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"Interstate Coordinated Enrollment and Coverage Process for Low-Income Children"

MEDICAID BILLING ACROSS STATE BORDERS
FOR AMERICAN INDIAN and ALASKAN NATIVES

Background: It is not uncommon for American Indian/Alaskan Natives (AI/AN) who are low-come and can be classified as Medicaid Beneficiaries to cross state borders to receive health care services from a medical provider(s) outside the home state of the AI/AN beneficiary, with the following exceptions:

- Unless the medical provider has a Medicaid Provider Agreement with the AI/AN beneficiary's home state, the Medicaid Benefits of the AI/AN beneficiary does NOT follow the patient.
- Many AI/beneficiaries receive their primary health care from an Indian Health Service (IHS)/Tribal provider who is unable to bill any Medicaid program due to absence of a Medicaid Provider Agreement.

Therefore the Tribal Technical Advisory Group (TTAG) of the National Indian Health Board seeks to encourage CMS and States to facilitate Medicaid billing across state borders, thus serving as a benefit to the IHS/Tribal provider, the State's Medicaid department, but most importantly assists in the AI/AN beneficiary obtain needed health care.

Fundamental Elements of Health Care for AI/AN persons:
AI/persons are able to receive health care services from an integrated health system made of three distinct separate operations commonly referred as Indian health programs or (I/T/U):

- **I**ndian Health Service (IHS) operated facilities;
- **T**ribal or Tribal organizational operated facilities under agreements with the DHHS/IHS; and
- **U**rban Tribal health programs.

Why AI/AN Medicaid Beneficiaries Cross State Borders for Care:
There are instances where AI/AN persons are traveling and can present to any I/T/U facility and receive care at any I/T/U program.

- AI/AN persons with or without any form of health care financing can receive health care at no-cost at while presenting for service at an I/T/U medical provider in their current state or travel to another state to receive care from another I/T/U provider.
- An AI/AN patient who lives in one State, but is enrolled or affiliated with a Tribe in another State may return to his/her home reservation to receive medical care at his home I/T/U provider or supportive services from family members during the period of illness.
- Referral of AI/AN patients to a specialized treatment centers for medical, behavioral, or mental services, especially for the delivery of culturally-appropriate care is another example of where the Medicaid benefits could follow the patient.
    - Behavioral health programs for AI/AN youth and adults with substance abuse issues already being limited in number, such programs will benefit from being able to receive Medicaid billing for their effective care, but most importantly, the AI/AN Medicaid beneficiary will receive effective, culturally-appropriate care.

- ❖ AI/AN students attend Department of Interior-Bureau of Indian Affairs (BIA) boarding schools where they travel from their home reservation to distant States like Oklahoma, Oregon, and South Dakota. Many of the students are Medicaid beneficiaries, are eligible to receive health care services at a local I/T/U facility near the BIA boarding school, but have to reapply for Medicaid of the State where they attend school. An example is where Oregon Medicaid has facilitated the enrollment of AI/AN students from other states who attend Chemawa Indian Boarding School.

The information presented in the Federal Register of December 18, 2009 referenced at least 5 options for low-income Medicaid beneficiaries:

(a) Interstate Agreements;
(b) 1115(a) Demonstration project(s);
(c) Amendment to current State Medicaid Plans;
(d) Establishment of a National Children's Health Benefit;
(e) Public-Private Partnership Initiative:

Advantage/Benefits:

Interstate Agreements:

- ❖ State Medicaid Plans who issue Medicaid Provider Agreements to out-of state IHS/Tribal health programs would be able to receive 100% FMAP which is 100% Federal fiscal resources for covered Medicaid services provided to those AI/AN patients. It is an obvious advantage to State Medicaid plans when there is reduced strain on State Medicaid budget resources used to provide care to AI/AN Medicaid beneficiaries.
- ❖ Indian patients benefit from Medicaid Provider Agreements because the patients are more likely to receive needed care, and with behavioral issues, the care is likely to be more effective than receiving care at a non-Indian treatment program.
- ❖ AI/AN youth in need of behavioral/substance abuse treatment will accept and receive culturally appropriate care from AI/AN people designed specifically for AI/AN people.
- ❖ I/T/U health programs benefit from receiving payment for service while reinvesting the Medicaid reimbursements into additional program development and enhancements.
- ❖ Interstate Provider Agreements that could help so as long as the facilitation of those arrangements would require execution of a provider agreements with each State and the I/T/U provider.
- ❖ Another potential advantage/benefit would include the development of an effective mechanism for the I/T/U provider to identify services covered by the home-state Medicaid Plan, applicable reimbursement rates; and efficient claims processing.
- ❖ Perhaps the biggest benefits to an effective initiative would be finding a current State Medicaid Plan willing to serve as a model of collaboration.
- ❖ NIHB technical staff has reviewed the Interstate Compact on Adoption and Medical Assistance (ICAMA) as the example of an Interstate Model program. The example provided relates to AI/AN communities as AI/AN persons experience adoption and maybe already effected by this initiative. www.aaicama.org/cms/
    - o The technical handbook by this organization was reviewed for cross-referencing and relevance to AI/AN children who are adopted, live in new states; and other related issues especially with special needs.
    - o Outlined specific procedures that could be adopted by AI/AN communities as a way how AI/AN children who attend boarding schools could continue to receive Medical Assistance/CHIPRA.

- Outlined procedures that could be "cut & paste" to address for the development of a special AI/AN Across State Borders Medicaid Compact. Further information and additional developed materials will be submitted to TTAG for future approval and recommendation.
- A comparative and cross reference review of multi-state agreements with AI/AN populations

1115(a) Demonstration Project:

- State Medicaid program can "….create a standard set of benefits or eligibility coverage across States or expands coverage to groups of individuals, including parents or caretaker relatives or provides greater flexibility…", the main challenge to this option is to find a State Medicaid Department, Governor, and State Legislature that would be willing to work with a Tribe or combination of Tribes for a special demonstration project.
- Having a State submit a joint application to CMS would serve as a model of success for other potential State/Tribal demonstration project. An example of sound, meaningful, successful State/Tribal consultation could serve as the basis of a demonstration project.
    - NIHB through TTAG representatives will organize a follow-up meeting with some key State Medicaid Directors (NASMD) to find a State or list of States that would be willing to submit a tribal demonstration 1115(a) project or develop a joint project that focuses on simplified eligibility criteria and determination processes.

Current Law Flexibility for State Plans:

- An amendment to a current State Medicaid Plan could explore current plan parameters to expand service delivery, enhance enrollment and portability coordination and enhance care coordination in AI/AN communities and I/T/U facilities.
- Even with the best State/Tribal Model of Consultation would require more involvement of both entities: Tribes and States and given the current fiscal strains of operational budgets, this option would take additional serious communication and development efforts

National Children's Health Coverage:

- Based upon the December 2009 Medicaid Benefits sub-committee conference call, there were concerns about having a national Medicaid benefits initiative was a little bit premature.
- Any consideration of a National Medicaid Benefit's Health Program would need further work in the following areas upon initial discussion:
    - Structure parameters, coverage options for the identified population; description of benefits; effect of changes or impact on current I/T/U programs and AI/AN under current law; the affect upon Federal Trust responsibility, and any political implications.

Public-Private Partnerships:

- This option involves expansion of a successful State/Tribal initiative to consider developing a whole new series concept of establishing a private/public partner.
- A regional initiative with that may include a private entity experienced in areas such as benefits administration, risk management; eligibility determination, case-disease management and clinical coordination combined with the "Tribal Consultation friendly "State Medicaid administration, and either single tribes or coalition of tribes.

<u>Disadvantages/Negatives:</u>

- Potential solutions and related comments on this current Federal register announcement has been addressed with recommendations as referenced by the January 31, 2007 Letter

from the Tribal Technical Advisory Group (TTAG) to Ms. Leslie V. Norwalk, Esq. and accompanying documents. These documents are attached for additional reference and consideration. After discussion with the Across State Borders Sub-Committee on a conference call on January 12, 2010, it was recommended to CMS that these issues remain unresolved.

Identification of Best Practices:

- In order to make it easier for Indian Medicaid beneficiaries to receive health care at in-state or out-of-state I/T/U providers , I/T/U providers to receive reimbursement from Out-of -State Medicaid plans, and Out-of-State Medicaid Programs to receive 100% FMAP for service provided to AI/AN beneficiaries would require the following:
  - Jointly advocate that CMS direct State Medicaid Plans in the state in which the I/T/U is located to pay the Medicaid claims for out-of state Indian patients/beneficiaries while receiving 100% FMAP for that provision of health care. Another advantage would be the reduction of the need for multi-state agreements, thus avoiding complications due to differences in plan benefits, parameters, and requirements. Recommendations for New Models
  - The facilitation and execution of Medicaid provider agreements with out-of-state IHS, Tribal/Tribal urban provider could mirror those efforts such as the Choctaw Nation of Oklahoma with the States of Arkansas and Texas. Initially, Texas was reluctant to participate because of Texas's policy of not contracting with health providers more than 50 miles from the exterior border of Texas. After reviewing the 100% FMAP calculation for service to AI/AN Medicaid Beneficiaries while improving access to health care for those same AI/AN Medicaid beneficiaries, Texas executed the requested provider agreement.
  - Affected states can also facilitate these arrangements by providing easy access to needed information about (1) which services are covered by the state's Medicaid plan; (2) the reimbursement rates for these services; (3) the extent to which any prior approval is required and where to obtain it; and (4) any payment limitations that apply. State assistance is also needed to clear the way for removing contractual language require all Medicaid providers who present for care accept all Medicaid patients. This requirement is a direct contradiction to the limitations outlined by the various Indian Health Service requirements on seeing non-IHS patients.

- **Additional Comments on Programmatic or Statutory Changes:**

Any CMS related project requires consideration of the goals tribes are trying to achieve so that various options and other strategies for achieving increased and more consistent coverage, can be fairly and thoroughly evaluated. We offer for tribal consideration the following goals.

Changes in Medicaid should:

- ✓ Be consistent with fulfillment of the Federal trust responsibility
- ✓ Support culturally appropriate health care services for AI/AN beneficiaries ;
- ✓ Improve access by Indian health programs (I/T/U) to Medicaid reimbursement;
- ✓ Respect the federal and tribal authority under which Indian health programs (I/T/U) operate;
- ✓ Support the health promotion and disease prevention focus of the Indian health system (I/T/U);
- ✓ Not to increase the enrollment burden or apply any financial risk to AI/AN beneficiaries
- ✓ Not increase the administrative burden or financial risk to Indian health programs (I/T/U).