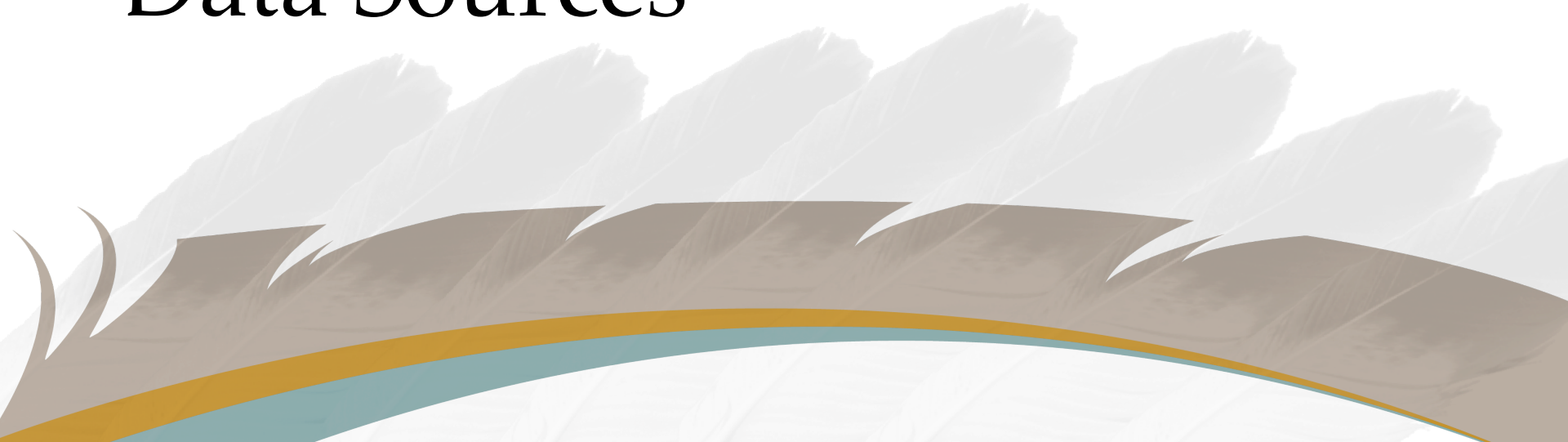
- 1) **Data Sharing Agreements**
- 2) **NORC and TMSIS Data**
- 3) **Direct information gathering**

Medicaid Analysis & Telehealth Supplement





Data Sources





Program Services Revenue

IRS Form 990

- Decent proxy for total third party reimbursement
 - Available prior to 2018
- Last 10 Available Years collected (FY 2008 – FY 2018)

Strengths

- Availability across all UIOs
- Generally rich data source

Weaknesses

- Lack of granularity
- Proxy limitations
 - Administrative Revenue, etc.
- Time intensive



Medicaid

Reimbursement Rate

- Public information
- Supplemented by Survey Items on record
 - Generally doesn't change too drastically year-to-year
- ~ 80% of UIOs known
- Last Available
 - 78% FY20 (or FY19/20)
 - 22% FY18

Medicaid Claims

- Transformed Medicaid Statistical Information System (T-MSIS).
- Collected by Centers for Medicare & Medicaid Services (CMS) from State-level Medicaid agencies.
- Most recent year of data is from 2018.
- Data quality prior to 2018 is insufficient for this project.



T-MSIS 2018: Facility-Level

- Analyzed by Facility:
 - Total 2018 Medicaid beneficiary counts.
 - Total 2018 Medicaid claims counts.
 - Total 2018 dollar amounts of paid Medicaid claims.



T-MSIS 2018: Patient Characteristics

Certified American Indian or Alaska Native Code

Code	Code value
0	Individual does not meet the definition of an American Indian/Alaskan Native
1	Individual meets the definition of an American Indian/Alaskan Native
2	Yes, Individual does have Certificate of Degree of Indian or Alaska Native Blood (CDIB)
Null/missing	source value is missing or unknown



T-MSIS 2018: Patient Characteristics

Research Assistance Data Center (RESDAC) Definition of Certified American Indian or Alaska Native Code:

“American Indian or Alaska Native” means any beneficiary defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, pursuant to 42 CFR § 136.12; i.e., a Certificate of Degree of Indian or Alaska Native Blood (CDIB). Please see COMMENT for a complete definition of CBID.

Comments:

Certificate of Degree of Indian or Alaska Native Blood (CDIB) means the beneficiary:

- a. Is a member of a Federally-recognized Indian tribe;
- b. Resides in an urban center and meets one or more of the following four criteria:
 - i. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
 - ii. Is an Eskimo or Aleut or other Alaska Native;
 - iii. Is considered by the Secretary of the Interior to be an Indian for any purpose; or
 - iv. Is determined to be an Indian under regulations promulgated by the Secretary of Health and Human Services;
- c. Is considered by the Secretary of the Interior to be an Indian for any purpose; or
- d. Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native; most recent in the calendar and all prior years.



T-MSIS 2018: Patient Characteristics

- Race-ethnicity composite variable categories (mutually exclusive):
 - Hispanic, any race
 - White, Non-Hispanic or Hispanic not reported
 - American Indian or Alaskan Native, Non-Hispanic or Hispanic not reported
 - Black, Non-Hispanic or Hispanic not reported
 - Asian American, Non-Hispanic or Hispanic not reported
 - Pacific Islander or Native Hawaiian, Non-Hispanic or Hispanic not reported
 - Multi-racial, Non-Hispanic or Hispanic not reported
 - Missing
- AI/AN race/ethnicity category only includes AI/AN “alone.”
- AI/AN patients reported with Hispanic ethnicity were probably coded in the Hispanic composite category.
- AI/AN patients reported as AI/AN and a 2nd racial category were probably coded in the Multi-racial composite category.



Other Sources

Surveys

- Pre-Pandemic Health Information Technology Survey (2017-2018)
- COVID-19 Needs Survey:
 - Spring 2020 (March-April)
 - Fall/Winter 2020 (Sept-Dec)
- Pre-Pandemic State Telehealth Policy Analysis



Findings

Data Samples, Estimates, and Projections



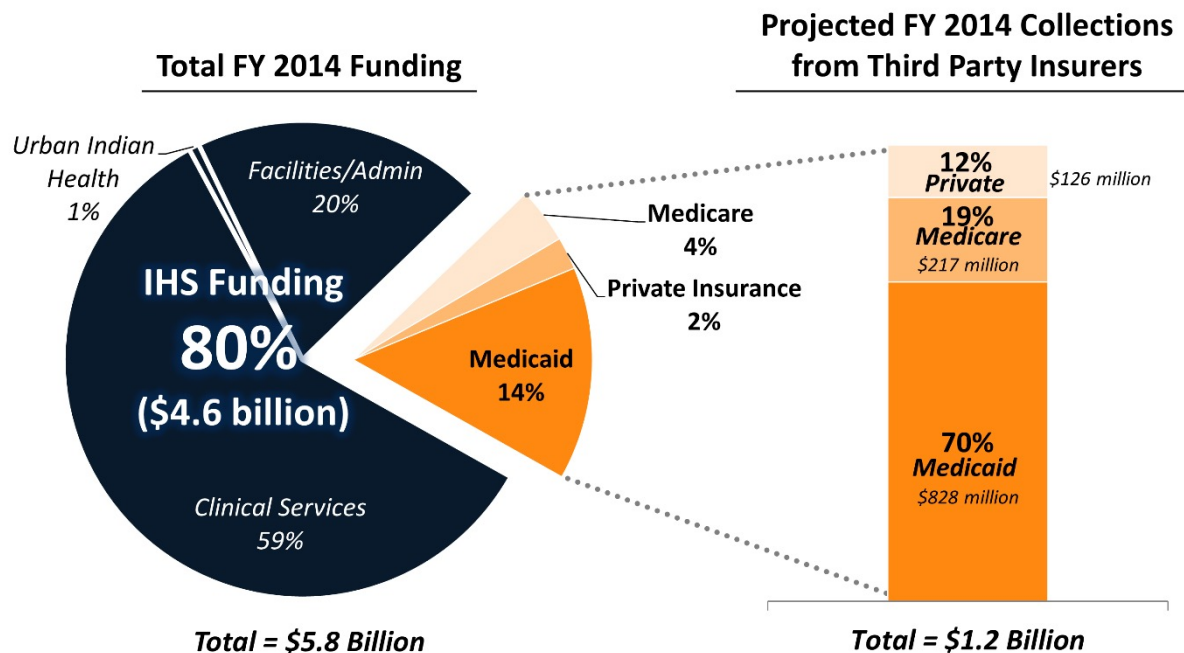
Program Services Revenue



Overall I/T/U System Funding

Figure 6

Allocation of Indian Health Service Program Funding, FY 2014



NOTE: "Clinical Services" includes physical, mental, oral, and preventive health services, as well as Purchased/Referred Care, and the Special Diabetes Program. Projected collections estimate is based on the 2015 IHS Congressional Budget Justification and does not convey any otherwise unreported revenues. SOURCE: Kaiser Family Foundation analysis of the Department of Health and Human Services, Indian Health Service, *Justification of Estimates for Appropriations Committees*, FY 2015.

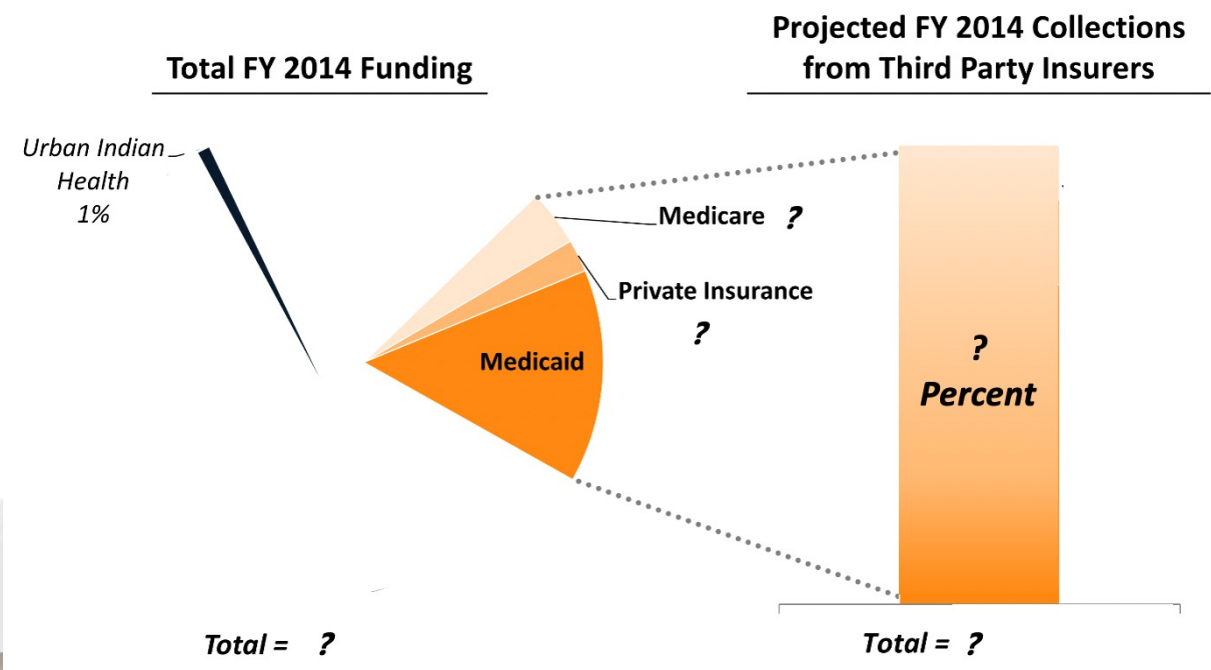




How much goes to Urban Organizations?

Figure 6

Allocation of Indian Health Service Program Funding, FY 2014

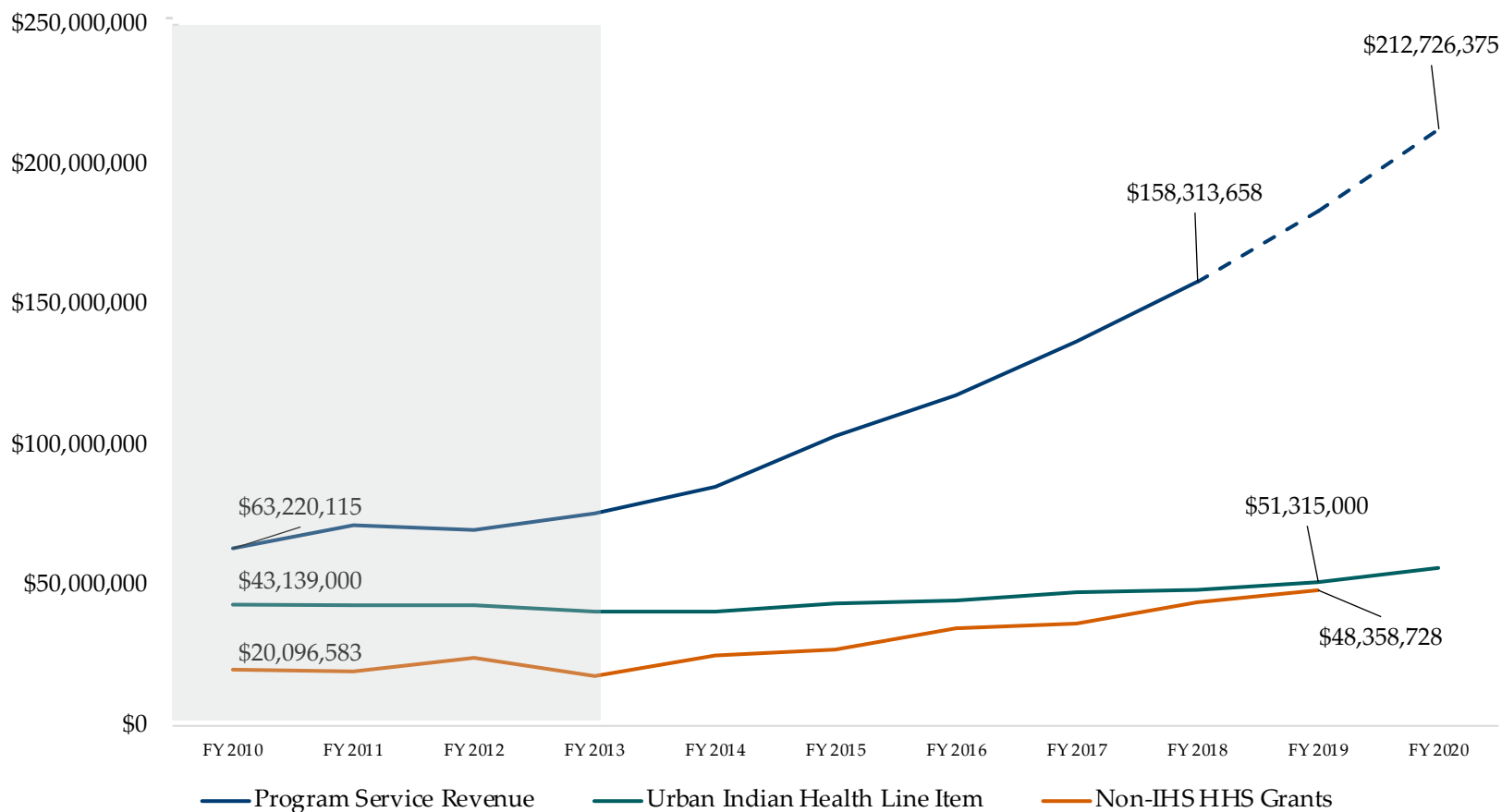


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Income to UIOs (by Fiscal Year)

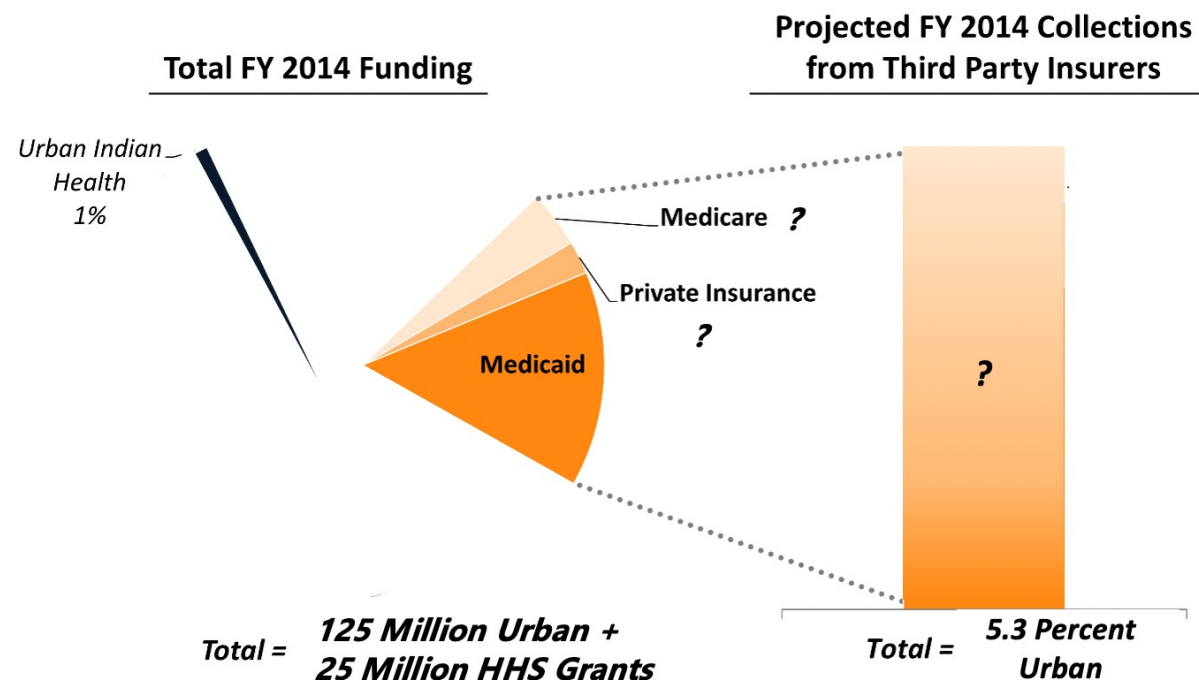




Last Year's Findings... and Filling in Medicaid

Figure 6

Allocation of Indian Health Service Program Funding, FY 2014



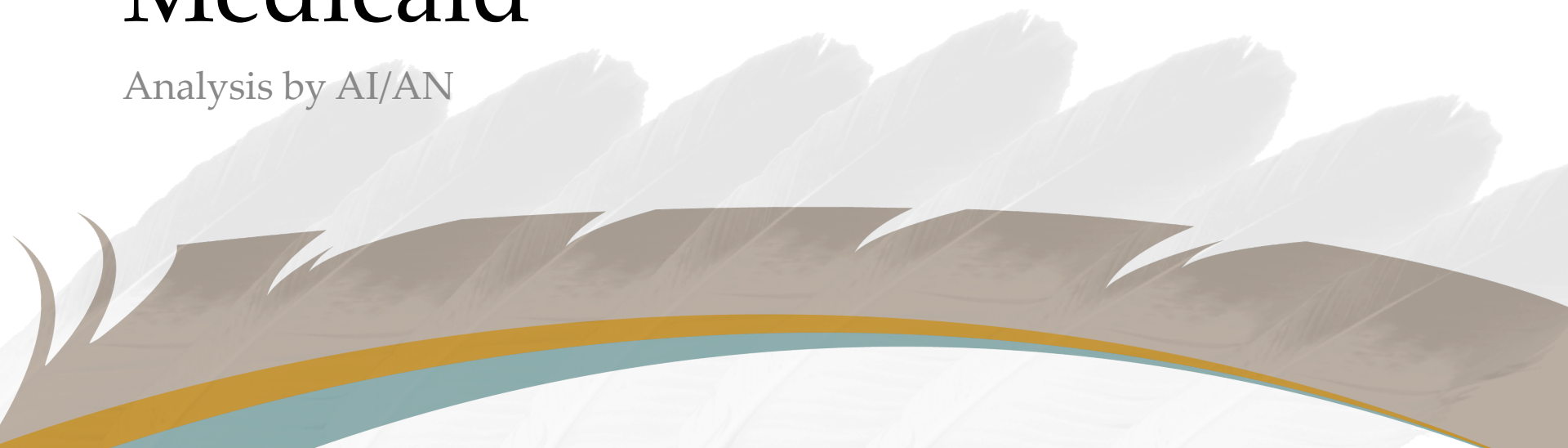
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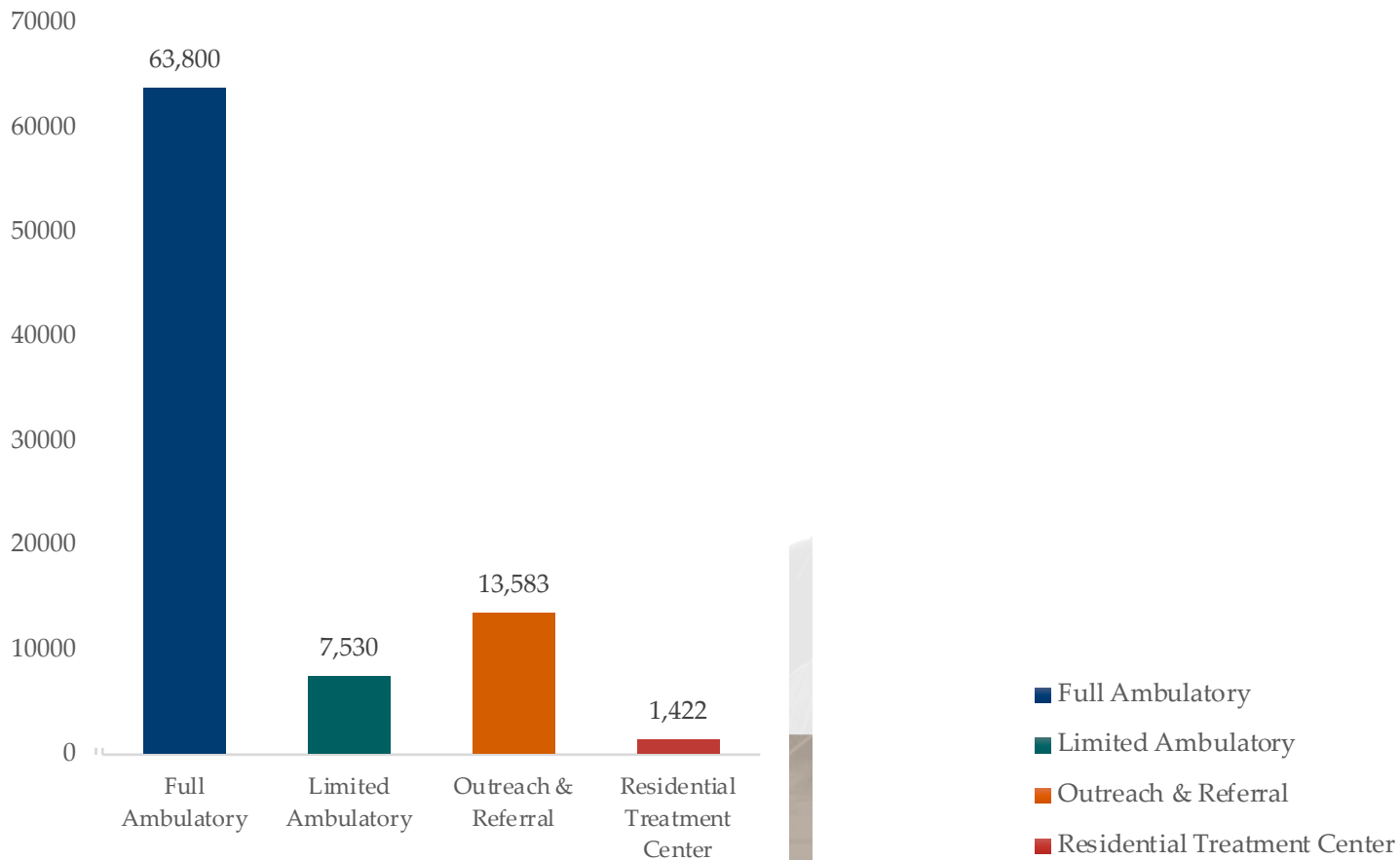
Medicaid

Analysis by AI/AN



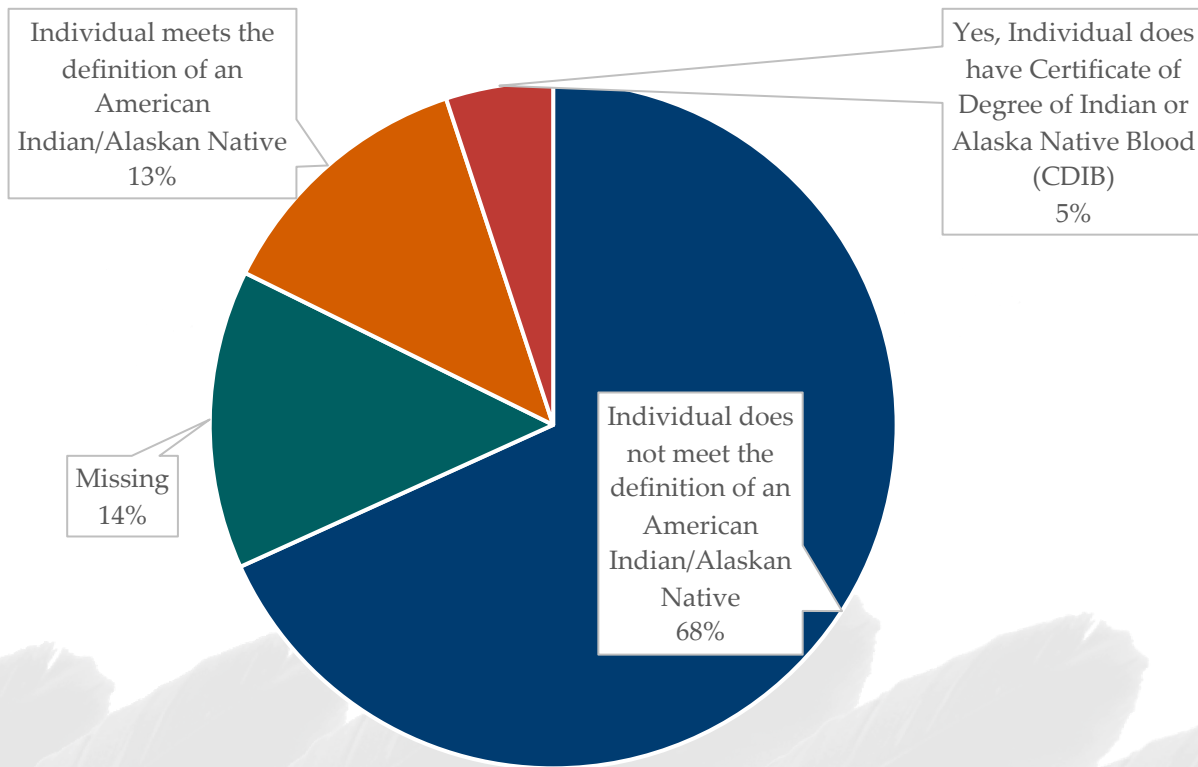


Beneficiaries by UIO Service Type



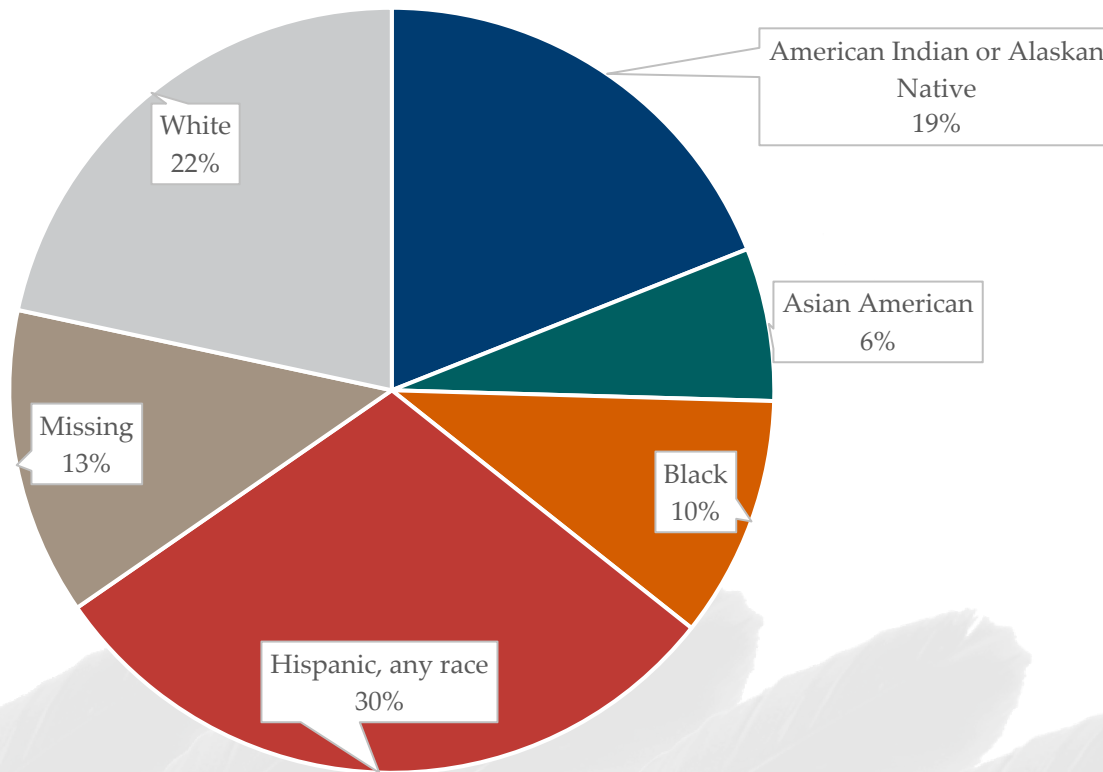


Beneficiaries by “Certified AI/AN” Status



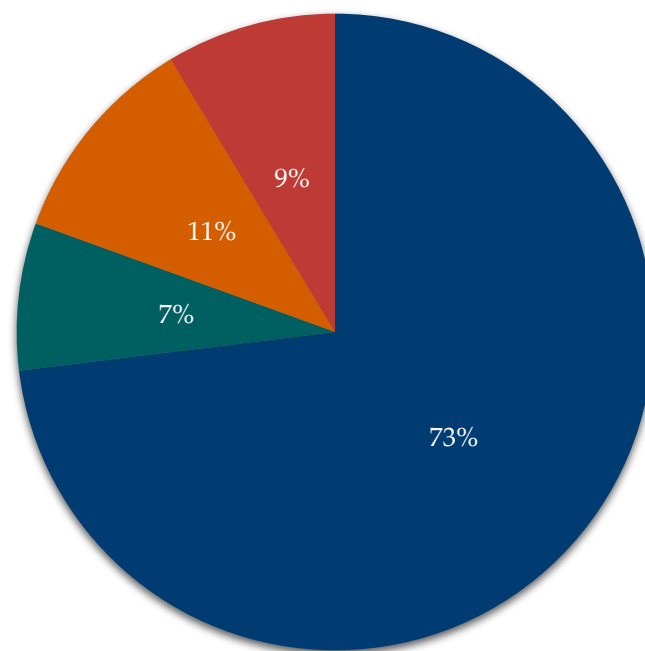
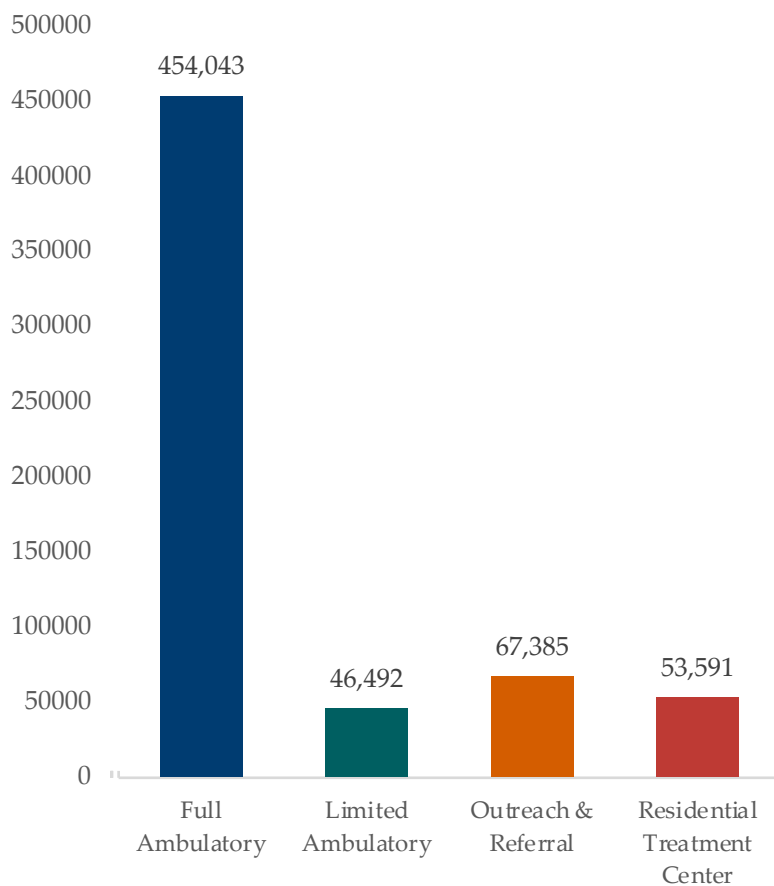


Beneficiaries by “Race/Ethnicity” Code





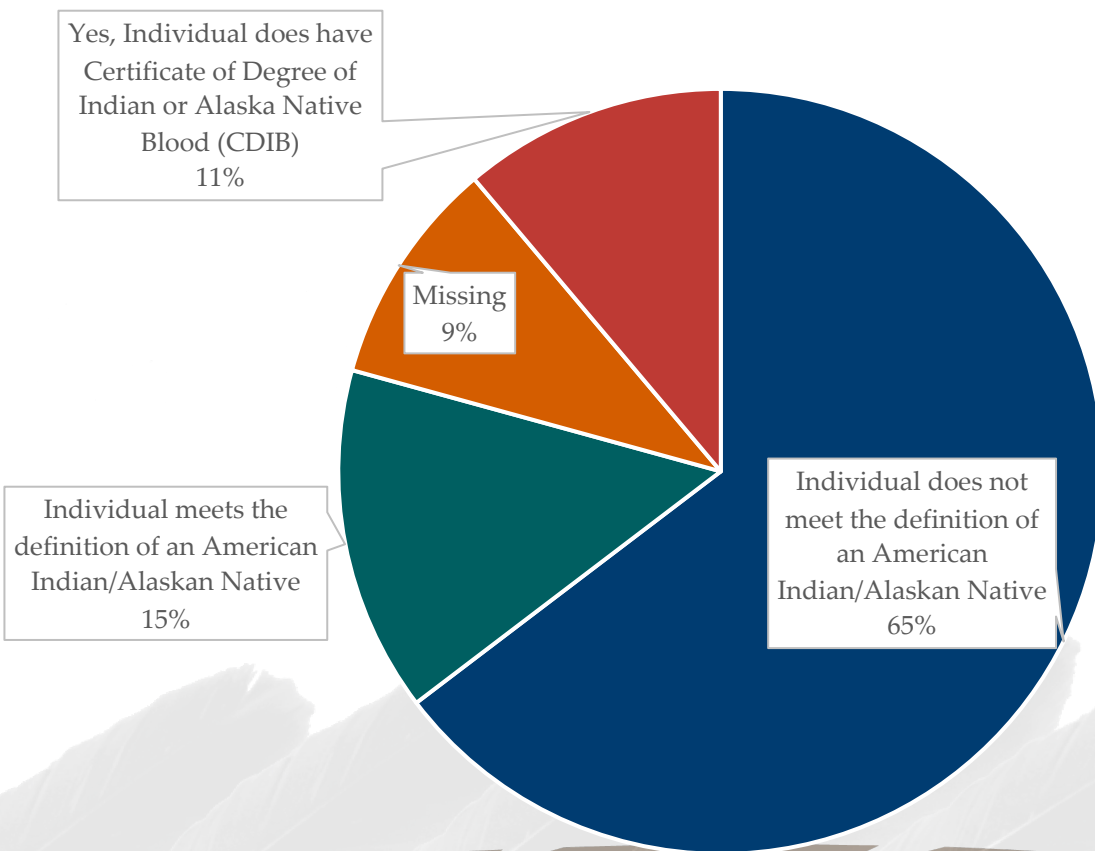
Claims by UIO Service Type



Full Ambulatory
Limited Ambulatory
Outreach & Referral
Residential Treatment Center

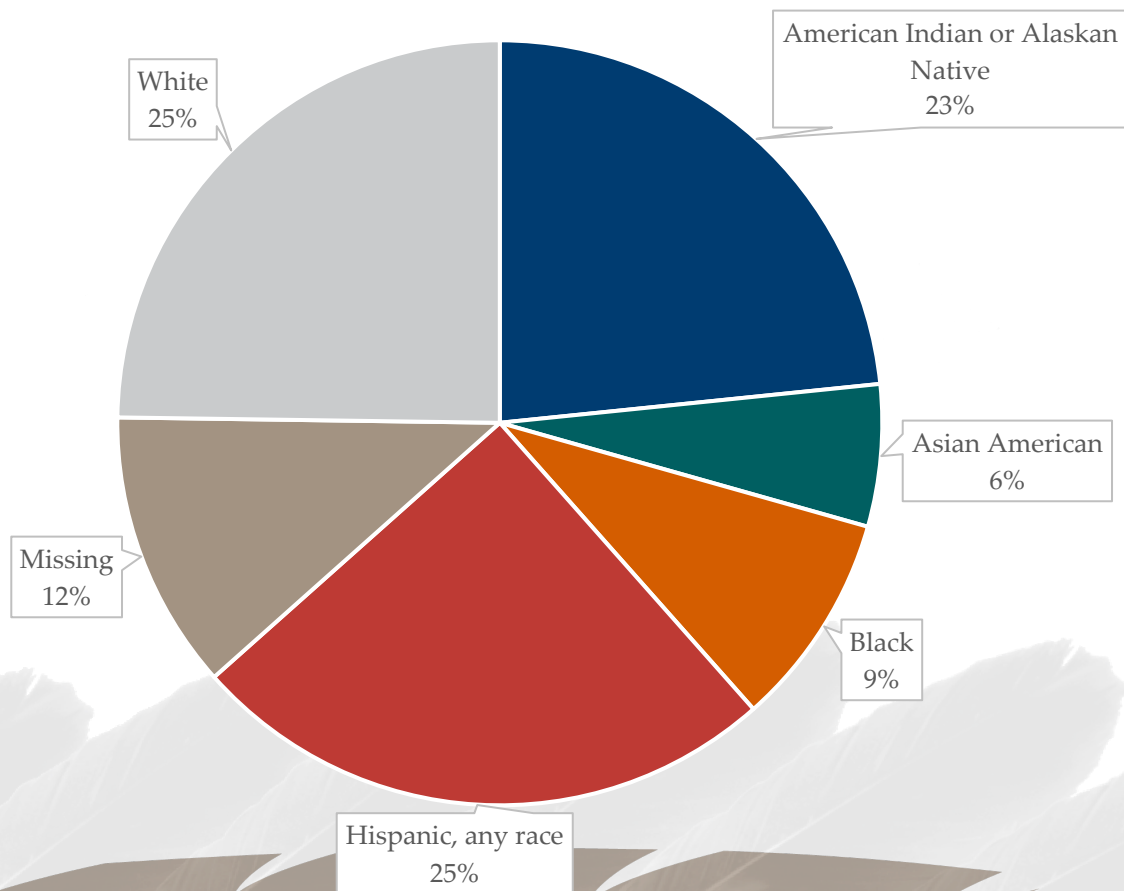


Claims by “Certified AI/AN Status”





Claims by “Race/Ethnicity” Code





Claims Denial By Certified AI/AN Code of Beneficiary

Certified AI/AN Code	Total Beneficiaries	Total Claims	Claims Per Beneficiary	Total Denied Claims	Claims Denial Rate
Individual does not meet the definition of an American Indian/Alaskan Native	58,764	401,838	6.84	4,167	1.0%
Missing	12,119	59,574	4.92	938	1.6%
Individual meets the definition of an American Indian/Alaskan Native	10,905	90,810	8.33	3,674	4.0%
Yes, Individual does have Certificate of Degree of Indian or Alaska Native Blood (CDIB)	4,347	69,286	15.94	827	1.2%
TOTAL	86,135	621,508	7.22	9,606	1.5%



Claims Denial By Certified AI/AN Code Findings

- Beneficiaries categorized as having a "Certificate of Degree of Indian or Alaska Native Blood (CDIB)" had the highest number of claims per beneficiary.
- The claims denial rate for beneficiaries categorized as "meeting the definition of AI/AN" is 4 percent, which is 4 times higher than non-AI/AN rate.



Claims Denial By Race/Ethnicity Code of Beneficiary

Race/Ethnicity	Total Beneficiaries	Total Claims	Claims Per Beneficiary	Total Denied Claims	Claims Denial Rate
Hispanic, any race	25,356	154,215	6.08	1,400	0.9%
White	18,467	153,046	8.29	2,641	1.7%
American Indian or Alaskan Native	16,207	144,412	8.91	2,854	2.0%
Missing	11,092	72,900	6.57	1,259	1.7%
Black	8,729	56,086	6.43	1,103	2.0%
Asian American	5,519	37,087	6.72	76	0.2%
Pacific Islander or Native Hawaiian	421	2,263	5.38	72	3.2%
Multi-racial	345	1,490	4.32	181	12.1%
TOTAL	86,136	621,499	7.22	9,586	1.5%



Claims Denial By Race/Ethnicity Findings

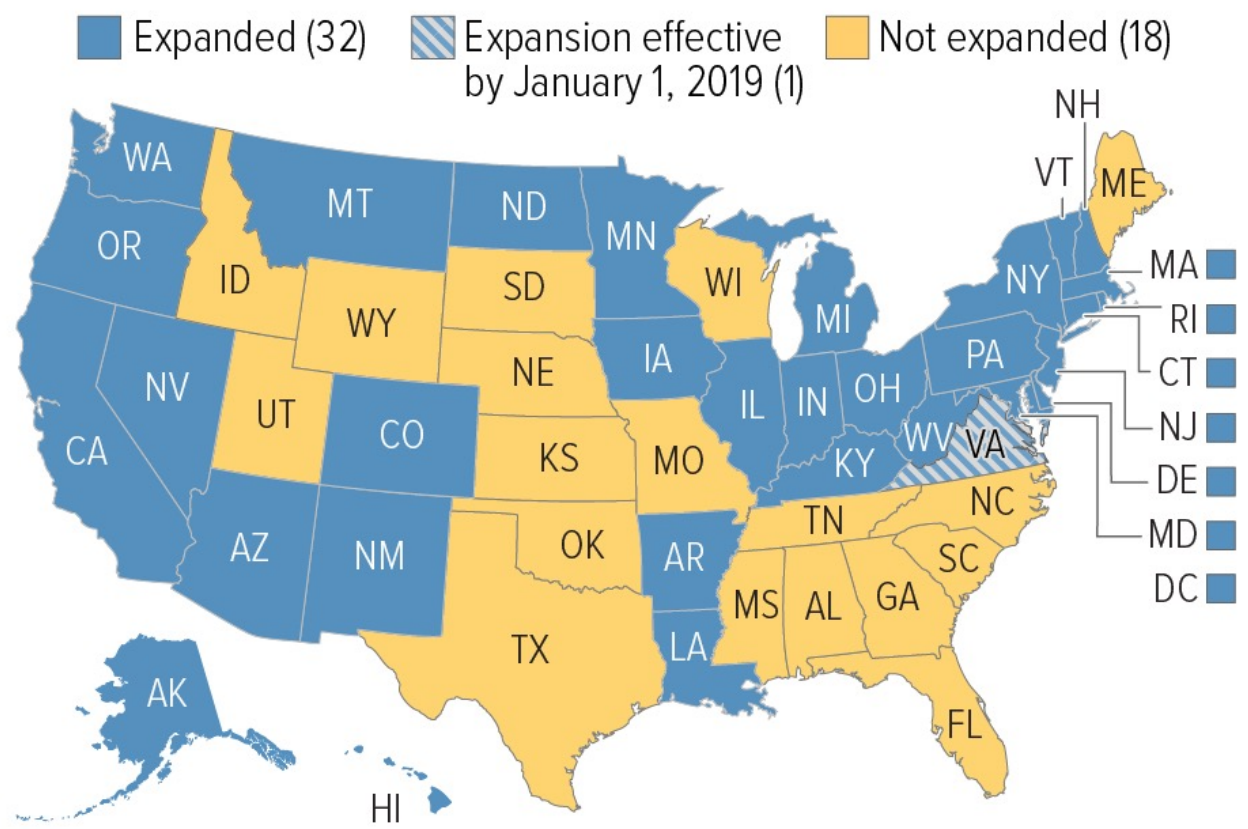
- Beneficiaries categorized in the AI/AN Race/Ethnicity category had highest number of 2018 claims per beneficiary (8.91).
- The claims denial rate for beneficiaries in the AI/AN Race/Ethnicity category is 2 percent, which is significantly higher than the Total Population average of 1.5 percent, based on a Chi-Squared test of statistical significance.



Claims Denial Rate Statewide Context

During the 2018 period of analysis, 31 States (+ DC) had implemented the Affordable Care Act Medicaid Expansion Program.

State Medicaid Expansion as of 2018





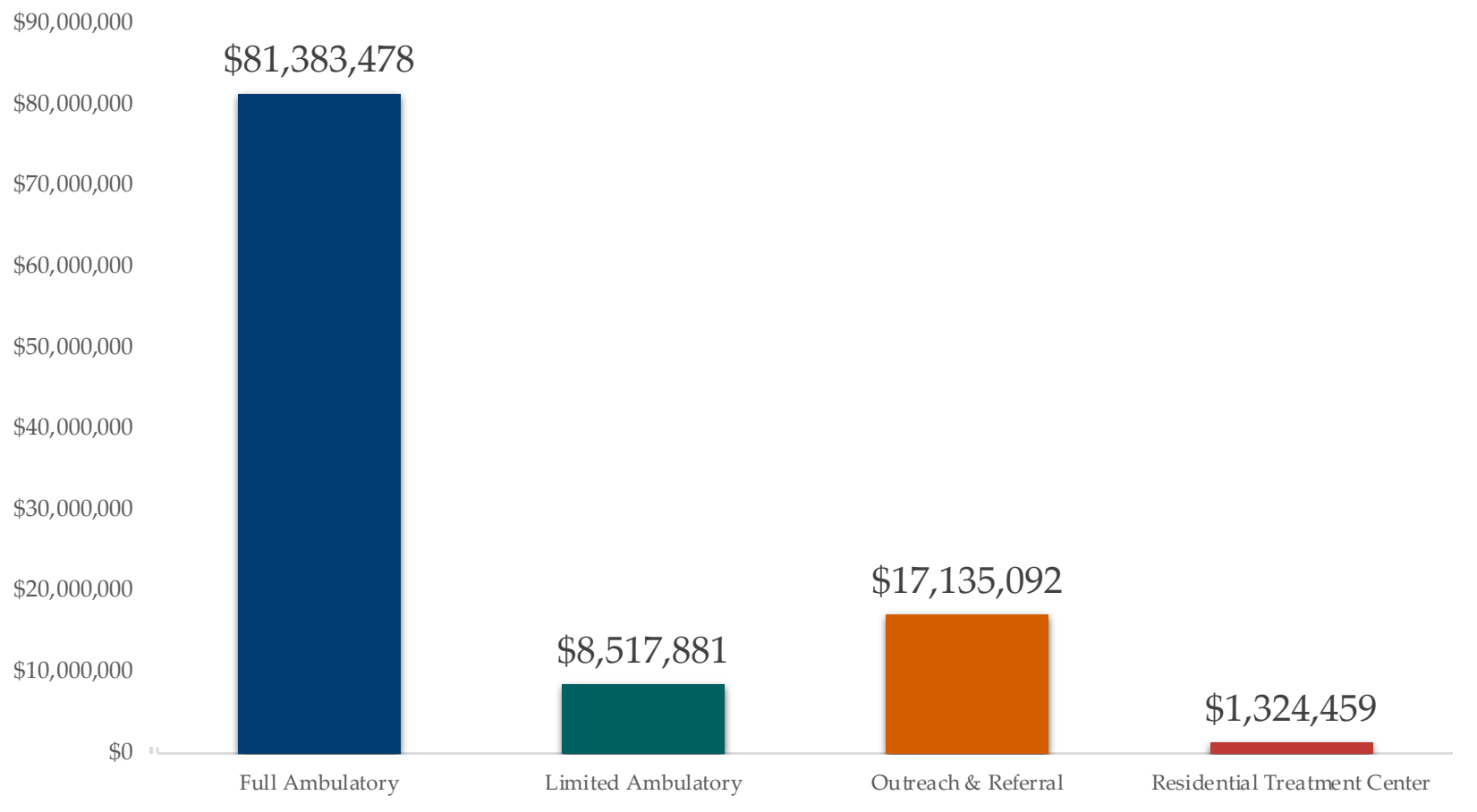
Claims Denial Rate Statewide Context

2018 UIO Medicaid claims were denied twice as often in states that were not participating in the ACA's Medicaid Expansion Program.

	Medicaid Expansion State in 2018	Non- Medicaid Expansion State in 2018
UIO Claims Denial Rate	4.64%	11.39%



MEDICAID PAYMENTS TO UIOs BY UIO SERVICE TYPE (2018)





State and Federal Cost Sharing of Medicaid Reimbursement

	2018 T-MSIS Medicaid Payments	2018 Federal Share	2018 Federal Share (Payments)	2018 State Share (Payments)
TOTAL	\$108,360,910	58.2%	\$63,069,980	\$45,290,930



Conclusions and Recommendations





Pandemic-Related Reimbursement Losses: Early Experiences

- Early work during the 2019-2020 project year suggested that by FY 2020, UIOs were projected to earn the largest amount of third-party reimbursement to date
- By the end of March 2020, some UIOs were reducing services to cope with the pandemic and losing up to three quarters of their expected reimbursement from third-party payers
- Losses were generally concentrated during the early-phases of the pandemic
 - Cancelled or postponed in-person services due to patient fear or risk of COVID-19 exposure
 - Recoup losses via reimbursement for telehealth services



Pandemic-Related Reimbursement Losses: Varied Experiences by Spring 2021

- Health Resources & Services Administration (HRSA): Every UIO that billed third-party payors was able to make use of the CARES Act Provider Relief Fund
- By March 2021, experiences and losses varied among UIOs:
 - Many UIOs were reporting a substantially lower loss rate than they had been the previous March
 - Some UIOs were reporting their reimbursement had somewhat returned to normal or stable levels
 - Telehealth; reopening of many in-person services; increased demand for behavioral health services compared to prior years
 - Some UIOs reported continued reimbursement losses, particularly for dental services.
 - Some UIOs still reported losses over the entire course of the year



Considerations for Future Work: Medicaid Managed Care

- Special protections for AI/ANs related to managed care in provisions of 42 CFR 438.14
 - Designed to be inclusive of UIOs and other Indian Health Care Providers
 - Ensure that Indian Health Care Providers get reimbursed fairly regardless of whether they are a part of a managed care organization's network
- Considerations
 - UIOs may consider whether contracting with Medicaid managed care organizations makes sense for their programs and patients
 - State Medicaid agencies may consider whether there are any challenges for UIOs that want to contract with Medicaid managed care organizations



Considerations for Future Work: Tracking 100% FMAP and the American Rescue Plan Act (ARPA)

- Section 9815 of ARPA temporarily extends (for 8 fiscal quarters, the equivalent of two years) 100% FMAP to UIOs
 - Strengthens the fulfillment of trust and treaty responsibilities to AI/ANs
 - Cost-effectively pours federal resources directly back into states
 - Potential to support resources going back into the Indian health care delivery system in state-based FMAP savings initiatives, thus expanding quality care to Indian Country
- Next year, NCUIH will analyze the impact that Section 9815 has on UIOs regarding increases in Medicaid reimbursements and access to Medicaid services for UIO beneficiaries



Recommendations for Future Work: Support UIOs with Technical Assistance and Funding to improve Data Quality

- Data management at UIOs can be complex
- For “AI/AN” status alone, UIO patient files may be marked with one identifier based on tribal code for reporting to IHS and another set of self-identified racial designations for HRSA, CMS, and their state
- Adequate funding is crucial for experienced billing, coding, and claims administration staffing that meets local needs
- More technical assistance, training, and funding for EHR and billing/coding specialists



Recommendations to Ensure Pandemic-Era Advancements in Increasing Access to Care Via Telehealth are Maintained for Urban AI/ANs

Maintain pandemic-era policy changes that have promoted telehealth utilization by UIOs and facilitated Medicaid and Medicare reimbursement for telehealth services

- Including services identified as:
 - temporary additions for the COVID-19 PHE
 - being available up through the year in which the PHE ends
- Examples:
 - “Originating Site” Rule
 - Coverage of Therapy and Behavioral Health Services
- [State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth \(COVID-19 Version\)](#)



Recommendations to Ensure Pandemic-Era Advancements in Increasing Access to Care Via Telehealth are Maintained for Urban AI/ANs

Promote further initiatives that support the long-term health of telehealth cost centers at UIOS

Examples:

- Federal, state, private sector, non-profits, innovative multisectoral partnerships
- Connecting UIOs with quality Technical Assistance (TA)
- Increasing the number of telehealth services and practitioner types that are eligible to be reimbursed and ensuring there is ongoing parity between telehealth and in-person rates
- Increasing the modes and types of telehealth that are permanently eligible for reimbursement



Thank you for joining us!

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