Medicine Dish broadcast

Dorothy:
Welcome to our December Medicine Dish Broadcast. I'm your host Dorothy Dupree.

The purpose of the Medicine Dish Broadcasts is to introduce you to various topics pertinent to Indian health programs operated by the Indian Health Service, Tribes, Tribal Organizations and Urban Indian programs.

You, our viewing audience, can access our monthly broadcasts, held the second Wednesday of each month from 1:30 to 2:30 p.m., Eastern Time; through either the DirecTV network installed at 120 Indian health facilities or through Web cast arrangements with the National Institutes of Health.

NIH archives each broadcast for easy access by those who cannot participate during the live Medicine Dish Broadcasts or by those who may simply want to review the information again.

The broadcast topic today is "Medicaid 101 and Providers". The majority of Indian health beneficiaries are enrolled in Medicaid and as a result income generated by Medicaid services provided by Indian health providers has become vital to the operations of your facilities.

The information provided today will be for the benefit of the Providers who work with beneficiaries.

Although individual beneficiaries are extremely important to CMS, we feel that it's the Indian health providers themselves who have the direct connection to and understand the needs of the American Indian and Alaska Native beneficiary.

And it's with this in mind that we direct our information to this network.

Thank you for joining us today.

I hope you find today's broadcast informative and again, Welcome to Medicine Dish!

VIDEO

Again, our topic is Medicaid 101. Our panel will be providing you an overview of Medicaid as the program relates to Providers.

Our Panel is comprised of Cyndi Gillaspie, Native American Contact & National Lead, Region 8

Peggy Clark, Technical Advisor, Division of Community and Institutional Services, CMSO

Adam Archuleta, Business Office Coordinator, Albuquerque Area, Indian Health Service

The Panel will provide a brief overview of the regulations and provide information to a few of the most commonly asked questions received from IHS, Tribal and Urban Indian programs.

Should you have questions during this Medicine Dish presentation, you can contact us during this broadcast by following one of two options:

1. You can call the 800 # listed on your screen and ask your question live or

2. You can fax your question to 410-786-0123 and the panel will be asked to respond.

(AD LIB)

Now I'd like to turn the mike over to our first panelist, Cyndi Gillaspie, who will provide a brief overview of Medicaid services and reimbursement and specific AI/AN provisions in the Medicaid program.

Cyndi is with the Centers for Medicare and Medicaid Services, Region 8 office and became the National Lead for the CMS Regional Offices Native American Contacts after working on AI/AN health with CMS for 9 years.

Cyndi has worked on Medicaid for 25 years. She's a great resource and I'm happy she is able to join us today. Cyndi.....

Cyndi:
Thank you, Dorothy.

Medicaid and Medicare are the second largest payers of Indian health next to the IHS. It is critical to the continued improvement and sustainability of Indian health care for providers to understand these two programs, how they work and how to maximize benefits to their communities.

Medicaid is a state administered, jointly funded program. The States and federal government share the administrative and service costs of the program.

The Medicaid program, by Statute, is administered by States and CMS provides oversight of the program.

States must cover certain services and meet certain payment requirements but also have flexibility to choose optional services and payment methodologies in many instances.

Because of this flexibility, no 2 state programs are alike.

CMS and the States enter into contracts, called State Plans.

The State Plan defines what services are covered, what the limitations on each service will be and how providers are paid.

In order to find out this information for your State, you should look at the Medicaid State Plan.

The State Plan, in Attachment 3.1a will describe all the services the state covers.

In the supplement to attachment 3.1a, it will describe any limitations on the specific services and Attachment 4.19 a or b will describe how providers are paid for services.

There are special provisions for payment for Indian Health Service, Tribal 638 providers and Urban Health Clinics who are enrolled providers in Medicaid.

Indian Health Service and Tribal 638 facilities can be paid an all-inclusive rate or AIR.

This is a reimbursement amount set by OMB each year based upon the costs of certain facilities.

When this method is used, a set amount is paid for each encounter with a Medicaid eligible person at the IHS/Tribal 638 facility. IHS and Tribal 638 facilities can also be paid fee-for-service.

If they are paid fee-for-service, the information about how the rate is calculated will be in the state plan in 4.19a or b. States and Tribes can also negotiate rates as long as they are reasonable as defined in the Medicaid program.

States ultimately make the decision about which payment methodology they will use for reimbursement to IHS and Tribal 638 clinics.

For Tribal and Urban Health Clinics, there is also a provision that allows them to become Federally Qualified Health Centers or FQHCs. If the facility is an FQHC, it bills on an encounter based upon costs of operating the facility.

The decision about whether or not to become an FQHC is the Tribe or Urban organization's choice and, if this option is chosen, the State must pay following the FQHC methodology.

More in-depth information about specific Medicaid services and provider types can be found at the web site on the screen.

To find out how to enroll as a Medicaid provider in your State, you should look at each State Medicaid program's web site.

Usually the state will have an online enrollment process. If you are unsure how to find this information for your State, contact the CMS NAC or Native American Contact for your Region.

There is a NAC in each CMS Regional Office who can assist you.

The Medicaid program also has numerous special provisions for AI/AN health care providers and beneficiaries.
Normally when States provide Medicaid health services, the State pays for the service and then the federal government pays the State a portion of what they paid for the service.

That federal portion or Federally Matching Assistance Percentage (FMAP) is at least 50% of the cost and can go as

high as 80%, depending upon the per capita income in the State.

When services are provided through Indian Health Service or Tribal 638 facilities and the State pays for that service through Medicaid, the federal government pays 100% of that payment back to the State.

This helps assure that dollars go back into the Indian Health system.

Another provision requires States to provide for outstationed eligibility at all Tribal health clinics and schools.

Outstationing means that families and children are able to begin the application process at that site, instead of having to travel to the nearest county or state office to make an application.

States can meet this requirement by putting eligibility workers at those sites, training individuals (such as Benefit Coordinators) to begin the application process, or through a volunteer network.

This next provision concerns Tribal consultation. The Department of Health and Human Services conducts consultation with Tribes on an annual basis but there are specific State/Tribal consultation requirements in Medicaid.

In 1998, President Clinton issued an executive order encouraging States to consult with Tribes on certain Medicaid changes.

CMS issued a letter to Medicaid Directors in each State requiring states to consult with all federally recognized Tribes about Medicaid waiver applications, amendments and renewals.

The Deficit Reduction Act of 2005 further encourages States to consult with Tribes about any Medicaid provision that may impact AI/AN beneficiaries.

Another provision designed to assist Tribes with the costs of doing business in the Medicaid program is the Medicaid Administrative Matching or MAM program.

This allows Tribes and States to work together to reimburse Tribes for part of the costs they incur for administrative functions of the Medicaid program, such as helping people enroll, collecting and providing documents to the Medicaid program, assisting with arranging appointments or transportation to Medicaid appointments and other activities that provide for efficient administration of the Medicaid program.

This process allows the Tribe to collect (through the State Medicaid agency) the federal share of administration costs which is 50% of the costs of those activities.
Other provisions allow Tribes who operate their own TANF programs to determine eligibility for Medicaid, like a county or State office.

Again, because States operate the Medicaid program, the State and Tribe would have to come to an agreement to allow the Tribe to perform this Medicaid function.

I/T/Us waive cost sharing for adults in Medicaid and children under 18 in Medicaid cannot be required to pay cost-sharing.

Finally, Medicaid programs must enroll all Indian Health Service and Tribal facilities as providers in the program.

These slides will ALSO be available for you to download from the CMS Medicine Dish website AND SECTION ON THIS BROADCAST.

I hope this has been helpful. Numerous CMS and State employees are involved in the administration of provider enrollment and payment in Medicaid.

If you need assistance, you can always contact your Native American Contact in each Regional Office or the Tribal Affairs Group at Central Office or you can find detailed information concerning Medicaid at the web site on the screen.

Thank you for your time and now I'll turn this back to Dorothy.

Dorothy:
Thank you.

Now, while our viewers prepare questions for our Q&A segment, let's go to our next panelist

Our next panelist is Peggy Clark who is a technical director in the Division of Community and Institutional Services in the Centers for Medicaid and State Operations here at CMS.

She has extensive knowledge and longstanding experience with mental health benefits and Medicaid including previous experience at the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services, where she was a Project Officer in the Community Support Program overseeing project grants to State Mental Health Authorities and has held other leadership positions at the national and state level.

She will share with today information about coverage and payment on Substance Abuse and Mental Health in the Medicaid program. Peggy... Dorothy

Peggy:
Thank you Dorothy.

As you know, Medicaid is a Federal/ State partnership.

Each state Medicaid program is unique.

If you know one state program, you know one program.

Medicaid is an important funding source for people with mental illness.

Medicaid has evolved into one of the most important components of the health care safety net for people with mental disorders.

Mental Health Medicaid spending is a large contributor to overall Medicaid spending and to Medicaid spending growth, even when mental health spending increases more slowly than all Medicaid.

Federal Medicaid rules define how states may deliver services and under what conditions they may choose to deliver services through managed care.

Provider mix of mental health spending has changed: inpatient, specialty hospital and nursing homes are down;

Multi-service mental health organizations (MSMHOs) and drugs are up.

Medicaid is providing more mental health services: more enrollees using mental health prescriptions; more admissions to general hospitals (but shorter stays); and more patients served in Multi-service Mental Health Organizations.

Private insurance-funded substance abuse treatment is a declining share of all spending. Private insurance only funded 10% of SA treatment in 2003.

Most Substance Abuse treatment is increasingly funded by the public sector.

A very small portion of Medicaid goes toward substance abuse treatment; similar for other payers.

Medicaid is a more important funder as private insurance is curtailed.

There is a shift from inpatient to outpatient.

Medications still play a small role.

Effective administration/ financing of State Mental Health services must involve collaboration between Medicaid and Mental Health agencies in the areas of planning, policy and data.

There are hopeful signs, I'll mention a few:
* Medicaid and Mental Health TAG (Technical Advisor Group) SAMHSA sponsored.

* Medicaid and Mental Health/ Substance Abuse Treatment Services Conference - co-sponsored by
SAMHSA and CMS

* MITA (Medicaid Information Technology Architecture) - efforts to make data collection more compatible.

* State Medicaid Directors believe that support for Mental Health consumers "could be improved by joint planning and collaboration."

Thank you and now let me turn this back to Dorothy.

Dorothy:
Re-intro Cyndi

Cyndi:
Thank you, Dorothy.

The State Children's Health Insurance Program or SCHIP is, like Medicaid, State administered and jointly funded by the State and CMS. The matching percentage for the federal share or FMAP is even higher for SCHIP than for Medicaid.

The States have even more flexibility for SCHIP than they do for Medicaid. They can operate the SCHIP program as a Medicaid expansion, a separate program or a combination of Medicaid & separate health plan.

The State also chooses whether to use a managed care model or a fee for service delivery and payment method. Again, because there are so many options, there are different programs in every State.

They even call them by different names, such as Badger Care in Minnesota and AR Kids in Arkansas.

States set their own income limits and can also set limits on the number of people they will enroll. This broad flexibility makes each program even more different than Medicaid in each State.

Right now, the SCHIP program is reaching the end of its authorization by Congress. Depending on the specifics in the legislation that may be passed to continue to the program, we can expect even more differences and changes as each State adapts to the new provisions.

As the SCHIP program exists today, however, there are several provisions designed to assist AI/AN beneficiaries and health care providers.

Unlike Medicaid, SCHIP can charge some cost sharing for children. There is a special cost sharing exemption in the statute for American Indian and Alaska Native children.

States are not allowed to charge ANY premiums, coinsurance or deductibles to AI/AN children in SCHIP.

To assure the SCHIP program brings money into the Indian Health system, the program requires that States enroll all Indian Health Service and Tribal Health facilities into the program as providers.

If a State chooses to expand Medicaid under SCHIP, the 100% FMAP or federal matching is applied. This means that any SCHIP service provided through IHS or Tribal 638 facilities under an SCHIP Medicaid expansion is reimbursed at 100% to the State.

States are required to consult with all federally recognized Tribes for any SCHIP state plan amendment or proposed waiver before the change is submitted to CMS.

This is very basic information regarding the SCHIP program. For more detailed information about the program in your state and links to the State Plans and waivers, you can go to our website seen on the screen.

Thank you for your attention. Dorothy, I will turn this back to you again.

Dorothy:
I want to remind viewers that they can download presentation documents from the CMS website.

www.cms.hhs.gov

We're getting closer to that portion of our agenda where you will be able to phone or fax your questions to our experts. Please begin preparing your questions.

Let's move on to our next panelist from the IHS.

CMS works closely with the Indian Health Service in all we do related to Medicaid. Adam Archuleta has graciously joined us today to talk about how IHS works with Medicaid.

He has extensive business office/ third party collections experience and is familiar with Medicaid in New Mexico.

He is a busy man who currently has two jobs! He is the business office coordinator for the Albuquerque Area IHS office as well as the business office coordinator and director of contract health services for ACL service unit of PHS Indian hospital in San Fidel, NM.

He shares a commitment to increasing access to services for our Indian people and we're pleased that Adam could join us today. Adam ...

Adam:
Thank you, Dorothy.

The Indian Health Service relies heavily on Medicaid dollars to supplement current congressional appropriations in providing direct health care services.

In 2007, we collected over $400 million dollars, which is about 70% of the total third party revenue from Medicare, Medicaid, SCHIP, and private insurances.

Overall, third party revenue from these programs pays for up to 50% of our hospital and clinic operating expenses.

Since congress granted IHS and Tribes the authority to start billing third party insurances in the Indian Health Care Improvement Act in 1976 (PL 94-437), Medicaid revenue has increasingly become vital to IHS and Tribes.

Some of the reasons why Medicaid is our biggest payer includes: a greater portion of our population is young (within the Medicaid age criteria);

Due to a high unemployment rate, which means that a greater portion of our population can meet the income criteria guidelines;

And thirdly, our population's health status is below the national average (compared to other racial groups).

The Indian Health Service is aware of these dynamics, and has since addressed and implemented many processes to identify and enroll potential Medicaid enrollees.

The hiring of Patient Benefits Coordinators has been key to increasing Medicaid enrollments and other alternate resource programs.

The Patient Benefit Coordinator can assist patients in applying for the Social Security Disability and Supplemental Security Income programs.

They can also assist our elderly in applying for the Medicare Part D Pharmacy program, as well as assist in processing both Qualified and Specified Low Income Medical Beneficiary programs, also known as the OMB/SLMB programs, which is available through each state.

States have also recognized the lack of access to health care in Native American communities.

The Presumptive Eligibility initiative in New Mexico has helped increase Medicaid enrollments when Indian Health staff have participated in outreach work, such as health fairs, which target special patient categories like children, pregnant mothers, and other community education, and outreach activities.
The Indian Health Service has also mandated that all patients who seek health care services at our facilities receive a Patient Registration interview.

This is to ensure that all Native American beneficiaries receive a screening for alternate resource programs, as well as update addresses, phone numbers, and other pertinent patient information.

The attached eligibility category from the IHS Patient Registration database illustrates the different combinations of third party coverage which includes Medicaid.

As you see from our latest figures from 2006, the majority or 68% of our Medicaid beneficiaries have only Medicaid and about 10% also have Medicaid and Medicare, referred to as "dual eligibles".

The balance of those with Medicaid also have an additional resource. So, it is important that the Indian Health Service capture all third party payer sources in order to maximize our revenue.

The coordination of benefits can make a huge difference on our billing to collection ratio and saving Contract Health Service funds for additional referrals.

The retrieval, enrollment, and collection of Medicaid information is also helpful in decreasing the costs associated with our Contract Health Services program.

Each year, the Indian Health Service CHS program pays out over $500 million dollars to outside providers.

This pays for primary, secondary, and tertiary care services to specialists and hospital providers.

By enrolling our patients in the various alternate resource programs, mainly Medicaid, will save the Indian Health Service and Tribal programs millions of dollars, which can be used for additional CHS referrals for outside services.

Since the Indian Health Service is the residual payer, or "payer of last resort", we are required to have all CHS eligible patients who are referred for outside services, to be screened and possibly enrolled for alternate resources.

This is in accordance with the Indian Health Service Manual, Part 3, Chapter 2.

As was mentioned earlier, Medicaid has a vast array of programs that vary from state to state.

For the state of New Mexico, there are over 40 categories of Medicaid eligibility that provides approximately 50 different types of services.

These include both financial and non-financial factors that need to be considered.

The most common Medicaid programs include the Temporary Assistance for Needy Families, or the TANF program;

and Medical Assistance for Women and Children (MAWC), which includes the SCHIP program.

New Mexico also has Institutional Medicaid;

Home and Community Based Waiver programs, the Medicare Premium assistance program, the Working Disabled Program; and the new State Coverage Insurance program, in which the State of New Mexico pays for commercial insurance premiums for those clients who are over income for Medicaid, but cannot afford to pay for the high cost of premiums.

In New Mexico, we have approximately 72,904 Native Americans enrolled in some type of Medicaid program.

This accounts for 18% of the total Medicaid population for the state.

The Indian Health Service is proud to take an active and aggressive role in providing the Medicaid program to our beneficiaries.

In addition, to direct care at IHS and Tribal facilities, Medicaid provides another resource for Native Americans to utilize when being referred to a private facility.

This is especially important for those Native Americans who are not Contract Health Services eligible.

As Cynthia had mentioned earlier, both Albuquerque and Navajo Areas now have approximately 8 Medicaid outstation workers assigned to Indian Health Service facilities.

The proactive step by these states have proven to be a great success and is a "Best Practice".

In addition, our State of New Mexico Native American Medicaid liaison, Miss Shari Roanhorse-Aguilar, has been instrumental in providing many collaborative efforts to ensure that the Native American voice is relayed to the state of New Mexico on impending federal/ state legislative

changes, demonstration projects, ombudsman activities, and any reimbursement issues that need to be resolved.

She ensures that any important information regarding Medicaid, is relayed back to the Indian Health Service and tribal sites.

As a result of these efforts, the both IHS and tribal programs have greatly benefited from the Medicaid program.

I am happy to answer all Medicaid related Questions and Answers at the end of this presentation.

Thank you for letting me share some of our activities with the Medicaid program on behalf of our agency.

Dorothy:
Thank you!

Now it's that time we move to that segment where we open the phones and faxes to you, our audience.
As a reminder, you have two options as to how you can contact us:

1. You can call the 800 # listed on your screen and ask your questions live or

2. You can fax your questions to 410-786-0123 and the panel will be asked to respond. If we don't know the answer, we'll take your contact information and get back to you.

To give you time to call in I would like to take this opportunity to share with you an informational DVD we have just released.

This is a short 7 minute piece made specifically for the AI/AN audience.

It is intended to encourage AI/AN beneficiaries to ask about enrolling in Medicare and Medicaid. As the presenters have mentioned, Medicaid is a very important revenue source for AI/AN health.

We want to help you enroll your Tribal members in the program so that your facilities can bill for services provided to Medicare and Medicaid beneficiaries.

The "Our Health, Our Community" DVD provides Medicare, Medicaid and SCHIP outreach to American Indians \ Alaska Natives and can be used in hospital and clinic waiting rooms, local TV stations, training events, health events, and anyplace AI/AN beneficiaries are gathered. Let's take a look now.

VIDEO

You can order copies at the web address on the screen.

Dorothy:

Questions

Dorothy: (CLOSING)
Well, we're at the end of our Medicine Dish hour and I and the Panel want to thank you for your participation in our broadcast on Medicaid.

I want to take this opportunity to remind you that our next Medicine Dish broadcast will be on January 9, 2008, called "Survey and Certification for Indian Health Providers".

I want to remind the audience that you can access previous broadcasts of our Medicine Dish programs at the NIH website. Instructions are on the screen.

Thank you and I hope you enjoyed and benefited from today's Medicine Dish hour. I'm Dorothy Dupree, your host of Medicine Dish, wishing you a very productive day!