Tribal Technical Advisory Group
to the Centers for Medicare and Medicaid Services
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January 31, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave
Washington, D.C. 20201

Dear Ms. Norwalk,

Thank you for meeting with the Tribal Technical Advisory Group (TTAG) on November 15, 2006. At the TTAG meeting, the TTAG passed a motion to transmit a briefing paper prepared by the Subcommittee on Across State Borders Issues. Please see enclosed document entitled, "Medicaid Billing Across State Borders for Indian Health Programs."

As this briefing paper explains, the Indian Health Service (IHS) and tribally operated programs are unable to receive Medicaid reimbursement for services provided to Indian Medicaid beneficiaries who cross state borders to receive services from IHS or tribal facilities. The IHS beneficiaries are eligible to receive health care services from IHS or tribal health care programs regardless of where they reside. However, the IHS or tribal program cannot bill for Medicaid covered services provided unless the IHS or tribal program has a provider agreement with the Indian Medicaid beneficiary's home state.

Because of the unique government to government relationship between the Federal government and Indian tribes, the Centers for State Medicaid Operations (CMSO) could administratively eliminate the barriers the IHS and tribal programs have encountered in Medicaid billing across state borders. For instance, because CMS reimburses states at 100% FMAP for Medicaid payments to IHS and tribal facilities, the CMS could develop policies to allow State Medicaid programs to reimburse for services provided to Indian patients enrolled in another State Medicaid program. This would alleviate the need for IHS and tribal facilities to enter into multiple out-of-state provider agreements.

There are other options outlined in the briefing paper and the TTAG respectfully requests a senior staff member from CSMO to participate in the February 22 – 23 TTAG meeting to discuss these issues with the TTAG further.

Sincerely,

Valerie Davidson, Chair
Tribal Technical Advisory Group

MEDICAID BILLING ACROSS STATE BORDERS FOR INDIAN HEALTH PROGRAMS

Briefing Paper from Tribal Technical Advisory Group (TTAG),[*]
Subcommittee on Across State Borders Issues

The Problem. It is not uncommon for Indian Medicaid beneficiaries to cross state borders to receive care from a provider in the Indian Health Service (IHS) system. Unless the provider -- the IHS or an tribally-operated program -- has a provider agreement with the patient's home state, the Indian health program is unable to bill any Medicaid program for the patient's care. The TTAG seeks to encourage States and CMS to facilitate Medicaid billing across state borders, as such arrangements can financially benefit the State and the Indian health provider, and help the Indian patient to obtain needed care.

Components of the Indian Health System. What we call the Indian health system is comprised of three types of operations: IHS direct-operated programs; programs operated by Indian tribes and tribal organizations through contracts with IHS; and urban Indian organizations whose programs are funded with grants from IHS. Collectively, this system is referred to by the shorthand "I/T/U".

100% FMAP. In recognition that health care for Indians is a totally **Federal** obligation flowing from the United States' trust responsibility to Indian tribes, Federal law provides that the Medicaid services supplied to Indians by IHS and tribally-operated facilities are reimbursed to the States at a 100% FMAP. (Services provided by urban Indian organizations do not qualify for 100% FMAP.) Note, however, that when services are provided to Indian Medicaid beneficiaries by any provider other than an IHS or tribal program, the regular State match applies. Thus, it is in the state's interest to facilitate arrangements with IHS and tribal providers in other states in order to obtain full Federal reimbursement for Medicaid-covered services to these Indian patients.

Why Indian Patients Cross State Borders for Care. There are several reason why Indians, who are entitled to care without cost from an IHS/tribal program, may seek care from such a program in another state. First, an Indian who lives in one state but is affiliated with a tribe in another State may return to his/her home reservation to receive care, particularly where he/she can be near family during a period of illness. Often, even Indian people who are not affiliated with a program on a particular reservation may also cross a nearby state border to receive no-cost care from an IHS-supported program.

Another common occurrence is the referral of an Indian patient in need of specialty care to an IHS or tribal program -- including a residential program -- where fellow patients are also Indians and the care provided is designed specifically for an Indian population. Key examples of this are behavioral health programs for Indian youth or adults with substance abuse problems. There are comparatively few such programs in Indian Country; thus, it is often the case that Indian patients must cross state borders to receive culturally competent -- and thus more effective --care at these facilities.

A third example is Indian students who travel from their home reservations to attend Bureau of Indian Affairs-funded boarding schools in distant states to receive an Indian-oriented education. These students often receive their medical care at IHS/tribally-operated health programs located near the boarding school. Where a student is eligible for Medicaid, the Indian health care program would like to bill the home state Medicaid Plan, or be able to enroll out-of-state Indian students in the local state's Medicaid program. An example of the latter is Oregon Medicaid which has facilitated enrollment of Indian children from other states who attend the Chemawa Indian Boarding School.

Benefits to States, Patients and Indian Health Programs. State Medicaid Plans who issue provider agreements to out-of-state IHS and tribal programs ***will receive 100% FMAP*** for the covered

[*] The TTAG, comprised of elected tribal leaders or employees, was chartered by CMS in 2003 to advise the agency on Medicare, Medicaid, and SCHIP issues involving American Indians/Alaska Natives (AI/AN) and the Indian health provider network. www.cmsttag.org.

Medicaid services those programs supply to Indian patients. This presents an obvious financial benefit to the state. Indian patients also benefit from these arrangements because they are more likely to receive the needed care, and, in the case of behavioral health programs, the care is likely to be more effective than would be available to them at non-Indian programs in their home states. For example, young people in need of behavioral health treatment are more likely to accept a referral to a program where they will receive culturally appropriate care *from* Indians designed specifically *for* Indians. And Indian health programs benefit by receiving payment for covered services, and thereby enable them to continue and expand their important health programs.

Challenges to be Addressed. Facilitation of across state border arrangements will require execution of a provider agreement between the Indian's home state Medicaid Plan and the IHS or tribal provider; development of an efficient mechanism for the Indian health provider to identify services covered by the home state's Medicaid Plan and the applicable reimbursement rates; the ability to efficiently process claims; and most importantly, a willingness on the part of the home state to enter into such arrangements.

Possible Collaborative Approaches. In order to make it easier for Indian health providers to bill for Medicaid services provided to out-of-state Indian Medicaid beneficiaries and for States to receive 100% FMAP for that care, the TTAG, individual States and the National Association of State Medicaid Directors could work together on several possible solutions, such as --

- Jointly advocate that CMS allow the State Medicaid Plan in the state in which the Indian health facility is located to pay the Medicaid claims for Indian patients enrolled in another state's Medicaid program and receive 100% FMAP for those claims. This would avoid the need for the Indian health programs to execute multiple out-of-state provider agreements. Of course, the home state's Medicaid plan provisions would apply.

- Facilitate and encourage execution of Medicaid provider agreements with out-of-state IHS and tribal providers.

    - For example, the Choctaw Nation of Oklahoma has entered into provider agreements with Arkansas and Texas that enable the tribal program to bill both states for care provided to Indians enrolled in the AR and TX Medicaid programs. Initially, Texas was reluctant to participate because of its policy to not contract with providers more than 50 miles from the Texas border. But upon recognizing the benefits of such an arrangement to the state, 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 language found in many state provider agreements that require providers to treat all Medicaid recipients who present for care, as Indian health programs, by definition, are not open to the public.

For further information, please contact:

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