

**OPERATOR:** —and thank you for standing by. At this time, all participants are in a listen-only mode until the question-and-answer session of today's conference. At that time, you may press star-one on your phone to ask a question. I would like to inform all parties that today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the conference over to Ms. Jasmine Aplin. Thank you, you may begin.

**JASMINE APLIN:** Hi! Thank you so much. And thank you so much, Sheila. And thank you, everyone, for participating. Today we're going to talk about Medicaid, and we're going to have—so Medicaid in light of COVID-19. And so today we have the incomparable Elaina Seep here to present. Before I give an introduction to Elaina, I just want to briefly remind everybody that we have our—we still have our regular Title VI calls, which everyone is welcome to participate in, and those are Friday from 3:00 to 4:00 p.m. And we'll have a—those are NICOA-hosted with ACL able to participate and answer questions. We'll answer your general Title VI questions, your COVID financial questions, and anything else you have to throw at us on Friday.

And—but today we're going to focus on Medicaid, and so we are very lucky to have Elaina presenting with us today. A lot of you might know Elaina, as she participates in a lot of our cluster trainings and helps people with Medicaid LPPS billing at those cluster trainings. And some of you also might know Elaina from outside of ACL work. She's been—has lots of state experience and has been an invaluable resource to ACL for several years now. But also, before I turn it over, sorry, one further announcement, for audio purposes, if you could please dial in on your phone and please dial 888-788-6210, and the passcode 818962. Elaina, I think we can now advance it to the cover slide.

**ELAINA SEEP:** Yeah, I think you missed a number in the passcode because I have—

**JASMINE APLIN:** Oh, sorry!

**ELAINA SEEP:** —I have 89762 as the last numbers.

**JASMINE APLIN:** Yes, it was—so the passcode is 8189762. So, thank you!

**ELAINA SEEP:** Sorry about that. I just—it's right in front of me, so I was like, I think we need one more number.

[Chuckling]

**JASMINE APLIN:** So I think—so that's the passcode, and I think, without further ado, we're ready to turn it over to Elaina.

**ELAINA SEEP:** Thanks, Jasmine! That was a really nice introduction, and I will certainly try to live up to it. [Chuckles] Now that the bar has been set high, we'll talk about—this is really meant to give you all some updates about some of the changes to Medicaid that the Centers for Medicare and Medicaid have put out in the past few months. They've released a lot of frequently asked questions as well as content directed to state emergency planning and how

that impacts Medicaid, and we wanted to make sure that we got that information out to you as well. I'll try not to be boring, but I make no promises.

So just to get everyone on the same page, Medicaid being a state entitlement plan, a lot of times, just like with Indian Health Services, people mistake Medicaid as being an insurance plan, but it isn't. It's what we would call an entitlement benefit plan. And an entitlement plan is really just any social program that a person may be entitled to when they meet the requirements of the program, and so then they're eligible for usually state or federal funding of certain types of benefits. The big ones that people know about are usually social security when you retire, disability benefits for people who have a serious illness or injury, and then Medicaid is one of those big social entitlement programs. So it provides payment for certain services to the state, under the state plans, and usually we hear about it in two different instances.

Most people know about what I like to call the bologna sandwich of Medicaid, which is whenever anyone has a lower income, they qualify for Medicaid, everybody gets the same services in their state with their Medicaid card, so you're really getting the same bologna sandwich on white bread. But then there's another set of Medicaid programs called waivers, and those are more targeted at specific populations of people or people with certain specific types of illnesses or injuries, and those are called waivers, and I like to think of that as the cheese on the sandwich because they still—when someone is enrolled in a waiver—and those are usually for people with chronic illnesses or disabilities or also people who are frail, what are called frail elders, and most states have just a stand-alone elderly waiver.

And when you are signed up for these waivers, which is the cheese, you still are getting that main Medicaid card service under the state plan as well. So, but again, it's not health insurance, and when we're talking about tribal elders, the program for Medicaid, including waivers, does not require that they pay co-pays, deductibles, or premiums. Currently, the only tribe who's administering—to my knowledge, so if there's someone else, please speak up in the Q-and-A, and I will correct it—but to my knowledge, the only tribe that's currently administering a Medicaid-authorized program is the Cherokee PACE Program out in Oklahoma.

Otherwise, Medicaid is a partnership between the state and the federal government, and it's managed by the state, which usually is why these notices when CMS updates things to Medicaid, that they go out to the state, and then it's up to your state agency to communicate with tribes, unless it's something that directly impacts tribal health. Sometimes that slips a little through the crack on whether or not there's an impact to tribal health. So, but we all know that COVID-19 has had serious impacts on how everyone is responding to health, and Medicaid is no different. So one of the things, if you're looking for any of this information online, that you might see is people talking about the public health emergency.

And you also—I was finding it as an acronym of PHE, and I had to go and look for what that was. So I was like, what are they talking—is this protective health? I'm not sure. So public health emergency, and that public health emergency is when the federal government has declared that state of emergency, then that impacts all of the states for Medicaid services and planning purposes. So under this public health emergency, CMS, which is the Centers for Medicaid and Medicare Services, they've authorized states to file for what's called an 1135 waiver. Now that 11—or 1135 State Plan Amendment. These different waivers have different sections of the Social Security Act or different laws and statutes that they refer back to, that's where you get an 1135.

So these 1135 amendments are sometimes called SPAs, and that just stands for State Plan Amendment. But, again, I'm just telling you this because, if you go out and you look for this information on your own, you're going to find a lot of acronyms, like PHE and SPA without anyone defining what that actually means in the document. So these State Plan Amendments are giving states the authorization to make changes to their Medicaid plan, changes to how they're processing information, but they're temporary. So if you read the different documents—and at the end of this PowerPoint I have a list to the different resources used to put this together, and it also has live links, and this webinar will be posted out, I'm not sure when, I'm sure Jasmine or someone else from ACL can tell us at the end when this will be posted—and you can go and look at the originating documents and look for anything specific that you want more information about.

So where a lot of these changes come from are also the Families First CARES Act of 2020. So this was the act that went back and forth in Congress and in the House about how to provide different COVID relief to everyone across the country. So I tried to break this information down into a couple of main points that had impact to tribes. So the first piece is that, under the CARES Act, in regard to Medicaid, it allows the states to take the option of creating a new Medicaid eligibility group, and that that group are people who are currently uninsured so that those people can receive COVID testing at no cost to that patient or that person in need.

Now part of the reason that's important to hear from a tribal standpoint is that Indian Health Services is not an insurance plan. People think that it is, and it's a misconception, especially among a lot of elders and other tribal members going to seek care from tribal clinic. Because we're tribal members and our tribe just takes care of us and that's how that is. And in many surveys when people are asked if they're insured, a lot of tribal members will respond, yes, I have Indian Health Service. That's not an insurance plan. This is a really important detail right now because the current White House administration and their guidance to CMS has been arguing with some leadership about whether or not states should be paying for COVID-19 testing for tribal members under that potential uninsured population group, and they're trying to go back to, well, IHS is providing some of this.

Now, I can't speak for anyone directly on the phone, but I know that what I've heard from some of the tribes that I work with directly is that many tribes aren't getting adequate testing supplies from IHS that some of the—some tribes in a couple of states out of—Minnesota actually has 11 federally recognized tribes, two of them received the testing machines needed to perform these COVID-19 tests, and each tribe only received 25 test kits. Well, in reality, that's—well, we know that's not enough, just number one, but when you're setting up new equipment like that to run a test, you usually use a couple of test kits just to calibrate a machine so that you know that it's working properly, so really it's like they gave them less than 25 test kits a piece, and those test kits aren't enough to cover staff at their clinic.

So knowing that we're this uninsured population, unless the tribe carries another group insurance plan that they cover their members under or that they cover tribal employees under. IHS is not an insurance plan, so tribal members who don't have private insurance or have an actual insurance plan provided by the tribe should count under that group. The other impact is under waivers. So Medicaid waivers, which I talked a little bit about being the cheese on the bologna sandwich, right? Well, when we work with people on waivers through the

Administration for Community Living and then specifically Title VI, we're really talking about elders, so our aging tribal members, but then also disabled adults.

And because you're an elder at 55 in most tribes, and in a few tribes it's even younger, then those people who may not qualify as elderly for a state plan but have a need because they have a chronic illness or a disability would also still sit under these waivers for their other chronic conditions. So what the Families First CARES Act has done, and then this is also reflected in the CMS guidance that came out, is that states may not drop people from their waivers or change those waiver plans during this public health emergency time period.

So if you have someone who's currently on an elderly waiver or maybe someone who has a traumatic brain injury and they're on a brain injury waiver in a state, even if they no longer need the same level of care or maybe their illness was temporary and they've started to recover and they're not meeting the same requirements, they cannot be dropped off of that waiver during this public health emergency. The only exceptions that a state can use to terminate someone from one of those waivers is if the member has passed away, if the member requests to be dropped from the plan or to have their plan changed, or if the member moves out of state where then they'd be applying for benefits in another area.

And then the last category is people who are SSI—and then I just did the same thing that I said you would find reading all the federal documents, I gave you an acronym without telling you what it was, so social security insurance. So social security disability eligible people, if they had a determination as of March 18<sup>th</sup> of 2020, they cannot have their coverage terminated before the end of the public health emergency period. So this is really referring to people who had that recent determination or people who, just like under the waiver, maybe they started to get better or something happened that they would normally lose their SSI determination, well, usually with that SSI determination, you are entitled to certain healthcare benefits. They cannot lose them before the end of the current public health emergency period, and right now, I don't know the hard date that's actually been announced.

If that member—now, if that person under SSI meets the requirements for another Medicaid group, then the state could transfer that individual to the group. That's the actual language from the Families First Act, but what it means in real people speak is that, if that person were to also still be eligible for, say, a disability waiver because they have a brain injury or a frail elderly waiver, then the state could move them to another group, but they can't lose their coverage entirely. And this is a lot harder to do this without being able to see all of you and kind of gauge if anyone has questions or if this is interesting, so hopefully we're giving you some good information here.

One of the other changes that happened is the general Medicaid processes and how states are allowed to make some changes under these emergency plans to their waivers. So right now, if you are part of a waiver group, so if you have an elder or a disabled adult who would need to apply for those services right now or has done so in the past, then part of that is a face-to-face screen that's called a functional screen, and we talk a lot about this in the cluster training because we really try and go through all of this soup to nuts about waivers because waivers tend to be focused on what we call home- and community-based services. And home- and community-based services are really what you're providing out of your Title VI program.

And it's everything from having a chore worker come and do some light dusting and cleaning inside somebody's house to having someone gather wood outside or mow their lawn,

snow shoveling, that's all chore and homemaker services that are included under these waivers and billable back to Medicaid, if that person is enrolled in the program and has that service in their plan. But in order to get on those programs, there's this functional screen that has to happen, and what that's meant to do is determine the level of care that that person needs, like how—like is their illness well-managed?

Because you could have two people who have diabetes, and we all probably know someone like this, where you have the one person who takes their medication, their blood sugars are pretty well in control, maybe they've made diet and exercise changes and they're doing pretty well, but then you could have a second person with the same diagnosis and they're having a much harder time, maybe they're losing some of their eyesight due to their blood sugars being so high and they're developing diabetic retinopathy, maybe they've already had an amputation. And that person who is in poorer health would be eligible for a waiver where the other person with the same diagnosis of diabetes would be considered well-managed and wouldn't be eligible to have that extra level of service because they wouldn't need it.

So—but anyway, these are face-to-face screens, and that's been a barrier for quite some time because elders are reluctant to have someone from a county come in or someone who's not from their community come into their home and then ask all of these really deeply personal questions. And by personal questions, we're—they're being asked things like, are you able to make a meal for yourself, can you—you know, can you do your laundry, can you keep your house clean, are you able to get in and out of the bathtub? And these are things that elders don't want to share, most people don't want to share, because no one wants someone from outside the community to think, well, if I tell them I can't get in and out of the bathtub, I don't want them to think that I'm not clean, or I don't want them to think that my home isn't clean because I'm telling them that I can't do the housekeeping anymore like I could.

Well, now those—because of COVID, those face-to-face assessments have ended and they're now over the phone. So that over-the-phone screening, this is a really good time to potentially do some outreach with elders and other members of the community to see who we could get enrolled in waivers because, now, what was a barrier of that face-to-face contact can now be done over the phone, and they can—and an elder or any other member of a tribe can absolutely request that a member of their Title VI staff, a family member, someone else from the tribe, like if you have clinical social workers at your tribal clinic, that those people be present on that call. They can be present when the face-to-face screens start up again, but they can also be present on that call to help guide that member through that screen.

Also, members still have to sign the different forms and verifications, but part of the CMS guidance in the CARES Act allows for a telephone confirmation of signature. So, in other words, they're just talking to the person, verifying their identity, they'll record that piece because they're supposed to keep—they being the state agency—is supposed to keep it on file with their Medicaid case, but they don't have to go anywhere and physically sign a form. Also, certain reports that the state might have made before, like to the federal government or even internally as far as if they're holding someone's application because they're waiting for different information, there are delays on all of this because the federal government is recognizing that states are also working with limited staff, that a lot of states have just completely shut down and have people working from home, and that they may not have the same kind of access that they did before.

Not to mention you have more people who have now lost their income, and so more people are qualifying for Medicaid, and these agencies are getting more applications, but that—this time period of lowered income is also a potential for tribes who maybe have a higher per cap that's kept your members right on the line of not being able to be eligible for Medicaid, well, that might not be the case now, and so this may be the time to do some outreach and see how we might be able to get some more tribal members enrolled in Medicaid itself or in these Medicaid waiver plans and take some of the financial burden off of the tribal system for paying for their medical care.

So this Appendix K, I mentioned the home- and community-based service waivers, so there's a whole guidance that's all around these particular waivers. A lot of times you will see them listed as what's called a 1915(c) Waiver, so 1915(c) like cat, and what that means is that in the Social Security Act, the great big long statute and regulation, there is a section and 1915(c) actually deals with home- and community-based services for the different state plans. So under these—and that's usually called a home- and community-based service. And I mentioned earlier that that's things like the homemaking, home-delivered meals, snow shoveling, chore services, all of these are considered home- and community-based supportive services.

So when it's happening in a home- or community-based setting, when it's not a nursing home or in-patient in a hospital, then it's considered home- and community-based. So under this Appendix K to the 1915(c), what the CARES Act and CMS has done is added that appendix into the 1915 waiver statute, and it allows states the option—and I can't stress that enough because a lot of these things are options to states—allows the states the option to increase eligibility cost limits, modify the services or the coverage requirements, exceed the service limitations, add services, provide service in out-of-state settings or also permit payments for services rendered by a family member or a caregiver or someone who is legally responsible for the individual.

So now we're talking about states have the option to apply for a waiver amendment and that comes from the states, but tribes absolutely can influence that. Tribal leadership has the ability to have that communication with these different states agencies and talk about what the impact to these options are to their tribe and how helpful pieces of this could be or if something is unhelpful. What is helpful is that allowing payment for family caregivers, that's not something that every state was doing, now it's allowable if the state chooses that as an option to amend their waivers. They can absolutely pay family caregivers for the services they're rendering to members. They can also add in critical services to a waiver. This might be a moment to press for some more traditional tribal services and ask for those to be added in waivers to certain states.

By exceeding the service limitation, whenever a state files for one of these waivers, so they don't just make it up and then that's the law in your particular state, they have to draft a copy, and then they send it to the federal government, to CMS, and CMS has—it goes through a fairly lengthy process where CMS has to approve the services and what the state is planning to do, and then the state and CMS go back and forth until the final waiver is considered approved and agreed upon, and then it becomes the plan in the state. And waivers are usually a maximum of a five-year period for waiver plans, and then they can either be renewed at that five-year point, or a state may decide to eliminate a waiver and create a new one entirely.

What we've seen a lot of in the past couple of years is states eliminating the individual

disability waivers, like traumatic brain injuries versus frail elders or disabled adults, and then combining them all into one long-term care home- and community-based service waiver. But this is a potential for states to expand some of those home- and community-based services, and you as tribes and as tribal providers of those services, that's a potential to be looking at, well, how do we create our own Medicaid billable services here at our tribe so that you can be capturing some of what you're doing and start with what you already know how to do, which is the services you're providing through Title VI.

So this is—we're almost to the end of my longwinded talking and opening it up for your questions, but I wanted to also comment on the stimulus payments and tribal supplements. So we—I think everybody knows about the different—er, the stimulus payments that have come out. A lot of people have already accessed them from the federal government, that it was like \$1,200 I think, between \$1,200 and \$1,500 per person and so much in a household and if you had children. So those stimulus payments in all of the different laws, under all—under the family CARES Act, under the CMS guidance, those stimulus payments are to be considered as federal unemployment and they do not count for Medicaid eligibility.

So what that means is that, if someone receives that Medicaid—er, receives that stimulus payment, it should not endanger their Medicaid eligibility. Because you could have people that are just barely over the line in income, and Medicaid looks at every dollar coming and going, and it's a delicate balance to make sure that people don't get kicked off their coverage for this short amount of time. So these stimulus payments do not count for Medicaid eligibility. However, on the other side, a lot of tribes have suspended their per cap payments because casinos or their other—if they had agriculture or other business that was paying into their per caps, that those are closed or they're seriously limited in operation, and so the revenue isn't the same.

So many tribes have looked at putting out a tribal supplement in lieu of per caps to their population, perhaps as one lump sum payment to cover the suspended amount of time for a few months. Now, I have not been able to find—so please note that I'm saying I have not found it—I have not found where the federal government has said that those supplements don't count when it comes to this—to Medicaid eligibility. So when we're talking about Medicaid eligibility, there's a formula called the Medicaid Adjusted Gross Income, or MAGI, and that MAGI is how they calculate if someone is financially eligible for Medicaid. And there are all sorts of exemptions for certain types of tribal income, like if your income is coming from tribal resource payments for oil or fossil fuels or other things like that, or if it's a tribal source, like it's cultural work, like with beadwork, or even certain tribes that may do some subsistence fishing, those are considered exempt incomes for MAGI purposes, but per caps are not.

The only way that I could see that a tribal supplement payment could be made and not affect Medicaid eligibility would be if a tribe followed that general Welfare Exclusion Act under IRS 139E. And I put a little note at the bottom, and then I've got a tag back to this in the resource page. What 139E under the IRS does is there was something that came out in 2014 called the Tribal General Welfare Exclusion Act, and in a nutshell, it means that tribes can set aside a special fund that they pay out to their members for their general health and welfare. And the IRS of every agency actually has a really simplistic and nice guide as to what a tribe can and can't do under one of these funds. And it does specifically say you can use gaming revenue

to put into this fund and to make those payments, but you cannot rename per caps into general health and welfare.

Well, a lot of these supplements that tribes are looking at paying, they're paying them in lieu of per caps, but they're paying them so that people are able to keep paying their bills, have food, have necessities, and I think that if it were followed underneath this 139E and the examples that the IRS has laid out, and it's pretty simplistic, it's that everyone is getting the same amount of aid, that the qualifications for it are the same to everyone who applies, that you can't show preference in certain places for, you know, members of leadership or council or things like that. It's pretty standard. And if a tribe could say, well, these are general health and welfare payments for our tribe as opposed to, this is per cap payments, because this is a supplement during COVID-19, then that should not count for MAGI, but I would want you to tag back with ACL staff so we could work on you a little—on that a little more closely, and definitely for tribal leadership and finance to look into that 139E.

Otherwise, I've not found anything from CMS saying directly that, if a tribe is a paying out a supplement payment, that it doesn't count towards MAGI. I have not found that information. If we find it, I will certainly pass that on to Cynthia and Jasmine and their team so that can be updated, but I have not found that anywhere, so I would caution tribes about making those supplement payments in case it—how you do it and what the amount is because it could impact some of your members who are on Medicaid. You made it! This is all the references of all the things I just talked about.

Here are all the places that you can go and directly find that information. A big one might be that IRS guidance at the bottom, that link takes you right to it. They have a seven-page document, and it's pretty much in plain, straightforward speak. It was very easy to go through and understand how to make health and welfare payments that are applicable under that act. So I guess we'll open it up for questions and if Jasmine and Laura have any announcements. Laura, I don't know if there were some questions sitting out there that we could answer that came up in the chat because I can't see all of that, so I will turn it over to the two of you.

**LAURA STEVENSON:** Yes, this is Laura. No questions in the chat. Just wanted to announce that these slides will be available on the Older Indians website within two weeks. If you want them sooner than that, if you can reach out, I'll put my email address in the chat box. And if you can email me and let me know that you'd like the slides sooner, we can send them to you. That's it, thanks.

**ELAINA SEEP:** Thanks, Laura.

**JASMINE APLIN:** Thanks, Laura. And this is Jasmine, and I think if, operator, if we can open it up for Q-and-A and give folks instructions again on how to get into the question-and-answer queue?

**OPERATOR:** Absolutely. Thank you. If you would like to ask a question, please press star-one, unmute your phone, and record your name clearly. Your name is required to introduce your question. If you need to withdraw your question, press star-two. Again, to ask a question,

please press star-one. It will take a few moments for questions to come through. Please standby.

**JASMINE APLIN:** Awesome! And so this is Jasmine, and while we're waiting on folks to have their questions come through, I'm going to do a little bit of a shameless plug here. I mentioned that we have cluster trainings and that Elaina participates in our cluster trainings with us, and so if what you're hearing today, you're like, yes, Medicaid, let's get our folks on Medicaid, and we want to hear more about this, a fantastic way to do that is to reach out to Cynthia or somebody on our team and say like, hey, I'm really interested in having a cluster training, I'm interested in hearing more from Elaina.

Because those are really great opportunities not only to have these conversations face-to-face—I swear Elaina is just as charismatic in person as she is on the phone, she's very wonderful—and also, you know, it's a good opportunity to hear much, much more information. Since this was kinda the view from 10,000 feet, we get to get into much more detail when we do those in person. So, I mean, if you're really interested in learning more, a really good idea would be to say—I mean, it's difficult now, we realize that, because we're all on travel bans and we're being—we're social distancing, and that's so important right now, but if in like six months, a year, whenever you're interested, that's really good for us to know so we can think about planning that in the future.

**ELAINA SEEP:** You know, and I would just add to what—this is Elaina—I would just add to what Jasmine said and say and let you all know that the previous cluster trainings are out on the Older Indians website. So now it's not a webinar the way this is, where you can hear me, but you can certainly go through the slides and find a lot of information that, if you have questions about, you know, you can get ahold of Jasmine, you can get ahold of anyone on Cynthia's team and, you know, we'll get you the material possible. There is also a LTSS, that's long-term service and support, billing manual that ACL has out that's all for tribes around long-term service and support billing that covers some of this Medicaid detail as well.

**OPERATOR:** Thank you. And our first question from the phone lines will come from Valerie, your line is open.

**VALERIE:** Hi, everybody. First, thank you for this—[audio cuts out]—there's a lot of things that I didn't—[audio cuts out]—so [audio cuts out]. I guess my question is, so there is—and I think you might have answered this before, but so right now the pandemic and all that, there's no restriction. We want them to sign up—[audio cuts out]—myself that IHS was our insurance. It would be nice to know that we—you know, there's more options for us. And I'm coming from the Navajo—[audio cuts out]—long-term care. I take care of the family and caregivers. So anything else that we could do, or you could elaborate on—[audio cuts out]—definitely a lot more questions, thank you.

**ELAINA SEEP:** This is Elaina, and you were breaking up a bit, Valerie, so I'm going to kinda try and repeat back what I heard was that you're looking for what your other options are when it

comes to that home- and community-based service piece that maybe gives you options that are expanded beyond IHS, am I understanding that right?

**VALERIE:** Yes, and you're saying that there's no limit right now due to COVID, like they're—our people are still able to get on.

**ELAINA SEEP:** Well, let's not say no limit because every state is going to be different, right, and you're across three states, but there's not a limit in terms of it didn't stop. You can still have people apply, and then states have the option to make all of these different expansions, but they can't drop someone off their coverage if they're already on there. So I guess I just don't want it to seem like, yes, now everybody can apply and they're all going to be accepted. Some of the same structure is still in place in regard to, you know, are they financially eligible or do they fit in one of these other—these waiver categories where you don't have to always meet the financial piece, you're meeting a functional piece.

The big thing that's changed that has impact for tribes is that that face-to-face screen has been a huge barrier because that's meant elders have had to—well, first off, that someone from a county and state agency was even coming out to the reservation, right? That they were going to come out there, and then that that elder was going to let them into their house. So that's been a big barrier. That is not there right now during this time period because now it can be done over the phone, and so that gives you an opportunity to hopefully connect some of these people with these services where then, depending on—so on these waivers, I'm going to get a little into the weeds here, on these waivers what happens is, depending on the state that you're in, they all have a here's the list of services that we think people need in this population group. So let's say elders, and then they'll have requirements for what it means for you to be an elder and be eligible.

If you meet those requirements, then there's going to be a list of services, like they would do chore work or homemaker services or transportation to like a bank or to the store or to pick up medication. And this is without COVID. This is just how these waivers operate period. Usually there's—you know, like there might be some supplies, like incontinence supplies, things like that, whatever is in that waiver plan, part of that assessment is seeing what that member might need out of that plan. First it's assessing, do they have a need, and when the answer is yes, then the second part of that screen is really saying, well, then what services out of the waiver match up to what they need? And then that becomes part of what's called their person-centered plan.

It's also—you'll hear it called a case plan or a care plan, they all kind of mean the same thing, and it's that plan that's set up around, how do we support this person individually out of this list of services? Do they need all of them, or do they need only two or three and that's enough to support them? Then, out of that, where the tribe comes in, if the tribe is the service provider and that member or that elder is saying, I want my home-delivered meals through the tribe, or I want the tribe to be the one to come in and do housekeeping for me or chore work in my yard or around my house, I want to keep that here in my community, well, then if the tribe is the provider of service, that's where the tribe has that ability to become a provider with the state for that home- and community-based service, and then it becomes a billable service to Medicaid. Did that make sense and answer your question more?

**VALERIE:** [Audio cuts out]—thank you so much.

**ELAINA SEEP:** The trainings are pretty intense. It's a lot of information, folks. And I promise that it's way better than sitting here just listening to each other blindly. [Laughs]

**OPERATOR:** Thank you. And once again, if you'd like to ask a question at this time, you can press star-one on your phone and record your name when prompted. Our next question comes from Cynthia. Your line is open.

**CYNTHIA LACOUNTE:** Thank you. Elaina, I was—I think you've answered all my questions I was going to ask about the waiver from CMS just yesterday or today about telehealth, that they don't need to look at our face to talk to us about our kidney stones. And then I was—my other question was going to be to ask you to kinda generalize some services that—and I know this is really hard because every state is so different—but what Title VI services are more likely to be in all waivers—

**ELAINA SEEP:** Ah, okay.

**CYNTHIA LACOUNTE:** —and if we were going to entice Title VI programs who have not started to bill for home- and community-based services, what's some enticing figures that we could use to get more folks billing to enhance their services? My dear.

**ELAINA SEEP:** Okay, so you want me to lay down the trail of breadcrumbs. [Laughs]

**CYNTHIA LACOUNTE:** I do, I do.

**ELAINA SEEP:** Well, first—so first, though, let me—I didn't touch on the piece about telehealth the way you're talking about it, so let me mention that because that just came out in the past day or two.

**CYNTHIA LACOUNTE:** Yep.

**ELAINA SEEP:** There was some hot debate about Medicare, which I deal personally more with Medicaid, but Medicare has not, in the past, been paying for telehealth in the same way, and it wasn't paying for telehealth the same way to tribal providers. Well, now Medicare is paying for telehealth because they have to during COVID because of social distancing, it's just impossible for everyone to come in. Well, one of the pieces that was still in contention between the tribal clinics and Medicare was that Medicare and CMS were requiring a video component so that they had to physically see the person either on Facetime or through a tablet, and obviously that's a problem when you're in rural areas where you don't have an Internet connection. Just—you might be able to get to a phone, but it doesn't mean that you have the Internet. So just between yesterday and today, CMS and Medicare did announce that that video component

is no longer—it will not be a requirement in order to get that full payment for telehealth. So there's that piece.

So the breadcrumbs about billing for Medicaid, the biggest thing and that you hear about the most in tribes that have started billing for Medicaid is home-delivered meals. So far I've only come across one state, and I want to say it was Nevada, that doesn't have home-delivered meals in their home- and community-based service plan. But I guarantee you that, when we gave our cluster training earlier in the summer last year, that those tribes will be having some conversations with the State of Nevada, and the state did have some people present at that training. So, otherwise, that's a big one, and I say that's a big one because home-delivered meals are something that you're tracking already to the individual for your Title VI reporting, and it's just a low-hanging fruit in terms of the service that you track that almost every state has it on their waiver plan.

And it's easy enough to not only be set up for current billing but then to go back and have retroactive billing. And what I mean by that is that, if you had people that were maybe enrolled in a waiver this whole time, you have 365 days from the date of service to bill for something to Medicaid, so that also includes your clinic. So if you start getting people enrolled, you can request a retroactive effective date of a minimum of 30 days, a maximum of 90 days. And CMS leaves that up to a state to determine whether or not they take that, but most states will allow you to request a retroactive effective date when you can show that their—that a person's circumstances were the same.

So for those of you who get the blast and get the newsletter from Title VI, you may have seen that Lac du Flambeau was featured as a tribe of the quarter, I think it was. And I worked with Lac du Flambeau on their home- and community-based service program, and their Title VI director, Sharon Thompson, did a ton of work to get their program up and running, but it was completely worth it. We were able to—we started with home-delivered meals and with snow shoveling and chore services, and between November of 2017 and February of 2018, the tribe collected almost \$80,000. Part of that was back-billing because they had already been providing home-delivered meals to waiver-enrolled people since June or July of that year, and so we build from June or July forward, and the payments came in between January and February, and they were significant. And since then, they've collected over I think, what, like almost \$120,000-\$130,000 into their program over the past year. Does that sound right, Cynthia? I think that was—

**CYNTHIA LACOUNTE:** Yes, it does.

**ELAINA SEEP:** So, but it started with home-delivered meals, snow shoveling, and chores. And that sort of thing adds up. Most plans, like Cynthia mentioned, all the states are different, but we do have a list out there in that billing manual of, as of the last publication date, what waiver services were in the different states that you can go and check. You can also go and look at CMS's waiver site and plug in your state and look and see what waivers are active and take a look at what services are in there. And ACL staff can show you where that's at, too, and how to look that up.

But home-delivered meals is the big one, chore services, personal emergency equipment, you'll see it as personal emergency response system, so PERS, Lifeline. So if you're

paying for Lifeline for your elders, that's also a Title VI service, you could be getting your Title VI funding in using that to be paying for your staff, for your equipment needs, and you can still turn around and bill for these billable services back into a state Medicaid when people are enrolled in these programs.

It is not considered double-dipping, because usually that's the next question, because under the Older Americans Act—which is where Title VI comes out of, it's Title VI of the Older Americans Act—under the Older Americans Act there's actually a funding section that specifically states that the funds contained within that act are not meant to keep a state, local agency, AAA, etcetera from being able to take in funding from other sources. How do you think county aging programs operate? Because they either take in donations from the public, they use volunteers, and they have billable time for their caseworkers back into the Medicaid program.

**CYNTHIA LACOUNTE:** Elaina, that's actually one of the reports we give to Congress annually, is a—and this is Cynthia, everybody, with ACL—and that report has to do with the amount of money that we have leveraged through Older Americans Act funds. So the concept is that for every dollar spent in Older Americans Act funds, we should be able to generate whatever, \$3 or \$4 and other money, however that funding formula is. But this is an avenue to, yes, leverage other funds. And, Elaina, would you talk one minute—and then I can be put back on mute again—would you talk one minute about the process of billing and whether or not a Title VI director needs to take time out from washing dishes or running meals around to be the only person on the reservation who knows how to bill, or is there somebody else we can help—go to for billing, and what role does tribal leadership and our clinics have in all of this? Thank you.

**ELAINA SEEP:** Okay, I'll try and condense that into a minute, but I make no promises. So for the billing thing, yes, depending on how your tribe operates, how big or how small you are, your Title VI director could do the billing. I don't recommend it as your long-term plan because it's going to get really burdensome and tiresome really fast. So to use that example of Lac du Flambeau, and Sharon Thompson is their aging director, she does a whole lot of work, and she was doing their billing for quite some time, between two different managed care organizations because that's how the State of Wisconsin has their home- and community-based services go through managed care. And so she had to go—has to go to two different systems, manually enter the spreadsheets in for her billing, that got old really quickly.

So they're planning on having someone to do their billing and help organize services for their programs so that that's not Sharon's job. Because aging directors already usually have five other jobs, like Cynthia said, you know, you may be throwing in a hand to wash the dishes or be the driver for meals, so to add billing to that really, really isn't sustainable in the long run. Now, my recommendation is it's a really good time and a good place for there to be a bridge built between aging and the tribal clinic. Because you know what the clinic has—and that's if you have a tribal clinic or you have tribal community health, if you have that kind of program in your community, they're already doing some kind of billing. And they already probably are Medicaid providers.

It will make a few of these steps much faster and easier to have a good partnership between the aging director and the tribal clinic or health or community health director. And

that's where leadership definitely has a role to play because I don't know about anyone else, but if I try to go into a different director's office and tell them that I have all this work that I'd like them to do for me and my program and I'm going to be keeping the money, they may not want to work with me, and they don't have to listen to me because we're both directors or we're both staff, and that's where leadership has a really important role to help bridge that gap between the two from that step of what's best for our elders as a whole, what's best for the tribe as a whole.

Because when you're—when you get into some of this billing, not only is it bringing back some significant revenue into the tribe that you've just been missing this entire time, but it's also a way to generate some jobs into the tribal community. Now, you know, someone who maybe already had, you know, a really small just hand-in-pocket business of mowing some lawns and doing some yard care, well, now your program could be paying them to go and, you know, bring in wood for all your elders who have wood-burning heat who are enrolled in waivers. You could now be paying them to, you know, shovel snow or whatever that looks like.

Same thing with some youth programs. It would be a nice way to create some programs and give some youth their first jobs, with a little pocket money in hand, give them some job experience and connect them back to the elders and keep the community knit closer together and do it in a way that's supporting elders and supporting the tribal culture as a whole but also bringing in that Medicaid revenue, and that's where tribal leadership really has that influence to see that bigger picture and pull it all together across the board. Did I do that how you wanted, Cynthia? [Laughs] I hope that answered what you were asking for.

**CYNTHIA LACOUNTE:** You did, thank you very much.

**ELAINA SEEP:** Okay, good. Because you—because really that tribal health piece is a tremendous resource to work with aging if you want to get into becoming a billable provider for these services. And usually when you're billing like that, one of the things that you would put into—build into your fee structure, so how much you decide it is for a chore worker, etcetera, would be to have an administrative percentage. So if I were the tribal health director who's going to, you know, have some expense, at least for the time of my employees to do your entry out of aging, then we could absolutely have an administrative percentage, some—you know, a couple of dollars or whatnot for every claim or whatever it is that would then come back to the clinic program. There are a ton of different ways that tribes could coordinate that between those departments.

**CYNTHIA LACOUNTE:** Thank you.

**OPERATOR:** And there are no additional questions at this time.

**JASMINE APLIN:** Well, this is Jasmine. Well, that's kind of perfect timing because we only have three minutes left, and so I'll turn it back over to Elaina for closing remarks. But before I do that, I'm going to once again let everyone know that we have our regular Title VI call from 3:00 to 4:00 p.m. on Friday and also we can answer some of these questions on that call, so if you want to do a lap through some of these resources in the meantime and then kind of come on

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Friday with your questions, that would be helpful. We'll also, like Laura said, we'll be putting out this information within the next two weeks. That'll go on Older Indians. So we just wanted to thank everybody for their time today. And, Elaina, did you have any closing remarks that you wanted to make?

**ELAINA SEEP:** Only to say thanks, I'm glad that we were able to put something together that hopefully answered some—a couple of questions and at least, you know, brought your attention to some of what—some of this—these COVID changes that are coming out of CMS. So thanks for having me, and I'm always happy to answer questions as well, if you want to, you know, reach out to Jasmine or Cynthia, they can connect us together, and we'll see what we can help you with. But thank you very much for having me, Title VI!

**JASMINE APLIN:** Awesome. Well, thank you, everyone. Thank you for your time, and we'll talk to you on Friday.

**ELAINA SEEP:** Buh-bye.

**OPERATOR:** This concludes today's conference. All participants may disconnect at this time. Speakers, please stand by for transfer—[audio cuts out]