

21. HEALTH CARE DELIVERY TO NATIVE AMERICANS

Introduction

This chapter describes New York State's plan for patient management and coordination of services furnished to Medicaid-eligible Native Americans. It also describes options for and responsibilities of urban Indian and tribal providers. It concludes by discussing the State's monitoring protocol for assessing the impact of The Partnership Plan on health service delivery to the Native American beneficiary population. Please also see Appendix 21.1 for the Native American Policies and Procedures.

Patient Management and Coordination of Services

Under The Partnership Plan, Native Americans will be allowed to enroll in managed care plans on a voluntary basis. Beneficiaries will be given the option to join an MCO at the time of eligibility determination under the same time frames as other voluntary groups. If a Native American beneficiary elects to enroll in managed care, his/her enrollment will be governed by the same guaranteed eligibility and lock-in provisions as apply to other voluntary groups.

Although Native American enrollees will be governed by program lock-ins, they will retain the right to self-refer to an urban Indian or tribal provider for MCO-covered services. LDSS staff will inform Native Americans of their self-referral options at time of enrollment. The Tribes also will educate Native American beneficiaries about their self-referral rights.

The State will, upon receipt from the Tribes/Nations, provide MA enrollment and certification personnel with a list and sample of the Native American means of identification that have been authorized/approved by the Tribes/Nations. The list includes: Bureau of Indian Affairs, Tribal, health, resolution, Long House, Canadian Department of Indian Affairs identification cards, documentation of roll or band number, documentation of parent's or grandparent's roll or band number together with birth certificate(s) or baptismal record indicating descentance from the parent or grandparent, notarized letter from a federally or state recognized American Indian/Alaska Native Nation/Tribe or Village Office stating heritage, or birth certificate indicating heritage. The sample list of Native American means of identification to be distributed to MA enrollment/certification personnel will include language stating that use of the Canadian Department of Indian Affairs identification card to indicate Native American heritage (or presence of this card in an informational file) should not have a negative impact upon determining a Native American's MA eligibility, provided the individual is otherwise eligible for MA and meets prevailing MA eligibility requirements.

The State has trained LDSS enrollment/certification staff regarding Native American - Medicaid Managed care policies and identification.

At the point of certification or recertification the LDSS enrollment/certification worker will request of applicant proof of Native American heritage. The applicant must provide one of the above listed documents as proof of Native American status.

- If the applicant is appropriately identified as a Native American then the certification/eligibility worker enters “I” code into the restriction/exemption file. The certification worker will also enter “I” at the Native American option in the appropriate race identification of the Medicaid eligibility forms. Entrance of the “I” code will automatically exempt the applicant from the auto-assignment process. Completing this field is now mandatory to ensure that the “I” codes are entered as appropriate.
- If the applicant is unable to provide appropriate identification verifying status as a Native American then the certification worker inserts the “91” code into the restriction/exemption file. The “91” code is a general exception code that will temporarily hold the applicant out of the auto assignment process. The “91” code is effective until the next recertification period.
- Persons who have previously identified themselves as a Native American during prior eligibility screenings do not need to provide any additional information. However, the enrollment worker will still need to enter the proper coding to avoid auto-assignment within a mandatory managed care environment.
- Effective June 23, 1997, the race code indicator became a required field to be filled out by certification workers at time of a face to face interview to ensure implementation of the above. A WMS coordinator letter dated June 6, 1997, has been issued indicating this new requirement.

The manner of payment for self-referral services will be dependent on whether the urban Indian/Tribal provider is part of the MCO network. Specifically:

- If the urban Indian/Tribal provider is part of the MCO’s network, the MCO will be responsible for paying the provider for medically necessary services, in accordance with provider/MCO contract terms.
- If the urban Indian/Tribal provider is not part of the MCO’s network, the provider will submit claims directly to the State and will be reimbursed fee-for-service.¹ The State will monitor all visits provided by tribal or Indian health clinics or urban Indian health facilities or centers to enrolled Native Americans, so that the State can reconcile payment made for those services, should it be deemed necessary to do so.

¹ The fee-for-service billing options described in this chapter will not apply to on-reservation primary care Indian health clinics operated and staffed by hospitals. Currently, these clinics are reimbursed with non-Medicaid State funds and do not bill Medicaid.

- In this instance, the State will pay FFS for MA services provided on-site at tribal owned/operated reservation health clinics, or urban health clinic/centers when billing MA. Effective 9/1/97, the appropriate system modifications will be made to allow for continued Medicaid fee-for-service payment for Medicaid bills submitted by any of the following Native American health center/providers:

<u>Native American Center</u>	<u>Provider Number</u>
Oneida Nation	01705682
Saint Regis Nation	00651785
Saint Regis Nation	01178234
Seneca Nation	01658520
Seneca Nation	01649476

In the event the urban Indian/Tribal provider determines that a client requires a referral to a private provider (i.e., physician or nurse practitioner) for additional care, payment for the referral service will occur as follows:

- If the private provider participates in the MCO's network, the MCO will be responsible for paying the provider in accordance with provider/MCO contract terms. The MCO will be permitted to require prior authorization for the referral, as long as it is not a "free access" service such as HIV counseling/testing.
- If the private provider is not part of the MCO's network, the provider will submit claims directly to the State and will be reimbursed fee-for-service. The State will monitor these claims, so that the State can reconcile payment made for those services, should it be deemed necessary to do so.

Effective 9/1/97, the appropriate system modifications will be made to allow for continued Medicaid fee-for-service payment for Medicaid bills submitted as referrals from any of these Native American health centers/providers for physician and nurse practitioner services using the provider number in the referral code box.

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Additional non-billing MEDS provider numbers will be made available to Indian Health Clinics not billing Medicaid for use in off-site referral.

The Tribal clinics will keep records of off-site referrals for audit purposes.

- If either the urban Indian/Tribal provider or a non-participating private provider determines that a client requires hospitalization, the provider will be required to refer the client back to the MCO. The only exception will be for medical emergencies.

Emergency room payment policies for Native Americans will be the same as for other clients enrolled in managed care. Specifically:

- If the hospital participates in the MCO's network, the MCO will be responsible for paying the hospital in accordance with hospital/MCO contract terms.
- If the hospital is not part of the MCO's network and an initial triage reveals the visit to be non-emergent, the MCO will be responsible for paying the hospital a triage fee in accordance with State law. The MCO also may authorize the hospital to furnish non-emergency services, in which case it will be responsible for payment of those services as well.
- If, using prudent layperson standards as defined in Chapter 705 of the Laws of 1996, a true emergency is determined, the MCO will be responsible for payment of necessary emergency services, whether or not prior notification was made.

Provider Participation

Urban Indian and Tribal providers will be encouraged to participate in MCO networks, to the extent they wish to do so. To facilitate their participation, these providers will be permitted to restrict their services to Native American beneficiaries only. Providers who elect not to participate in MCO networks will be expected to coordinate the care they furnish to MCO enrollees with MCO PCPs. For their part, MCO PCPs and specialists will be required to advise the urban Indian/Tribal providers about the course of treatment rendered pursuant to a referral, subject to confidentiality rules.

The policy document developed with the Nations includes language requiring them to develop a relationship with the MCO/PCP. Also, language in the model contract specifies that MCOs must develop relationships with tribal clinics when they have Native American enrollees who seek to use the tribal clinics.

Monitoring Impact

Because of their voluntary enrollment status and self-referral rights, the State foresees no issues for Native Americans in terms of reduced accessibility to IHS/tribal providers and services. The State's monitoring efforts for Native Americans therefore will be focused on measuring health outcomes and service utilization patterns among MCO enrollees. The service use analysis will include a profiling of the out-of-MCO self-referral rates of Native Americans, based on claims paid fee-for-service by the State. Monitoring efforts will also include an analysis to determine the occurrence of individual Native Americans or tribal clinics being held liable for bills resulting from an initial emergency room

admission to the nearest hospital and subsequent transfer to a second emergency room, should the first emergency room be unable to treat the individual's condition.

Education and Ongoing Communication

Department of Health staff worked cooperatively with a variety of tribal representatives and others as appropriate to create an informational instrument/brochure to assist Medicaid eligible Native Americans to understand their voluntary Medicaid managed care enrollment options. The final informational brochure will be written at a fourth to sixth grade reading level.

Department of Health - Division of Managed Care and Program Evaluation staff, tribal representatives, Indian Health Service staff, CMS staff, and others as appropriate will participate in quarterly conference calls to ensure continued discussion of any emerging issues and concerns related to the provision of Medicaid Managed Care services to Native Americans.

21. HEALTH CARE DELIVERY TO NATIVE AMERICANS IN FAMILY HEALTH PLUS

Native Americans enrolled in FHPlus receive benefit package services provided or arranged directly by the MCO.

FHPlus MCOs were encouraged in the Recruitment Notice to include Urban American Indian and tribal providers in their networks. To facilitate their participation, these providers are permitted to restrict their services to Native American beneficiaries. Such providers who elect not to participate in MCO networks are expected to coordinate the care they provide to FHPlus enrollees with MCO Primary Care Providers (PCPs). MCO providers are required to advise the urban American Indian/tribal providers about the course of treatment rendered pursuant to a referral, subject to confidentiality rules.