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.

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Part I. Introduction

Report Overview

The purpose of this report[1] is to describe how Urban Indian Organizations (UIOs) bill third-party resources; particularly Centers for Medicare and Medicaid (CMS) programs: Medicare, Medicaid, CHIP, Health Insurance Marketplace and other third-party resources. This report will share data insights, including information such as the percentages of amounts billed and collected along with identifying best practices that facilitate successful third-party reimbursement policies. It will address the impact of the 2019 Novel Coronavirus (2019-nCoV) Public Health Emergency.[i]

The National Council of Urban Indian Health (NCUIH), in partnership with NORC at the University of Chicago (NORC), set out to research and compile data regarding if and how UIOs are billing the following federal programs:

- **Medicare:** Medicare Part B, Medicare Part D, and Medicare Advantage and Medicare Advantage prescription drug plan (MA-PD)
- **Medicaid:** Medicaid Fee-for-Service and Medicaid Managed Care
- **The Children's Health Insurance Program (CHIP):** CHIP Fee-for-Service and CHIP Managed Care
- **Qualified Health Plans (QHPs)** that offer health insurance coverage through Individual or Small Business Health Options Program (SHOP) Health Insurance Exchanges, operated by states through State-based Exchanges (SBEs), or operated by the federal government through the Federally-facilitated Exchange (FFE)

Several months into the project period, Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) and the disease it causes, COVID-19, began spreading in cities with UIOs, such as Seattle and Santa Clara. The global pandemic did not allow for primary data collection. As a result, this report uses only secondary and public data, as the use of a survey tool became unfeasible. However, third-party billing losses and changes to billing practices became extremely important to UIOs as part of crisis response – providing a rich context and focus for this work. As such, this report is intended to contain a review of some baseline trends prior to the coronavirus pandemic, while looking forward wherever possible.

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[1] This report was commissioned by the Centers for Medicare & Medicaid Services through a contract with NORC. The views, opinions, and data analysis published in this report are those of NCUIH, and do not necessarily reflect the policies or positions of any other partner or reviewer. We thank all reviewers at CMS and IHS for lending us their valuable time and expertise, and our partners at NORC for their assistance in facilitating data access and analysis. For questions or comments, please contact Andrew Kalweit or Sunny Stevenson at akalweit@ncuih.org or sstevenson@ncuih.org, respectively.

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Information gathered has been analyzed and compiled in this report and will be shared in a presentation to a national audience of Indian health care leaders and stakeholders during a webinar. Finally, NCUIH will assist NORC in creating research tools through the formation of a UIO data collection template for future use.

Methods

This report was created through a two-stage process.

1) First, an environmental scan and literature review was completed to identify and explain any relevant health care policy factors (described in Part II) as well as any data sources that may help measure these factors (described in Part III).
2) This then allowed for analysis of these data sources (Part IV), with context from the literature review in mind.

The report closes on an analysis of current issues related to third-party reimbursement and coronavirus response (Part V), and suggestions for future work (part VI).

Part II. Urban Indians and their Health Care Delivery System

Congress has specifically declared that the policy of the United States is "to ensure the highest possible health status for Indians and urban Indians[.]"[ii] The federal government has a trust responsibility to American Indian and Alaska Native (AI/AN) people – a legal and fiduciary duty to act in the best interest of tribes, American Indians, and Alaska Natives.[iii] Both legislative and executive branches have long recognized that the federal government's trust responsibility is not restricted to the borders of Indian reservations, but includes the provision of health care to all AI/ANs wherever they might reside.[iv] The trust relationship is a "political relationship that further distinguishes Indians from racial classification for purposes of affirmative action laws and in other federal statutes that establish federally funded programs for the general public."[v] The Indian Self-Determination and Education Assistance Act at 25 U.S.C. § 5387(g) clearly states: "The Secretary [of Health and Human Services] is prohibited from waiving, modifying, or diminishing in any way the trust responsibility of the United States with respect to Indian tribes and individual Indians that exists under treaties, Executive orders, other laws, or court decisions."

Under the Indian Health Care Improvement Act (IHCIA), the only distinction between an individual who meets the criteria in its definition of "Indian"[vi] and an individual who meets its definition of "Urban Indian"[vii] is that the latter means the individual also resides in an "Urban center." IHCIA defines the term "Urban center"[viii] as "any community which has a sufficient urban Indian population with unmet health

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needs to warrant assistance under subchapter IV, as determined by the Secretary."[ix] As independent non-profit health facilities, each UIO defines its own service population.

Today, more than 70% of the country's AI/AN population are Urban Indians, as compared to 45% in 1970 and 8% in 1940.[x] This migration has occurred for several reasons, but mainly because of federal government policies during the Relocation Era (1945-1968) and later because of lack of economic opportunities or higher education on reservations. Recognizing this migration, UIOs were established to provide off-reservation healthcare, yet receive 1% of the Indian Health Service yearly budget.[xi]

UIOs provide affordable, culturally-competent health care services to Urban Indians in their communities. The IHCIA defines "Urban Indian [O]rganization" as:

> "[A] nonprofit corporate body situated in an urban center, governed by an Urban Indian-controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in [25 U.S.C. § 1653(a)]."[xii]

The most critical and primary source of funding for AI/AN health care is the Indian Health Service (IHS), which uses a three-prong delivery system to implement its mission: IHS facilities, Tribal Health Programs, and Urban Indian Organizations (I/T/U). IHS is consistently and drastically under-resourced, with recent calculations finding funding at just 46.6% of the total level of need.[xiii] Additional funding for Urban Indian health care comes from a variety of sources, including private insurance, marketplaces/exchanges established under the Patient Protection and Affordable Care Act (ACA), Medicare, Medicaid, specialty programs, and other sources. Since FY 2007, many UIOs have built more diverse revenue streams, and expanded their capacity to both provide more services and bill third-party payers effectively for those services. However, until the creation of this report, it was difficult to provide a reasoned estimate on the proportion of funding appropriated through IHS compared to those obtained from these other sources.

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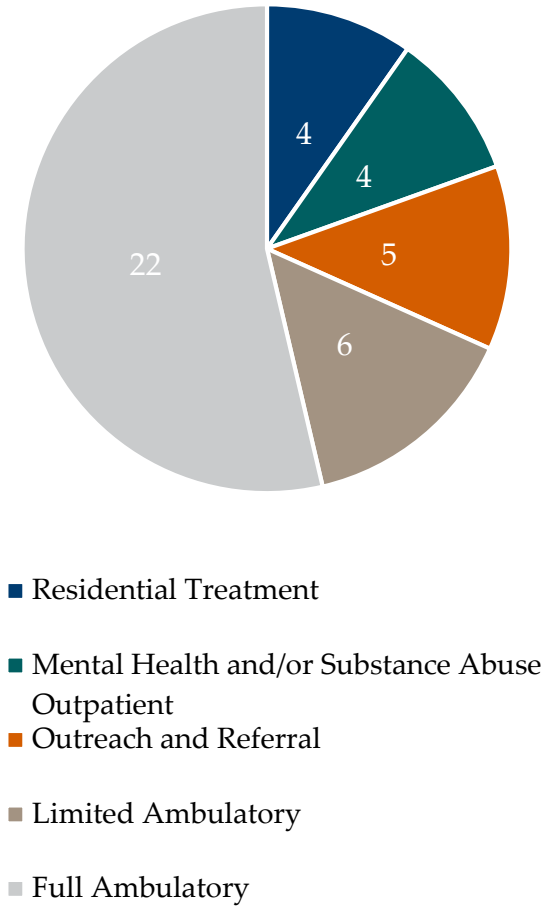
FIGURE 1. UIO TYPES



Types of Services

The IHS Office of Urban Indian Health Programs (OUIHP) funds four types of UIO programs: Outreach and Referral, Limited Ambulatory, Full Ambulatory, and Outpatient and Residential Substance Abuse Treatment Programs. Each program type differs in terms of service delivery model, staffing, and program expectations.[xiv] A full ambulatory program provides direct medical care to the population served for 40 hours or more per week, whereas a limited ambulatory program does so for less than 40 hours per week. For the purposes of this report, the UIOs located in Oklahoma are considered full ambulatory facilities given their similarity in services.[2] In addition to medical care provided by UIOs, full ambulatory programs often offer a host of other services to best serve their communities, including transitional housing, nutrition, oral health services, inpatient or outpatient substance use disorder treatment centers, elder services, and programs for new mothers. Outreach and referral programs do not provide direct medical services, but instead provide referrals to specialists, in addition to wellness, prevention, and community programs. Outpatient and residential substance abuse treatment programs offer a range of alcohol and substance use disorder services, including prevention initiatives, outpatient counseling, or residential treatment centers. For the purposes of this report, residential and outpatient facilities are considered separately, given that they have large differences in services provided and reimbursement methodologies.[3]

[2] The two Oklahoma UIOs are unique among UIOs in that they are considered permanent programs under IHS's direct care program, pursuant to 25 U.S.C. § 1660b.

[3] Four UIOs provide residential treatment alone, two provide residential and outpatient treatment, and two provide outpatient treatment alone.

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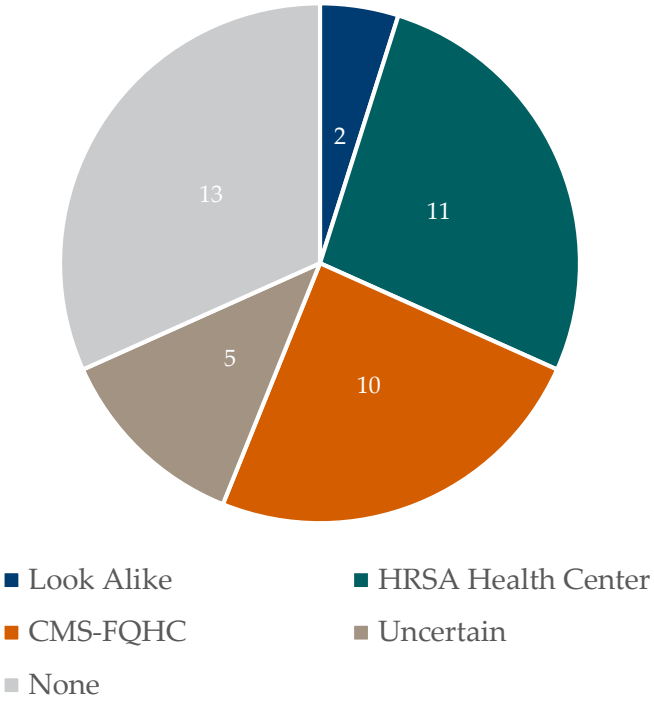
FQHC Designation

Outpatient health programs or facilities operated by a UIO are by definition Federally Qualified Health Centers (FQHCs).[xv] Yet, the extent to which a UIO enjoys some existing protections or opportunities available to FQHCs depends on whether it participates in the Health Resources and Services Administration (HRSA) Health Center Program under Section 330 of the Public Health Service Act as award recipients or look-alikes,[xvi] and whether it seeks reimbursement from the Centers for Medicare and Medicaid Services (CMS) under FQHC Medicare and Medicaid payment methodologies.

FIGURE 2. UIOS BY FQHC STATUS



For the purpose of analysis throughout this report, NCUIH categorized UIOs by their FQHC-status (see fig. 2). This list represents multiple synthesized sources; an IHS-provided list of UIO designations and accreditations, a continually-tracked internal NCUIH file, the 2020 and 2022 HHS listings of Essential Community Providers (which includes FQHC status), and a self-reported item from a 2018 NCUIH survey. This synthesized list represents agreement between different sources. While the HRSA health centers and CMS-FQHCs are certain and consistent, the "uncertain" designation represents facilities which self-reported as "CMS-FQHCs", "look-alikes", or a similar designation on either the ECP list or NCUIH survey, without this being later maintained on any other list. Finally, it should be noted that self-report accounts include designations such as CMS-FQHC look-alike, CMS-Indian, and other designations that do not exist as worded. This likely represents a lack of clarity when UIOs are asked to report the complex provider enrollment options that are available to them when billing Medicaid.

HRSA Health Center (or HRSA-FQHC)

Community-based health care providers that receive funds from the HRSA Health Center Program to provide comprehensive, culturally-competent, high-quality health care services in areas where economic, geographic, or cultural barriers limit access to affordable health care services, are often referred to interchangeably as "HRSA

330" facilities or "Community Health Centers". By definition, entities who receive HRSA 330(a) funding must serve a "population that is [in] a medically underserved area" to receive base Community Health Center funding, or serve a "special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing".[xvii] Of the 11 UIOs receiving HRSA Community Health Center funds in 2018, 4 also received Healthcare for the Homeless funds. No UIOs served as a Migrant Health Center or Public Housing Primary Care site. As part of the HRSA 330 funding they receive, participating FQHCs are required to increase the number of consumers they serve each year. If an FQHC experiences a decrease in its service population, it can lose some or all of its HRSA 330 grant funding. Health centers must submit utilization data to HRSA annually to account for this, including the number of consumers served, the average number of times they received services, and their age distribution.[xviii]

HRSA Look-Alikes Designation

A HRSA look-alike is an entity determined by HRSA to meet the requirements of the Health Center Program, but which does not receive Health Center Program funding. Although look-alikes do not receive Health Center Program funding, they are eligible to apply to CMS for reimbursement under FQHC Medicare and Medicaid payment methodologies. Look-alikes are also eligible to purchase discounted drugs through the 340B Federal Drug Pricing Program,[xix] receive automatic Health Professional Shortage Area designation, may access National Health Service Corps providers, and become eligible for Medicaid and Medicare FQHC Prospective Payment System (PPS) reimbursement and other related programs. [4]

Medicare and Medicaid FQHC

An amendment to the Omnibus Budget Reconciliation Acts created and defined the FQHC category of facilities under Medicare and Medicaid.[xx] FQHCs are eligible for enhanced reimbursement from Medicare and Medicaid but must meet certain requirements.[xxi] Sometimes an FQHC may be required to enroll separately in its state Medicaid program as another type of provider and use a non-FQHC Medicaid provider number in order to receive separate payment for a service or supply that cannot be claimed as an allowable FQHC service, or it may be paid according to a fee schedule (not a FQHC PPS or Alternative Payment Methodology rate).

[4] Tribal and Urban Indian organizations that receive funds from IHS may already be considered eligible for FQHC benefits and may not derive additional benefits from applying for look-alike initial designation.

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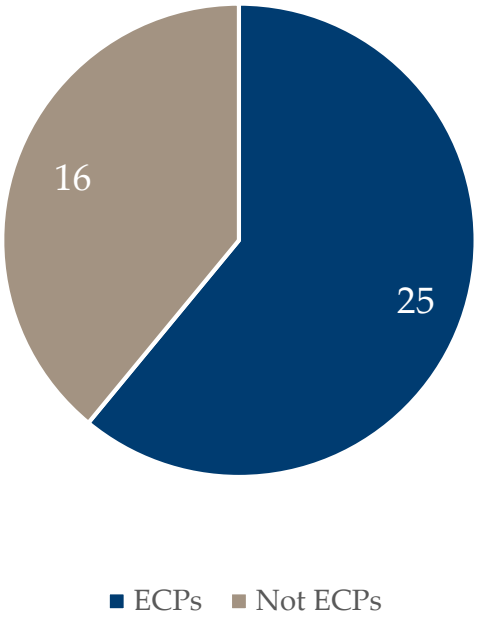
Tribal FQHC

The "Tribal FQHC" designation[xxii] is an option for tribal health facilities that are enrolled in state Medicaid programs as "clinic services" providers but seek to bill for services furnished outside of the 4 walls of the clinic by tribal employees or by off-site non-tribal providers at the facility rate.[xxiii,5] Per Frequently Asked Questions (FAQs) published on January 18, 2017, tribal clinics notify their state Medicaid agency that they want to be designated as a FQHC. The state, in consultation with the tribes and IHCPs, can submit a reimbursement SPA to pay the Tribal FQHC an Alternative Payment Methodology (APM) at the IHS All-Inclusive Rate (AIR). Oklahoma State Plan Amendment (SPA) No. 17-05[xxiv] implemented this policy to designate health care facilities operated by IHS, Tribal, and the two UIOs in Oklahoma as Federally Qualified Health Centers (ITU-FQHC). For services provided to AI/ANs by the UIOs, the all-inclusive rate (AIR) will be paid as annually published by the IHS and specified in the Federal Register. If the facility contracts with the Medicaid agency as an FQHC, referred to in the SPA as an "ITU-FQHC", an alternative payment method (APM) is allowed. The APM rate for services provided by an ITU-FQHC is set at the AIR.

FIGURE 3. UIOS BY 2022 ECP STATUS



Essential Community Providers

As defined in the ACA, a qualified health plan (QHP) is an insurance plan that provides essential health benefits (EHBs), follows established limits on cost-sharing, and meets other requirements. The certification process and regulating body will differ depending on whether the marketplace is the federally-facilitated exchange, a state-based exchange, or a state-based exchange on the federal platform.[xxv] One of the requirements to achieve QHP certification is to have a sufficient number and geographic distribution of Essential Community Providers (ECPs), where available. Under 45 CFR 156.235, ECPs are defined as providers who serve predominantly low-income, medically

[5] This is not to be confused with the "Grandfathered Tribal FQHC" designation, which is not expanded upon here because it is irrelevant to UIO reimbursement.

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underserved individuals. CMS has established two ECP standards: the general ECP standard and the alternate ECP standard. One of the requirements for issuers to satisfy the general ECP standard is to offer contracts in good faith to all available Indian health care providers in the plan's service area for the respective QHP certification plan year. This can be easily facilitated by use of the Model QHP Addendum for Indian Health Care Providers.[xxvi] ECPs are eligible to purchase drugs at a discounted rate through the 340B Drug Pricing Program, and may include state-specific categories and benefits beyond the core set of federal provisions.[xxvii] HHS maintains a rolling list of ECPs, broken into federal categories.[xxviii] Providers can petition to be added to this list, year-round.[xxix]

Funding Sources

Urban Indian Health in the IHS Budget

Federal funding from IHS to UIOs is distributed via grants, contracts, and cooperative agreements. The authority for this is found in the Indian Health Care Improvement Act. Outreach and referral programs, limited ambulatory programs, and full ambulatory programs receive awards from IHS under 25 U.S.C. §§ 1652-1653. Outpatient and residential substance abuse treatment programs receive awards from IHS pursuant to 25 U.S.C. § 1660c. All UIOs receive direct funding primarily from one line item in the IHS budget – Urban Indian Health. They do not receive direct funds from other distinct IHS line items, including the Hospital and Health Clinics, Mental Health, Alcohol & Substance Abuse, Indian Health Care Improvement Fund, Health Education, Indian Health Professions, or any of the line items under the IHS Facilities account.[6] Due to historically low funding levels for the Urban Indian Health line item, UIOs are chronically underfunded and rely on third-party reimbursement to keep their operations financially viable.

Other Federal Grants

UIOs may be eligible to apply for grants from other federal agencies as community-based non-profits. They often apply for grants under the U.S. Department of Health and Human Services, including CMS, the Substance Abuse and Mental Health Services Administration (SAMHSA), Administration for Native Americans

[6] As noted infra, the Oklahoma UIOs are treated as permanent programs within the IHS direct care program. These facilities do not receive funding from the Urban Indian Health line item, and receive funding through other IHS line items, but they do not have access to all other line items like IHS and tribal facilities do.

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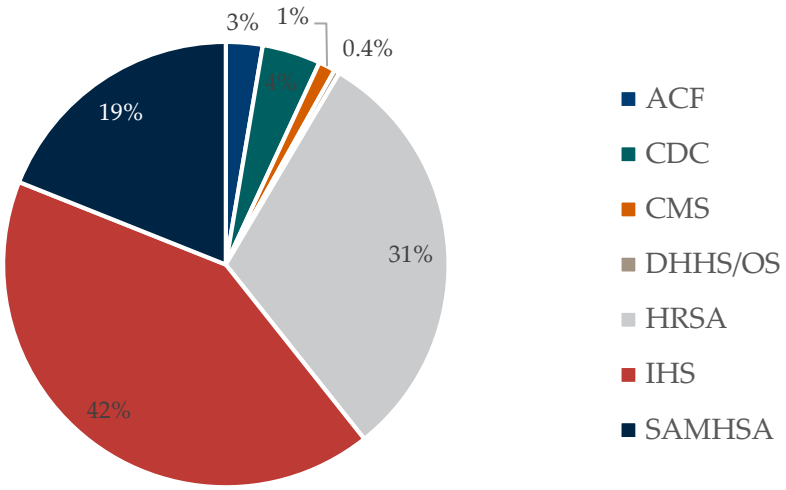
(ANA) under the Administration for Children and Families (ACF), HRSA, and the Centers for Disease Control and Prevention (CDC), provided they meet the eligibility requirements of this grant.[7] However, UIOs are not directly eligible to apply for all grant programs designed to be AI/AN-specific.[xxx] For example, UIOs are ineligible[xxxi] to apply for SAMHSA Tribal Opioid Response Grants on their own, although this funding could enable UIOs to expand their services and workforces to help address the catastrophic impacts of the opioid epidemic in Indian Country.

FIGURE 4. HHS GRANT SPENDING ON UIOS BY AGENCY (FY13-FY19)



Source: HHS grant spending is available via the Tracking Accountability in Government Grants System (TAGGS) at https://taggs.hhs.gov/SearchRecip. This graph represents all HHS grant spending available for 88% of UIOs (n=36), and is broken down by the funding agency.

Reportable "Program Services" Revenue

Apart from IHS and grants funding, UIOs are able to collect revenue and reimbursement for the services they provide like any healthcare non-profit organization. These must be reported on yearly tax returns to maintain non-profit status. The vast majority of these funds come from third-party billing, although other revenue sources may be reported. The following are a few considerations specific to understanding UIOs' program service revenue.

[7] UIOs have also obtained grants from other federal agencies, for example Project Beacon in the Office of Victims of Crime in the Department of Justice, which is used to address and prevent human trafficking. However, for the purposes of this report, only HHS grants were analyzed.

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Payor of Last Resort:

In 1990, two decades before the ACA, IHS had adopted regulations with a payor of last resort rule.[xxxii] The 1990 regulation was intended to emphasize the Congressional intention that "State programs may not avoid responsibility for health care to Indians by insisting that such programs are residual to IHS."[xxxiii] The statutory payor of last resort provision was added in 2010 by the ACA as an amendment to the Indian Health Care Improvement Act (IHCIA):[xxxiv] "Health programs operated by the Indian Health Service, Indian Tribes, Tribal organizations, and Urban Indian organizations ... shall be the Payor of last resort." 25 U.S.C. § 1623(b).

Non-Clinical Revenue

Some UIOs have historically collected small amounts of revenue for other community services they provide apart from clinic activities. Examples include minor materials fees for community engagement programming such as after-school language classes, economic development activities, facility space rental revenue, or any other limited funds a community non-profit may collect.

Administrative Revenue

As local experts on their urban AI/AN communities, UIO administrators may bring their UIO income from external sources such as speaker fees or paid trainings to partners and other healthcare stakeholders. These incomes usually are comparatively minor, though still reportable on financial reports.

Overview of the Client Population

The Office of Urban Indian Health Programs (OUIHP) in IHS provides yearly reports on the demographic profile of UIO clients using the National Uniform Data System (UDS). This remains the only unified estimate of all UIO users combined, and is broken down by facility type. The most recent report – covering calendar year 2018 – is the first to include data from all UIOs[8], with full integration of outpatient and residential substance abuse treatment programs.[xxxv] A brief description of relevant service population characteristics is in Table 1.

[8] Data from 40 out of 41 UIOs are included, though 1 UIO was not designated as such during CY18.

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TABLE 1. IHS UDS SUMMARY REPORT (2018 CALENDER YEAR)

Number of Clients	Residential Treatment		Outreach and Referral		Limited Ambulatory		Full Ambulatory		Total	
	Total	AI/AN	Total	AI/AN	Total	AI/AN	Total	AI/AN	Total	AI/AN
Total	2,674	1,434	2,088	1,957	12,442	4,918	161,992	63,934	179,196	72,243
Pediatric*	160 (6%)	29 (2%)	188 (9%)	196 (10%)	2,613 (21%)	590 (12%)	34,018 (21%)	12,787 (20%)	37,631 (21%)	13,726 (19%)
Geriatric†	27 (1%)	14 (1%)	230 (11%)	215 (11%)	995 (8%)	393 (8%)	12,959 (8%)	5,115 (8%)	14,336 (8%)	5,779 (8%)
By insurance status…										
Unknown‡	348 (13%)	359 (25%)	1,482 (71%)	1,389 (71%)	9,705 78%	2,754 (56%)	43,738 (27%)	13,426 (21%)	55,551 (31%)	18,061 (25%)
Medicaid	2,006 75%	846 (59%)	313 (15%)	313 (16%)	1,991 (16%)	1,721 (35%)	80,996 (50%)	29,410 (46%)	86,014 (48%)	31,787 (44%)
Medicare	0 (0%)	0 (0%)	104 (5%)	98 (5%)	498 (4%)	344 (7%)	14,579 (9%)	6,393 (10%)	14,336 (8%)	7,224 (10%)
Private Insurance	53 (2%)	43 (3%)	292 (14%)	274 (14%)	871 (7%)	492 (10%)	43,738 (27%)	27,492 (43%)	44799 (25%)	28897 (40%)

** Pediatric clients include those aged 0-15 years*

† Geriatric clients include those aged 65 years or more

‡ Unknown insurance status indicates both "unknown" and 'uninsured" clients, as it simply reports a lack of reported insurance coverage in the patient file

This provides a sense of current possible baseline service populations eligible for different insurers, nationwide. It may also suggest gaps in either client coverage or billing capacity – for instance by comparing the number of geriatric patients to those covered by Medicare. It is also helpful when interpreting other data – for example a minimum of 6% of outreach and referral patients are over 65, yet none of these sites bill Medicare. Furthermore, 4% are over 65 years at limited ambulatory facilities, yet some of these facilities also do not bill Medicare. However, there are also other reasons for Medicare eligibility, such as disability, so these remain minimum estimates.

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Overview of Third-Party Payers

Medicaid

Medicaid provides health coverage to 73 million Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid covers at least 86,014 people at UIOs, or 48% of all clients. Medicaid is administered by states, according to federal requirements, and funded jointly by states and the federal government. States may offer Medicaid benefits on a fee-for-service (FFS) basis, through managed care plans, or both. Although the majority of Medicaid enrollees are in managed care plans,[xxxvi] the majority of Medicaid spending still occurs under FFS arrangements.[xxxvii]

Fee-for-Service

The Social Security Act[xxxviii] requires that the FFS provider payments set by states be consistent with efficiency, economy, and quality of care, and sufficient to provide access equivalent to the general population. Under the FFS model, the state pays providers. States may also leverage the FFS model to promote certain actions or efforts among providers, if appropriate. For example, a state (within applicable Federal payment limits) could determine to pay providers that utilize health information exchange at a higher FFS rate than providers who do not.[xxxix] Although they vary greatly by state and by service, on average, Medicaid FFS physician payment rates are two-thirds of the rates Medicaid pays.[xl]

Managed Care

Managed care is a health care delivery system that is designed to manage the quality, cost, and utilization of medical services that plan members receive. In Medicaid managed care, the delivery of Medicaid health benefits and additional services are arranged through contracts between state Medicaid agencies and managed care entities that accept a set per member per month (PMPM or capitation) payment for these services. Under managed care, the state pays a fee to a managed care plan for each person enrolled in the plan. In turn, the plan pays providers for all of the Medicaid services a beneficiary may require that are included in the plan's contract with the state.

The American Recovery and Reinvestment Act (ARRA) of 2009[xli] provides protections[xlii] for Indians that prohibit states from imposing Medicaid premiums or any other Medicaid cost sharing on Indian enrollees who have used the Indian Health Service, Tribal Health Program, and UIO (I/T/U) system. Section 5006 also

formally requires that states consult with the Indian community on Medicaid and CHIP policy matters. Specifically, states must seek advice from designees of Indian health programs and UIOs in the state when Medicaid and CHIP matters have a direct effect on Indians, Indian health programs, or UIOs. States must also describe the process for seeking advice from Indian health programs and UIOs in their Medicaid and CHIP state plans.

Managed care regulations[xliii] recognize four types of managed care entities: Managed Care Organizations (MCOs), Primary Care Case Management (PCCM), Prepaid Inpatient Health Plan (PIHP), and a Prepaid Ambulatory Health Plan (PAHP). UIOs who provide services to AI/ANs enrolled in MCOs are entitled to be reimbursed. There are separate rules for FQHCs. Section 5006(d) of ARRA added a new section 1932(h) to the Medicaid statute and section 2107(e)(1)(J) to the CHIP statute, which apply consistent rules governing the treatment of Indians, Indian health care providers–I/T/Us, and Indian Managed Care Entities (IMCEs) in a State Medicaid or CHIP managed care program. An Indian Managed Care Entity (IMCE) is a managed care entity that is controlled by the IHS, a tribe, tribal organization, or UIO, or a consortium, which may be composed of one or more tribes, tribal organizations, or UIOs, and which may also include the IHS. An IMCE may restrict its enrollment to Indians in the same manner as Indian health programs may restrict the delivery of services to Indians.

There are three basic types of federal authorities in the Social Security Act by which states can implement a managed care delivery system: state plan authority (Section 1932(a)); Section 1915(a) and (b) waiver authority; and Section 1115 waiver authority. Under a Section 1932(a) State Plan Program, states are prohibited from mandatory enrollment of AI/ANs into a Medicaid managed care program, and under 1915b and 1115 waivers, states have the option to exempt AI/ANs from mandatory enrollment in managed care.[xliv]

Prospective Payment Systems and Alternative Payment Methodologies for FQHCs[xlv]

The FQHC Prospective Payment System (PPS) recognizes that FQHCs are a unique type of provider. Under the FQHC PPS, health centers receive a single, bundled rate for each qualifying patient visit. However, PPS rates have not kept up with inflation. The Social Security Act[xlvi] also gives states and FQHCs the ability to agree to use an Alternative Payment Methodology (APM) in determining Medicaid payment rates. An April 2016 CMS State Health Official

(SHO) Letter provides guidance to states on the requirements for payment methodologies for FQHCs under managed care.[xlvii]

Children's Health Insurance Program (CHIP)

To provide health coverage to eligible children, states can operate CHIP as a program separate from Medicaid, as an expansion of the Medicaid program, or as a combination of both program types. Like Medicaid, CHIP is administered by states, according to federal requirements, and funded jointly by states and the federal government through a formula based on the Medicaid Federal Medical Assistance Percentage (FMAP). "As an incentive for states to expand their coverage programs for children, Congress created an "enhanced" federal matching rate for CHIP that is generally about 15 percentage points higher than the Medicaid rate — averaging 71% nationally. For example, if a state has a 50% match rate for Medicaid, they may have a 65% match rate for CHIP."[xlviii] States may not impose cost-sharing on AI/AN children.

Managed Care

CHIP managed care provides for the delivery of CHIP health benefits to eligible children through contracted arrangements between state CHIP agencies and managed care plans that accept a set per-member-per-month (capitation) payment for these services.[xlix]

Medicare

Medicare is a health insurance program for people age 65 or older, under age 65 with certain disabilities, and those of all ages with End-Stage Renal Disease (ESRD). Medicaid covers at least 14,336 people at UIOs, or 8% of all clients. Medicare covers 10% of AI/AN patients, though only 8% are 65 years of age or more. This may indicate that ESRD and disability are particularly important for AI/AN clients. The different parts of Medicare help cover specific services. Most people pay a monthly premium for Parts B and D.[l]

Medicare Part B (Medical Insurance)

Part B helps cover doctors' services, outpatient care, and supplies when they are medically necessary.

Medicare Part D (Prescription Drug Coverage)

Medicare prescription drug coverage is available to everyone with Medicare; they need only join a plan approved by Medicare that offers Medicare drug coverage.

Medicare Advantage Plans

Medicare Advantage Plans are a type of Medicare health plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits. Most Medicare Advantage Plans also offer prescription drug coverage. Plan rules and costs vary. People can join a separate Medicare Prescription Drug Plan with certain types of plans that either cannot offer drug coverage (like Medicare Medical Savings Account plans) or choose not to offer such coverage (some Private Fee-for-Service plans).

Medicare Prospective Payment System (PPS) for FQHCs

The ACA[li] established[lii] a payment system for the costs of FQHC services under Medicare Part B based on prospectively set rates. The PPS for FQHC Final Rule[liii] published by CMS in 2014 implemented a methodology and payment rates for FQHCs under the PPS beginning on October 1, 2014. Under the Medicare PPS, Medicare pays FQHCs a single encounter rate per beneficiary per day for all services provided, with some exceptions. For example, the rate is adjusted based on geographic factors.[9] Medicare pays FQHCs based on the lesser of their actual charges or the PPS rate.

Marketplace

Private insurance – including marketplace plans - covers at least 44,799 people at UIOs, or 25% of all clients. However, 40% of AI/ANs (or 28,897) who receive services at UIOs are covered by private insurance. The ACA includes specific provisions relevant to AI/ANs purchasing coverage on Exchanges. Some benefits are only available to members of federally recognized tribes, while others are available to people of Indian descent or otherwise eligible for services from the I/T/U system. Marketplace protections are limited to tribal members. AI/ANs with household incomes below 300 percent of the federal poverty level who are enrolled in a QHP offered through the individual market Exchange will not have to pay any cost-sharing. If an AI/AN is enrolled in a QHP and receives services directly from a UIO, the individual will not have to pay any cost-sharing for those services. Members of federally recognized tribes can enroll in Marketplace plans at any point during the year and access special enrollment periods outside the annual open enrollment period. Section 206 of the Indian Health Care Improvement Act (IHCIA) provides that all Indian health providers

[9] In accordance with Section 1834(o)(1)(A) of the Social Security Act, the FQHC PPS base rate is adjusted for each FQHC by the FQHC Geographic Adjustment Factor (GAF), based on the Geographic Practice Cost Indices (GPCIs) used to adjust payment under the Physician Fee Schedule.

have the right to recover from any third-party payers, including insurance companies, up to the reasonable charges billed for providing health services; or if higher, the highest amount the insurer would pay to other providers to the extent that the patient or another provider would be eligible for such recoveries. Section 206 of IHCIA applies to all third-party payers, including QHPs.

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Part III. Billing Data Sources

Program Services Revenue and Financial Records[10]

As part of this project, NCUIH collected all UIOs' tax information from IRS Form 990 covering the last 10 available years (FY 2008-2018), and compared this information with other available information at NCUIH. As non-profit organizations, all UIOs are required to submit a yearly Form 990 to the IRS to retain their tax-exempt status. The accompanying financial records are public, and often easily searchable for 10 years or more. Apart from these financial records, some organizations may release more detailed public yearly financial reports on their websites.

The strength of this approach is the consistency across all UIOs, allowing for the collection of large amounts of basic information without the administrative burden of primary data collection via organizations themselves. This allows for the creation of general revenue estimates for each program and year, with trends can that can be correlated with facility types and projected into the future. The downside is a lack of granularity and specificity by payer, as well as a logistical burden on the interpreter. Some programs may report Medicare and Medicaid as separate revenue items, others may collapse these under "clinic services". Furthermore, while these financial records are generally accurate, "program services" are not synonymous with "third party revenue", and are instead a good proxy for overall billing capacity. Some smaller UIOs who do not collect third party revenue will still collect small amounts of client fees, so these must be manually accounted for by checking other records, cross referencing with yearly reports, and reading full returns. Thus, some organizations may report a small program services income, even though they bill $0 to third-party payers – which requires manual correction.

On the whole, the benefits outweigh the limitations. Based on full records, NCUIH assumes that "program service revenue" is a decent proxy for "third party billing", with billing revenue making up approximately 90% of all UIO revenue. Care was taken to remove "non-medical" service revenue whenever possible given that a few specific facilities have a higher proportion of this revenue than others – such as from supportive housing or speaking fees. Therefore, the reported services included in this report are a better proxy for third party billing than raw tax reports alone. Based on the percentage of "removed" revenue from non-medical services, there may be a residual

[10] Hereafter referred to as "Program Service Revenue from 990 Tax Forms".

3% margin of error due to inseparable non-medical program revenues at organizations who do not provide the same granularity in their accounting.

CMS Chronic Conditions Warehouse[11]

Some information on Medicare Part B claims made by all UIOs was available from the Chronic Conditions Warehouse (CCW) for claims between 2013-2018.[12] The CCW is a set of data files from CMS which are easily merged to allow analysis of beneficiaries and claims by Medicare, Medicaid, CHIP, and ACOs.[liv] For the purposes of this report, only Medicare Part B fee-for-service claims were feasible for analysis, as other program files lacked the same level of detail from all requisite states and years. Therefore, Medicare claims discussed in this report are still incomplete regarding Medicare Advantage plans, Part D, or other relevant supplemental plans. However, they do provide some glimpse into overall Medicare claims and reimbursement trends at UIOs.

To collect this information, both the outpatient and carriers files of the CCW were merged and queried, as some UIOs bill through physician groups, others bill as FQHCs, and others may show up in both files with some services billed by the facility with other specialty services through individual providers. The only type of UIO data systematically excluded by this process would be a UIO who bills entirely through individual physicians who are not under a physicians group – though NCUIH is not aware of any specific facilities this would apply to.

NORC aggregated individual claims and beneficiaries by each of the 41 UIOs using the facilities' National Provider Indexes (NPIs), which are publically available in an online registry.[lv] There are limitations to this approach. Use of the UIO's CCN (CMS Certification Number), a 6-digit certification number for a facility, may be more accurate. However, CCNs are not as easily identified without requests to facilities themselves. The analysis does not include data from 2-3 facilities due to this issue; therefore, Medicare data should be assumed to be minimum estimates. Because the error is endemic to how the data was pulled and shared across all facilities in the dataset, NCUIH assumes that overall trends in this report are not strongly affected.

Claims were aggregated by Medicare beneficiaries, claims, and payment data specific to each UIO. Each facility-level estimate included three race categories:

[11] Hereafter referred to as "CCW"

[12] Calendar year 2018 was the most recent year available during the project period.

"AI/AN," "Other or Unknown," and "Known non-AI/AN race" (which included all White, Black, Asian, or Hispanic). Race was identified using the beneficiary file, and did not use the corrected RTI race code.[13,lvi] As a result, some racial misclassification of AI/AN patients as White is expected, yet this should be comparable with other sources given it is a known issue with these claims datasets.

Unpublished other information available from prior projects and membership surveys. Wherever applicable, the source of an internal NCUIH source is listed. In preparation for this report, NCUIH compiled basic billing and revenue questions from 3 separate surveys fielded during the winter of 2017-2018. NCUIH also included data that is being collected as part of ongoing COVID-19 response efforts. Estimates from NCUIH sources have only been combined when they were collected during the same time period. NCUIH has not included any information that is identifiable for a specific UIO if not publically available, and only presented aggregate data in agreement with the purpose of the original data collection.

NCUIH also collected Medicaid reimbursement rates for 80% of UIOs, primarily through public sources (which was supplemented via pre-existing survey data). Although the majority of these were collected through public records, they are de-identified as much as possible due to their sensitive nature.

Lastly, NCUIH has included preliminary results on the impact of coronavirus response. On March 23, 2020, NCUIH asked UIOs to respond to a survey on their coronavirus needs. This survey included, amongst other things, a question asking about their billing losses compared to their projections for each week between January 19, 2020 and March 21, 2020. Analysis using this survey has been included.

HRSA Unified Data System (UDS)[14]

The 11 UIOs that are HRSA Health Centers are subject to more intensive public reporting of their patient characteristics, provided services, outcomes, revenue, and spending than most other UIOs due to their statutory status.[lvii] Each year of data reported to the Uniform Data System (UDS) is available for every HRSA Health Center via a commonly-requested Freedom of Information Act (FOIA) full dataset on HRSA's website.[lviii] Each UIOs that is a HRSA Health Center is included in this dataset, though

[13] The RTI race code was not used due to concerns it would not improve AI/AN data quality. See full endnote citation for relevant literature.

[14] Hereafter referred to as "HRSA-UDS".

individual variables may be missing for some items (data is usually only data missing if pertaining to a contract with insurers).

HRSA-UDS data should not be taken as representative of trends in the UIO program as a whole, but rather are helpful as a point of comparison for how much these 11 programs contribute to overall program trends.

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Part IV. Findings

This section presents findings from the secondary data analysis, beginning with a general review of overall program service revenue by program type. This is followed by an analysis of facilities' Medicaid reimbursement rate, trends in Medicare Part B spending, changes in HRSA facilities, and tentative projections of the impact of the coronavirus outbreak on reimbursement.

Overall Program Service Revenue

Since at least 2010, the Urban Indian Health line item has not received more than 1 percent of the IHS budget, and thus UIOs rely heavily on third-party reimbursement to operate their programs. For Title-V UIOs as a whole, revenue (from all sources) more than tripled in the 10 -year period from fiscal year (FY) 2008 to FY 2018, with a particular acceleration in the trend after FY 2014 (see Fig. 5). During this time period, non-IHS grants from HHS have increasingly supported UIOs as well, reaching levels similar to the IHS UIH line item by FY2019.

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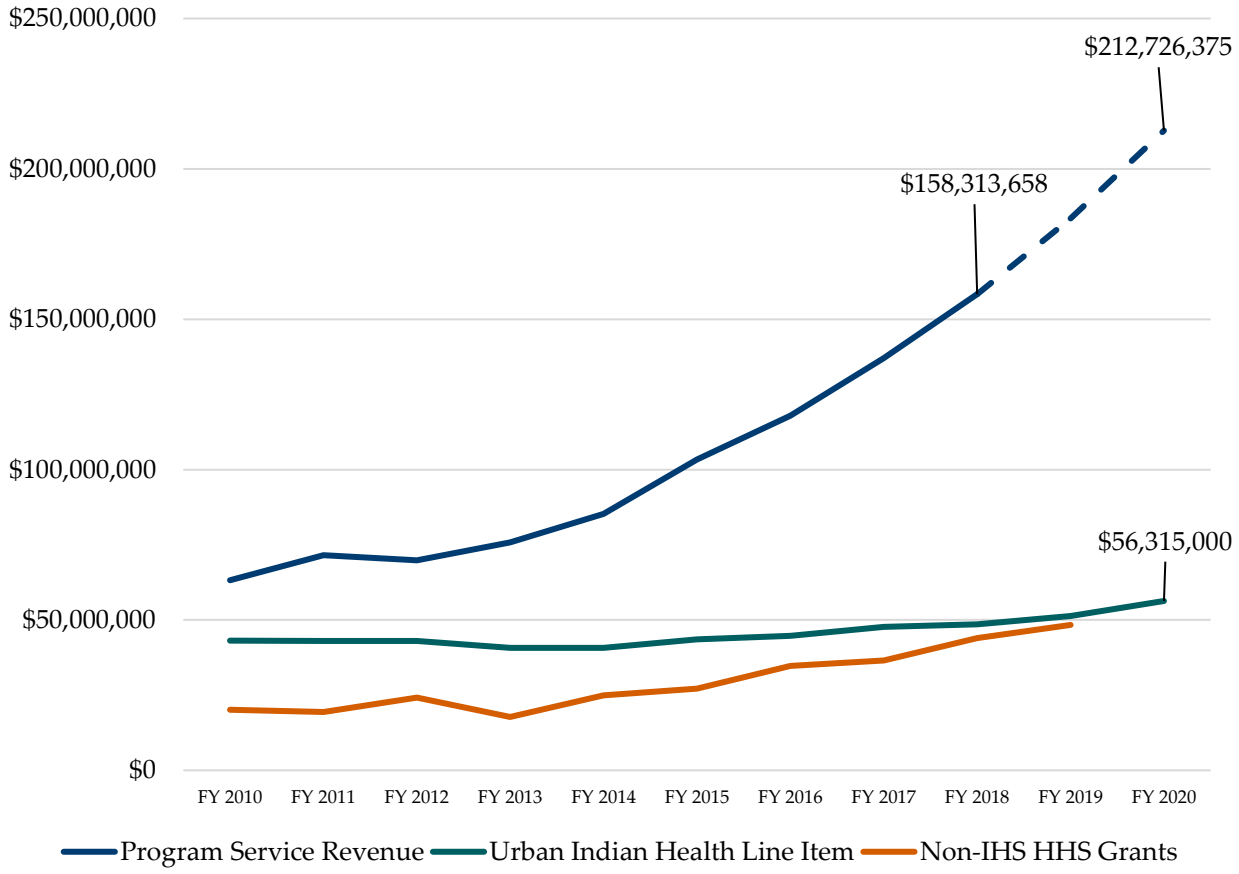
FIGURE 5. UIO INCOME FROM THIRD-PARTY BILLING, APPROPRIATIONS, AND GRANTS



** Note: FY2019 and FY2020 service revenues are projected estimates for all UIOs known to be collecting revenue, based on the growth rate from the previous 5 years. FY2020 will not be accurate due to impacts of the novel coronavirus.*

Sources: Program Services Revenue from 990 tax returns. Estimates are known to be minimums, with data missing from between 3-8 UIOs per year. IHS UIH line item data is the exact maximum amount based on budget formulation, before dispersal. Non-IHS HHS grants are also a minimum estimate obtained via TAGGS, and represent the available data of 88% of UIOs until FY 2019 (n=36).

Although these estimates represent trends across all 41 programs as a whole, not all programs bill third-party payers. Clearly this has become a more attractive option over time, as more UIOs have built out this capacity (see fig. 6). However in 2018, five UIOs reported small amounts of program service revenue, but also were known not to be billing Medicare or Medicaid. This indicates that there remains another small set of programs who are either entirely self-pay or collect private insurance reimbursement alone. These sites were primarily small substance abuse programs which may provide services that are not reimbursed by most payers such as traditional practices, housing, or other social services.

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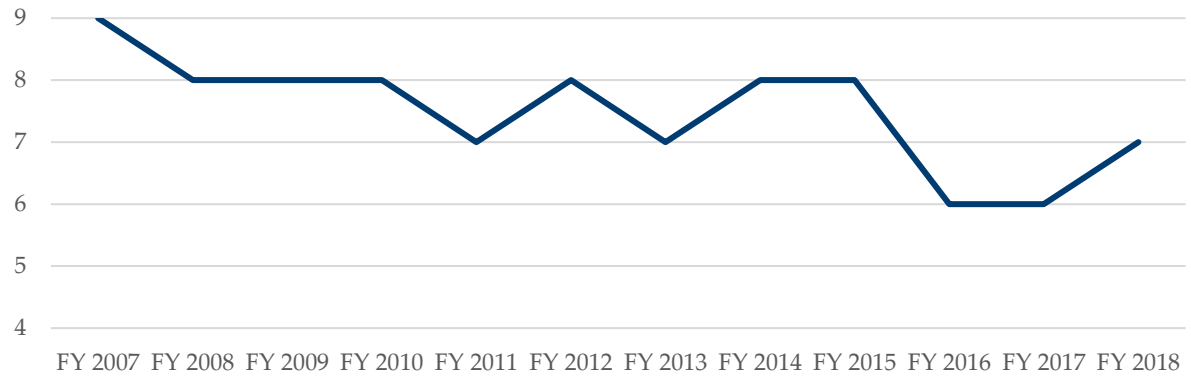
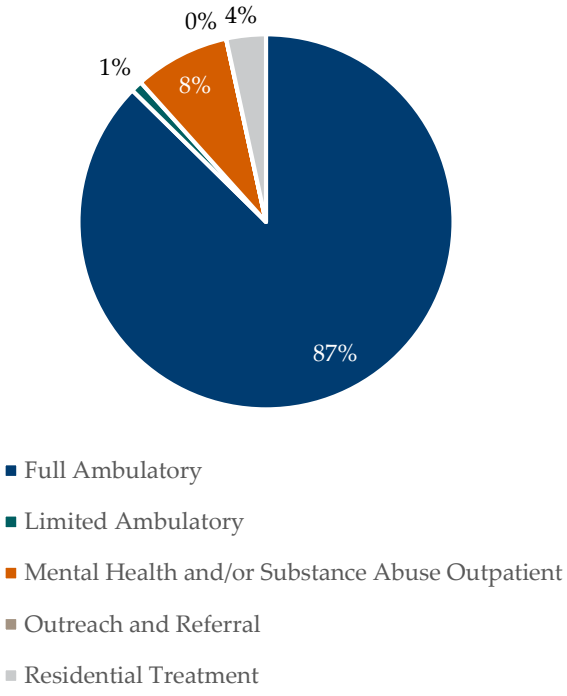
FIGURE 6. NUMBER OF UIOS REPORTING $0 OF PROGRAM SERVICES REVENUE



Source: Program Services Revenue estimates from yearly tax returns.

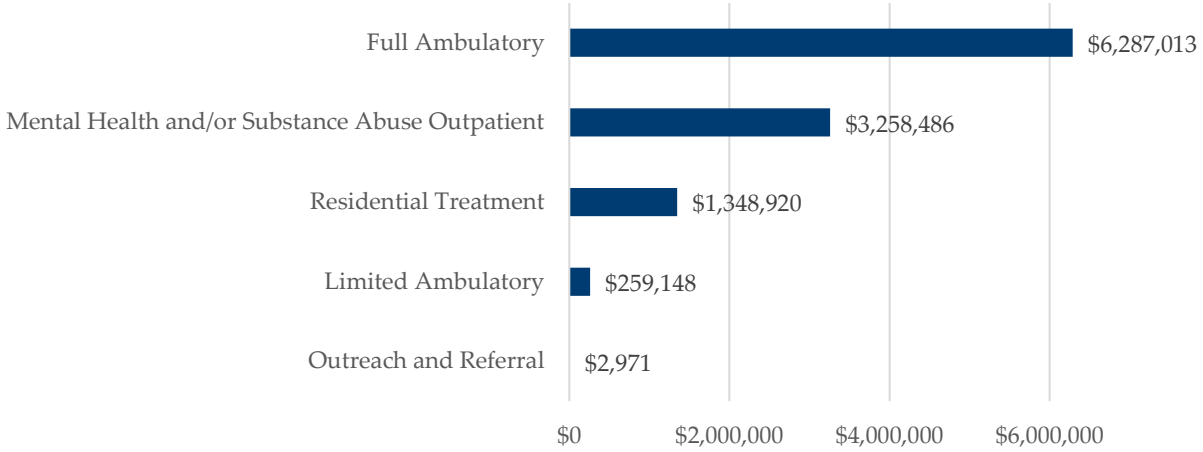
FIGURE 7 TOTAL UIO REVENUE BY PROGRAM TYPE (FY18)



It is worth noting that some smaller programs report service revenue, but not from insurers, and instead minor revenues such as rent and community development activities. Furthermore, although residential treatment or outpatient mental health and substance abuse facilities may report revenue, many traditional or non-medical services may not be reimbursable from Medicare or Medicaid, indicating sources from clients and private payers. Still, "program service revenue" captures well over 90% of billing at the vast majority of most UIOs, and thereby serves as a decent proxy for third-party billing trends across the Urban Indian Healthcare system as a whole. This is particularly true given the magnitude of services revenue compared to the IHS budget line item; even with a 10% margin or more, it remains clear that third-party billing reimbursement increasingly exceeds funding from grants and IHS appropriations combined. Revenue from third party sources seems to be primarily concentrated in full ambulatory facilities. Although full ambulatory facilities only

represent a little over half of UIOs, they represent nearly 90% of the revenue reported by UIOs (see fig. 7).

FIGURE 8. AVERAGE REVENUE PER UIO TYPE (FY18)



Mental health and Substance Abuse Outpatient facilities make up about 10% of all UIO facilities and also make up about 10% of the revenue that UIOs collect. However, residential treatment facilities report about half the revenue of outpatient facilities despite having only one fewer UIO in this category (fig. 8). Although UIOs vary strongly on their revenue due to client population size and location, the average yearly revenue per facility still provides relevant information. Particularly, outreach and referral programs receive very little revenue from all sources, and most do not bill directly. Surprisingly, the average yearly revenue at a limited ambulatory facility remains very low compared to other types of UIO (fig. 8). The amount – roughly $260K – can be roughly on par with IHS yearly appropriation amounts at some facilities, indicating that some smaller UIOs remain highly dependent on IHS funds to survive.

Although full ambulatory facilities clearly bill the most with $6.3M per facility, it is important to note a high variation in the amount of billing – with some UIOs reporting more than three times that amount per year. Conversely, this indicates that some UIOs still bring in very little payer reimbursements, though they provide full ambulatory services. Future inquiry should focus on gathering qualitative information to compare the contexts of these high and low billers at limited and full ambulatory clinics.

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Registered Essential Community Providers (ECPs) are also more likely to report higher amounts of revenue – in FY18 they collected over 80% of total UIO revenue despite only representing about 60% of all UIOs (see fig. 9). The average ECP is able to collect over 3 times the amount of revenue of a UIO that is not listed (see fig. 10). Crucially, all UIOs should be eligible for inclusion on HHS' list of ECPs, a primary tool used to identify providers that meet the network adequacy requirements of reimbursement by Qualified Health Plans.[lix]

FIGURE 9. TOTAL UIO REVENUE BY ECP STATUS (FY18)

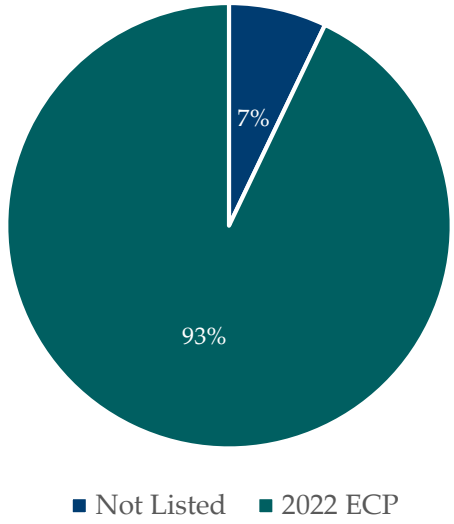
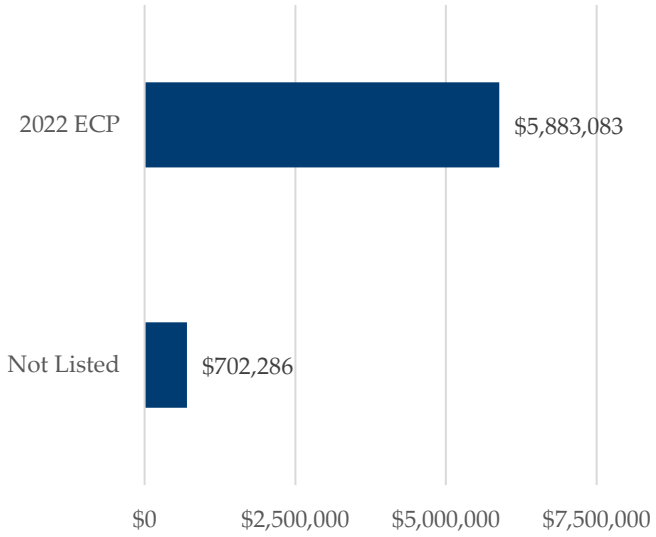


FIGURE 10. AVERAGE REVENUE BY ECP STATUS (FY18)



Out of the 25 UIOs that are listed as ECPs, nearly all are listed as FQHCs (though one is not). However, 3 programs are not categorized as Urban Indian Health Programs on the ECP list (see fig. 11). Fifteen ECP programs are categorized as dental providers as well, and 5 programs are listed as family planning and community mental health centers each.

However, inclusion on this non-exhaustive list does not guarantee that a UIO will end up in a contractual agreement with a QHP, and a UIO may not be listed if UIOs or QHPs do not see such an arrangement as likely, valuable, or feasible. Clearly, substance abuse treatment programs are least likely to be listed as an ECP – only the two facilities who provide both residential and substance abuse are listed as ECPs (see fig. 12).

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FIGURE 11. LISTED CATEGORIES OF ECPS

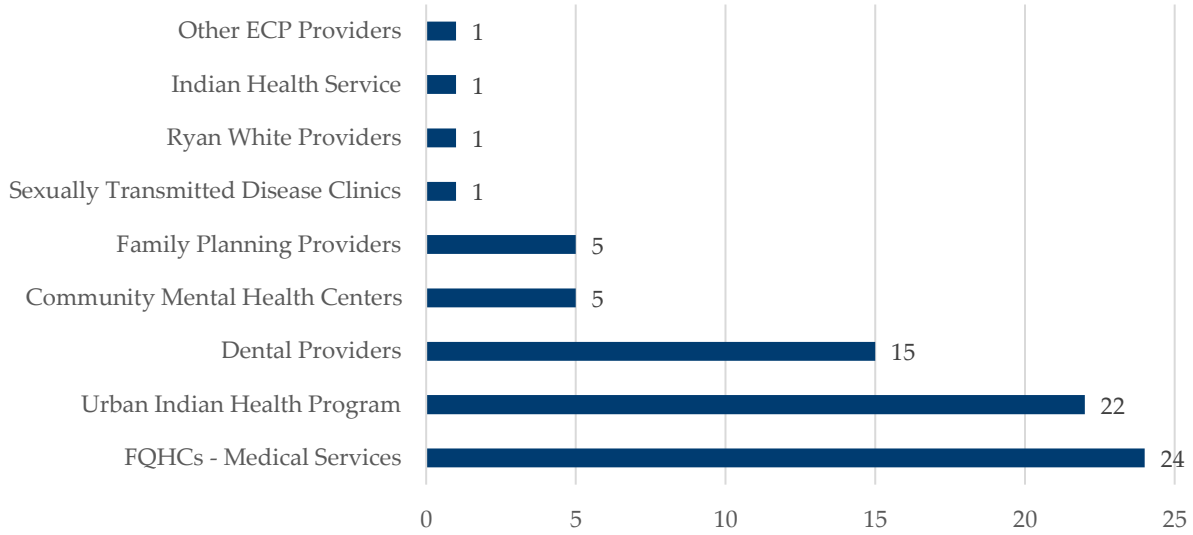
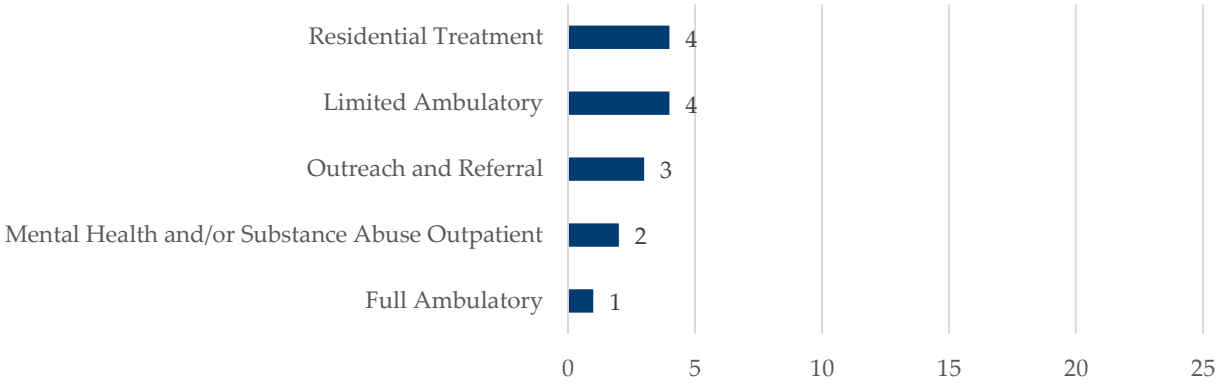


FIGURE 12. TYPES OF UIOS NOT LISTED AS ECPS



However, the large number of limited ambulatory facilities not listed as ECPs (four out of six) is somewhat surprising; on a 2018 survey, one of these programs reported being an FQHC and another, a look-alike. Though not listed as ECPS, the full ambulatory facility is listed as an FQHC by IHS. This may indicate some unmet marketplace inclusion, and these facilities are priority facilities for engagement. Further qualitative information gathering would help determine whether marketplace plans identify the opportunities that UIOs provide (and vice versa).

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HRSA Health Centers and look-alikes also represent almost half of all UIO billing revenue, despite only representing 11 out of 41 programs (see fig. 13). On one hand, this is partially because of the patient volume at these facilities, which are among the higher at UIOs. However, it is worth noting HRSA Health Centers as a specific case to illustrate a broader principle across UIOs. Many of the advantages of Health Center Status – for example, coverage under the Federal Tort Claims Act (FTCA), access to capacity-building grants, and access to capital loans - do not influence revenue per client directly. However, they do allow for the development of more robust client services, which in turn allow for greater volumes and rates of reimbursement.

FIGURE 13. TOTAL UIO REVENUE BY FQHC STATUS (FY18)

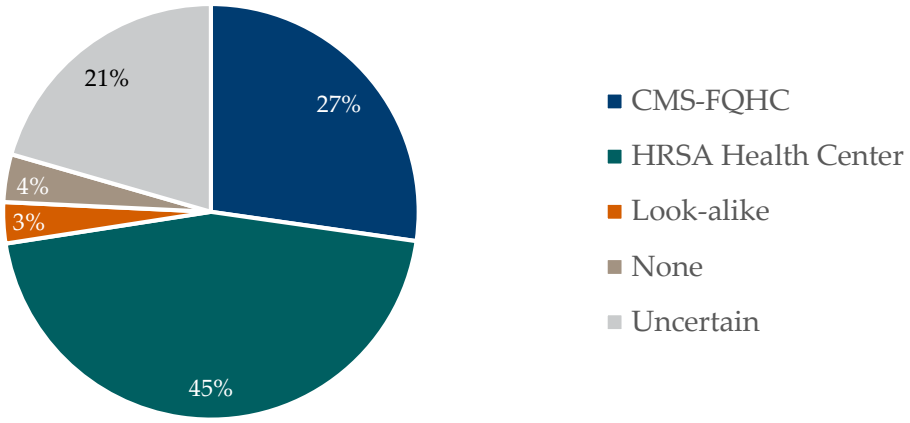
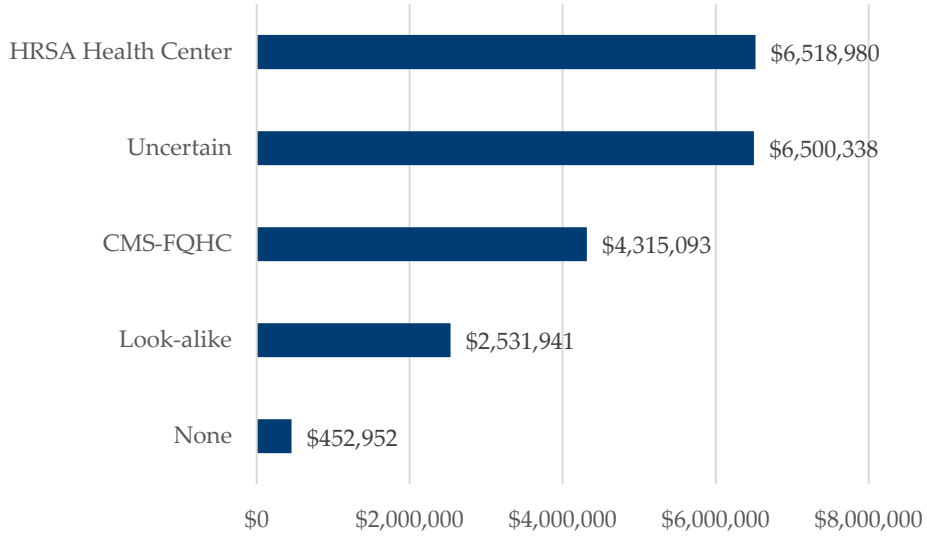


FIGURE 14. AVERAGE REVENUE BY FQHC STATUS (FY18)



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Full Ambulatory facilities that are not HRSA Health Centers, but instead CMS-FQHCs, may still benefit due to incentive payments and a PPS rate based on clinic history. And similarly, HRSA FQHC look-alikes may benefit from an enhanced ability to apply for community health grants. However, both types collected slightly less on average facility during FY18 (see fig 14). This emphasizes the role of capacity in reimbursement trends over time – UIOs who have had the space to quickly establish more robust services have been able to snowball these advantages to ensure stability through continued third-party billing support. However, the converse is also true; facilities with limited reimbursement and lacking external capacity-building support will likely struggle to build a billing system as sustainable as their counterparts. Future qualitative information-gathering should be performed to compare the experiences of those looking to expand beyond look-alike status (or those that have recently done so successfully), to determine facilitators and barriers to this key step in establishing robust billing.

Medicare Part B

As a whole, UIOs were billing Medicare for a growing service population between 2013 and 2018 (see fig. 15). And while UIOs saw growth in both AI/AN and non-AI/AN beneficiaries served, growth among non-AI/ANs was comparatively more pronounced. Some UIOs saw basically no change in their population of AI/AN beneficiaries. This resulted in a slightly decreased percentage of AI/AN Medicare use at UIOs compared to other races.

FIGURE 15. DISTINCT MEDICARE-B USERS AT UIOS BY RACE

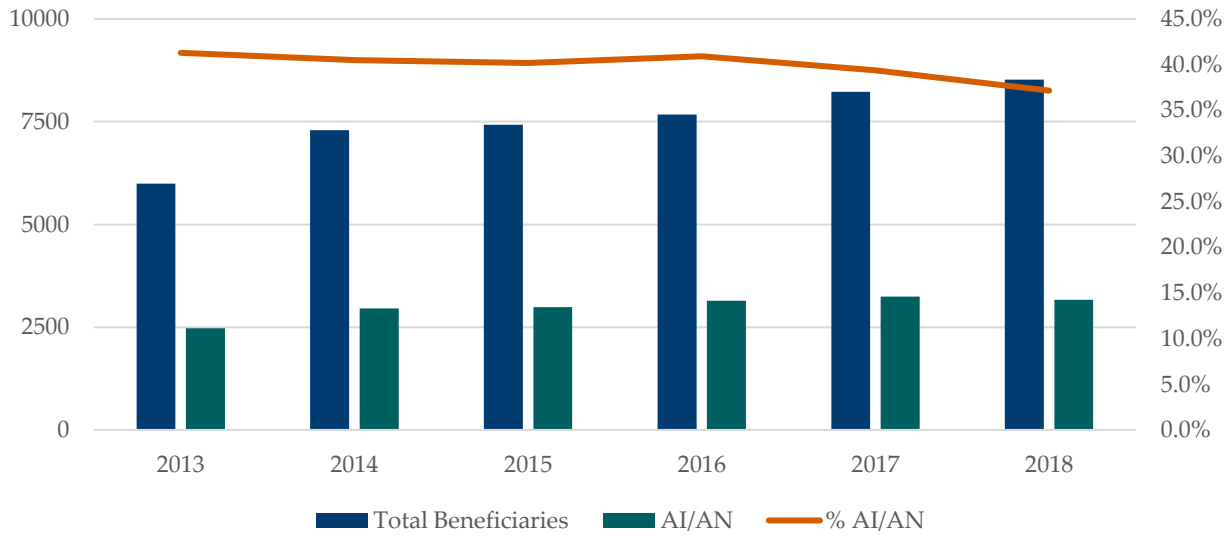

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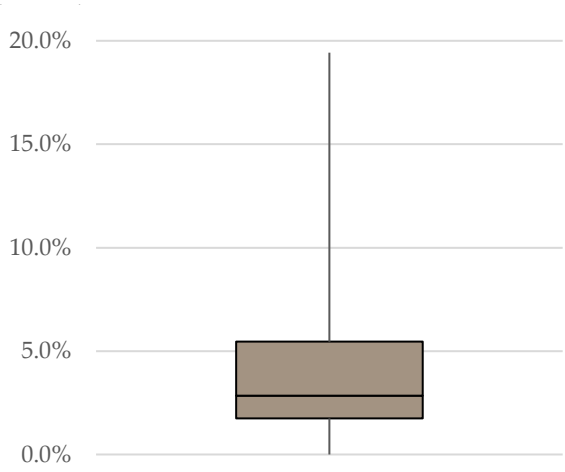
FIGURE 16. RANGE OF BENEFICIARIES WITH OTHER/UNKNOWN RACE AT UIOS



This may be due to a number of different factors. Although it is possible that the urban AI/AN elder population has grown more slowly or requires less medical care than the general population in cities over 65 years of age, this explanation seems unlikely given that national research has consistently shown the opposite.[lx] However, it is possible that UIOs' AI/AN clientele have not expanded as quickly as this group is in the overall population, or that capacity is not growing at the same rate as need. Furthermore, non-AI/ANs may increasingly use UIOs for their healthcare needs in the growing subset of HRSA/UIO facilities, inflating the growth rate of non-AI/ANs due to the large amount of billing conducted by HRSA Health Centers. AI/AN beneficiaries that use UIOs to meet their health needs are increasingly entitled to Medicare due to Old Age and Survivors Insurance (OSI), and the proportion solely eligible through Disability (DIB) was seen to be decreasing steadily from 2013-2018 (see fig. 17). End-stage renal disease (ESRD) remained an uncommon factor in entitlement throughout, but decreased by about half from about 1.6% of cases to 0.8% during the same period. By 2018, 64% of UIO beneficiaries were eligible due to OSI, and 35% due to DIB.

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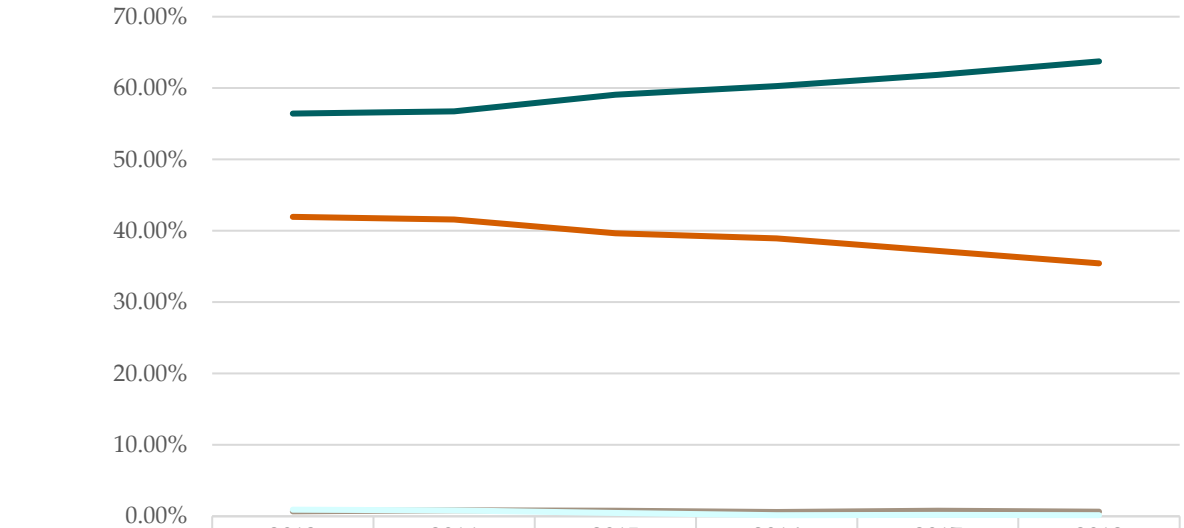
FIGURE 17. AI/AN ENTITLEMENT REASONS OVER TIME



	2013	2014	2015	2016	2017	2018
OSI	56.43%	56.76%	59.06%	60.30%	61.84%	63.74%
DIB	41.96%	41.58%	39.66%	38.94%	37.20%	35.44%
ESRD	0.69%	0.85%	0.80%	0.60%	0.77%	0.66%
DIB & ESRD	0.93%	0.81%	0.47%	0.16%	0.19%	0.16%

These changes in beneficiary usage were met with similar changes in the number and value of claims, as well as reimbursement. Although there were fewer claims made for AI/AN beneficiaries, rate of growth increased for both AI/AN and non-AI/AN patients at similar yearly rates (see figs. 18 and 19). Clients with Other or Unknown race, however, represented a small but comparatively quickly growing portion of claims at UIOs. UIOs vary widely as the percentage of their service population who are marked at "other or unknown" in Medicare claims records – between 0-19% depending on the facility - though most are between 2-5% (see fig. 18). HRSA Health Centers represent most of the higher numbers of "other/unknown" clients, perhaps due to their mandate to see all clients within their catchment area or service to populations (such as drop-in homelessness programs) where AI/AN race may not be verified in the same way as when determining IHS eligibility.

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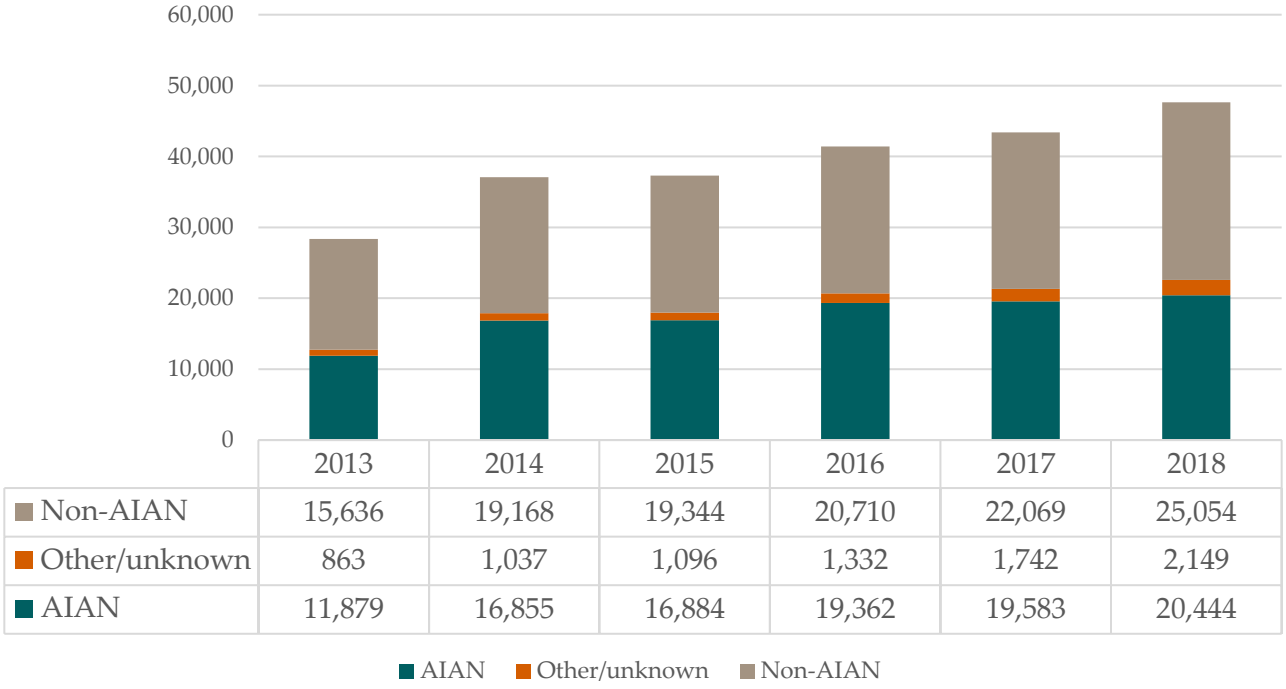
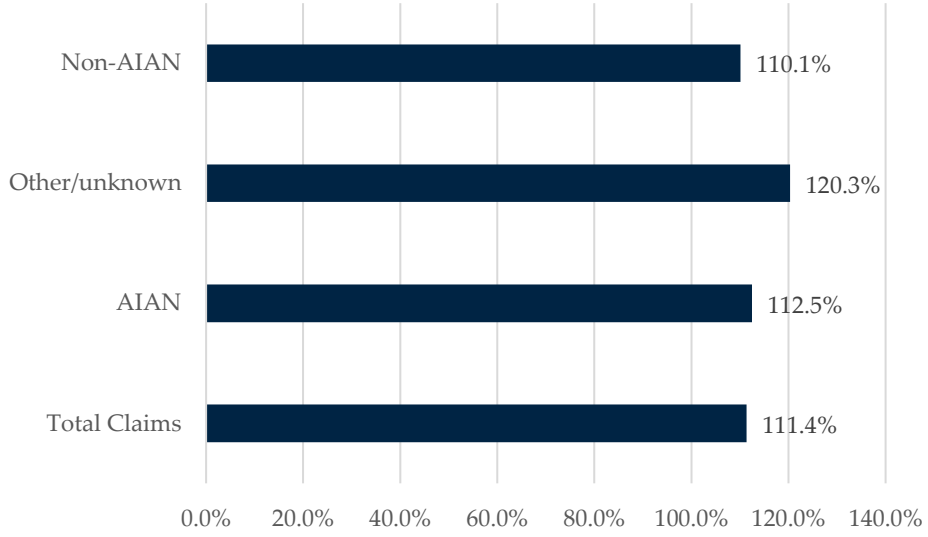
FIGURE 18. NUMBER OF MEDICARE PART B CLAIMS BY ALL UIOS



	2013	2014	2015	2016	2017	2018
Non-AIAN	15,636	19,168	19,344	20,710	22,069	25,054
Other/unknown	863	1,037	1,096	1,332	1,742	2,149
AIAN	11,879	16,855	16,884	19,362	19,583	20,444

Figure 19. AVERAGE YEARLY GROWTH IN NUMBER OF CLAIMS BY RACE (2013-2018)



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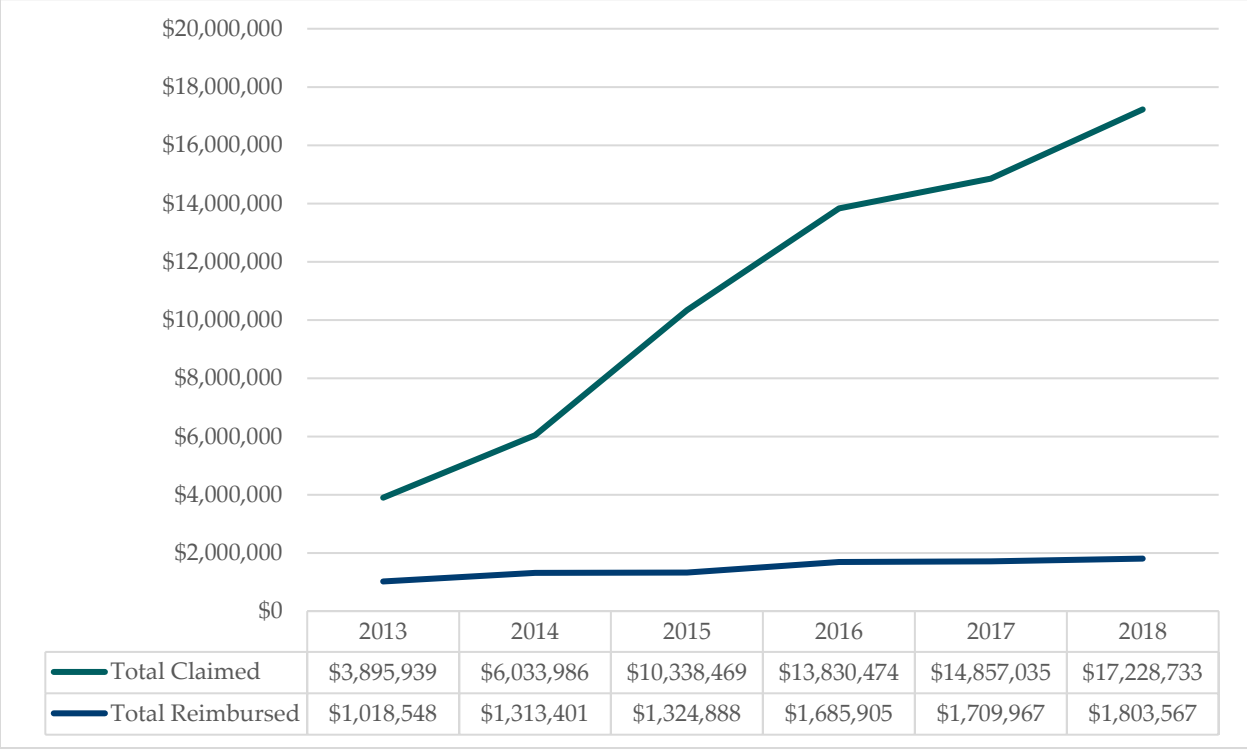
While the *number* of FFS claims was increasing steadily, the *amount* of these claims grew comparatively more quickly during the same period – about 20% faster per year on average (see fig. 20). Between 2013-2018, the amount claimed by UIOs more than quadrupled, although the amount reimbursed did not even double. By 2018, UIOs claims of at least $17.2 M were recorded in the CCW, with final Medicare payments of $1.8M. These estimates are known to be very low estimates based on yearly reports from some UIOs who estimate a substantial portion of this $1.8M just at their respective organizations.

FIGURE 20 MEDICARE PART B CLAIMS AND REIMBURSEMENT (TOTAL AT ALL UIOS)



	2013	2014	2015	2016	2017	2018
Total Claimed	$3,895,939	$6,033,986	$10,338,469	$13,830,474	$14,857,035	$17,228,733
Total Reimbursed	$1,018,548	$1,313,401	$1,324,888	$1,685,905	$1,709,967	$1,803,567

At face value, this trend implies that Medicare Part B billing has been providing diminishing returns to UIOs over time, but there are a number of factors that may be contributing to this trend. One could be a rise of successful application of coinsurance, signifying that Medicare payments have been reduced while the balance is still being settled. There is also the possibility that the implementation of ICD-10 during this time resulted in a period of coding adjustment at UIOs, with user error causing a larger volume of non-reimbursable encounters. Another possibility stems from the role of Medicare Administrative Contractors (MACs). If UIOs are not well-trained or engaged in utilizing these contractors (or if relevant MACs do not understand the ITU system)[lxi] this may indicate an untapped potential for effective reimbursement. Each of these

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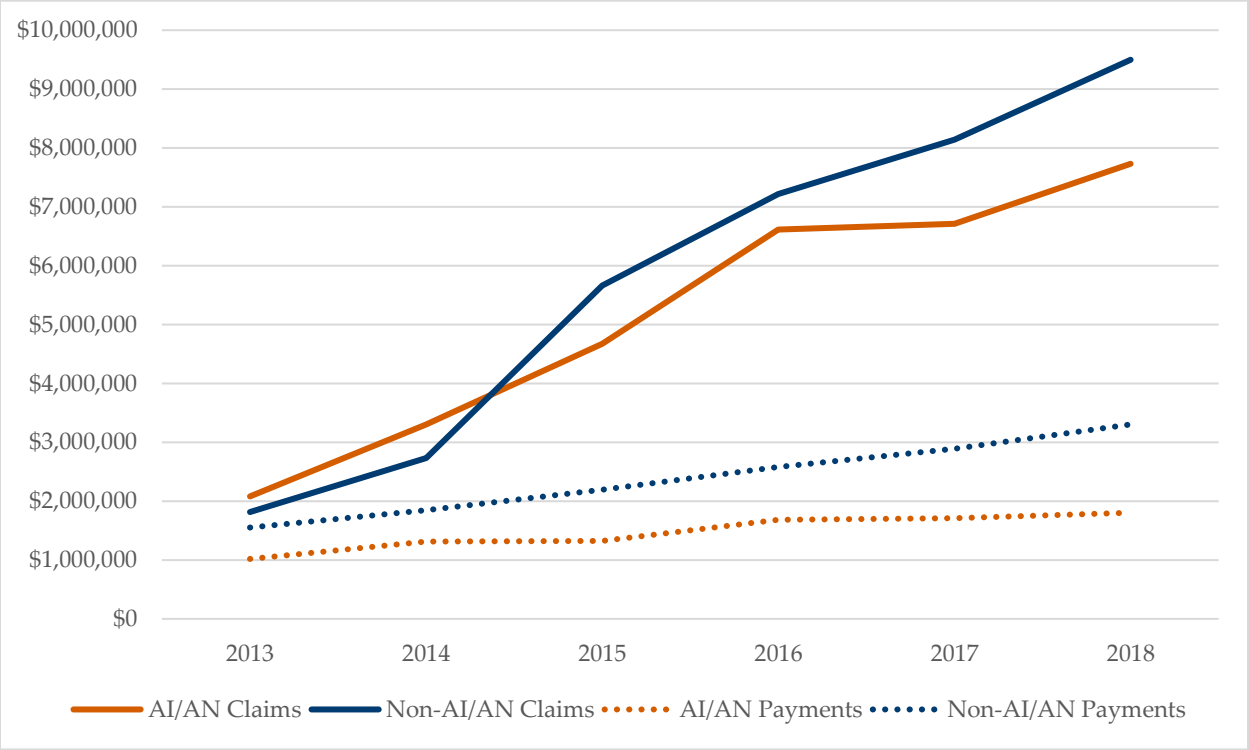
possibilities indicate a space for further external engagement with payers, and/or a need for increased culturally-competent training and TA for UIOs on Medicare billing.

FIGURE 21. MEDICARE CLAIMS AND PAYMENTS BY RACE



Similar to trends in beneficiary entitlement, Medicare claims and reimbursement differ by race at UIOs in the period between 2013-2018 (see fig. 21). Clearly, non-AI/AN claims have experienced the most growth over time, from under $2M in 2013 to over $9M in 2018. Though AI/AN claims were also very close to $2M in 2013, they instead rose to just under $8M in 2018. This may be due to ongoing growth of billing capacity at HRSA health centers over this time (combined with the fact that they serve a greater proportion of non-AI/ANs).

However, there is also a preexisting (and possibly increasing) racial difference between the amount of payments received for services performed for AI/AN clients and those performed for non-AI/AN clients. In 2013, UIOs received about $0.6M dollars less for services performed for AI/AN patients compared to non-AI/AN patients, and this gap widened to $1.5M by 2018. Although there was no statistical difference between

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AI/AN and non-AI/AN *claims* during this time, the racial difference was statistically significant over this time period when it comes to *payments*.[15]

Lastly, it is worth noting that although Medicare claims and payments both grew during this time period, growth did not occur in both at the same rate. This implies that an increasing volume of claims is not as easily translating into an increased revenue stream across UIOs. The yearly growth of AI/AN and non-AI/AN Medicare beneficiaries was about the same (112 and 110% respectively - see fig. 19), though they have not been the same when it comes to claims and reimbursement (see fig. 22).

Figure 22. **AVERAGE YEARLY GROWTH OF CLAIMS and REIMBURSEMENT BY RACE (2013-2018)**

Medicaid, CHIP, and Reimbursement Rate Setting at UIOs

Medicaid reimbursement at UIOs is heavily influenced by state policy and context. Although HRSA and CMS FQHCs may have certain reimbursable services available across state lines, other types of care such as telehealth or the use of cross-state providers are regulated at the state level. Furthermore, care provided to an IHS-eligible AI/AN patient at UIOs is reimbursed at the state FMAP rate, not 100% FMAP – unique among I/T/U providers.[lxii] Parity in 100% FMAP for services rendered by UIOs would save states money. Other policy items related to parity include the need to allow UIOs

[15] P-value = .05 for payments, using a two-sided Wilcoxon Rank-Sum Test for a small sample of non-parametric data.

to access to the Federal All-Inclusive Rate for Indian Health Care Providers (AIR) and negotiate other Medicaid benefits, like increased coverage.

FIGURE 23. REIMBURSEMENT RATES AT UIOS

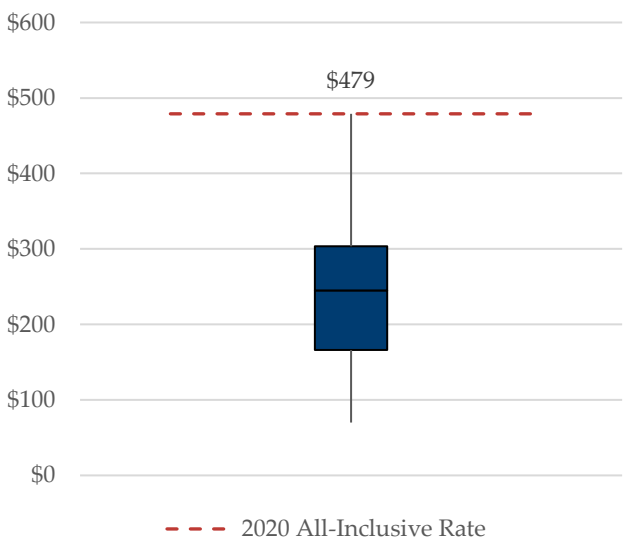

Fig. 24 represents the distribution of rates that UIOs are reimbursed at, instead of this AIR. However, although a minority of UIOs have obtained the AIR of $479 or close, the minimum rate NCUIH has on record is $70 per encounter. The bulk of programs skew closer to this minimum than they do the AIR, with 50% of UIOs falling in between $170 and $300 (see fig. 25). At present, UIO reimbursement rates average around $245 per encounter – just over half the current AIR.

The range in reimbursement rates means that – as a collective – UIOs are missing a large portion of their potential reimbursement. In fig. 25, each UIO has been mapped out separately in a clockwise circle, in order of their distance from the all-inclusive encounter rate. Clearly, the Urban Indian Health Program as a whole is missing a large amount of money per encounter – in the majority of locations more than $200 per encounter. Full parity for Urban programs would mean that all UIOs were able to obtain full levels of reimbursement on par with other parts of the ITU system – visuatlized in fig. 25 as perfect circle.

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Figure 24. "Missing Pieces of the Pie": Reimbursement at each UIO

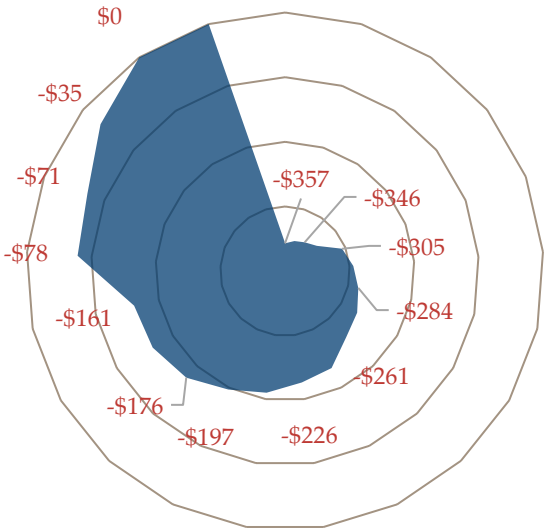
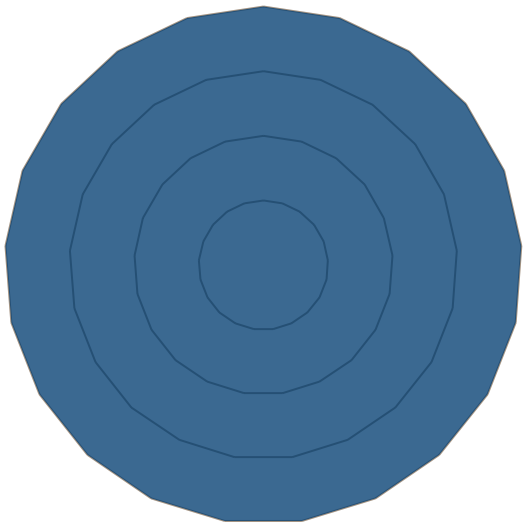


Figure 25. Urban Parity with the All-Inclusive Rate



Changes at HRSA Health Centers

Although only 11 of 40 UIOs are HRSA Health Centers, these 11 health centers make up a substantial portion of UIO patient population and third-party revenues. Comparing IHS's estimate of the overall UIO service population with the combined service populations of the 11 HRSA facilities (Table 2), it is clear these facilities make up over half the total UIO client population, and about 40% of the AI/AN client population. However, it should be noted that 13.3% of clients at UIO HRSA Health Centers are reported as other or unknown race in their medical records. Furthermore, HRSA and IHS definitions of "AI/AN" may not line-up depending on the source of the information and how IHS-eligibility is factored in.

Table 2

	Total Client Population	AI/AN Client Population
OUIHP Service Population	179,196	72,243
11 HRSA Health Centers	97,333	29,010
HRSA % of UIO population	54.3%	40.2%

Source: IHS UDS 2018 Report and HRSA UDS Data

As such, it is worth investigating HRSA facilities separately to understand their influence on national UIO insurance and billing trends. From 2015-2018 onwards, the

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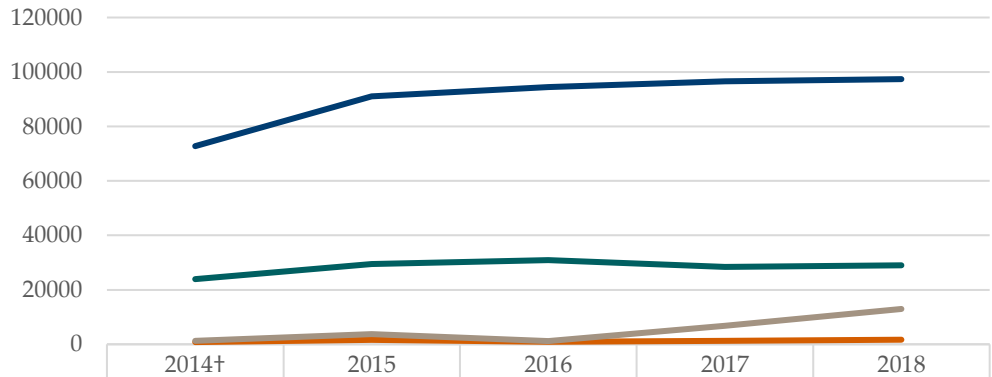
total patient population grew slightly by 7%, though the AI/AN patient population remained fairly stable (see fig. 26).[16]

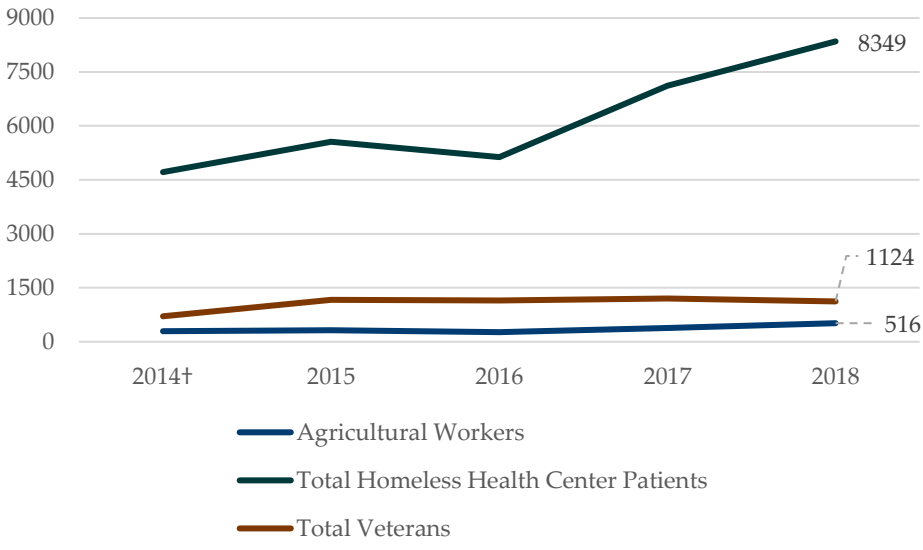
FIGURE 26. HRSA/UIO PATIENTS BY RACE



	2014†	2015	2016	2017	2018
Total Patients	72760	91022	94443	96566	97366
AI/AN Total	23936	29418	30917	28437	29010
More than one race	815	1661	920	1315	1682
Unreported/Refused	1284	3693	1184	6750	12980

Interestingly, the largest growth in racial category occurred in "unreported or refused" race – an overall growth of 246% over 4 years. Although initially a small percent of clients, clients of "other" or "unknown" race represented

FIGURE 27. TYPES OF HRSA HEALTH CENTER PATIENTS



[16] Though data is available between FY14-18, it should be noted that a jump in recorded patient volume between FY14 and FY15 was due to the inclusion of an additional facility, as one UIO transitioned from a look-alike to a HRSA Health Center.

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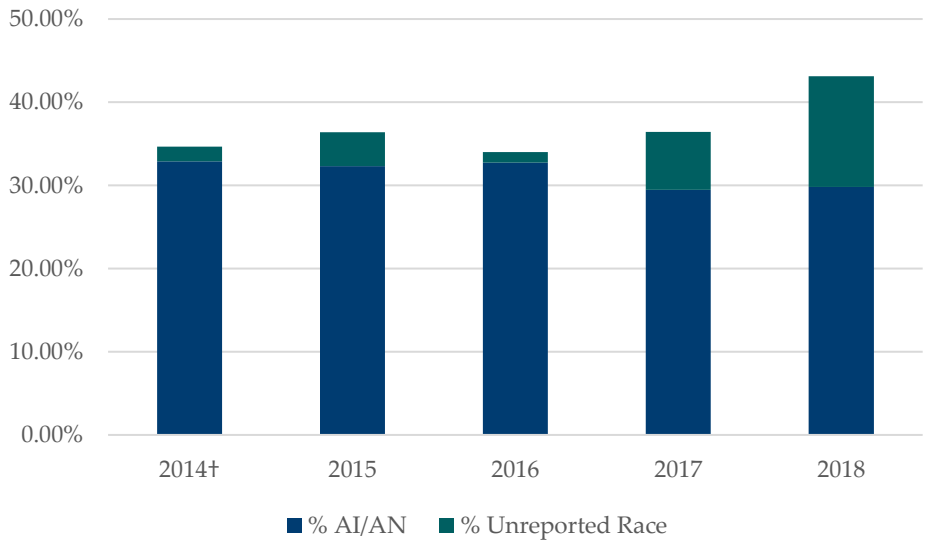
approximately 13.3% of those attending HRSA Health Center UIOs by 2018 (see fig. 28). Because the reason race was not recorded is unclear, it cannot be suggested how much this trend is driven by changes in policy, facilities, or even sociological changes. It is worth noting, however, that the volume of Homeless Health Center patients nearly doubled during this time period as well, with comparatively smaller and more stable veteran and agricultural worker patients (see fig. 27). If race is less frequently recorded for drop-in clients who do not receive routine care, it may be possible that the two trends are related. The same trend would be seen if facilities use tribal identification cards or other proof of IHS eligibility to record AI/AN race, yet patients experiencing homelessness were less likely to provide this documentation. Depending on whether this category represents "refusals" or people who may otherwise identify as AI/AN, there could be a false impression of a slight decrease in the percentage of AI/AN attendance at HRSA facilities (fig. 28). The increase of ~4000 homeless Health Center patients is still smaller than the growth of nearly 7000 clients with unreported race, however, indicating multiple factors are likely at play.

FIGURE 28. PERCENT OF HRSA CLIENTS BY RACE



When it comes to client income levels at UIO HRSA Health Centers, the profile of clients remained relatively stable until 2017 (see fig. 29). From 2014-2017, about half of HRSA users were under the federal poverty line (FPL), another quarter between 101-150% of FPL, and around 5% were >151% of the FPL. This meant that at least three-fourths of patients were known to be below 150% of the FPL, and between 10-20% of clients had unknown income status. However, there was a sharp increase in the number

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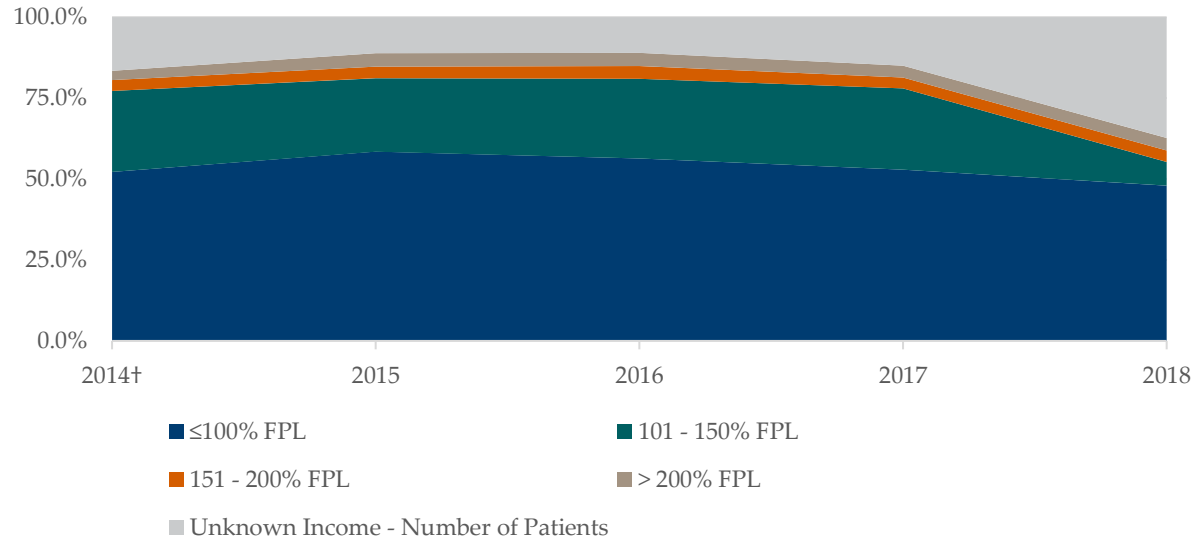
of clients with unknown income in 2018 – increasing to 37% of clients. This came almost entirely at the expense of those in the 101-150% of FPL bracket, who shrunk from 25% to 7% of clients in one year.

FIGURE 29. PERCENT OF HRSA CLIENTS BY INCOME LEVEL



These income profiles may color the enrollment profile of children (aged 0-17) and adults (18+) at UIO HRSA facilities over this time period (fig. 30 and 31, respectively). By 2018, children were most likely to be insured under regular Medicaid (79%), followed by no insurance at all (16%), and private insurance (4%). Insurance was much more common in adults, and was the largest group (41%), closely followed by Medicaid (40%), and small but sizable populations reliant on private insurance (10%) or Medicare (9%). Notably, 5% of the population was dual-eligible in Medicare and Medicaid, indicating more dual-eligible patients than the 4% relied on Medicare without Medicaid.

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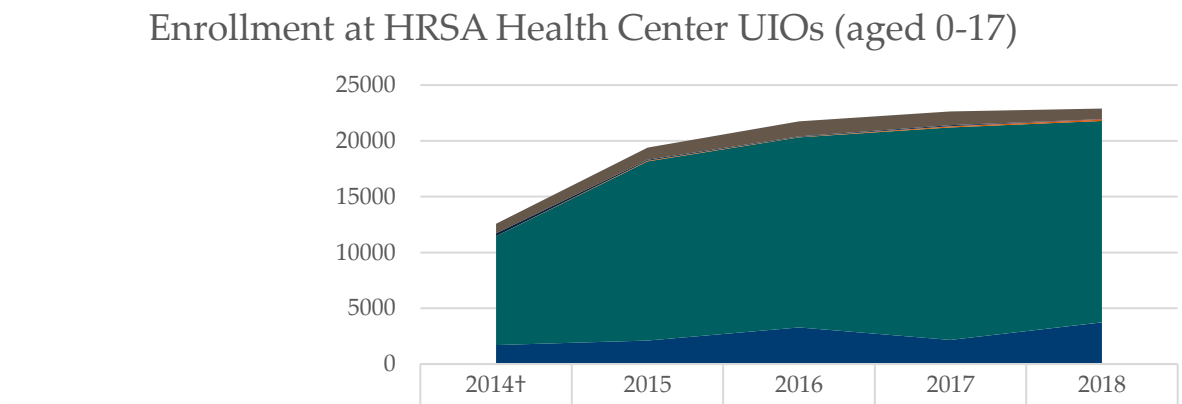
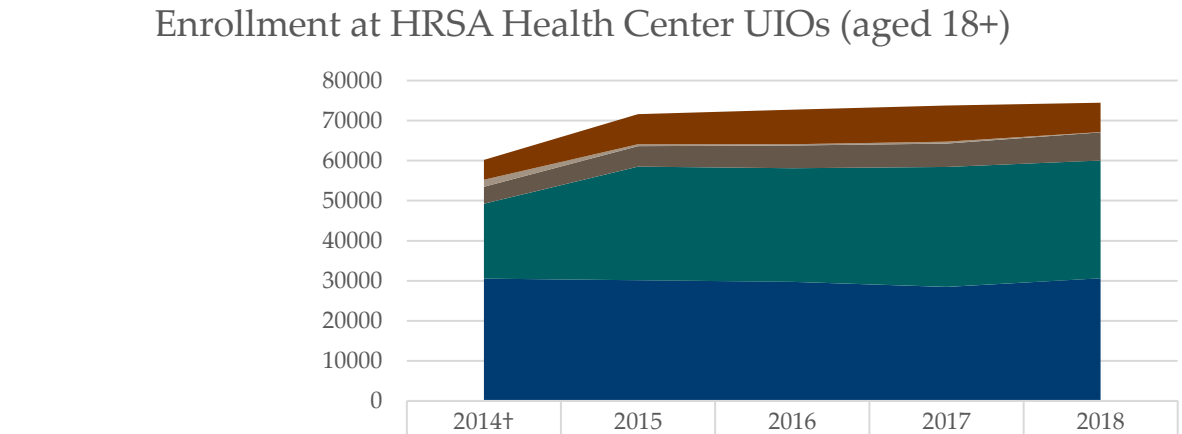
FIGURE 30



	2014†	2015	2016	2017	2018
Private Insurance	872	1094	1330	1244	940
Other Public Insurance (Non-CHIP)	243	72	74	80	2
Medicare (Inclusive of dually eligible and other Title XVIII beneficiaries)	3	1	1	23	56
CHIP Medicaid	6	69	7	94	113
Regular Medicaid (Title XIX)	9745	16058	17035	19032	18044
None/Uninsured	1705	2095	3287	2163	3739

FIGURE 31



	2014†	2015	2016	2017	2018
Private Insurance	4954	7570	8635	9068	7343
Other Public Insurance Non-CHIP	1759	444	281	426	58
Medicare (Inclusive of dually eligible and other Title XVIII beneficiaries)	4226	5074	5657	5846	7018
Regular Medicaid (Title XIX)	18735	28408	28409	29963	29408
None/Uninsured	30512	30134	29727	28485	30634

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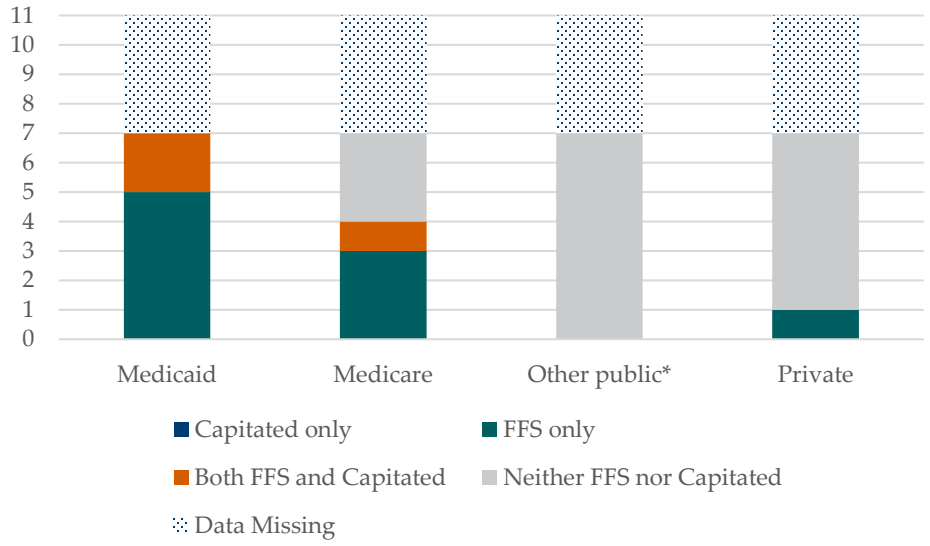
Although not complete, HRSA-UDS records also provide some insight into the manner of billing for Medicaid, Medicare, and private insurance. HRSA facilities report the member months for managed care payments per year, as well as participation in FFS billing (see fig. 32). Although HRSA facilities are subject to the demands of different non-profit finance models than other UIOs, results from these 11 may hint at underlying trends that the remaining 12 full-ambulatory facilities face as well.

FIGURE 32



In 2018, 5 facilities did not report their billing methods. But for the remaining 7, each facility billed Medicaid, with 5 facilities only billing FFS and 2 facilities billing both FFS and managed care. Four facilities reported not billing Medicare, though 3 billed FFS and another 1 billed managed care as well. One facility reported billing private insurers FFS, with 6 facilities not reporting income from private insurers. No facility billed only using managed care alone for any payer.

This represents a growth in utilization of FFS, managed care, and UDS reporting of each by facilities over the available time period. By 2018, use of FFS and capitation models for Medicaid had grown substantially at HRSA Health Center UIOs, and missing data had decreased (see fig. 33). While reporting increased during this time period, there were a consistent set of UIOs billing Medicare during this time period, without much growth in either capitation for FFS models' use (see fig. 34 and 35).

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FIGURE 33. MEDICAID

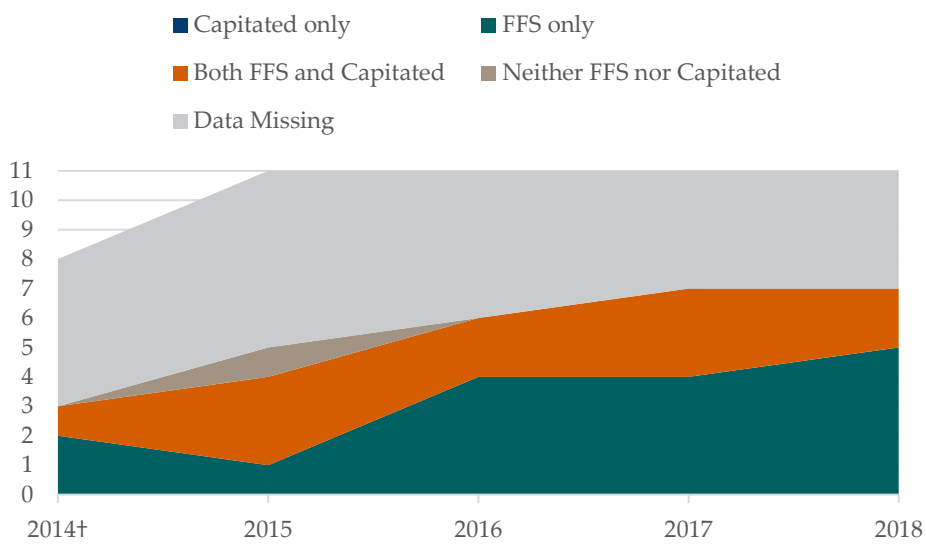


FIGURE 34. MEDICARE

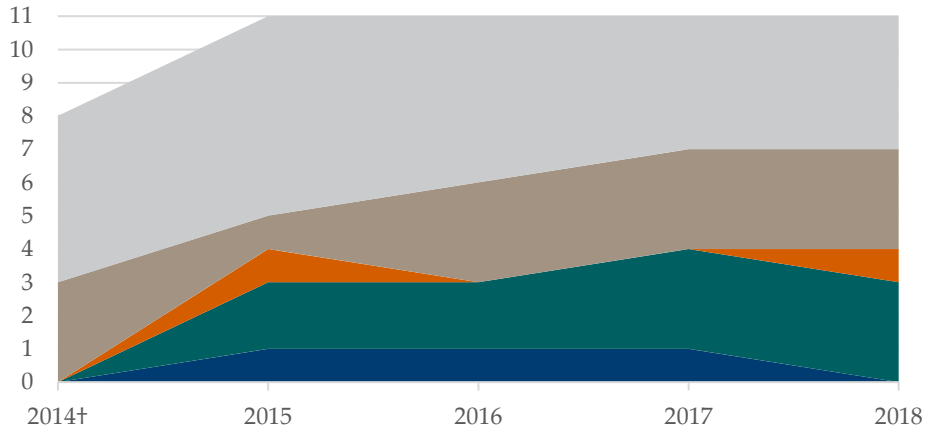
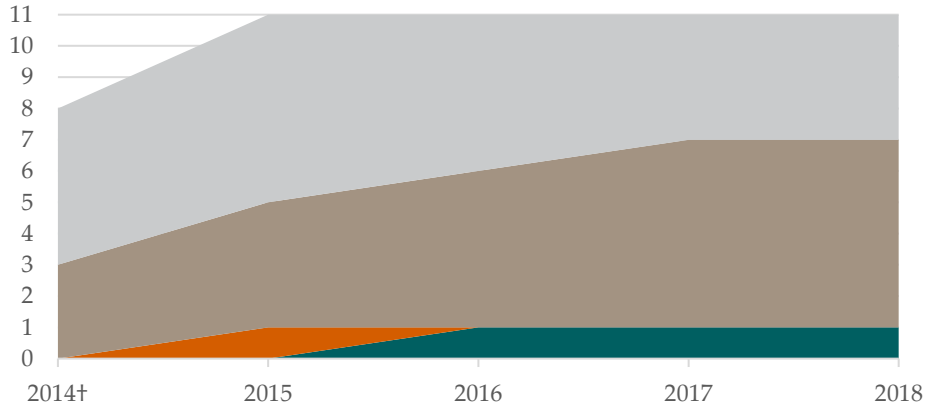


FIGURE 35. PRIVATE INSURANCE



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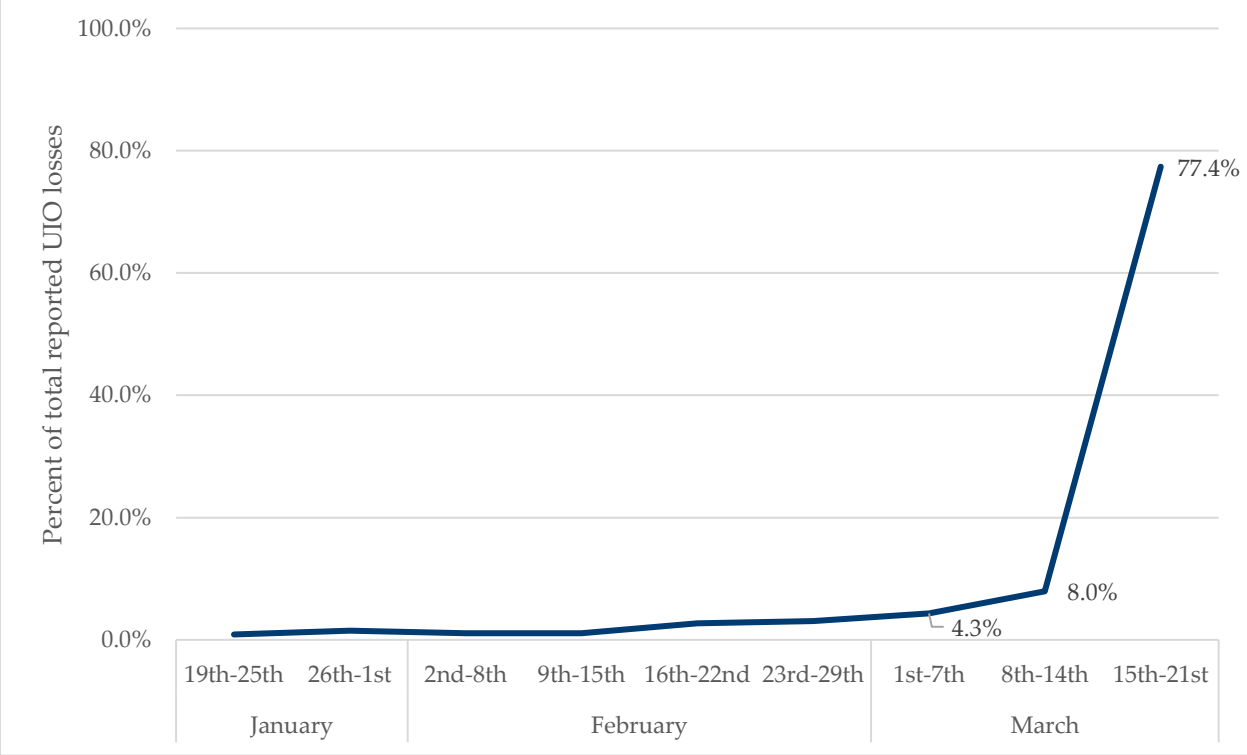
Part V. Third-Party Reimbursement in the Age of Coronavirus

Coronavirus Pandemic Response and Reimbursement Losses

Early work for this report suggested that by FY 2020, UIOs were projected to earn the largest amount of third-party revenue to date. However, as fear spread in early community-transmission areas where UIOs are located (such as the Northwest and San Francisco Bay Area), revenue losses due to cancelled appointments were apparent by January – two months prior to the declaration of a National Public Health Emergency. This has threatened UIOs' overall long-term capacity, particularly for programs servicing Medicare populations, due to the disproportionate risks these clients face should they enter a public space and become exposed to the virus.

FIGURE 36. REVENUE LOST DUE TO CANCELLATIONS, BY WEEK



While it is clear that revenue losses have been unprecedented and widespread, the precise impact to UIOs as a whole is still too early to calculate. Many respondents noted that the sudden acceleration of these losses – two UIOs reported no loss in one week and $25,000 in the next – has prevented their financial departments from capturing their losses in usual monthly or bimonthly reporting. Although most programs have reported losses, only 15 of 29 survey respondents (or about one-third of all UIOs) were able to quantify the problem and provide NCUIH with an estimate of

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their losses by March 21, 2020. Non-responses suggest that the burden of rapid financial reporting may underrepresent those UIOs whose cash flow has been most severely limited. As a result, all survey estimates of revenue loss should be taken as a very low estimate, and used in complement with other approaches.

Revenue losses due to cancellations were reported as early as January, with each week accounting for about one to three percent of the total amount that UIOs reported. However, the largest impacts were felt by mid-March, with the vast majority of UIOs reporting large and consistent losses by this time (see fig. 36). The 15 survey respondents who provided an estimate combined for a total loss of $3.3M. However, during the week that the survey was fielded, some UIOs that did not provide estimates on the survey forwarded NCUIH separate revenue loss estimates of between $700K and $1.6M during roughly the same time period. These estimates were combined with survey data to show a loss of $7.2M by March 21 with 18 UIOs reporting. When averaged out to all UIOs (with the assumption of equal effects for non-responding UIOs), NCUIH can show a minimum of $16.4M revenue losses between January 19 and March 21, 2020 across all UIOs.

TABLE 3. PROJECTED UIO LOSSES

Loss Estimate[lxiii]	Already Lost by Survey (March 21st)	Monthly loss rate	Minimum Loss by June 21st
	(in millions)		
Based on survey responses alone, extended to all UIOs	$16.4	$14.7	$ 60.5
Based on survey and public data (accounting for program type and billing capacity)		$ 12.9	$ 55.1

In reality, this figure was likely much higher and growing with increasing speed through April as more UIOs were affected by the spread of SARS-CoV-2. As such, survey estimates should be taken simply as the basis for projections of financial impact during early response only and it is unclear yet what the full impact will be. This depends on the length of the outbreak, monthly loss rate, and the extent to which policy

changes and supports are provided during this time (see table 2). By comparing losses from survey estimates with monthly projections, NCUIH estimates that UIOs will have lost a minimum of between $55.1 and $60.5 million in third-party reimbursement by June 21, 2020. This is in the range of the entire yearly UIH IHS budget line item.

Importantly, NCUIH expects that loss rates will increase from this minimum estimate because the survey was conducted before all stay-at-home orders were in effect. In time, the rate may plateau or marginally decrease as more UIOs set up testing and recoup losses via reimbursable telehealth. Critically, this estimate is NOT an estimate of the overall cost that UIOs are incurring. Instead, this is an estimate of amount that would usually be relied on to make ends meet, but are not available due to the nature of the pandemic. UIOs will still incur increased costs due to the need to pay employees, purchase novel equipment and supplies, and provide services.

Provider Relief

While UIOs are trying to transition more towards remote health service delivery mechanisms like telehealth, these services are not consistently reimbursed at the same level as in-person care. UIOs are experiencing millions in lost third-party reimbursement as a result. UIOs would benefit from the ability to access relief funds for the purpose of covering past or current COVID-19 healthcare expenses, and to compensate for shortfalls in third-party reimbursement dollars as a result of the pandemic. Because each tribe, tribal organization, and UIO's financial situation is unique, UIOs and their national Indian organization partners have been urging Congress to create a $1.7 billion relief fund, whereby Indian health programs can submit claims for relief funding based on their health care service needs or losses related to COVID-19.

Some Administrative Actions Taken

CMS has undertaken several steps to reduce the burden on health care facilities during the pandemic, including with respect to reimbursements. The information below represents **examples of some of the administrative actions** CMS has taken to assist health care facilities, including UIOs, in their preparation for and response to COVID-19.

Medicare

On April 15, 2020, CMS announced the Medicare program would "nearly double payment for certain lab tests that use high-throughput technologies to rapidly diagnose large numbers of [COVID-19] cases."[lxiv] In effect, the agency significantly increased the

reimbursement under Medicare in order to expand COVID-19 testing – particularly in hard-hit components of the health care sector, including long-term care and other facilities that see a high proportion of Medicare patients. This also confers a benefit to UIOs, particularly those operating facilities in high COVID-19 incidence areas and with a high proportion of patients enrolled in Medicare. For example, some UIOs have experienced significant numbers of patients presenting with COVID-19 symptoms since the beginning of the pandemic. By mid-May, 2020, one UIO with at least 1,500 distinct Medicare beneficiaries[lxv] in 2018 reported an approximately 13% positive COVID-19 test rate. The same facility collected nearly $1.4 million in Medicare billing in 2019, which was approximately 7% of their overall billing revenue. Thus, this facility could benefit from this change in Medicare policy.

In addition, CMS took steps to broaden coverage for telehealth services under the Medicare program to enable Medicare beneficiaries to receive a wider range of services that would not require traveling to a health care facility – thereby reducing the potential exposure of patients and practitioners to others who may have been exposed to the virus that causes COVID-19. Previously, telehealth was mainly available to rural areas and when the person receiving the service was located at a clinic, hospital, or certain other facilities. During the public health emergency, CMS used its 1135 waiver authority to expand Medicare telehealth benefits.[lxvi] The waiver enables the Medicare program to cover office, hospital, and other telehealth services from providers including doctors, nurse practitioners, clinical psychologists, clinical psychologists, and licensed clinical social workers beginning on March 6, 2020. The eligible services include common office visits, mental health counseling, and preventative screenings. This telehealth capacity builds on the previously-allowed virtual services under Medicare: virtual check-ins (short patient-initiated communications) and e-visits (utilizing an online patient portal). These types of virtual services have increased in need during the COVID-19 pandemic in an effort to reduce the risk of virus spread to practitioners, other patients, and, importantly, high risk individuals. The chart below provides a snapshot of the 1135 waiver and other changes to Medicare during the COVID-19 pandemic as of April 30, 2020. These telehealth flexibilities continue to evolve.

Medicare Telehealth Services: Existing Policy vs. COVID-19 Policy

On March 30, 2020, CMS released a new round of updates on the use of Telehealth during the COVID-19 National Public Health Emergency (PHE). Effective March 1, 2020 and for the duration of the PHE, Medicare will make payment for Telehealth services. The chart below highlights the differences and similarities between existing and temporary COVID-19 Telehealth rules. These temporary rules will expire when the Secretary of HHS declares the end of the public health emergency. The following information, developed by the American Society of Clinical Oncology (ASCO) for its members, is in reference to a specific list of Medicare Telehealth Services; for information on Telephone E&M, E-visits and remote check-ins, please see page 2.

	Policy Prior to COVID-19 Emergency	Temporary Change During COVID-19 Public Health Emergency
What services are eligible for telehealth?	Refer to Medicare's List of Telehealth Services. Examples include office visits (99201-99215), advance care planning (99497, 99498), and annual wellness visits (G0428, G0439)	The list of services has been expanded to home visits, inpatient visits, radiation treatment management, telephone E&M and others. See Medicare Telehealth Services for the complete list of eligible services.
Which patients are eligible?	Some services require an established relationship between the patient and provider	New or established patients; not limited to patients with or suspected of having COVID-19; HHS will not audit for prior patient/physician relationship
What are the geographic restrictions?	Patient must live in a rural area	All Medicare beneficiaries are eligible regardless of where they live
Where can the patient be located?	Patient must receive services at physician office or other qualifying facility (originating site)	May receive services at home or in a facility; originating site requirements are waived
How are levels of service selected?	In 2020, level of service is based on 3 components: history, exam and medical decision-making.	The level of service may be selected based on medical decision-making or total time spent on the E&M service. A medically appropriate history and patient-assisted examination should be performed
What is the cost sharing for the patient?	Beneficiary cost sharing applies	The HHS Office of the Inspector General (OIG) provides physicians the flexibility to waive or reduce cost-sharing for telehealth services; OIG will not subject physicians and other practitioners to OIG administrative sanctions when cost-sharing is reduced or waived. An OIG policy statement with further details is available here
Which communication platforms can be used for telehealth visits?	Must be real-time audio-visual communication through a HIPAA approved communication platform with vendors that will enter into HIPAA business associate agreements	Must be a real-time, audio-visual communication platform, with one exception. Telephone E&M visits, codes 99441-99443, may be audio only HIPAA requirements are waived temporarily; however, communication must NOT be public facing. Examples of what currently is and is not allowed below: Allowed Platforms: • Apple FaceTime • Facebook Messenger Video Chat • Google Hangouts Video • Skype Not Allowed: • Facebook Live • Twitch • TikTok
What is the payment for telehealth visits?	During the public health emergency, providers are instructed to bill Medicare based on their typical place of service, i.e. where the service would have been otherwise performed (office, outpatient hospital). The resulting payment will be equal to what you would have otherwise been paid	
How do I report these visits?	Place of service code: **(during the public health emergency, bill using your typical place of service code, with modifier 95 to signify a telehealth service)** Other Modifiers: GQ for services through an asynchronous telecommunications system	
Who is a Qualified Provider for this service?	Physicians, nurse practitioners, physician assistants, certified nurse midwives, certified nurse anesthetists, licensed clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals, physical therapists, occupational therapists, and speech language pathologists within their scope of practice and consistent with Medicare benefit rules that apply to all services	

Answers given within this document are based on Medicare & Medicaid rule CMS-1744-IFC, and were last updated on March 30, 2020. Coronavirus Waivers & Flexibilities, and the HHS Telehealth website and were last updated on April 23, 2020. Medicare and Medicaid rule CMS-55341 and were updated on April 30, 2020.

In addition, CMS informed Medicare Advantage Organizations and Part D Sponsors via a memorandum of the flexibilities they may utilize during the COVID-19 pandemic. For example, CMS provided that Medicare Advantage Organizations "may waive or reduce enrollee cost-sharing for beneficiaries enrolled in their Medicare Advantage plans impacted by the outbreak."[lxvii] In addition, they have some flexibility to expand telehealth coverage during the pandemic – depending on what each organization decides to do.[lxviii]

Medicaid

Physical distancing and reductions in individual travel during the COVID-19 pandemic helps to limit community spread of the virus, many states have expanded telehealth in their Medicaid programs.

Given that each state has different Medicaid rules governing telehealth,[lxix] on April 23, 2020, CMS released a toolkit for states to accelerate the use of telehealth in Medicaid and CHIP during the COVID-19 pandemic.[lxx] The CMS toolkit seeks to "help states identify policies which may impede the rapid deployment of telehealth when providing care."[lxxi] CMS has provided for considerable flexibility in the construct of telehealth coverage, including with respect to qualifying technology/communication methods, as well as the broad flexibilities states enjoy with respect to eligibility, benefits, and payment policies.[lxxii]

States use the Appendix K process to broaden or otherwise change their Medicaid programs in response to COVID-19.[17] For example, Arizona's Appendix K expands locations at which services can be provided.[lxxiii] The Center for Connected Health Policy published a living document entitled *Quick Glance State Telehealth Actions in Response to COVID-19* that captures some of the key changes related to telehealth each state has made in responding to the pandemic.[lxxiv] Sample state activities in addition to Appendices K include Arizona's Executive Order to expand telemedicine coverage[lxxv] and Colorado's Temporary Expansion of Telehealth Services.[lxxvi]

Although these are only some examples of administrative actions to help providers during the COVID-19 pandemic, the success of these and other policy responses will dictate the extent to which UIOs are able to weather projected revenue losses. Future data collection will enable comparisons between pre- and post-COVID-19 reimbursement trends and conditions.

[17] A state may use standalone appendices during emergency situations to request amendments to its approved waiver or multiple approved waivers.

Part VI. Recommendations for Future Work

Fielding Billing Questions and Qualitative Questions

Although a shift to secondary data was necessary due to the effects of the coronavirus pandemic, its effect on reimbursement forms a crucial moment where NCUIH and its partners need to understand rapid changes in the billing landscape. In some ways, the shift to secondary data has helped determine where questions about the UIO program would be best directed, while the ongoing pandemic has focused directors on very specific questions about changes to longstanding reimbursement policy (for instance, telehealth).

While immediate implementation of a quantitative survey may not be feasible, this work has provided the backbone for more targeted questions with the right types of UIOs. For example, using reimbursement data, NCUIH is now able to identify facilities with a high proportion of Medicare reimbursement constituting their overall service revenue. There is an improved accounting of where, for instance, Medicare and Medicaid changes to telehealth reimbursement policy due to the coronavirus may be having an effect, allowing for better analysis in future years.

In general, there is an enhanced ability to sort facilities based on their financial information and facility type, providing NCUIH with a quicker infrastructure to direct qualitative questions about the impacts of reimbursement policy changes in the time of coronavirus response. This will benefit UIOs as a whole.

Supporting Medicare Utilization for AI/ANs at UIOs

It seems like Medicare Utilization of urban AI/ANs may be a particularly under-looked – and increasingly important - aspect of third party reimbursement. Apart from the effects of coronavirus on this population and their services in the coming year, there is likely to be continual growth in this client population. Although disparities persist, the life expectancy of American Indian elders is 22 years longer than it was 80 years ago. The number of AI/ANs aged 65 or older increased by 40.5 percent between 2000-2010, more than twice the growth rate of the general elder population.[lxxvii]

As a result, it will be increasingly important to understand how UIOs successfully serve Medicare clients, and support them in doing so. This should take a two-part approach, both a) enhancing the visibility of UIOs and supporting greater community engagements by Non-UIO stakeholders in the Medicare claims process and b) supporting the development and implementation of culturally-competent technical assistance, trainings, tools, and guides to be used by UIOs and Urban AI/ANs directly.

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More outreach on the dual-eligible programs (where Medicaid pays Part B premiums for low-income individuals) is needed.

Establish Routine Collection of UIO Facility-Level Claims

A more regular collection of UIO reimbursement data can be accomplished through a variety of methods.

Survey Approaches

First, a survey of UIOs, with detailed questions on both claims and reimbursement amounts supplemented by qualitative questions to provide context and input from the respondent. Using the survey created for this project period, NCUIH is well-poised to pursue an Office of Management and Budget (OMB) clearance package to field this survey to all 41 UIOs. The main limitation would be administrative burden and its effect on survey response rates – particularly given a protracted coronavirus pandemic and what is likely to be a lengthy recovery time. On one hand, NCUIH surveys have provided quality responses from facilities in the past - around 70% based on prior work, though incentives to compensate for time required to complete the survey improves response rates. On the other hand, there are a number of drawbacks:

1. The extent to which program billing trends can be established is fully-dependent on the regularity of the survey and participation from year-to-year. Low survey participation due to pressing yet unforeseen issues (such as budgetary changes, including lapses in appropriations) may inherently limit response rates.
2. Surveys may also be a burden to the respondent, influencing response rates and causing bias in the sample. This can cause a non-response bias based on billing capacity. Many UIOs operate with very limited billing departments, and some survey respondents leave questions blank if the level of granularity required will take too much staff time. Unfortunately, this has the potential to undercount those who experience the most challenges establishing consistent billing practices.
3. A regular "all-UIO" survey would need to go through an OMB clearance package due to the Paperwork Reduction Act,[lxxviii] lengthening the amount of time and effort required to collect this dataset. Otherwise, only nine entities can be surveyed using one tool.

Secondary Data Collection

Alternatively, UIO facility-level data may be collected though secondary collection of preexisting administrative or research files. This approach bolsters the regularity of billing data collection and comparability across time periods, and can be pursued via two different methods that come with their own considerations.

1. **PRE-EXISTING ADMINISTRATIVE OR RESEARCH FILES.**

a. Existing reimbursement data on Medicaid, CHIP, and Medicare programs may be available via pre-existing CMS data warehouses, such as the Chronic Conditions Data Warehouse (CCW). A data use agreement as part of this project would make ongoing collection efforts more sustainable than through survey data. This also frees up survey efforts within the nine allowable entities under the Paperwork Reduction Act[lxxix] to focus more on priority facility and service types.
b. As shown in this project, this approach still requires some baseline data collection (e.g., UIO CCNs), and data quality in these datasets come with their own limitations. The ability to pull comparable data for each payer over the same time period, continuously, is unlikely, although "snapshot" years or case states may be more possible. Furthermore, racial misclassification will be an issue with enrollment and beneficiary data.

2. **DATA USE AGREEMENTS.**
   a. Another approach is to execute data use agreements directly between NCUIH and individual UIOs, to provide routine sharing and collection of required administrative reports[lxxx] when they are compiled by billing and accounting departments. An advantage is the level of granularity to each type of program, and the ability to compare claimed and reimbursed amounts over time within each state. However, potential limitations are based on buy-in from each organization. Each of the 41 organizations would need to both 1) agree to share their data and 2) dedicate billing and coding staff time to make this data available.

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Endnotes

[i] "Determination That a Public Health Emergency Exists," U.S. Department of Health and Human Services, January 31, 2020, https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx.

[ii] 25 U.S.C. § 1602(1).

[iii] The trust responsibility to Indians has been affirmed by: *United States v. Jicarilla Apache Nation*, 564 U.S. 162, 176 (2011); *United States v. Navajo Nation*, 537 U.S. 488, 506 (2003); *United States v. Mitchell*, 463 U.S. 206, 225 (1983) (determining that there is "the undisputed existence of a general trust relationship between the United States and the Indian people"); *Board of County Commissioners of Creek County v. Seber*, 318 U.S. 705, 715 (1943) (stating that "the United States assumed the duty of furnishing . . . protection [to Indian tribes] and with it the authority to do all that was required to perform that obligation "); *United States v. Kagama*, 118 U.S. 375 (1886) (stating that the government has a duty to "protect" Indians); *Cherokee Nation v. Georgia*, 30 U.S, 1 (1831) (describing Indian Tribes as "domestic dependent nations" whose relationship with the United States "resembles that of a ward to his guardian.").

[iv] The trust responsibility duty to provide health care has been affirmed by: the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1601 as amended by the Section 10221 of the Patient Protection and Affordable Care Act, P.L. 111-148 (Mar. 23, 2010) ("Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians: to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy") and ("A major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States."); *White v. Califano*, 437 F. Supp. 542, 555 (D.S.D. 1977) aff'd *White v. Califano*, 581 F.2d, 697, 698 (8th Cir. 1978) (The Snyder Act of 1921 and the IHCIA create a "legal responsibility to provide health care to Indians"); The Snyder Act of 1921 at 25 U.S.C . § 13 (instructing federal agencies to "direct, supervise, and expend such moneys as Congress may from time to time appropriate, for" among other things, "relief of distress and conservation of health" of Indians throughout the United States).

[v] "Fact Sheet: Basis for Health Services," Indian Health Service, published January 2015, https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/BasisforHealthServices.pdf.

[vi] 25 U.S.C. § 1603 (13).

[vii] 25 U.S.C. § 1603 (28).

[viii] 25 U.S.C. § 1603 (27).

[ix] See 25 U.S.C. Subchapter IV—Health Services for Urban Indians

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[x]Tina Norris, Paula L. Vines, and Elizabeth M. Hoeffel, "The American Indian and Alaska Native Population," U.S. Census Bureau, January 2012, https://www.census.gov/history/pdf/c2010br-10.pdf.

[xi] This percentage can be determined by comparing the amount of funding for the Urban Indian Health line item of the Indian Health Service compared with the total amount of funding appropriate to the Indian Health Service in any given fiscal year. See also Ralph Forquera, Issue Brief: Urban Indian Health, (KFF, November 2001), citing Indian Health Service, Health Service Appropriation History, 1983–1999, March 12, 1999; Indian Health Service, History of Appropriations 1911–1982, January 9, 1982; FY 2001 Approved I.H.S. Budget.

[xii] 25 U.S.C. § 1603(29).

[xiii] "FY 2017 Indian Health Service Level of Need Funded (LNF) Calculation," Indian Health Service, Last modified February 14, 2018, https://www.ihs.gov/sites/ihcif/themes/responsive2017/display_objects/documents/2018/FY_2017_LevelofNeedFunded_(LNF)_Table.pdf.

[xiv] OUIHP Resource and Patient Management System Uniform Data System (UDS) Summary Report Final – Calendar Year 2017," Indian Health Service, December 13, 2018, https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/2017_UIHP_UDS_Summary_Report_Final.pdf.

[xv] Section 1905(l)(2)(B) of the Social Security Act at 42 U.S.C. § 1396d(l)(2)(B).

[xvi] A HRSA look-alike meets the requirements of the Health Center Program, but does not receive Health Center Program funding. *See* 42 U.S.C. §254b. Regulations implementing this law are at 42 CFR 51c and 42 CFR 56.201 – 56.604.

[xvii] "Health Center Program Terms and Definitions," Health Resources and Services Administration, accessed July 10, 2020, https://www.hrsa.gov/sites/default/files/grants/apply/assistance/Buckets/definitions.pdf.

[xviii] Section 330(k)(3)(I)(ii) of the Public Health Service Act; 42 CFR 51c.303(j) and 42 CFR 56.303(j); and 45 CFR 75.342(a) and (b).

[xix] Title V UIOs are eligible entities for the 340B Drug Pricing Program. See "Tribal and Urban Indian Health Centers," Health Resources and Services Administration, last modified, May 2018, https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/tribal-urban-indian/index.html.

[xx] Omnibus Budget Reconciliation Acts (OBRA) of 1989, 1990, and 1993, amended section 1905 of the Social Security Act (SSA). 1905(l)(2)(B) defines FQHCs to include an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93–638 at 25 U.S.C. § 5321 et seq.) or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act (25 U.S.C. § 1651 et seq.) for the provision of primary health services.

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[xxi] Section 330 of the Public Health Service Act (42 U.S.C. § 254b) and Health Center Program regulations at 42 CFR 51c and 42 CFR 56.201 – 56.604 govern the HRSA FQHC programmatic requirements. Per the Center for Medicare and Medicaid Services (CMS) Division of Tribal Affairs, Tribal Health Programs and UIOs enrolled in Medicaid do not need to comply with HRSA FQHC guidelines.

[xxii] "Frequently Asked Questions (FAQs): Federal Funding for Services 'Received Through' an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives (SHO #16-002)," Centers for Medicaid and Medicaid Services, Center for Medicaid and Chip Services, January 18, 2017, https://www.tribalselfgov.org/wp-content/uploads/2017/02/01-faq11817.pdf.

[xxiii] "Frequently Asked Questions (FAQs): Federal Funding for Services 'Received Through' an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives (SHO #16-002)," Centers for Medicaid and Medicaid Services, Center for Medicaid and Chip Services, January 18, 2017, https://www.tribalselfgov.org/wp-content/uploads/2017/02/01-faq11817.pdf.

[xxiv] "Oklahoma State Plan Amendment No. 17-05 Transmittal and Notice of Approval of State Plan Material," Centers for Medicare and Medicaid Services, March 20, 2018, https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OK/OK-17-05.pdf.

[xxv] "Qualified Health Plan Certification Information and Guidance: Welcome to the Qualified Health Plan Website," Centers for Medicare and Medicaid Services, accessed July 10, 2010, https://www.qhpcertification.cms.gov/s/QHP.

[xxvi] "Overview of the Model QHP Addendum for Indian Health Care Providers", Centers for Medicare and Medicaid Services, April 4, 2013, https://board.coveredca.com/meetings/2016/4-07/Attachment%2012%20Addendum%20for%20Indian%20Health%20Care%20Providers.pdf.

[xxvii] "Definition of Essential Community Providers (ECPs) in Marketplaces" Kaiser Family Foundation, accessed July 10, 2020, https://www.kff.org/other/state-indicator/definition-of-essential-community-providers-ecps-in-marketplaces/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[xxviii] "Rolling Draft Plan Year 2022 ECP List," Centers for Medicaid and Medicare Services, December 4, 2019, https://data.healthcare.gov/dataset/Rolling-Draft-Plan-Year-2022-ECP-List/ecf3-gujb.

[xxix] "Essential Community Provider Petition for the 2022 Plan Year," Centers for Medicare and Medicaid Services, accessed July 09, 2020, https://data.healthcare.gov/cciio/ecp_petition.

[xxx] UIOs are an eligible entity to apply for the Children's Health Insurance Program (CHIP) American Indian and Alaska Native grants. For example, NATIVE HEALTH in Phoenix, Arizona was one of the 2019 grantees. Other UIOs have also received CHIP grant funding. For more information, see www.insurekidsnow.gov.

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[xxxi] For example, the Substance Abuse and Mental Health Services Administration Funding Opportunity Announcement (FOA) No. TI-20-011 for Fiscal Year 2020 Tribal Opioid Response Grants posted on March 3, 2020 announced an anticipated total available funding amount of $50,000,000. Applicants were required to either be a federally recognized American Indian or Alaska Native tribe or tribal organization. Tribes and tribal organizations could apply individually, as a consortia, or in partnership with a UIO. However, UIOs were ineligible to be the legal applicants and apply for awards individually or as a consortia with other UIOs.

[xxxii] 42 C.F.R. § 136.61.

[xxxiii] IHS; Contract Health Services, 55 Fed. Reg. 4606–01, 4607 (Feb. 9, 1990).

[xxxiv] Patient Protection and Affordable Care Act, § 2901(b), Pub. L. No. 111–148, 124 Stat. 333 (2010) (codified at 25 U.S.C. § 1623(b)).

[xxxv] "UDS Summary Report Final – Calendar Year 2018," Indian Health Service, May 4, 2020, https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/2018_UIO_UDS_Summary_Report_Final.pdf.

[xxxvi] "EXHIBIT 30. Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group," Medicaid and CHIP Payment and Access Commission, December 2019, https://www.macpac.gov/publication/percentage-of-medicaid-enrollees-in-managed-care-by-state-and-eligibility-group/.

[xxxvii] "EXHIBIT 17. Total Medicaid Benefit Spending by State and Category," Medicaid and CHIP Payment and Access Commission, December 2019, https://www.macpac.gov/publication/total-medicaid-benefit-spending-by-state-and-category/.

[xxxviii] Section 1902(a)(30)(A) of the Social Security Act.

[xxxix] "Fee-for-Service HIE Policy: The Fee-for-Service Model," Centers for Medicare and Medicaid Services, accessed July 10, 2020, https://www.medicaid.gov/medicaid/data-systems/health-information-exchange/fee-for-service-hie-policy/index.html.

[xl] "June 2013 Report to the Congress on Medicaid and CHIP (Chapter 2)", Medicaid and CHIP Payment and Access Commission, June 2013, https://www.macpac.gov/publication/report-to-the-congress-on-medicaid-and-chip-613/.

[xli] A final rule issued in 2016 codified many Indian managed care protections, including those in section 1932(h) of the Social Security Act, as added by section 5006 of ARRA. See "CMCS Information Bulletin: Indian Provisions in the Final Medicaid and Children's Health Insurance Program Managed Care Regulations," Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services," December 14, 2016, https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib121416.pdf.

[xlii] "SMDL # 10-001 RE: ARRA Protections for Indians in Medicaid and CHIP," Centers for Medicare & Medicaid Services, January 22, 2010, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10001.pdf.

[xliii] 42 C.F.R. § 438.

[xliv] "CMCS Information Bulletin [CIB]: Indian Provisions in the Final Medicaid and Children's Health Insurance Program Managed Care Regulations", Centers for Medicare and Medicaid Services, December 14, 2016, https://www.medicaid.gov/federal-policy-guidance/downloads/cib121416.pdf

[xlv] There are multiple rates that are billed by encounter and considered all-inclusive rates (Medicare FQHC PPS rate, Indian Health Service rate, FQHC rates), and no type of FQHC inherently gets one over the other because it will depend on what is available in each state (e.g. Alternative Payment Methodologies, waivers, etc.) and which rate a program chooses. Additionally, given the complexity of cost-sharing charges and structures, including deductibles, copayments, coinsurance, and fee schedules (e.g. the National Health Service Corps Sliding Fee Discount Program), these topics are beyond the scope of this project.

[xlvi] Section 1902(bb)(6) of the Social Security Act.

[xlvii] "SHO # 16-006 RE: FQHC and RHC Supplemental Payment Requirements and FQHC, RHC, and FBC Network Sufficiency under Medicaid and CHIP Managed Care," Centers for Medicare & Medicaid Services, April 26, 2016, https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/SMD16006.pdf.

[xlviii] "CHIP: Financing," Centers for Medicare & Medicaid Services, accessed July 10, 2020, https://www.medicaid.gov/chip/financing/index.html.

[xlix] "CHIP Managed Care," Centers for Medicare & Medicaid Services, accessed July 10, 2020, https://www.medicaid.gov/chip/chip-managed-care/index.html.

[l] "Medicare Program - General Information," Centers for Medicare & Medicaid Services, last modified November 13, 2019, https://www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/index.

[li] Section 10501(i)(3)(A) of Pub. L. 111–148 and Pub. L. 111–152.

[lii] Section 1834(o) of the Social Security Act.

[liii] "Medicare Program; Prospective Payment System for Federally Qualified Health Centers; Changes to Contracting Policies for Rural Health Clinics; and Changes to Clinical Laboratory Improvement Amendments of 1988 Enforcement Actions for Proficiency Testing Referral, Centers for Medicare & Medicaid Services, May 2, 2014, https://www.govinfo.gov/content/pkg/FR-2014-05-02/pdf/2014-09908.pdf.

[liv] Chronic Conditions Date Warehouse: Data Dictionaries" Centers for Medicare and Medicaid Services, July 10, 2020, https://www2.ccwdata.org/web/guest/data-dictionaries .

[lv] "NNPES NPI Registry: Search NPI Records", Centers for Medicare and Medicaid Services, accessed July 10, 2020, https://npiregistry.cms.hhs.gov/registry/?.

[lvi] The RTI race code was not used, given that its method of correction largely involves reclassification of "Hispanic" last names. Although this may improve Hispanic misclassification, there is little evidence it does much to correct AI/AN data quality. Furthermore, there is the potential for this "correction" to actually "unclassify" certain Urban Natives, given that Hispanic heritage and residence in cities contribute to misclassification. See:

- Olga F. Jarrin et al. "Validity of Race and Ethnic Codes in Administrative Data Compared with Gold Standard Self-Reported Race Collected During Routine Home Health Care Visits." *Medical Care* 58, no. 1 (2020): e1-e8, doi: https://doi.org/10.1097/mlr.0000000000001216;
- Haozous, Emily A., et al.. "Blood Politics, Ethnic Identity, and Racial Misclassification among American Indians and Alaska Natives." *Journal of Environmental and Public Health* 2014 (2014): 1–9. https://doi.org/10.1155/2014/321604;
- Olga F. Jarrin, Abner Nyandege, Irina Grafova, "Patterns of Racial and Ethnic Misclassification Errors in Medicine Administrative Data" Academy Health, accessed July 10, 2020, https://academyhealth.confex.com/academyhealth/2019arm/meetingapp.cgi/Paper/34316.

[lvii] For a full explanation of required reporting items in FY2018, see "Uniform Data System: Reporting Instructions for the 2018 Health Center Data," Health Resources and Services Administration, June 1, 2018, https://bphc.hrsa.gov/sites/default/files/bphc/datareporting/reporting/2018-uds-reporting-manual.pdf.

[lviii] At time of writing, this was available for years 2014-2018 inclusive. See "Freedom of Information Act: Electronic Reading Room," Health Resources and Services Administration, accessed July 10, 2020, https://www.hrsa.gov/foia/electronic-reading.html.

[lix] "Qualified Health Plan Certification: Information and Guidance: Essential Community Providers and Network Adequacy," Centers for Medicare and Medicaid Services, accessed July 10, 2020, https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy.

[lx] Jessica Bylander, "Meeting the Needs of Aging Native Americans, Health Affairs," March 8, 2019, https://www.healthaffairs.org/do/10.1377/hblog20180305.701858/full/.

[lxi] UIOs have the option to use Novitas Solutions as their MAC. Novitas has IHS expertise. More information can be found at https://www.novitas-solutions.com/webcenter/portal/IndianHealthServiceIHS_JH.

[lxii] For more information on 100% FMAP and best practices regarding UIOs, see "Best Practices Guide for Urban Indian Organizations and Federal Partners," Centers for Medicare and Medicaid Services, (publication forthcoming).

[lxiii] Minimum estimates depend on how missing data is treated – if survey data alone is used it may overemphasize the effect of large facilities, and if public data projections are used it may artificially suppress some programs.

[lxiv] "CMS Increases Medicare Payment for High-Production Coronavirus Lab Tests," Centers for Medicare & Medicaid Services, Apr. 15, 2020, https://www.cms.gov/newsroom/press-releases/cms-increases-medicare-payment-high-production-coronavirus-lab-tests-0.

[lxv] According to a large undercount using CCW data when compared to yearly reports.

[lxvi] COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers," Centers for Medicare and Medicaid, June 25, 2020, https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf.

[lxvii] "Letter to All Medicare Advantage Organizations, Part D Sponsors, and Medicare-Medicaid Plans: Medicare Advantage Organizations," Centers for Medicare & Medicaid Services, March 10, 2020, https://www.cms.gov/files/document/hpms-memo-covid-information-plans.pdf.

[lxviii] "Medicare Telehealth Services: Existing Policy vs. COVID-19 Policy," American Society of Clinical Oncology, last modified March 30, 2020, https://www.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/2020-Telehealth-Quick-Reference-Guide-Medicare.pdf.

[lxix] Historically, very few UIOs have been able to sustain telehealth programs because of high operating costs and low opportunities for reimbursements, complicated by the state-by-state variability in Medicaid's treatment of telehealth. NCUIH has conducted a more in depth analysis of telehealth at UIOs, *see Policy Considerations for the Implementation of Telehealth at Urban Indian Organizations* (publication forthcoming pending external review).

[lxx] "State Medicaid & CHIP Telehealth Toolkit," Centers for Medicare and Medicaid Services, accessed July 10, 2020, https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf.

[lxxi] "Trump Administration Releases COVID-19 Telehealth Toolkit to Accelerate State Use of Telehealth in Medicaid and CHIP," Centers for Medicare & Medicaid Services, Apr. 23, 2020, https://www.cms.gov/newsroom/press-releases/trump-administration-releases-covid-19-telehealth-toolkit-accelerate-state-use-telehealth-medicaid.

[lxxii] "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies" Centers for Medicare & Medicaid Services, last modified June 30, 2020, https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.

[lxxiii] "Appendix K: Emergency Preparedness and Response and COVID-19 Addendum," Centers for Medicare and Medicaid, accessed July 10, 2020, https://www.medicaid.gov/state-resource-center/downloads/az-appendix-k-appvl.pdf.

[lxxiv] "Quick Glance State Telehealth Actions in Response to COVID-19," Center for Connected Health Policy, last edited May 13, 2020, https://www.cchpca.org/sites/default/files/2020-05/STATE%20TELEHEALTH%20ACTIONS%20IN%20RESPONSE%20TO%20COVID%20OVERVIEW%205.5.2020_0.pdf.

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[lxxv] "Governor Ducey Expands Telemedicine Coverage for Arizonans," Arizona Office of the Governor Doug Ducey, March 24, 2020, https://azgovernor.gov/governor/news/2020/03/governor-ducey-expands-telemedicine-coverage-arizonans.

[lxxvi] "Colorado Department of Health Care Policy & Financing: Letter to Providers," Colorado Department of Health Care Policy and Financing, accessed July 10, 2020, https://www.cchpca.org/sites/default/files/2020-03/Colorado%20Mandate%20including%20PT%20%28002%29.pdf.

[lxxvii] Jessica Bylander, "Meeting the Needs of Aging Native Americans, Health Affairs," March 8, 2019, https://www.healthaffairs.org/do/10.1377/hblog20180305.701858/full/.

[lxxviii] 44 U.S.C. § 3501 et seq. (1980).

[lxxix] 44 U.S.C. chapter 35; *see* 5 CFR Part 1320.

[lxxx] This would require careful consideration as to which reports would be best, weighing factors such as the associated administrative burden and compliance with health information privacy laws.