# INSTRUCTIONS FOR MEDI-CAL INDIAN HEALTH SERVICES/MEMORANDUM OF AGREEMENT (IHS/MOA) 638 CLINIC AND TRIBAL FEDERALLY QUALIFIED HEALTH CENTERS (TRIBAL-FQHC) RECONCILIATION REQUEST

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# INSTRUCTIONS FOR MEDI-CAL INDIAN HEALTH SERVICES/MEMORANDUM OF AGREEMENT (IHS/MOA) 638 CLINIC AND TRIBAL FEDERALLY QUALIFIED HEALTH CENTERS (TRIBAL-FQHC) RECONCILIATION REQUEST

**Please read all instructions carefully before completing the form.**

42 CFR section 438.14, Welfare and Institutions Code, and CCR Title 22, Chapter 5.5 authorize IHS-MOA and Tribal FQHC providers to receive payment for providing covered services to Medi-Cal eligible individuals who are members of a federally recognized Indian tribe under a Memorandum of Agreement (MOA). The MOA rate covers 100 percent of the IHS provider's reasonable costs for providing services to Medi-Cal beneficiaries.

For beneficiaries who participate in Medi-Cal and are enrolled in Medicare, the Department of Health Care Services (DHCS) pays IHS-MOA and Tribal FQHC providers a supplemental payment, commonly referred to as the wrap payment, which is equal to the difference between visits reimbursed at the federal All Inclusive Rate (AIR) and the amount received by third-party payers. DHCS pays the supplemental payment in two stages – an interim payment, referred to by DHCS as a differential rate, is paid on a per visit basis each time the IHS-MOA or Tribal FQHC provider files a claim, and, if necessary, a final payment once the reconciliation process is complete. If the amount of Medi-Cal Program interim payments and third party payments received by the IHS-MOA or Tribal FQHC provider is less than the amount of actual visits reimbursed at the AIR, the provider will be paid the difference. However, if the amount of Medi-Cal Program interim payments and third party payments is more than the amount of actual visits reimbursed at the AIR, the provider must repay DHCS the difference. California's State Plan at Attachment 4.19-B, Supplement 6 describes the IHS-MOA and Tribal FQHC reimbursement methodology DHCS must follow with respect to Tribal health providers.

At the end of each IHS-MOA or Tribal FQHC 's fiscal year, the provider must file a Reconciliation Request. The total amount of Medi-Cal interim payments and third party payments received by the IHS-MOA or Tribal FQHC provider, e.g. Medicare and other party third party payments, if applicable, will be reviewed against the amount of the actual number of visits the provider was reimbursed by the Medi-Cal Program.

Beginning January 1, 2018, visits occurring at Tribal clinics for beneficiaries enrolled in a Medi-Cal managed care plan will be paid the AIR directly by the managed care plan. Therefore, DHCS will not reconcile these visits or payments. However, for beneficiaries enrolled in a Medi-Cal managed care plan and also enrolled in Medicare, the managed care plan pays a partial payment that may be higher or lower than the AIR. Therefore, it is necessary to reconcile the dual eligible visits to ensure full reimbursement by the Medi-Cal managed care plan for all eligible visits. Only the applicable visits that were adjudicated by the Medi-Cal managed care plan for Medicare/Medi-Cal beneficiaries will be included in the reconciliation calculation to determine the difference between visits reimbursed at the IHS-MOA or Tribal FQHC provider's rate and the amount received by third-party payers.

Pursuant to W&I Code section 14132.100(h), IHS-MOA and Tribal FQHC providers must disclose all payments received from Medicare and all other third party sources for the provision of Indian Health

services to Medi-Cal beneficiaries, regardless of whether services were rendered and regardless of whether the third party payments resulted in a billable visit to the Medi-Cal Program. Financial incentive payments that meet the requirements of federal and state law may be excluded from the annual Reconciliation Request. Verification of third party payments are subject to the Medicare reasonable cost principles found in 42 CFR, Part 413, and in accordance with California's IHS-MOA and Tribal FQHC policies and procedures.

A Reconciliation Request must be submitted for each separate National Provider Identifier (NPI) number annually, within 150 days after the end of the provider's fiscal year. Please note: DHCS will **NO LONGER** accept consolidated reconciliation forms with multiple NPIs.

Incomplete forms will be returned for correction. If returned, an explanation will be provided identifying the deficiencies and corrective action needed. It is important that all FQHC/RHC providers follow the Electronic Submission Protocol when submitting Reconciliation Requests. Upon submission of the Reconciliation Request to Reconciliation.Clinics@dhcs.ca.gov you will receive an email response confirming receipt. For questions or assistance, contact the FQHC/RHC Section at (916) 322-1681 or Clinics@dhcs.ca.gov.

## RECONCILIATION PROCESS

The Reconciliation Request forms consist of a Cover Sheet, Statistical Data and Certification Statement, Request to Update Differential Rates, Reconciliation Request Summary (Worksheet 1), and Worksheets 2, 3, and 4 which requests detailed visit and payment information for Medi-Cal Non-Managed Care Crossovers, Medi-Cal Managed Care (only for dual eligible beneficiaries), and Medi-Cal Non-Managed Care Crossovers with Capitated Medicare Advantage Plans (MAP), respectively. Worksheet 3A must be completed to provide DHCS the necessary information regarding managed care plans.

The data reported on the Reconciliation Request forms is subject to audit by DHCS. In accordance with 42 CFR § 413.20, DHCS reserves the right to request supporting documentation such as remittance advices, explanation of benefits, or other relevant and verifiable evidence to minimize the need for onsite reviews.

The Department has 3 years from the date the Reconciliation Request forms are received and accepted to determine if the total payments were greater or less than the provider's allowable IHS-MOA All-inclusive Rate (AIR) reimbursement.

To assist the Department in their review, supporting documentation may be submitted with the Reconciliation Request forms. This is optional and is useful in determining revenue from payers other than Medi-Cal. For example, revenue received from Medicare for those services covered both by Medicare and Medi-Cal can be supported by data from the practice management system. The data would still be subject to audit and additional verification by the department, if deemed necessary.

## PAGE 1—COVER SHEET

This Worksheet will automatically populate based on the information entered on Statistical Data Certification Page 2.

## PAGE 2—STATISTICAL DATA AND CERTIFICATION STATEMENT

### PART A—GENERAL INFORMATION

The purpose of this page is to collect licensee information, the licensee's mailing address, and the name of the person to contact for necessary information and to have the contents of the report certified. A licensee is defined as a legal entity, e.g., the organization to which the actual license is issued.

1. Enter FQHC/RHC Legal Name
2. Enter Doing Business as (DBA)
3. Enter National Provider Identifier (NPI)
4. Enter Type of Control (Select from drop-down menu)
5. Enter FQHC/RHC Street Address
6. Enter City, State, Zip Code
7. Enter Fiscal Year Begin (mm/dd/yyyy)
8. Enter Fiscal Year End (mm/dd/yyyy)
9. Enter Preparer Name or Contact Person
10. Enter Contact Person E-mail Address
11. Enter FQHC/RHC Owned by
12. Enter Business Phone Number (xxx) xxx-xxxx
13. Enter Offsite Provider Name(s)
14. Enter Offsite Provider Address(s)
15. Enter Offsite Provider NPI(s)

### PART B—CERTIFICATION STATEMENT

The Administrator, Controller, Corporate Officer, or member of the Board of Directors must electronically sign and date the DocuSign Certification Statement (separate form.) The official signing the report must have the legal capacity to make commitments for the organization.

## PAGE 3—REQUEST TO UPDATE DIFFERENTIAL RATES

This page is only used to request updates to differential rates. Use the drop-down menu to select "Yes" or "No" in the column if rate updates are required complete the applicable forms. Enter the Fiscal Period, and the remaining worksheets will populate automatically. If you wish to update the Medi-Cal Non-Managed Care Crossover rate, no special form is necessary. DHCS will contact you to obtain the relevant information.

## SUMMARY OF VISITS AND PAYMENTS WITH SETTLEMENT DETERMINATION—WORKSHEET 1

This page summarizes Worksheets 2, 3, and 4 will populate automatically when the provider completes the worksheet.

**Note:**

1. Date of Service should be used as the basis for reporting visits and payments.

2. The AIR rate increase on January 1st of each year. The time interval before the increase is Period 1 and after the increase is Period 2.

**Please enter the applicable AIR rates for Period 1 and Period 2 in the yellow boxes on Line 15.**

## MEDI-CAL NON-MANAGED CARE CROSSOVER DETAIL—WORKSHEET 2

Beginning with the column on the left:

1. Enter the months included in the fiscal period beginning with the first month of the fiscal period. Enter the month and year (i.e., January 2020.)

2. Enter the number of visits next to the appropriate month. Report only adjudicated visits during the reporting period for dual eligible beneficiaries not enrolled in any Medi-Cal Managed Care plan and not paid using a capitated MAP arrangement.

3. Enter the payments that correspond to the monthly visits in the appropriate payment column. Report all payments received from the Medi-Cal FI for dual eligible beneficiaries not enrolled in any Medi-Cal Managed Care plan and not paid by Medicare using a capitated MAP arrangement.

### Payment Explanations

- **AIR/Upper Payment Limit (UPL)/Fee for Service (FFS)** – Combine payments received from the Medicare Administrative Contractor (MAC) whether from a MOA, UPL, or FFS arrangement for dual eligible patients not enrolled in a Medi-Cal Managed Care plan, and not participating in any MAP arrangement.
- **FFS MAP**—Input payments received from MAP for beneficiaries enrolled in a FFS arrangement and **not** enrolled in a Medi-Cal Managed Care plan.
- **CODE 519**—Input only wrap-around payments received from the MAC for beneficiaries enrolled in any MAP arrangement, and **not** enrolled in a Medi-Cal Managed Care plan.
- **PART D**—Input payments received from Medicare prescription drug plans for beneficiaries **not** enrolled in a Medi-Cal Managed Care plan.

- **3rd PARTY PAYER**—Input all payments received for IHS services from any other source not already reported.

**Only include payments related to Medi-Cal beneficiaries for all types listed above.**

1. Enter a formula for Period 1 Total and Period 2 Total in the "VISITS" Column to calculate the appropriate visits for each period.

For example: If the provider's fiscal year is July through June, in the "Period 1 Total" box, enter the formula to sum July, August, and September. In the "Period 2 Total" box, enter the formula to sum October through June.

2. Copy the appropriate Period 1 and Period 2 formulas to the "PAYMENTS" columns to calculate Period 1 and Period 2 payments for all types.

**MEDI-CAL MANAGED CARE DETAIL—WORKSHEET 3**

Beginning with the column on the left:

1. Enter the months included in the fiscal period beginning with the first month of the fiscal period. (Automatically populates from Worksheet 2.)
2. Enter the number of visits next to the appropriate month. Report only adjudicated visits for all Medi-Cal Managed Care plan beneficiaries who received services.
3. Enter only Medi-Cal Managed Care plan payments related to beneficiaries in Medi-Cal managed care and Medicare, in the appropriate “MEDI-CAL MANAGED CARE PLANS” column. This should be the amount received from all managed care plans. If the provider contracts with multiple managed care plans, the amount received from all plans should be combined into the appropriate columns. All capitation payments received, regardless of whether services were ever rendered and resulted in a billable visit, must be reported for Medi-Cal/Medicare beneficiaries only. All fee-for-service payments received from a Medi-Cal Managed Care Plan, including payments received for services when a billable visit does not occur, must be reported for Medi-Cal/Medicare beneficiaries only. Financial incentive payments that meet the requirements of federal and state law may be excluded from the annual Reconciliation Request.

**Payment Explanations**

- **AIR /UPL/FFS –** Combine revenue received from the MAC whether from an AIR, UPL, or FFS arrangement for dual eligible patients enrolled in a Medi-Cal Managed Care plan and not participating in any MAP arrangement.
- **FFS/CAPITATED MAP**—Input payments received from MAP for beneficiaries enrolled in a FFS or Capitated arrangement and enrolled in a Medi-Cal Managed Care plan.

- **CODE 519**—Input only wrap-around payments received from the MAC for beneficiaries enrolled in any MAP arrangement and enrolled in a Medi-Cal Managed Care plan.
- **PART D**—Input payments received from Medicare prescription drug plans for beneficiaries enrolled in a Medi-Cal Managed Care plan.
- **3rd PARTY PAYER**—Input all payments received for reported visits from all other sources not already reported, only if applicable.

**Only include payments related to Medi-Cal beneficiaries for all types listed above.**

4. Enter a formula for Period 1 Total and Period 2 Total in the “VISITS” column to calculate the appropriate visits for each period.

5. Copy the appropriate Period 1 and Period 2 formulas to the “PAYMENTS” columns to calculate Period 1 and Period 2 payments for all types.

## MEDI-CAL MANAGED CARE PLAN INFORMATION—WORKSHEET 3A

Enter the name of each Medi-Cal Managed Care Plan the provider contracted with during the reconciliation period.

## MEDI-CAL NON-MANAGED CARE CROSSOVERS WITH CAPITATED MAP DETAIL—WORKSHEET 4

Beginning with the column on the left:

1. The months included in the fiscal period beginning with the first month of the fiscal period. (Automatically populates from Worksheet 2.)

2. Enter the number of visits next to the appropriate month. Report only adjudicated visits for dual eligible beneficiaries not enrolled in any Medi-Cal Managed Care plan and paid using a capitated MAP arrangement.

3. Enter the Medi-Cal crossover payments that correspond to the monthly visits in the “MEDI-CAL CROSSOVER” column. This should be payments received from the Medi-Cal FI for dual eligible beneficiaries not enrolled in any Medi-Cal Managed Care plan and paid by Medicare using a capitated MAP arrangement.

4. Enter the Medicare Advantage Plan payments that correspond to the monthly visits in the appropriate "MEDICARE ADVANTAGE PLANS" Column.

**Payment Explanations**

- **CAPITATED MAP**—Enter capitated payments received from MAP arrangements.
- **CODE 519 –** Input only wrap-around payments received from the MAC for beneficiaries enrolled in any type MAP arrangement and not in a Medi-Cal Managed Care plan.
- **PART D**—Input payments received from Medicare prescription drug plans for beneficiaries **not** enrolled in a Medi-Cal Managed Care plan.
- **3rd PARTY PAYER**—Input all payments received for reported visits from all other sources not already reported, only if applicable.

**Only include payments related to Medi-Cal beneficiaries for all types listed above.**

5. Enter a formula for Period 1 Total and Period 2 Total in the "VISITS" Column to calculate the appropriate visits for each period.

6. Copy the appropriate Period 1 and Period 2 formulas to the "PAYMENTS" Columns to calculate Period 1 and Period 2 payments for all types.

# Appendix A—Glossary

**Capitation**—Payments used by managed care organizations to control health care costs. Capitation is a fixed amount of money per patient per unit of time paid in advance for the delivery of health care services. The actual amount of money paid is determined by the ranges of services that are provided, the number of patients involved, and the period of time during which the services are provided. Capitation rates are developed using local costs and average utilization of services and therefore can vary from one region to another.

**Code 519**—A Medicare wrap-around rate which makes IHS-MOA whole to the Medicare FQHC Rate for beneficiaries enrolled in Medicare Advantage Plans.

**Crossover Payment**—Payment for a beneficiary who is eligible for both Medicare and Medi-Cal, where Medicare pays a portion of the claim and Medi-Cal is billed for any remaining portion.

**FFS**—Fee for Service, a payment model where services are unbundled and paid for separately.

**MAC**—Medicare Administrative Contractor, a private health care insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B medical claims or Durable Medical Equipment claims for Medicare fee-for-service beneficiaries.

**MAP**—Medicare Advantage Plan, a type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits. Most Medicare Advantage Plans offer prescription drug coverage.

**Medi-Cal Fiscal Intermediary**—A fiscal agent who is a private contractor to the state, normally selected through a competitive procurement process. The FI's contract requires them to process claims submitted by Medi-Cal providers for services rendered to Medi-Cal eligible beneficiaries.

**Medi-Cal Managed Care**– Provides high quality, accessible, and cost-effective health care through managed care delivery systems. Medi-Cal managed care contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of care.

**Medicare Part D**—An optional federal government program to help Medicare beneficiaries pay for self-administered prescription drugs through prescription drug insurance premiums.

**AIR**— An Indian Health Service All-inclusive Rate published each Calendar Year in the Federal Register payable to IHS-MOA providers and to Tribal FQHCs as an alternative payment methodology.

**State Plan**— The state plan is an agreement between a state and the Federal government describing how the state administers its Medicaid and CHIP programs. It gives assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed, and the administrative activities that are underway in the state. When a state is planning to make a change to its program policies or operational approach, states send state plan

amendments to the Centers for Medicare and Medicaid Services (CMS) for review and approval. States also submit SPAs to request permissible program changes, make corrections, or update their Medicaid or CHIP state plan with new information.

**Third Party Payer**— Any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients. Third party payments are distinguished by the separation between the individual receiving the service (the first party), the individual or institution providing the service (the second party), and organization paying for it (the third party).

**UPL**—Upper Payment Limit, a per visit rate that CMS establishes to reimburse RHC providers for their services to Medicare eligible beneficiaries.

**Visit**— A face to face encounter between an IHS-MOA patient and any provider as specified in the California State Plan, Attachment 4.19-B, Page 6B.1 Supplement 6.

**Wrap-Around Payment**— A payment from Medi-Cal or Medicare to an IHS-MOA and Tribal FQHC providers equal to the amount or difference between the payment under the AIR and the payment provided by Medicare or a Medicare Advantage Plan.

# Appendix B—Billing Rates/Codes

**Table B-1**

The table below illustrates the different Medicare and Medi-Cal arrangements and the billing codes used for each.

| Type of Medicare Arrangement | Type of Medi-Cal Arrangement | Former Billing Code | New Billing Codes | | |
|---|---|---|---|---|---|
| | | | Revenue Code | HCPCS/ CPT | Modifier |
| Not Qualified | Straight Medi-Cal | Code 01 | 520 | T1015 | |
| Not Qualified | Managed Care Plan | | | | |
| Straight Medicare | Straight Medi-Cal | Code 02 | 520, 900 | G0466 - G0470 | |
| Straight Medicare | Managed Care Plan | | | | |
| Medicare Advantage Plan<br>Capitated Arrangement | Medi-Cal<br>Non-Managed Care | Code 20 | 529 | G0466 - G0470 | |
| Medicare Advantage Plan<br>Fee for Service Arrangement | Medi-Cal<br>Non-Managed Care | Code 02 | 520, 900 | G0466 - G0470 | |
| Medicare Advantage Plan<br>Capitated Arrangement | Medi-Cal<br>Managed Care | | | | |
| Medicare Advantage Plan<br>Fee for Service Arrangement | Medi-Cal<br>Managed Care | | | | |

The Health Insurance Portability and Accountability Act (HIPAA) mandated changes to billing requirements for IHS-MOAs. The changes became effective October 1, 2017 and include the use of Healthcare Common Procedure Coding System (HCPCS) Level I and Level II national codes. Transition from the HCPCS Level III local per visit codes to HIPAA-compliant billing code sets means IHS-MOA and Tribal FQHC providers who previously submitted HCPCS Level III local per visit codes when billing for their services are required to submit claims using the specified HIPAA-compliant Common Procedural Terminology – 4th Edition (CPT-4) Level I and HCPCS Level II code sets for dates of service on or after October 1, 2017.

Please refer to the IHS-MOA Provider Manuals for detailed billing instructions and billing codes.

Billing Instructions:
https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/indhealth.pdf

Billing Codes:
https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/indhealthcd.pdf

Supplement 6 Attachment 4.19-B:
https://www.dhcs.ca.gov/Documents/Supplement6toAttachment4.19-B-2-26-21.pdf