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Operator: Welcome and thank you for standing by. At this time, all participants are on a listen-only mode. During the question-and-answer session, please press star-one. Today's conference is being recorded. If you have any objections, you may disconnect at this time. Now let's turn the meeting over to Tara Nokelby. Thank you, you may begin.

Tara Nokelby: Thank you! Good afternoon, everyone, and thank you for joining us today. My name is Tara Nokelby, and I'll be facilitating your webinar. Today's webinar will be on Medicaid billing for long-term services and supports with our speaker, Elaina Seep. There will be a question-and-answer session at the end of the presentation. You can open up your line by pressing star-one or you may also use the chat box at that time on WebEx, and I can read them aloud. This presentation will also be recorded and posted on Older Indians at a later date. At this time, I will pass it off to Elaina, thank you.

Elaina Seep: Thanks, Tara. Hello, everybody. Thanks for joining. This is part of a series that I give in conjunction with cluster trainings that Title VI gives nation-wide to tribes. And we're really trying to be really stirring up that movement for long-term care, services, and supports, and how tribes can start becoming—start—get re—well, I clearly can't talk this morning, so thank goodness we're part-way through the [chuckles] week—so that tribes can start being reimbursed for the services that you're already providing to your elders and also to some of your adults with disabilities. This particular presentation is roughly an hour. It's really geared towards a general overview and also how you can—the sorts of things you would want to discuss with leadership in order to get leadership to support you in this project because it's really important to have council and tribal chairs and presidents engaged in supporting the work that you're doing, because some of the decisions that you'll need to make about the structure of your program and how you'll approach it really have to come either from tribal council or get some of their approval, and I try to be very aware of that. So, that—all of that being said, we'll kinda jump right in. You know, I like to start out talking a little bit about what long-term care really is. People have different ideas of what that means. Is long-term care being in a nursing home? Well, yes, it is. But long-term care can also be services that you're getting at home, or in a community-based setting like an assisted living center, a step-down center. So, at the heart of it, long-term care is any service that's helping an elder or a disabled adult to stay in their own home and in their own community for as long as possible. We call that "aging in place" from that elder and aging standpoint, is what sorts of supports does an individual need based on them as a person, where they're living, types of physical or illness-related barriers or difficulties they may have that they need supported. What's it going to take in their individual case to help them live independently, where they'd like to be, for as long as possible. All tribes are providing some kind of long-term care. Also, if I ever go to fast, please feel free to type a message into the pop-up so that Tara can let me know to slow down or that you wanted something clarified. I know we're gonna have questions-and-answers afterwards, but I also don't want—if you have something you really would like to know, I don't wanna go too fast and miss it.

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So, this slide gives you an idea of some of the ways that tribes are providing long-term care. Whenever I give the cluster trainings, one of the things I like to do is ask the question of people in the room, is your tribe providing long-term care? I have a little sheet and sometimes we do it online as a little poll. It's always interesting to me to see how many people say no because they think they're not providing it. Then, by the time we're done talking, even in just an hour, everybody's turned to yes because you're probably giving some kind of service that counts as a long-term care support. Things like chore workers, and under chore workers, that's your lawn care, somebody coming in to do some dusting and cleaning in an elder's home. Home-delivered meals, that's also a way to provide long-term care. Transportation, and that transportation isn't just going back and forth to their doctor's appointments. You can have transportation that's covered under long-term care programming that means if they need a ride to the bank, maybe they need a ride to the store. Maybe you, out of your aging program, maybe you have a small van or some kind of small bus and you're doing a once-a-month or twice-a-month shopping trip where you take everybody into town, and everyone goes to Walmart, or to a grocery store. These are some of the things that not only are you providing them, and they're considered long-term care, but they're also usually billable under state programs. Home modifications, so if you're housing or even if council is getting request of, "Hey, we need to build a wheelchair ramp," or, "Someone just came home from the hospital and they need to have some grab bars put in, those sorts of things, that's also long-term care. A big one that I like to share with everyone is loaning out that reusable medical equipment. The reason that's a big one to me is because that's not just a waiver service, which I'll talk about in a minute, that's also a Medicaid card service. What that means is this entire time, if you have a loan closet, certain medical equipment, you could've been—you can be billing as a rental. When you have that equipment out in the community—a walker is a really good one because sometimes people only need a walker for a few months. Maybe they had some surgery on their knee, they need a walker for a short time, you loan it out from your loan closet in your program, there are Title VI dollars for your loan closet, and you loan that out. Well, you could also be billing that back to Medicaid. There's a modifier you use for that. It's RR. That RR just tells the Medicaid system that this is a rental.

So, then, you can bill it by the month, you can bill it by the week, because the rental price breaks down to something small. So, in Wisconsin, the rental for a walker is something like a dollar and 40-some odd cents a day, but then if you've rented it for about a three-month period, then you hit what they consider the purchase price, which is like 40-some odd dollars. That is roughly the price of a walker. If you were to go to Walmart's website where they've got some durable medical equipment like walkers and wheelchairs, you could turn around and buy a brand new one. So, something to know when you do some of those rental—the rental of equipment is that when the Medicaid purchase price is met, Medicaid considers that it belongs to that member that you rented it to. So, if Ida Smith came in and she needed a walker for three months, and you rented it to her, and in that three-month time period, you hit the maximum that Medicaid considers it purchased, they would send you back an explanation of benefits, telling you that you'd reached the purchase price. Then you would need to give that walker to her, but now you just made the money to turn around and buy a brand-new one and you

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didn't even touch your Title VI funding. So, there are other—that's just a really good example because that's—almost everyone has a loan closet. So, we're not just talking about—but we're not just talking about loan closets, we're talking about all of these services that you may be providing, and this is a small list that could be a really significant return for your tribe, and you can hang onto your Title VI and maybe some other grant monies.

One of the things I like to tell everyone is that setting up a long-term care service and support program, it's pretty daunting. It's a lot of work, I'm not gonna lie, but you can start with what you already do. Start with where you are. So, start by looking at what—what long-term care is in your community and where you might be providing it. So, even though you may want to have this really big program for all of your elders and some of your disabled adults, that just might not be feasible for you to start out with. So, what I like to see tribes doing—and I know that what the Title VI program is encouraging—is how do we maximize your Title VI grant dollars so that you can conserve some of those and pay some of your costs of operating your program like your—you know, here's how I pay part of the salary for our cooks that do our home-delivered meals, and we're also able to bill our home-delivered meals out and get that revenue back in so that then you can start to have a self-sustaining program, but it really can start with one service. So, start with what you do. But, in order to know what you do, these are some departments within a tribe that we've identified as this is where a lot of those long-term care services and supports live. We all know they live in elder and aging programs in your Title VI program, but if you are a tribe that has social or human service programs, tribal housing, tribal transportation, if you have a health center, or a community health worker, or a community health nurse, these are all different places that are probably providing some of these different services that are billable back to Medicaid. So, it's good to bring those departments together, talk to the different directors, and this is also where leadership, having them on board, is so important. Because, I don't know about you, but even when I do consulting, sometimes when I send out those emails that go to everybody, not everybody necessarily responds to me until leadership tells them, "Hey, we're having this meeting," and then everyone shows up.

So, it's really important to have leadership involved because they give that—they have that level of authority that you may not have as a—from program director to program director, to gather everyone together. But it is worth reaching out to the different departments and saying, "Hey, we're trying to see what you're doing that we could potentially put Medicaid dollars back in your budget. Especially, you know, as an example for tribal housing, I work with a tribe that their housing department, they know exactly what their budget is out of the general funds from the tribe, and what they're able to build and do for their members. So, they know that it costs them around 2,500 dollars, up to 3,000 dollars to build an accessibility ramp into a house. Well, when that—that's not inexpensive. You build—if you build 10 ramps, that's 30,000 dollars. That eats up a budget really fast. Anyone that they're building a ramp for free for and assuming that cost, that's a first come first serve and then need-based within the first come first served. So, if they run through those dollars, then they're just quoting a job maybe at a discount and some people might have to pay for that or they may have to wait until the

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next year to get what they need. So, to have some of those people be enrolled in these Medicaid programs where now you can turn around and bill that whole 2,500 or 3,000 dollars back to Medicaid and get that paid back to you, that's huge because now you don't have to turn people away until next year.

Now you've also got more funds for the people that maybe don't qualify for Medicaid, but are right on the line, you can expand and provide more services. So, it's not just about serving people who are Medicaid eligible and getting those reimbursements, it's also how you could serve people who aren't Medicaid eligible, but you want to serve them because they're an elder or because they're someone with a disability and you're trying to take care of your community. This gives you more leverage and wiggle room to do that with what you have and what you're already doing. So, long-term care, how it adds to your community, some of these are pretty obvious, but sometimes people don't always think of them and if you are talking to leadership, leadership's going to want to know what the bigger picture is and, obviously, we wanna serve elders and we wanna serve our people with disabilities, keep them here in our communities as long as possible, give them the best quality of life and care that we can. So, that should always be the top, is it's giving these much-needed services to your elders, to your people with disabilities, but then it's also increasing tribal program revenues, and it's helping you become more self-sustaining. I can't think of a bigger and better way to support tribal sovereignty than to have self-sustaining programming. Someone that I've heard speak, Denise Pomer, who is a Stockbridge member here in Wisconsin and has also worked for Menominee Nation and she now works for Lac Courte Oreilles, I've heard her speak and say there's nothing more culturally competent than a tribe caring for tribal people. That's absolutely true. And so, to me, we could add on to that and say there's nothing greater to support tribal sovereignty than a program that's self-sustaining, when it's operated by the tribe, when it's serving tribal people, and it's really supporting what you do and what you do well. It's also creating—you know, having these programs create employment opportunities for tribal members.

If you are—well, I'll take Menominee Nation in Wisconsin as an example. Menominee Nation started with their home-delivered meal program because almost everybody's doing that, and they have their Title VI money. They reached out to the state of Wisconsin, so they did get some seed money to expand, but it was only after they started realizing, "Oh, hey, we're providing this service, and we've really not—we've just been skating by on our Title VI funding and then whatever the tribe puts back into it, but this could be billed to Medicaid." So, that's where they started. They provide a few more services past that, but they now have a waiver program, or this long-term service and support program, that's over a million-dollar program, that's the revenue that it's generating. So, they actually took over—so, Menominee Nation, their reservation boundary is shared with Menominee County. So, the majority of the Menominee County residents are Menominee Nation members. So, they wound up actually approaching the county and saying, "We would like to do some subcontracting with you to help us with our case management so that we can expand services and learn from you, and then we'll take it back." And that's what they did. Well, now, fast-forward by about four or five years and now Menominee Nation has taken over in the past couple of years a lot of

those duties from the county. Then they became a waiver agency, administering these programs and doing their own screening. So, it took them some time, but they built a really worthwhile program and they started with home-delivered meals. I'm working currently with another tribe with Lac Du Flambeau and they also have started billing their home-delivered meals. One of the other things—this is an important thing to know about your billing and when you're talking about Medicaid—you can retroactively bill Medicaid by 365 days from the date of service. So, if you have someone who's been enrolled in Medicaid this whole time, been enrolled in a waiver, and they should've been getting their home-delivered meals paid for, you can absolutely retroactively bill for that. So that's what we did in Lac Du Flambeau. They had—Wisconsin had a different system come in—and I don't know what states everyone is from here in the room, but many states are going to what's called a managed care model. Really what that is, is a way to contain cost. They're looking at long-term care programs because long-term care is so expensive.

To give people an idea of what I mean, in Wisconsin, we did some data numbers—and just on tribes—that in the Medicaid system the physical number of claims received for long-term care made up a little less than 25 percent of the total claims volume received. But it made up over 55 percent of the cost. So, there's a big drive in many states to contain that cost and a way to do that is to introduce a managed care system. Now, there is federal law that says that you cannot force Native American people and Alaska Natives into managed care in—unless you have a special dispensation or special permission from the Secretary of Interior or the MCO, the Managed Care Organization, is operated by IHS or operated by a tribe. However, there's a loophole to that, which is what Wisconsin has gone to and other states, I know it's happened already in New Mexico and a few others, is that if that's the only system that you offer these services in, then you're not forcing native people into it, but they don't have any other way to access the services, unless they join into the managed care program. So, it's really important for you to keep an eye on in your state, is to know how your state is providing these—this long-term care home and community-based service programs. Is it through an MCO system because it adds an extra layer for tribes to be aware of because there's an extra entity for you to work with besides working with the state. But it can be done and, as I mentioned in Lac Du Flambeau, they—Wisconsin's long-term care MCO system didn't launch to the whole state. They had like a so-many-year plan, and it's been going by different regions. It came into Lac Du Flambeau's three or four-county area last year. Well, then once the MCOs took over, they were administering the program for everyone, tribal and non-tribal people, and the tribe said, "Hey, we've identified these 30, 40-some odd people that we've been providing home-delivered meals to this entire time, that were enrollees of your program, so here's our bill for a year." Like, or, "Here's our bill all the way back to June and July [chuckles] of 2017." As of February, we recovered a little over 50,000 dollars just for their home-delivered meals. For nine months' worth of home-delivered meals, they recovered over 50,000 dollars. By the end of this fiscal year, they'll probably have gotten close to around 70,000 dollars, maybe more, maybe closer to 80 only on home-delivered meals. So, this is not small change. They were able to turn around and turn to their elders and say, "We have this extra money. Here's why we have it. What is something that you need, and you want in our Aging Center?" Their

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elders really wanted and needed a table and chairs in their sunroom, and so, that's what they bought. The elders picked it out and they were super thrilled with it and super thrilled to be able to do it. Obviously, a table and chairs did not cost 50,000 dollars, so they still had other money in their program where, talking to their Aging Director, Sharon Thompson, she said, "This just met like our paper good budget for the year." So, part of what they have in their home-delivered—er, in just their meal program in general, congregate and home-delivered meals, they just met all their paper products, all those plastic utensils, etcetera, paid for, for the year.

Obviously, this also can—you know, you're talking about money that you can use to hire another member of staff because you're going to be expanding your services. So, one of the questions everybody asks, especially if they're members of leadership is, "Show me the money. Who pays for long-term support? Who pays for these services, and how do tribes get reimbursed?" That's where we—you've heard me mention Medicaid waivers along with Title VI funding. So, just to break it down, Medicaid does pay for long-term care services—in these instances, when the person receiving them is enrolled in Medicaid, or—and/or an Medicaid waiver program. When those services that you are providing are allowed under the waiver or the Medicaid card, and then when the tribe bills Medicaid with right service codes for their state. Now I'll take it back and let's dial it back a bit and give you the difference between, well, what is a waiver? Everyone wants to know, well, what are we waiving? Because it makes it sound like the member is waiving something or the tribe is waiving something, but it's not. The easiest way to think of Medicaid waivers is I like to say Medicaid is a bologna sandwich. If you are enrolled in Medicaid, everyone gets the same bologna sandwich, but if you're enrolled in Medicaid and qualify for a Medicaid waiver program, now you get cheese on your sandwich. Still getting the same bologna sandwich of Medicaid that everybody else got, but you get a little something extra. That little something extra, our waiver service is intended to keep you independent and give as long as possible in your home or community setting. It's keeping you out of nursing home. That's the point of waiver services, is to keep people as independent as possible for as long as possible and keep them out of nursing homes for as long as we can. So, why it's called a waiver is if you've ever heard Medicaid called Title XIX, just like Older Indians funding is Title VI, these are all referring to different sections of the Social Security Act, so Title XIX is Medicaid and underneath Title XIX are all of the different ways that a state can have Medicaid. Then you have something called 1915(b) and (c) waivers, there's—and it goes through the whole alphabet, from (a) to like, I think, (k) or (l), but those are all different ways that a state can say, "Hey, we know that there are these requirements for everyone of Medicaid where we have to make it fair across the board to everybody, but we as a state are asking you, CMS, for permission to waive or put aside those requirements so that we can serve a specific group of people a very specific set of services that aren't available to everyone."

When it comes to long-term care waivers, your specific group of people are frail elders and adults with disabilities. I mean, there are also children's waivers and children with disabilities, but these are the ones that we're talking about for use with Older Indians Title VI grants. So, they're saying, "Okay, here's the people that we wanna serve

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specifically, and only these people in this waiver." So, it's not available to anyone under 18 who doesn't have a disability or anyone who's 35 and doesn't have a disability or a physical need. They're gonna get—they'll still get regular Medicaid, they'll still get their bologna sandwich, but we recognize that these frail elders and these people with disabilities, they need cheese on their sandwich because they need special services we don't give to everyone else in order to help them manage and be independent. So, when we talk about enrolling people in those programs, you want to look at who you have that's already enrolled in Medicaid because then they need to go through a second type of enrollment. So, when people are enrolling in Medicaid card services versus Medicaid waiver services, one of the requirements is we all know you have to financially qualify for Medicaid, right? Well, underneath waivers you have to qualify—you have to qualify for Medicaid the normal way, financially, but you also have to qualify for it functionally. That's where it gets into what kind of physical, mental, etcetera disabilities or illnesses that—does that person have that creates a functional issue for them. When I gave this as a longer talk, I mentioned the instruments of daily—and activities of daily living.

So, those ADLs and IADLs, which anyone here who's a nurse or a community health rep probably knows what I'm talking about, where these are those day-to-day tasks. How does your illness affect your ability to cook a meal for yourself? How does your condition affect your ability to get yourself dressed in the morning, take yourself to the store? All of these are these different tasks that we take for granted all the time, but when you're someone who's struggling and you're someone who's not as well as they could be, who's not in good health, or who has permanent disabilities or permanent or chronic illnesses, even buttoning a shirt can be a struggle. And so, there's a functional screening process that happens to determine the level of need that someone has and get them enrolled and eligible for these waiver programs. Now, from a tribal standpoint, depending on how your state works, which obviously every state is different, that some states who are on that MCO model like Wisconsin—Wisconsin has two parts to that, Wisconsin has aging and disability resource centers, which used to be part of the counties, but now they're consortia in regions, and they do the initial screen to determine if someone's eligible. Once that person is deemed to be eligible, they can choose from the different providers and the different MCOs in their area, and then the MCO works with them to create a case plan. Sometimes you'll hear it called a care plan. That's the case and care management piece that tribes need to be aware of because it's every state has a different law, every state has different challenges for tribes to get certified to do that, but whether you want to pursue doing that case and care management yourself or not, you need to be involved in how your state is handling that with your elders and with your vulnerable adults because that care plan and that case management is what says, "Oh, we think Ms. Echo Hawk needs 10 hours of personal care," while your doctor at the tribal clinic may have said, "No. She needs five hours a day, five hours a week [misspoke]. She needs 25 hours." So, it's very important for tribes to work with their members as they go through this process and make sure that they're being—they are with their elder, with that vulnerable adult, to help them and their family navigate through that case plan, and also to pay attention for things that the tribe is providing that sometimes some of those organizations like to say, "Oh, well, that's a

natural support." And natural support is another way for saying, "We're not going to pay for it, we're gonna make it your responsibility." Well, as a tribe, there are federal provisions that say, "No. Actually, there's a federal responsibility for the health and welfare of Native Americans, Alaska Natives, Hawaiian Pacific Natives, for their health and wellbeing." And so, tribes who are providing these services to Medicaid-eligible tribal members absolutely get to be reimbursed for that. I'll talk about that a little bit more when we slip over to the next slide. But an important thing to know as we kinda get off of this topic is that you can still bill Medicaid and keep your Title VI funds without conflict.

Now, there are some exceptions to that and that's where knowing what your state's waiver programs have—what services they do and don't cover and what they say. One of the Dakotas, and I don't remember which one, I think it's South Dakota, but there is at least one state I know that does not cover home-delivered meals at all in their waiver plans. They don't pay for them because they're aware of Title VI and they're aware of Title III, which Title III is kind of that non-native counterpart under the Older Americans Act, and home-delivered meals are under both Title VI and III and because there's funding through those grant programs, the state has made it where you can't bill for those home-delivered meals. It's just not part of their waiver program. So, there is some—a research component to this. As I work more with Title VI, we've been working on every state we present in, looking at what's on their waivers and creating charts of, "Here are the services that match Title VI where you could bill across what you're doing." And if there are some exceptions, we try and let you know like, "Hey, you can't bill for home-delivered meals." No one can bill for congregate meals, and that's actually a slide further in. So, you do—as you get into this, you will wanna know and you'll need to know what your state Medicaid waivers look like. There are some resources out there. A lot of them—anything that I've done as a presentation or training with Title VI always comes out to their website. I also have that content to my presentations linked on my own website, which is at the end of this presentation, so that you can go and see, "Well, here are some of these maps where you can find that waiver information more easily." I always tell everyone please feel free to email me and I'll do the best that I can to answer your question or to point you in the right direction. A few of these services might be billable to Medicare. I don't deal as much with Medicare, I'm very focused on Medicaid waivers, but there're certain services such as some of the nutritional services like nutritional assessments, if someone has CKD, so chronic kidney disease, and adrenal disease, certain diabetic education, diabetic foot care, those are things that are also billable to Medicare. And so, if you have someone enrolled in Medicare, that's worth pursuing because then you have the potential of having three different billing sources. First to Medicare, then to Medicaid, then to IHS. It really makes a difference in supplementing your revenue stream to make sure that you're working individually with your members to make sure that if they're eligible for Medicare, if they're eligible for Medicaid, that we're working to get them enrolled. Medicare people think, "Oh, you have to be 65 or older," but actually you can also be younger than that if you have certain types of illness and diseases. When you've been declared disabled through Social Security, SSI, SSDI, once you get that official determination of disability, the next year you qualify automatically for Medicare, regardless of your age.

Then there are also certain types of chronic illnesses that automatically qualify you for Medicare. So, it is worth exploring what everyone might be eligible for because it gives them better access to more care because I don't know—I know a few tribes, but I know not all 566 all have their own dialysis units. So, people are going to be going outside of the tribe for some of their care. The more of these programs that you can get them enrolled in, the more options they're going to have to see providers, but also that's going to give them better access to care. It's also a way for the government to provide for the care that they should be providing for through IHS, which we all know that IHS is only funded at like 40 to 50 percent of its actual need. In the entire time that IHS has operated, it has never ever in its entire history ever been funded at 100 percent of what it actually needs. So, no one in this country, tribal, native, non-native government, whoever, can say that they have any idea what IHS would really be capable of because it's never received full funding. So, Medicaid and Medicare are also ways—because these are government-operated programs, and these are ways that tribal members can get their treaty rights met for their healthcare needs. If you are a tribal member and you are enrolled in Medicaid and Medicare, you do not have deductibles, copays, cost shares with very few exceptions. In Medicare, you do have some premiums for part D, for the prescriptions you might have a couple of deductibles, but tribes are able to sponsor that and then the tax break on some of that. In Medicaid, there are no—there's no cost sharing except long-term care. However, there are ways—and I'll talk about that a little bit further, I'm trying to keep an eye on the time, too—there are ways to eliminate that cost share.

There are ways for tribes to pitch in on that or help a member to reduce the cost share or eliminate it. There is work that's being done by tribal advocates to eliminate that cost share. So, it's in the works, but that is the one place in long-term service and supports that if a member had a higher income, they could say, "Oh, yes, you can participate in this program, but you're—" say, let's say they are 1,200 dollars over in income on a yearly basis, if they have the functional need what would happen is the state would say, "Okay, we'll take the 1,200 dollars that you're over and we're gonna break it into—we'll divide it by 12," and whatever that number comes up to be, like a little under 120 dollars, let's just say 100 for the sake of math that I'm bad at off the top of my head, then that's your cost share a month. That causes a lot of elders especially to drop out 'cause why would they pay when they could just go to the tribal clinic and get their services for free. That's where it's important to have tribal leadership onboard because leadership's going to need to make the decisions, are we able—even if we're a small tribe—are we able to pay that 100 dollar a month cost share for some of our members to participate in long-term care. You're going to make that money back. If you have to pay a 1,200-dollar cost share and you ha—on this member who also has maybe Alzheimer's, the cost of their care and what you're getting reimbursed is going to far exceed that 1,200 dollars that's being spent on their cost share so that they can participate in that program. But, again, that is something that program staff have to have leadership to weigh in on. So, here are some other programs that pay for some of that long-term care. Right now, they're Money Follows the Person. I say it's two programs in one because it really is. There's the state Money Follows the Person and that is—all of the expansion states for

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Medicaid are participating in this. There are more states than that. States that didn't take the expansion are also participating in Money Follows the Person. You can go to CMS's website and see—find a big list, find out if your state is one of them. There are—and then every state was able to use that federal funding and craft their program to be specific to their state. So, it's really geared towards having those home and community-based supports for people and identifying people who are in not just nursing homes, but also any kind of intermediate care facility that could come back to their home or to a community-based setting if they had the right support. Every state is doing this diff— [audio cuts out], but, like—so, like, Minnesota, it's actually got a name, and it's called Moving Home Minnesota. There's a Community Options in Wisconsin. So, every state calls it some—that's participating calls it something different. There's also a Tribal Initiative. The Tribal Initiative is only operating in five states because it had limited funding. What a surprise. [soft chuckle] And it was a competitive grant. The five states that are participating in that and working directly with tribes are Wisconsin, Washington State, Oklahoma, North Dakota, and Minnesota. So, if you're in one of those five states, it may be worth looking at what—well, really four because I know what Wisconsin's doing and I don't recognize anyone in here as being one of those 11 tribes. So, what Wisconsin did with their money was they put it into non-competitive grants. Everyone got the same amount of money. Tribes put together a grant proposal for what they were going to do with the money and how they were gonna set up some programs, what they were gonna focus on. Those were all distributed at the end of last year to all 11 tribes. So, it's worth—there are some other options out there to take a look at to see how you could maybe get some extra funding to set up a more robust program.

But there's nothing stopping you from just looking at what you're already doing and where you may have billable time and hours. I hope you can all see that [referring to slide] because I—it looks smaller to me than I remember it was when I made it. So, the ARRA provisions for tribes, that just stands for the American Recovery and Reinvestment Act of 2009. Section 5006 is what's really important for tribes to know. Underneath that, CMS defined Indian, in relation specifically to Medicaid, to mean that it had the same designation as anyone who was I—who met IHS's eligible requirements and that tribes determine who meets that IHS eligibility. It also created a payment obligation so that when an IHS tribal or urban Indian provider is giving Medicaid-allowable services—and what we mean by allowable is that state's Medicaid plan allows for those services, it pays for those services—that if you're providing Medicaid-allowable services to Medicaid-eligible tribal members, then you have to be paid as if you're a contracted provider, regardless of having an actual contract. So, that's really huge for tribes that are in MCO states where a lot of states have said, "Oh, we created this MCO system and then we leave it to the MCOs to negotiate directly with providers for the lowest amount possible." Tribes need to know this so that they can turn around to the MCO and the state and educate them and say, "Actually, no. We don't need to have a contract with you when we're serving native members. And here's our bill. So please pay it." It has been an educational process even though this has been out there since 2009. It really came into immediate effect in 2010, which is also when all the Affordable Care Act provisions were out there, and yet there are still states and still state-controlled entities like MCOs and HMOs and PTOs, so all those provider networks that really don't

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understand ARRA and that there is an obligation to pay tribes for serving tribal members. Now, if you have blended families, and you're serving non-native members, ARRA does not apply. So, if the state law says you have to have some kind of a contract with an MCO to serve people the long-term care, anyone who's not native, who doesn't need that IHS-eligible status, you would need to meet whatever that state requirement says in order to get paid for serving them. But, for a lot of tribes, I know that the preference is more to keep those services internally for your tribal members and for anyone who's IHS-eligible.

So, [referring to slide] these numbers are for Oklahoma for different tribes, as you can see. This is for 2015, I went out and pulled up so people could see, like, if you went and looked right now at the Title VI data, it's current up until 2015. They're getting ready to load more. As of 2015, for each of these nations, these are the amount of meals that they reported for their home-delivered meals for that year. Now, in Oklahoma they reimburse providers for home-delivered meals at a rate of four dollars and 88 cents per meal. So, that very last column is what each one of these nations could—could—have gotten if all of those people that they delivered those meals to had been enrolled in this Medicaid waiver and they billed those meals, that's how much they would've gotten for that year. And, again, we're just talking home-delivered meals. So, in order for you to bill for those, that—or any of these waiver services—a member has to be enrolled in Medicaid and the Medicaid waiver, the service—so, in this case, home-delivered meals—has to be a part of their service plan—that's where I mentioned that being part of that case management piece is so important to make sure that what you're providing makes it into their case plan—and the other thing is that if you're billing Medicaid for these meals, you can't claim the INSEP, but that's something like 80 or 88 cents a meal, which does not add up to 74,000 dollars in a year. So, would you rather have four dollars and 88 cents a meal as your reimbursement or 88 cents? And that's only on the meals that you bill. So, as you track those meals that you serve, if you're serving anyone who isn't Medicaid waiver enrolled and you're not billing for those meals, you can still claim the INSEP for that particular person or persons. You can also continue to claim the INSEP on your congregate meals. Congregate meals, there is none—none of the states allow you to bill for congregate meal sites. But you can still claim your INSEP for it. [referring to slide] This is just another chart, again, from Oklahoma where I looked at the waiver services, gave you what the service type was. These are all service types that are also services you could provide underneath Title VI, and this, again, gives you what the rates are. This is their maximum rate and then what you'd get as a tribe if you were billing for these services by the hour. So, again, very—it's good for you to know, as you assess your own program, and know that this is the money that's already laying on the table if you're already doing it, and then, to translate that or communicate that back to leadership that, you know, we're after the low-hanging fruit. Things where leadership needs to be involved and—that you need to know, but also leadership has a place when it comes to long-term care. That Medicaid enrollment piece, whether you're doing it or in your state it somehow goes back to a state, you'll need to be reaching out to people to make sure you're maximizing that Medicaid enrollment.

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When people come to those different service departments and start asking for some of these waiver services, a No Wrong Door policy is a really good one to adopt where not everybody needs to be a Medicaid expert, but you can start asking everybody who says, "Oh, hey, my grandma needs lawn care," or, "My grandma needs some grab bars installed." [in response] "Hey, is your grandma enrolled in Medicaid?" We're still gonna give her the service, but now we've got, "We're gonna make a referral and someone from Aging and Long-Term Care is gonna call you here in the tribe to discuss getting grandma enrolled in this waiver service," because you're gonna save those purchased in referred-care dollars and you're also gonna save what the clinics writing off 'cause you're gonna have a billing source for it. When we talked about getting people eligible and reducing those cost shares, especially if you're the member of a nation who has a lot of revenues, maybe you have gaming revenues, you wanna be familiar with the General Welfare Doctrine and the Tribal Welfare Exemption Act, which is actually a tax code enacted, I believe, in 2014, but it's still not really widely known. What it says is that you can take dollars and put them aside in a fund or use them to be paying for people with general welfare needs, and it's not counted as income, but you can absolutely use that. Whatever you're paying off for them is their out-of-pocket cost. So, think of all the things that your clinic might write off. If my grandma goes to the clinic and gets her flu shot, and it should really be a 200 dollar-visit, but you don't charge her because she's an elder, you write that off, you never bill her. But that would've been her responsibility. The tribe, by writing it off, paid for it on her behalf.

Because you didn't really write it off, it went against your loss in the clinic. Then the following year's budget takes all that loss into consideration, the tribe puts money into the general fund or into your budget, however that goes. So, when people go to apply for Medicaid, you need to be working with the clinic and other departments to say, "Well, what kind of things has the tribe paid for or written off for this member?" Because those need to be put in their Medicaid enrollment as their out-of-pocket expense so that their cost share goes down or becomes nothing, and they come closer to qualifying for Medicaid, and it can't be counted as income that's taxable. The tribe paid it for—on their behalf and the tribe, as a government, has the right to do that under these welfare doctrines. I talked already a bit about cost share and about that long-term care department and staff. As you get into this, you may find that you have a need to hire at least one staff person to work for your long-term care program to do all the coordination between the different departments to do the billing. I recommend to everyone that that person be a social worker if you can get that because, then, if you're in a state where they're supporting doing tribes and doing case management and you want to pursue that, much easier to get started if you already have someone with a social work background, where case management is part of what they do. State and Federal consultation issues, you may come up against some things that leadership really needs to be aware of, like this cost sharing for long-term care. There's language there that really needs tribal leadership to take some action and advocacy as well at a federal level. Not something that, any of us here on the ground, we can advocate, but the best advocacy is to inform leadership of the places that they need to be aware of. The big one is FMAP and these coordinated care agreements. So, FMAP stands for Federal Medicaid Assistance Percentage and that is because Medicaid is a partnership between

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the federal government and the state. So, no state actually pays 100 percent of your Medicaid budget. If you ever listen to that from a politician, just know that they're lying because the minimum a state can get is 40 percent, the maximum they can get is like 80 or 83 percent.

So, that's the match they're getting on the dollar from the federal government for all of their Medicaid spending. So, in Wisconsin it's 40 percent. So, for every dollar that the state spends in Medicaid, they get 40 cents of it back from the federal government, but under the Affordable Care Act, there was an expansion made and specific provisions for tribes where the government actually said, "We recognize we have this responsibility for the health and welfare of tribal members and we've not been fulfilling it. A lot of burden has fallen onto the state Medicaid plans." So, that federal matching percentage, when it comes to a tribe has performed the service for a tribal Medicaid enrolled member, the state can recoup that money at a 100 percent on the dollar. Every dollar spent on a Native American member is reimbursable at 100 percent when the tribe is the provider of service—of a Medicaid service to a Medicaid enrolled tribal member. That's huge for states, and states have been quietly collecting this since 2010. But now, as of a couple of years ago, there was some guidance issued on that Medicaid expansion, and now it's expanded to outside the tribe.

So, now I'm a tribal member and I need to go, you know, see a cardiologist. My tribe doesn't have one, you refer me out. As long as there is a care coordination where the tribe is managing that relationship between the tribal clinic, myself, and that non-tribal provider, now the state can collect that non-tribal provider's number—er, money back at 100 percent. But only if the tribe participates with them. So, and what that means is—that's these care coordination agreements—is that the tribes have a level of effort in order for the state to collect that money back. Now it is the state money that the state spent, but you're going to have to do some work for states to get that money back in full on non-tribal providers, and on a bigger range of services. That is a huge leverage point for tribes to turn to their state and say, "What are you going to give back to us for our participation? Because you can't get this without us." And it is absolutely something that should be on the radar of every member of leadership, and certainly every health director in every tribal nation. They can't—states cannot get that full expansion without tribal participation. So, I would think that's worth the state helping you build your long-term care program. I went a little over, it's a lot of information, and I hope that it was useful information. [referring to the slide] There's my contact. Like I said, you're free—feel free to email me, email the people who work with me, ask some questions, go check out our website and see some of that content. It's a little hidden. There's two different tabs on the website. One says, I think, like "Presentation and Other Materials," and underneath that is a link to the different cluster trainings that I've given with Title VI and those presentations. You're free to look at them, you're free to download them. I put a lot of stuff out there just for tribes to use and I'm happy to do it. So, if anybody has any questions? Tara, do I need to hand the ball back over to you?

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Tara Nokelby: Nope! You are good. If anybody has any questions, please press star-one and the operator will open up your line. If you would like to type it in the WebX, we can certainly read those allowed as well. We have about five minutes for Q-and-A.

Elaina Seep: Sorry, I did a lot of talking.

Tara Nokelby: No, no, no! It was perfect. Thank you!

Operator: And, again, as a reminder, if you do have any questions or comments, please press star-one and record your name.

Tara Nokelby: And also, if you would like this presentation after, if you wanna put your email address in the WebX chat box, I can send those to you immediately. Then it'll also be posted on Older Indians at a later date as well.

Operator: I show no questions.

Elaina Seep: Well, I can't wait for everybody to build their programs. [chuckles] In my inbox later on. It's a lot of information, and—it's also—it's not an easy thing to say, "Oh, we're gonna talk about Medicaid billing." And there's no one-hour session that anyone could ever sit in that would give you everything you'd need to start your billing because you need to know this background stuff first. But it's not impossible to do. A lot of the codes that you need and the things that you would need to know to bill for Medicaid are actually already out on your state's website. The big thing you need is to know what codes you're billing for the different services. Some states are easier to navigate than others. As I said, please get ahold of me because I develop content based on the states that we perform cluster trainings in or if the tribe specifically contacts me, I will put that together for you and look at, you know, well, what are the waiver billable services in your state and what does it look like because we're trying to build up some kind of a resource for all 50 states that'll be out on the Title VI site. So, please feel free to get ahold of me and ask for that. I may not be—it may take me a couple of weeks to get it to you, but if I already have it developed, I'll send it right out. If it's something that I need to develop, I'm happy to do it.

Tara Nokelby: So, Elaina, we have a couple questions here on WebX.

Elaina Seep: Yep!

Tara Nokelby: It said, from Lacey, it said, "Can you ask her what the replacement MFP will be in Minnesota?"

Elaina Seep: Oh! What they're gonna do when Moving Home Minnesota goes away?

Tara Nokelby: Yes.

Elaina Seep: I don't know. I have not heard yet. I do know that they do still have some money for tribes to apply for through the Tribal Initiative. And the project manager for the state for the Tribal Initiative, who could also get you connected with the regular MFP side, is John Anderson. And if—Lacey, if you email me, I will get you and John connected.

Tara Nokelby: And then we have another question here from Susan, it says, "What is the Recovery Act of 2009?"

Elaina Seep: Oh! The American Recovery and Reinvestment Act? [no response] Of 2009. So, that is—everybody calls it ARRA and that was a big act to reduce administrative burden and there's a bunch of other stuff that's packed underneath it. But it's a federal law that was passed in—and written in—in 2009, really didn't go into full effect until 2010. Section 5006 of ARRA all deals with tribes in a managed care or a Medicaid setting. Then there were also state health official letters that went out with guidance on ARRA 5006. There are several important provisions that happened underneath ARRA, such as defining Indian as to mean IHS-eligible, really explaining and spelling out to states and to NCOs and PPOs how they should be paying and reimbursing tribal providers, and also the options that tribal members have in Medicaid. So, if I live in—if I'm like right on the border and I live in a state where there's no tribal healthcare, but my tribe is across the state line or maybe my tribe is two hours away, I have the right as a tribal member to go seek my healthcare from a tribal provider and the Medicaid program in the state I live has to reimburse that provider and has to allow me to go see that provider. So, that's, in a nutshell, some of the big provisions. And again, Susan, if you email me or email Tara—and actually, Tara, if you help me remember, I will make sure that I send over to you a copy of the state health official letter that gives the guidance on it, and you guys can publish that out on the Title VI website and give it to the people that were on the call today.

Tara Nokelby: Okay, perfect! And I don't see any other questions here and we're just—we're out of time at this point, but I did wanna say thank you to all of the participants and thank you, Elaina, for the presentation. I will send out the presentation to all the folks that have put their email addresses in the WebX link.

Elaina Seep: Alright, perfect! Well, thank you for inviting me. I appreciate it. I hope it was some useful content.

Tara Nokelby: Of course. Thank you, and we hope to see everyone next week at the Title VI conference.

Elaina Seep: Yep! I will be there. I have a whole day that has more detailed information on this and we talk a little bit more about how to get the billing accomplished and steps to build a long-term care program.

Tara Nokelby: Perfect. Thank you, everyone. Have a good day.

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Elaina Seep: Thanks, Tara. Bye.

Tara Nokelby: Bye.

Operator: Okay. That concludes today—