

**REPORT TO CONGRESS**

**ON**

**THE FEASIBILITY OF A NAVAJO NATION MEDICAID  
AGENCY**

**May 2014**

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## Executive Summary

### *Background and Purpose*

The Navajo Nation spans a geographic area that is larger than 10 of the 50 states, and its boundaries extend through three states—Arizona, New Mexico, and Utah. Navajos experience a heavy disease burden with a mortality rate 31 percent higher than the overall U.S. rate. Health services on the Navajo reservation are provided primarily through the Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS) and through tribal health providers operating under the authority of the Indian Self-Determination and Education Assistance Act (PL 93-638). Funding for these programs is provided through federal appropriations supplemented by third-party revenues collected by IHS and tribal health providers. Medicaid is a major source of third-party revenue that supplements IHS base funding. However, Medicaid is administered by individual states, and residents of the Navajo Nation, depending on their location within the reservation, may be eligible for the Arizona, New Mexico, or Utah Medicaid program. Eligibility rules, benefits, provider agreements, claims submission processes, and payment levels differ among these three state Medicaid programs. These differences introduce considerable complexity for eligible Medicaid beneficiaries, who have access to different sets of benefits and policies depending on their state of residence. Similarly, IHS and tribal health providers located on the Navajo reservation that must do business with the different states face complexities in order to be paid for services rendered. For these reasons, the Navajo Nation has advocated that Congress should consider establishing a Medicaid agency within its borders and serve Indians who reside within boundaries of the Navajo Nation.

The Indian Health Care Improvement Reauthorization and Extension Act was reauthorized and amended by the Affordable Care Act of 2010 and requires the Secretary of HHS to conduct a study of the feasibility of establishing a Navajo Nation Medicaid agency (see 25 USC Section 1647D). The Centers for Medicare & Medicaid Services (CMS), within HHS, was delegated responsibility for this feasibility study and, in June 2012 awarded a contract to Econometrica, Inc., to help with preparation of the study. CMS obtained input from the Navajo Nation and the states impacted throughout development of the study.

### *Overview of the Study*

The feasibility issues examined in the study include: requirements and costs necessary for design and start-up of the Navajo Nation Medicaid agency; operational costs and distribution of those costs between the federal government and the Navajo Nation; legal and regulatory issues; other operational issues; and impacts on the three states that currently provide Medicaid to residents of the Navajo reservation.

The results of the study show that it could be feasible for the Navajo Nation to operate as a Medicaid agency. The findings of the study highlight the many challenges that the Navajo Nation would face should it be deemed a state for purposes of operating its own Medicaid agency. A discussion of some potential costs is provided below.

### *Planning and Start-Up Requirements and Costs*

If Congress were to authorize the Navajo Nation as a Medicaid agency, the Navajo Nation would need time for infrastructure development and preparation to begin offering a Medicaid program.

Costs that would be incurred during the planning and start-up period for a Navajo Nation Medicaid agency are difficult to estimate since these costs would vary depending on the number of years that the Navajo Nation would require to prepare for implementation, whether the Nation chose to rely on internal staff or outside contractors for much of the planning and development, and whether the Nation decides to contract claims adjudication with a state. Assuming a total start-up cost of between \$134.2 million and \$243.2 million over a 5-year period and an average administrative Federal Financial Participation rate of 60 percent, the remaining 40 percent of administrative costs would be in the range of \$53.7 million to \$97.3 million. A breakout of the start-up costs is provided in Table 2.2.

### *Cost Estimates for Annual Operation of the Navajo Medicaid Agency*

The estimate for annual administrative costs and provider payments for covered services of a Navajo Nation Medicaid agency was developed based on 2010 population data, and other data provided by the Nation and the three states currently providing Medicaid coverage to residents of the Navajo reservation. Since the Navajo Nation has not yet defined the characteristics of the Medicaid program that would be offered, assumptions were made about eligibility requirements, “take up” rates, the costs of the benefit package that would be offered, and the administrative costs that would be incurred. The Federal Medical Assistance Percentage (FMAP) that might be provided to a Navajo Nation Medicaid agency was calculated at 83 percent (the longstanding statutory maximum FMAP rate for states and the District of Columbia) based on 2010 benefits and services. An assumption was also made that one-third of claims would be from IHS and tribal health programs and reimbursed at 100 percent FMAP. Administrative costs were assumed to be 8 percent of claims costs, which would be comparable to such costs for other small population Medicaid programs. However, administrative costs could be higher in early years of starting up the Navajo Nation’s program, especially if the Nation performs more of the tasks itself rather than contracting them out to an existing state program.

Table 3.5 provides the cost estimates for a proposed Navajo Nation Medicaid agency if it were fully operational in 2010. These and other cost estimates in the report represent very general approximations of the potential costs of a Navajo Nation Medicaid agency. For example, the estimates for FY 2010 are based on historical data and policies, prior to enactment of the Affordable Care Act.

We estimate it could take approximately five years for a Navajo Nation Medicaid agency (after authorization by Congress) to be designed and implemented as an operational Medicaid agency. Meanwhile, in 2014, the Affordable Care Act is being implemented and is the new regulatory framework for Medicaid, affecting eligibility, benefits, delivery system, administrative requirements, and costs. Health care costs are also likely to continue rising over the five-year implementation period. These changes (and others that may not be anticipated) could increase and/or decrease the costs of a Navajo Nation Medicaid agency, and it is impossible to predict with accuracy the potential future costs or distribution of such costs, as the economy, health care

system, and regulations change. In considering the cost estimates, offsetting savings could be generated by improved health outcomes among the Nation's Medicaid population.

### *Other Feasibility Considerations*

Costs comprise only one important consideration for assessing the feasibility of establishing a Medicaid program. The feasibility of a Navajo Nation Medicaid agency may also be affected by a number of other factors, including:

- Availability of professional and management staff needed to design, implement, and manage the Medicaid agency.
- Contracting for a Medicaid Management Information System (MMIS) and other services.
- Legal and regulatory issues.
- Provider network and payment issues.
- Outreach and education needs.
- Impact on the residents of the Navajo reservation.

Each of these issues was examined and considered for start-up and implementation of a Navajo Nation Medicaid agency. While these feasibility issues might impose substantial challenges to establishing and operating a Navajo Nation Medicaid agency, it was noted that the Navajo Nation has experience in operating a number of other federal programs (e.g. Women, Infants and Children (WIC), Temporary Assistance for Needy Families (TANF), Low-Income Home Energy Assistance Program (LIHEAP)) with their own requirements for determining program eligibility, contracting with and paying service providers, providing due process notices and offering fair hearings to benefit recipients, and investigating and prosecuting fraud in the receipt of benefits. In addition, the Nation has an established legal and regulatory system and framework which would provide the basis for developing the additional legal/regulatory structure needed to operate the Medicaid agency.

### *Impacts on the States and the Federal Budget*

Potential impacts of a Navajo Nation Medicaid agency on the States of Arizona, New Mexico, and Utah include:

- Reduction in the number of state Medicaid enrollees.
- Reduction in state Medicaid costs associated with those enrollees.
- Possible change in each state's FMAP due to potential increase in state per capita income when Navajo Nation Indian residents are excluded from calculation of state per capita income.
- Transitional costs of the policy change.

The net cost impacts on the three states of a Navajo Medicaid agency would be relatively small; however, a change in the FMAP could have longer-term impacts on state budgets.

The impact of the Navajo Nation Medicaid agency on federal budgetary costs would depend on many factors and policy decisions which, at present, are unknown or undecided such as numbers of eligible and enrolled Medicaid recipients, selection of optional covered services, and the

potential to increase the use of services provided by IHS and tribal providers that are paid at 100 percent FMAP.

*Conclusions*

This feasibility study highlights a number of the many complex elements that would be needed to design, implement, and operate a Navajo Nation Medicaid agency and provides some estimates of the potential costs associated with start-up and operations. It also offers some possible models from the federal and state experience of implementing changes brought about by the Affordable Care Act which could serve as a foundation for the Navajo Nation in selecting and implementing these key elements. The experience of the Navajo Nation with other programs suggests that a Navajo Nation Medicaid agency could be feasible. Additionally, this study, at Appendix A provides more detailed information on federal requirements for Medicaid agencies and Appendix B provides an overview of the consultations held with the Navajo Nation.

## Section 1: Background and Purpose of Study

### 1.1. *Medicaid Program Overview*

Title XIX of the Social Security Act, as amended, establishes a State Medical Assistance Program to provide medical and health services to low-income and needy individuals and families by paying providers and suppliers under the program. Each state Medicaid program operates within broad federal guidelines through statutes, regulations and policies, and with states determining program content in several areas: (1) eligibility and the setting of standards; (2) services, determining the type, amount, duration, and scope of benefits; (3) payment, determining fiscal reimbursement rates; (4) administration, methods for managing all operations; and (5) quality control. Section 1902 of Title XIX sets forth the major requirements for a state medical assistance program and its operation.

The Indian Health Care Improvement Reauthorization and Extension Act, included in the Affordable Care Act, authorized a study on the feasibility of creating a Navajo Medicaid agency.

### 25 USC SECTION 1647D - NAVAJO NATION MEDICAID AGENCY FEASIBILITY STUDY

#### **(a) Study**

The Secretary shall conduct a study to determine the feasibility of treating the Navajo Nation as a State for the purposes of title XIX of the Social Security Act [42 U.S.C. Section 1396 et seq.], to provide services to Indians living within the boundaries of the Navajo Nation through an entity established having the same authority and performing the same functions as single-State Medicaid agencies responsible for the administration of the State plan under title XIX of the Social Security Act.

#### **(b) Considerations**

In conducting the study, the Secretary shall consider the feasibility of—

- (1) assigning and paying all expenditures for the provision of services and related administration funds, under title XIX of the Social Security Act [42 U.S.C. Section 1396 et seq.], to Indians living within the boundaries of the Navajo Nation that are currently paid to or would otherwise be paid to the State of Arizona, New Mexico, or Utah;
- (2) providing assistance to the Navajo Nation in the development and implementation of such entity for the administration, eligibility, payment, and delivery of medical assistance under title XIX of the Social Security Act;
- (3) providing an appropriate level of matching funds for Federal medical assistance with respect to amounts such entity expends for medical assistance for services and related administrative costs; and
- (4) authorizing the Secretary, at the option of the Navajo Nation, to treat the Navajo Nation as a State for the Purposes of title XIX of the Social Security Act .... under terms equivalent to those described in paragraphs (2) through (4).

#### **(c) Report**

Not later than 3 years after March 23, 2010, the Secretary shall submit to the Committee on Indian Affairs and Committee on Finance of the Senate and the Committee on Natural

Resources and Committee on Energy and Commerce of the House of Representatives a report that includes—

- (1) the results of the study under this section;
- (2) a summary of any consultation that occurred between the Secretary and the Navajo Nation, other Indian Tribes, the States of Arizona, New Mexico, and Utah, counties which include the Navajo reservation, and other interested parties, in conducting this study;
- (3) projected costs or savings associated with establishment of such entity, and any estimated impact on services provided as described in this section in relation to probable costs or savings; and
- (4) legislative actions that would be required to authorize the establishment of such entity if such entity is determined by the Secretary to be feasible.

## 1.2. *Background and Rationale for the Navajo Nation Feasibility Study*

### ***Overview of the Navajo Nation and Health Care System***

The Navajo Nation is the largest federally recognized Tribe in the United States, with over 307,000 enrolled members. The reservation extends over 27,000 square miles in the States of Arizona, New Mexico, and Utah; is larger than 10 of the 50 states; and includes three satellite reservations in New Mexico: Ramah, Tohajiilee (Canoncito), and Alamo.

Reservation residents are scattered widely over this rural and remote area, often living in isolation, and many do not have basic services to support a safe and healthy living environment: 60 percent of the people do not have telephones, 32 percent lack plumbing, 28 percent lack complete kitchen facilities, and many do not have electricity. Transportation is a challenge, as many lack vehicles or cannot afford fuel. There is limited public transportation and 78 percent of the roads on the Navajo Nation are unpaved dirt, which can become impassible during inclement weather, requiring air transport for medical emergencies.

Navajos experience a heavy disease burden, with a shorter life expectancy than other races, a mortality rate 31 percent higher than the U.S rate, and high rates of diabetes and obesity. The leading causes of death are unintentional injury and heart disease, and the population is at high risk for alcohol and substance abuse problems. The reasons for these health disparities include barriers to access to health services due to shortages of health professionals and services, transportation challenges, socioeconomic challenges, and uninsured rates.

The Indian Health Service (IHS), through the Navajo Area Office and the Albuquerque Area Office, provides basic and some specialized health services to Navajos residing on or near the reservation. Additional services are provided through tribally operated health facilities on the reservation. Overall, the health care delivery system on the reservation is composed of 6 hospitals, 16 health centers, and 8 health stations/clinics. Additionally, there are 5 hospitals and 3 health centers that are located outside of the boundaries of the Navajo Nation and are frequently used by AI/ANs who reside within the Nation's boundaries. All of these providers, both on and near the reservation are operated by IHS or the tribe under the authority of the Indian Self Determination and Education Assistance Act (PL 93-638). Table 1.2 provides information on these health facilities.



**Table 1.2. Indian Health Service and Tribally-operated Health Facilities Located on the Navajo Reservation**

Service Unit	State	Facility	Beds	Location
Chinle	Arizona	Chinle Hospital Tsaile Health Center Pinon Health Center Rock Point Health Station	60	Chinle, AZ Tsaile, AZ Pinon, AZ Rock Point, AZ
Crownpoint	New Mexico	Crownpoint Hospital Pueblo Pintado Health Center Thoreau Clinic	25	Crownpoint, NM Pueblo Pintado, NM Thoreau, NM
Fort Defiance	Arizona	Tséhootsooí Medical Center Nahata Dziil Health Center	52	Fort Defiance, AZ Sanders, AZ
Gallup	New Mexico	Tohatchi Health Center		Tohatchi, NM
Kayenta	Arizona	Kayenta Health Center Inscription House Health Center Dennehotso Health Station		Kayenta, AZ Shonto, AZ Dennehotso, AZ
Shiprock	Arizona New Mexico	Four Corners Regional Health Center Northern Navajo Medical Center Dzilth Na O Dith Hle Health Center Sanostee Health Station Toadlena Health Station	67	Red Mesa, AZ Shiprock, NM Huerfano, NM Sanostee, NM Toadlena, NM
Tuba City	Arizona	Tuba City Hospital Dinnebito Health Station	73	Tuba City, AZ Dinnebito, AZ
Winslow	Arizona	Dilkon Health Center Leupp Health Center		Dilkon, AZ Leupp, AZ
Utah Navajo Health Systems	Utah	Montezuma Creek Community Health Center Navajo Mountain Community Health Station Monument Valley Health Center		Montezuma Creek, UT Navajo Mountain, UT Monument Valley, UT
Sage Memorial Hospital	Arizona Arizona	Sage Memorial Hospital Greasewood Health Station	25	Ganado, AZ Greasewood, AZ
Tohajiilee	New Mexico	Tohajiilee Health Center		Tohajiilee, NM
Zuni-Ramah	New Mexico	Pine Hill Health Center		Pine Hill, NM
Alamo	New Mexico	Alamo Navajo Health Center		Magdalena, NM
<b>IHS Facilities Located Near the Navajo Reservation That are Utilized by Indians Living on the Navajo Reservation</b>				
Service Unit	State	Facility	Beds	Location
Zuni	New Mexico	Zuni Hospital Pueblo of Zuni Behavioral Health	45	Zuni, NM
Keams Canyon	Arizona	Hopi Health Center	6	Polacca, AZ
Phoenix	Arizona	Phoenix Indian Medical Center	127	Phoenix, AZ
Albuquerque	New Mexico	Acoma-Canoncito-Laguna Hospital	25	San Fidel, NM
Gallup	New Mexico	Gallup Indian Medical Center	78	Gallup, NM
Tuba City	Arizona	Sacred Peaks Health Center		Flagstaff, AZ
Winslow	Arizona	Winslow Health Center		Winslow, AZ

Service Unit	State	Facility	Beds	Location
Utah	Utah	Blue Mountain Hospital	11	Blanding, UT

***Navajo Nation Governance***

The Navajo Nation has a government structure consisting of executive, legislative, and judicial branches located in Window Rock, Arizona. The Executive branch of the Navajo Nation is an entity independent of the Council, headed by a president and vice-president who are elected every four years. The executive branch consists of several divisions, departments, offices, and programs that administer the laws of the Navajo Nation. An eight-member Health, Education and Human Services Committee oversees the Navajo Division of Health, which is responsible for health planning and health education and promotion, as well as administration of the Navajo Area Agency on Aging; Behavioral Health; Public Health Nursing; Special Diabetes Program; Breast and Cervical Cancer Early Detection Program; Women, Infants and Children (WIC); Food Distribution Program; and Office of Environmental Health. The Division of Health also has a Centers for Disease Control and Prevention (CDC) Public Health Infrastructure Grant and is seeking recognition from the Navajo Nation Council to attain Department status.

The Navajo Nation Council, formerly the Navajo Tribal Council, is the legislative branch of the Navajo Nation. As of 2010, the Navajo Nation Council consists of 24 delegates representing the 110 Chapters, elected every 4 years by registered Navajo voters.

In December 1985, the Navajo Tribal Council passed the Judicial Reform Act of 1985, which eliminated the Supreme Judicial Council. It redennominated the “Navajo Tribal Court of Appeals” as the “Navajo Nation Supreme Court” and redennominated the “Trial Courts of the Navajo Tribe” as “District Courts of the Navajo Nation.” There are 10 judicial districts, centered respectively in Alamo (Alamo/Tó’hajiilee), Aneth, Chinle, Crownpoint, Dilkon, Kayenta, Ramah, Shiprock, Tuba City and Window Rock. All of the districts also have family courts, which have jurisdiction over domestic relations, civil relief in domestic violence, child custody and protection, name changes, quiet title, and probate. As of 2010, there were 17 trial judges presiding in the Navajo district and family courts.

***Rationale for a Navajo Nation Medicaid Agency***

Because the Navajo Nation is so large and spans three states, it is under the jurisdiction of two Area Offices of the Indian Health Service (Albuquerque and Navajo), three state Medicaid Agencies (Arizona, New Mexico and Utah), and three CMS Regional Offices (Regions 6, 8, and 9). Jurisdictional issues lie at the heart of the Nation’s pursuit of designation as a “state” for purposes of operating a Medicaid program.

States have wide latitude in designing their Medicaid program within federal rules enacted under Title XIX of the Social Security Act; groups of people eligible for Medicaid, eligibility income levels, covered services, payment methodology, and claims processing procedures are all determined by the states. As a further example of differences among the states in Medicaid program characteristics, the 2014 eligibility rules for each state vary by category. Illustration of these variations includes:

- *Pregnant women* are Medicaid-eligible in Arizona if income is below 156 percent of the Federal Poverty Level (FPL), in New Mexico if income is below 250 percent of the FPL, and in Utah if income is below 139 percent of the FPL.
- *Children, ages 6-18 years*, are Medicaid-eligible in Arizona and Utah if their family income is below 133 percent of the FPL and in New Mexico if family income is below 240 percent of the FPL.
- *Parents of children* are Medicaid-eligible in Arizona and New Mexico if income is below 133 percent of the FPL, and in Utah if income is below 45 percent of the FPL.
- *Adults with incomes up to 133 percent of the FPL* are eligible in Arizona and New Mexico, and up to 100 percent of the FPL in Utah.

Thus, a family (a pregnant woman, husband, and child age 6) residing on the Navajo reservation in New Mexico with income of 175 percent of the FPL would lose Medicaid coverage if the family moved from New Mexico to another location on the Navajo reservation in Arizona or Utah. Other differences among the three state programs include covered benefits; managed care options; unique programs offered under Medicaid waivers; and payment rates for IHS and tribal health providers.

Additionally, Arizona and New Mexico are heavily invested in purchasing Medicaid services through managed care organizations (MCOs); although the majority of American Indians (85 percent in New Mexico and 75 percent in Arizona) chose to receive services at IHS, Tribal, and Urban Indian programs (I/T/U) rather than join a managed care organization. Indians who voluntarily enroll in an MCO are still entitled to receive services at I/T/U facilities. Billing and contracting issues are complicated, both for Indian health programs seeking payments from MCOs and for the MCOs themselves, because frequently both are unfamiliar with the other's system of operating.

It should also be noted that many Navajos seek health care in the closest facility—which may be in a different state from the state in which they live. Many Navajos are people in motion; they move to different locations for a variety of reasons, which can include employment, cultural and ceremonial activities, seasonal migrations to care for livestock, or other patterns of behavior related to their extended families. These patterns of movement may lead them on and off the reservation or between states and may result in compromising their Medicaid eligibility, as well as creating billing confusion for IHS and Tribal providers that have to enroll with Medicaid in multiple states and deal with different processes for claims submission, eligibility, and covered services. Additionally, as the Affordable Care Act is implemented, Medicaid coverage for adults with incomes up to 133 percent of the FPL is available in the States of Arizona and New Mexico. While Utah (with the smallest number of Indian people residing on the Navajo reservation and potentially eligible for the expansion) has not yet elected to proceed with the Medicaid expansion, it may do so at any time. The Arizona and New Mexico Medicaid expansions will increase the number of Medicaid eligibles within the Navajo Nation boundaries more than was anticipated at the time that this study was being prepared. As a result of the Medicaid expansion

occurring in 2014, there will be an estimated 30 percent increase in the number of potential new enrollees in the Navajo IHS area.<sup>1</sup>

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<sup>1</sup> Source: The September 2013 GAO report entitled, “Indian Health Service—Most American Indians and Alaska Natives Potentially Eligible for Expanded Health Coverage, but Action Needed to Increase Enrollment.”

## Section 2: Considerations of Timeframe and Start-Up Costs to Establish a Navajo Nation State Medicaid Agency

If Congress were to authorize the Navajo Nation as a Medicaid agency, the Navajo Nation would need extensive time for planning, infrastructure development, and preparation to begin offering a Medicaid program. These start-up activities would necessitate significant expenditures, some of which would likely be reimbursed by the Federal Government and others would presumably be the responsibility of the Navajo Nation. Because federal matching funds are not available until the Medicaid program is operational, the Navajo Nation or Congress would need to identify funding for startup costs.

In this section, an overview of the major components of the development stage for the Medicaid agency are described, followed by a discussion of the range of potential costs that might be incurred and the timeframe that might be required to have all of the necessary infrastructure and operational requirements in place prior to enrolling and providing services to Medicaid beneficiaries. Appendix A contains a detailed planning document that outlines the key requirements and steps that would need to be accomplished prior to implementation of the Navajo Nation Medicaid agency.

### *2.1. Major Requirements for Start-Up of a Medicaid Agency*

This section discusses actions that the Navajo Nation, acting as a Medicaid state agency, would have to undertake to establish a Medicaid program. An overview of the major requirements that would need to be met prior to implementation and operation of the Navajo Medicaid agency is provided. Due to the many requirements and the potential costs that would be incurred, it is likely that these start-up activities would occur over a five-year period.

#### ***Legal Framework***

The Navajo Nation would need to establish the legal framework for the program as an initial step in the development of its Medicaid agency. State legislatures establish the legal authority for the creation of the Medicaid program, both to establish the state's willingness to enter into a contract with the Federal Government to operate a Medicaid program and to retain control over optional groups of people, benefits, and waiver provisions, which will have cost impacts on a state's general fund.

The Navajo Nation would then need to develop detailed policy for the Medicaid program. Thoughtful consideration of program specifications will be required by the Nation in completing a Medicaid state plan and in designing the eligibility and claims processing systems.

#### ***Infrastructure***

In order to support a Medicaid program, the Navajo Nation would need to assure that the infrastructure is in place to meet all of the requirements contained within 42 and 45 CFR with respect to financial management and contracting such as the following key components:

- *Accounting system.* A robust accounting system is required to track enrollment and expenditures for purposes of federal claiming and reporting. States make payments for Medicaid services and then claim the federal matching funds; the accounting system must be able to categorize all Medicaid administrative and claims costs by the applicable matching rate. The Nation might find it beneficial to identify another state with which to partner in order to utilize its newly established eligibility and enrollment system. The Navajo Nation may also want to contract with another state to adjudicate payment of claims. If the Nation decides to contract claims adjudication with another state, it will still need to make payments to providers and submit that information to the Internal Revenue Service (IRS) by Social Security Number (SSN) or Employer Identification Number (EIN) for each enrolled provider. All records must be maintained for a minimum of 3 years; however, a longer retention period is recommended, since CMS has no time limits for disallowing expenditures.
- *Contracting.* Federal rules for contracting must be followed when a state purchases electronic systems or subcontracts work to the private sector, such as audits, utilization review, third-party recoveries, etc. Public bidding and awarding processes are required in compliance with 45 CFR Part 92.
- *Property management.* Federal rules applicable to equipment purchases and disposition contained in 45 CFR Subpart G must be followed, so a Medicaid agency needs to purchase equipment using a compliant procurement process, track all equipment, and monitor disposal of expired equipment, as well as retain these records.
- *Cost allocation plan.* Each Medicaid program must have an approved Cost Allocation Plan meeting the requirements of the Office of Management and Budget (OMB) Circular A-87 to delineate federal claiming and the applicable match rates for all expenditures.
- *Legal services.* The Navajo Nation Attorney's General office will need to support the Medicaid agency in regulatory development and hearings and by housing the Medicaid Fraud Control Unit to investigate and prosecute instances of fraudulent behavior by providers, as well as cooperate with the U.S. Department of Justice (DOJ).

Other infrastructure needs include:

- *Office space.* A Medicaid agency will employ a large number of people who need space in which to do their jobs. Offices will need furniture, equipment, and office supplies, as well as definition of space for work areas and meeting rooms; some leased space will need build-out of walls for private offices. Costs for utilities, cleaning services, shredding, and garbage should be planned. Telecommunications costs are often a very costly budget item, including purchase of a telephone system.
- *Internet connectivity.* High-speed internet connectivity is a critical element to support staff. This is an important consideration for the Nation's eligibility, outreach and customer service functions, which will operate in various locations across the reservation; eligibility workers will need reliable access to the system to process timely applications and certified application counselors (CACs) will need to be able to utilize laptops and internet access to assist people in completing the Medicaid application.

- *Mainframe computer capacity.* A Medicaid agency will either contract out the claims processing function to a fiscal intermediary or purchase the system and operate it with employees. An eligibility system is also required, and both systems will need significant mainframe computer-processing availability to operate. Contracted systems will include data processing within the contractual framework; agency-operated systems will need to provide or purchase mainframe capacity. Other data processing needs will include the accounting system; any databases developed for tracking, monitoring, and reporting; payroll systems; and the local area network for office staff. States have considerable mainframe capacity to operate the many shared systems of state agencies, such as accounting, personnel, payroll, procurement, property management, leasing, and budgeting. The Nation should explore costs and capacity experience of other states when planning its program design and also consider partnering with or purchasing a newly developed system from another state.

### ***The State Plan***

A contract with CMS to operate Medicaid, called a state plan, requires a state to agree to cover groups of people and benefits mandated by Congress, as well as agree to follow numerous other Medicaid and CHIP laws (Title XIX and XXI) and regulations (42 and 45 CFR) governing legal requirements, hearings, quality measures, interagency agreements, and safeguarding of federal funds. The Medicaid state plan is a document that consists of checklist forms (called preprints) covering organization, eligible persons, benefits and coverage limits, and financial administration. Attachments to the state plan include narrative descriptions of required elements, such as limitations on services and the payment methodology for each service. Many states post their state plans on their websites, and CMS posts Medicaid state plan amendments and waiver documents on its federal website, [www.Medicaid.gov](http://www.Medicaid.gov). The Navajo Nation could review these documents for possible guidance.

Development, submission and approval of the Navajo Nation state plan will be one of the first tasks the Nation will need to undertake should the Congress authorize a Navajo Nation Medicaid agency. The Nation will need to have a complete and detailed understanding of the Medicaid program envisioned in order to establish its plan. Professional staff who are subject matter experts will need to be engaged in order to describe services, limitations and payment for those services, describe eligibility groups and processes and any Medicaid waiver services that the Nation chooses to pursue. All other required components of the Medicaid program (e.g., program integrity) will also need to be refined in order to determine how each aspect will be operationalized. The extensive detailed planning that will go into the development of the state plan will also inform the development of regulations enabling the Medicaid program and the design of the eligibility and claims processing systems. The design and implementation will likely take five years and require hiring of experienced Medicaid staff to guide the development process. The Nation also will likely want to develop a financial model in order to project potential expenditures under different options; financial staff will need to be trained in federal claiming and reporting procedures as well.

The state plan and any changes to the state plan (called a state plan amendment or SPA) must be submitted to CMS prior to going into effect. However, once approved the policy may go into effect as early as the first day of the calendar year quarter in which it was submitted. Specific



assurances are required for a SPA that affects payment of hospitals and nursing homes (42 CFR Section 447.253).

- State plan documents are submitted to the CMS Regional Office and are forwarded to the CMS Central Office for final approval.
- Home and Community-based Waiver programs have separate application processes and requirements. Home and community-based services may be implemented as either a state plan optional service (subject to requirements in law and regulations) as a SPA or through a waiver in which the state may propose the groups of people to be served and the services provided.

If the Navajo Nation decided to implement a Children's Health Insurance Program (CHIP), it would need to develop a state plan for that program and decide how to structure eligibility, benefits, and cost sharing. However, the Nation may also elect to provide all of its children's coverage through Medicaid, without the need for a separate CHIP program to be in place. This may be the most cost-effective and administratively simple approach for the Nation. As such, this feasibility study does not include cost estimates or estimated take-up rates for a CHIP program.

### ***Electronic Systems***

Prior to operation, a state must have in place a certified claims processing system and an eligibility system. Both of these mechanized systems are complex and must be approved by federal agencies through Advanced Planning Documents and cost allocation plans. Development of these systems requires policy experts and technically skilled employees or contractors to develop the detailed design and implementation plans and requirements analysis. From start to finish, it is likely to take several years to develop and implement a Medicaid Management Information System (MMIS) and the required claims processing system and perhaps slightly less time to develop and implement an eligibility system. An MMIS and an eligibility system are estimated to cost between \$80 and over \$120 million dollars each (based on costs for new systems in Alaska, New Mexico, and North Dakota, although Wyoming is planning a Medicaid-only eligibility system for \$35 million). There is a possibility for a slightly shorter timeframe and reduced long-term costs if the Nation were to partner with another state in order to leverage their system for use in administering the Navajo Nation's Medicaid program. Arizona and Hawaii are engaged in such a partnership, which could serve as a model.

- *Claims Processing Systems.* If the Nation elected to design and operate its own claims processing systems, prior to designing these systems, it would need to develop detailed policy on eligibility, health care services coverage, and provider payment that will be incorporated into the requirements analysis for the system design. These policy provisions will need to be described in regulations and the Navajo Nation Medicaid plan.

The requirements analysis will be the starting point for developing the bid specifications for a contractor who will be hired to build the MMIS. The requirements analysis specifies the information needs and the functional and technical requirements the proposed computerized system must satisfy. Work performed under contract for the design,



development, and installation of a claims processing system may be eligible for 90 percent federal match if approved in advance by CMS. CMS will be involved in providing technical assistance and approving each step in the development and acquisition of the system and may make one or more site visits to review the operability of the system.

Six subsystems are also required to fulfill federal quality control and reporting requirements. These subsystems include: 1) recipient; 2) provider; 3) claims processing; 4) reference file; 5) surveillance and utilization review; and 6) management and administrative reporting. Each subsystem has detailed requirements (contained in the State Medicaid Manual at [http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/P45\\_11.zip](http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/P45_11.zip)).

The claims processing system is required to interface electronically with multiple external programs, including the eligibility system, Medicare, state child support enforcement agency, etc. A thoughtful design should incorporate all of the required system elements, as well as those desired by the Nation for any Nation-specific initiatives. If the Navajo Nation decided to develop its own unique systems, the design process is a sophisticated endeavor that will require a sizeable staff whose members are experienced and familiar with federal policy, the Navajo Nation's policy direction, medical care standards, quality assurance standards, auditing standards, federal Medicare costs reports, federal claiming procedures, and technology. The Navajo Nation should strongly consider contracting with another state to share its claims processing system, which may lessen start-up time and overall costs significantly. The Nation would still need to produce a detailed design of its system requirements, hire competent technical staff to oversee the system, share operating costs, and negotiate an agreement with the chosen state Medicaid agency (Arizona reported that negotiating the agreement with Hawaii to share the MMIS took a year).

- *Eligibility System.* An eligibility system has very similar requirements to an MMIS system, including advance planning documents and federal approval and oversight of the design, development, and installation processes. Eligibility system costs must also be included in a cost allocation plan developed by the Nation. These eligibility systems will qualify for the enhanced federal match that is available for claims processing systems; however, that increased matching rate may not be available beyond December 31, 2015. If the system is in place by that time, the Nation would qualify for a 75 percent federal matching rate for maintenance and operations of the new system in perpetuity. Given the shortness of time at this point, the Navajo Nation, however, might request that the ACA provisions for 90 percent match for new eligibility system development be extended beyond the current statutory sunset date of 2015 in order to give the Nation adequate time to complete the system procurement and development processes.

Beginning in 2014 the rules and standards for calculating eligibility are based on Modified Adjusted Gross Income (MAGI) rules--the same rules that are applicable to the Health Insurance Marketplace and many Medicaid and CHIP populations. However, SSI rules will remain for the aged and some disabled populations. The eligibility system must

accommodate the post-eligibility determinations required for institutionalized persons and home and community-based waiver clients, as well as the multiple categories of Medicare clients who qualify for premium assistance or payment of other Medicare costs such as deductibles and coinsurance.

Given the significant eligibility changes that took effect on January 1, 2014, the Navajo Nation is uniquely positioned to benefit from starting directly with MAGI-based eligibility rules and income standards for the applicable eligibility groups. All of the states are now operating under these MAGI-based standards, but had to undergo a “conversion” process in order to move from the old process for determining Medicaid eligibility to the more streamlined approach under the Affordable Care Act.

The Nation’s eligibility policy will need to describe the rules the Navajo Nation decides to adopt and the system will code client categories and insurance status, link clients in households, monitor eligibility periods, maintain client history, produce client notices, and manage required interfaces with other agencies in order to provide verification of eligibility requirements. The eligibility system will also need to interface with the Health Insurance Marketplace required under the Affordable Care Act and other interfaces (such as the IRS) required in 2014.

### ***Eligibility and Enrollment***

The Navajo Nation Medicaid agency, if authorized by Congress, would likely use the federal model streamlined application for Medicaid, CHIP and coverage through the health insurance Marketplace. The Nation would want to consider a strong consumer education campaign to help the community understand the benefits of enrolling in Medicaid coverage and ensuring that they can navigate the system in order to gain access to the comprehensive set of benefits provided through the Medicaid program. Online applications, availability of applications in many locations, and out-stationed eligibility workers and certified application counselors in community gathering places (such as Navajo Chapter Houses) will all be critical to a successful enrollment process. Additionally, strategies like mobile health clinic and dental vans, telemedicine and other proven approaches should also be considered in establishing a healthcare delivery system that will meet the needs of the Navajo Nation’s residents.

Another area of consideration in establishing a Medicaid program is how best to provide coverage for the Nation’s elderly and disabled population. The federal Medicaid statute provides automatic eligibility for individuals who are receiving Supplemental Security Income (either on the basis of age of 65 or older or adjudicated disability status), and states have a great deal of flexibility to structure coverage for these populations more broadly. The Nation will also have an opportunity to streamline its eligibility requirements for the elderly and disabled within federal parameters.

Federal Medicaid law also provides for coverage of people who are institutionalized or who are eligible for home and community-based waiver services.

The Navajo Medicaid agency may also select a medically needy option in which people with incomes above the eligibility standard for Medicaid may “spend down” their income on health

care in order to become Medicaid eligible, a monthly determination of Medicaid eligibility must be made based on review of medical expenses.

Additionally, the Navajo Medicaid agency must have procedures in place to protect the privacy and confidentiality of information of applicants and beneficiaries used in the application process and stored in the eligibility system.

#### *Covered Services*

The Navajo Nation will also need to determine the benefit package that will be offered to its Medicaid population under the new program. As with eligibility, the statute provides flexibility for states to determine what optional benefits will be provided in addition to the mandatory benefit package that is outlined in the law. There is significant variation across the states in the design of their benefit packages. Reviewing a sample of existing Medicaid state plans would provide some good information on available choices. The States of Maryland, New York, Massachusetts, Washington, and Minnesota are good examples of state plans that maximize optional benefits under Medicaid. CMS is also available to provide technical assistance to ensure coverage of benefits that are particularly relevant to the Navajo Nation.

It should be pointed out that while optional services spelled out in Title XIX of the Social Security Act are provided to adults at the discretion of the Nation, Medicaid beneficiaries under the age of 21 must receive a benefit package that consists of all services found at section 1905(a) of the Act, when medically necessary. This is due to requirements of the Early and Periodic Screening, Diagnostic and Treatment provisions of section 1905(r).

The Affordable Care Act called for a set of “essential health benefits” that must be provided through Medicaid (and the Health Insurance Marketplace). These benefits represent a minimum standard of coverage for any Medicaid beneficiary receiving services under Section 1937 of the Social Security Act, which includes individuals in the Medicaid expansion population of non-pregnant adults ages 19-64 with income up to 138 percent of the federal poverty level and other non-exempt individuals at the Nation’s choosing. The exempted groups are listed at Section 1937(a)(2)(B) of the Social Security Act and 42 CFR Section 440.315. These benefits are authorized by CMS through approval of an Alternative Benefit Plan, which becomes a part of the approved Medicaid plan. If this benefit structure is of interest, CMS is available to provide technical assistance. Approved Alternative Benefit Plans will be posted to the Medicaid.gov website for public inspection.

The Navajo Nation Medicaid agency would also need to establish provider payment rates. Medicaid requires that payments be consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. (See Section 1902(a)(30) of the Social Security Act and 42 CFR Section 447.204.)

Payments are generally made for services through fee-for-service or managed care arrangements. Under the fee-for-service arrangement, providers would be paid directly for covered services.

The Nation could develop its payment rates for fee-for-service providers based on: costs of providing the service, a review of what methodologies and amounts other state Medicaid programs use to pay for similar services, an analysis of what commercial payers pay in the private market, or a percentage of what Medicare, Veterans Affairs, or other payers pay for equivalent services. Under managed care arrangements, the Nation could contract with organizations to deliver care through networks and pay providers. Nationally, approximately 70 percent of Medicaid enrollees are served through managed care delivery systems, where providers are paid on a monthly capitation payment rate. Currently, the States of Arizona, New Mexico and Utah reimburse Medicaid participating providers on a fee-for-service or managed care basis.

Regardless of which provider payment options the Navajo Nation may cover, and which Indian health programs it may choose, the Navajo Nation would be reimbursed by the Federal Government at 100% FMAP for whatever methods and amounts it uses to pay IHS and tribal (but not urban Indian) providers.

The Nation would need to establish provider payment rates for non-IHS/non-tribal providers serving beneficiaries of the Navajo Nation Medicaid program. Most such providers are located off the reservation and could account for a large portion of services (estimated at 67 percent) that the Navajo Nation Medicaid agency would authorize. These services would be reimbursed from the Federal Government to the Navajo Nation at its usual FMAP, which, in this report we assume would be at the current statutory cap of 83 percent. Thus, in setting provider payment rates, the Navajo Nation would also have to take into consideration its ability to generate its share of matching funds (in this report, we assume 17 percent for such non-IHS/non-tribal providers).

In addition, the Navajo Nation would need to establish provider payment rates for the Indian Health Services and the Tribal health providers located on or near the reservation. Currently, most States (including the 3 at issue here) opt to pay the IHS and tribal health providers using the IHS all-inclusive rate, approved by OMB and published in the *Federal Register* on an annual basis, and at the fee-for-service rate for certain other services. The Navajo Nation would have the same option as other states, to choose to use the all-inclusive rate for IHS and tribal providers (as we believe would be likely), or some other payment method. IHS and tribal providers can be reimbursed using the payment method for which they qualify. While IHS (as a federal agency) is not eligible to be paid as an FQHC or FQHC look-alike, tribal and urban Indian health programs that qualify for such status may choose to participate in Medicaid and be paid on that basis.

Payment rates are often updated based on specific trending factors, such as the Medicare Economic Index. The payment [methodologies](#), including the method for updating the rates would have to be described in the Navajo Nation Medicaid plan.

### ***Pharmacy Review and Management Controls***

Certain services, such as *pharmacy* and *medical supplies and equipment*, are challenging to manage due to the sheer volume of drugs and items to be managed. The Medicaid agency will want to monitor and control access to costly items and guard against overuse and diversion of prescription medication. Medicaid agencies must establish a drug utilization review function,

which can be a committee of health care professionals or a contracted entity, charged with oversight of drug use by clients and drug prescribing habits of health care professionals. Many Medicaid agencies also establish a preferred drug list, implement specifications for the prescribing of generic drugs, authorize coverage of certain over-the-counter items if prescribed, and must establish dispensing fees and secure rebates from drug manufacturers.

### ***Long-Term Care Access Standards and Criteria***

A Navajo Nation Medicaid agency will need to develop access standards for all *long-term care services*; the nursing home admission criteria will be the same criteria used for home and community-based waiver services if such waiver services are offered. Long term care services are high cost services, and therefore must be carefully managed to assure meaningful access for clients as well as protect the financial interest of the state and Federal Government. All clients will need to be screened with a standardized assessment tool to determine if each meets the standard of care established by the Nation. Assessments must be performed on a regular basis or as needed by a client to meet changing health and cognitive conditions. PASRR (preadmission screening and resident reviews) is required for nursing home and institutions for mentally retarded patients to assure that people are not inappropriately placed in institutional care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for mental illness and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings.

A significant number of Navajo Nation residents are receiving nursing home services and community-based care, therefore, the Nation will likely want to initiate community-based care in order to assure that clients currently being served do not lose these services. As mentioned above, there are many options available for providing community-based services to support the elderly and disabled in their home communities: there are state plan community-based care options, including the new Community First Choice benefit that has a six percentage point higher match rate, or home and community-based waiver services which can be targeted to specific groups of people (elders, physically disabled, developmentally disabled, persons with traumatic brain injury, AIDS/HIV, medically fragile children, people needing psychiatric care, etc.). Any of these options will allow people accepted to the program to receive a package of services unavailable to other Medicaid clients such as chore services, private duty nursing, home delivered meals, transportation, specialized equipment, medical supplies, and home modifications. Each client will have a specific care plan designed to meet their individual needs and each plan must be approved by the Medicaid agency. Community care services may not cost more than institutional services (in the aggregate), so the Medicaid agency must carefully monitor the consumption of services. An additional control can include expenditure monitoring through the MMIS if the system is programmed to pay for only those services approved in a care plan.

Quality monitoring of long term care services is an essential component of Medicaid programs and adequate controls must be maintained to assure that high quality care is being provided by qualified providers. Currently, many state Medicaid programs conduct training programs, or require specific types of training for home care workers such as certified nurse aide (CNA) or specific training of personal care attendants. The supervision of home care workers and scope of



practice for each type of worker must be described by the state. Under several options, a Medicaid client may employ and manage their own home care staff, so it is critical to assure that standards are in place to protect a potentially vulnerable population. CMS has a grant program to assist all states that desire to institute or upgrade their systems of employee background checks to ensure that employees hired to serve the long term care population do not have histories that make them unfit to be hired. Medicaid programs must have processes in effect to investigate allegations of abuse, neglect and exploitation of clients, and adequately monitor the provisions of care. Federal oversight of waivers and other community-based care is significant, and states must agree to meet standards and report, as required, on various aspects of the program. Long term care services are complicated and therefore must be managed by adequately trained and experienced staff. The Navajo Nation should carefully review the federal rules for these services in order to understand the scope of requirements for each in order to select the model of care that best meets the needs of Indians living within the boundaries of the Navajo Nation and the management structure.

### ***Behavioral Health System***

Behavioral health is another challenging area. Medicaid is the largest payer of behavioral health services in the country, particularly for serious mental illness. There is flexibility in designing services to support behavioral health clients in the community, which can include home-based and school-based services. Designing the service delivery model to provide culturally appropriate services for residents of the reservation will be a great opportunity to expand the capacity of IHS and tribal health providers in this service category.

### ***Skilled Professional Medical Personnel***

Some positions will be considered Skilled Professional Medical Personnel (SPMP) under Medicaid rules (those positions that are required to use professional medical skills to perform their work) and, as such, qualify for a 75-percent match rate as opposed to the normal 50-percent match rate. These positions are likely to be medical doctors, registered nurses, and pharmacists. Assistants to SPMP who perform necessary work related to medical services may also be claimed at the higher match rate. The kind of work they perform includes medical review of services, authorization of services/treatment, drug utilization review, etc.

### ***Rate Setting and Audits***

Accountants and auditors will need to be employed by the Medicaid agency in order to develop payment methodologies, hold public hearings on payment methodologies, and review cost reports. The claims processing subsystem for surveillance and utilization review will report on outlier payments for desk audits. The Medicaid agency will need to contract for provider audits and with a Recovery Audit Contractor (RAC) as required by federal rules to assure that payments are justified. These processes will need to be overseen from the public bidding process, contract management, verification of audit findings, negotiation of repayments, and coordination with provider appeals. This unit may also handle provider sanctions for inappropriate billing activities and other violations of federal provider requirements and interface with the Fraud Unit.

### ***Hearings and Appeals***

The Navajo Nation Medicaid agency will need to provide two appeal processes: one for applicants and beneficiaries and one for providers. Medicaid applicants and beneficiaries are

entitled to a fair hearing for matters related to Medicaid eligibility, services, and payment for services. A state must establish a hearing and appeals system that meets federal standards; all notices sent to applicants and beneficiaries must explain their hearing rights. A state will generally have an administrative appeal process in place for the first level of appeal using hearing officers or similar types of positions with final appeal at the judicial level. An applicant or beneficiary of Medicaid may appeal any action by the Medicaid agency that includes eligibility decisions, coverage decisions, and actions affecting payment for services. Hearing officers must be thoroughly familiar with both eligibility and coverage policy.

A system of hearings and appeals for providers must also be in place. Providers are entitled to appeal enrollment decisions, rates of payment, payment issues with specific claims for services, audit findings, provider sanctions, and recoupment and recovery of payments. These hearings and appeals will have an administrative and judicial component using different personnel than those utilized at client hearings. The first level of appeal may be at the department level, or the Nation could require a first level of review by the MMIS contractor for certain types of issues, such as denial of a claim. Provider hearings are more complex due to the subject matter involved; complex rate setting issues may require legal counsel.

### ***Fraud Unit***

Federal law and regulations require that a Medicaid agency have methods in place to detect suspected fraudulent behavior and these legal requirements will need to be extended to the Navajo Nation Medicaid agency so that potential fraud cases may be referred to a Medicaid Fraud Control Unit (MFCU) or other law enforcement agency. Federal law also requires the state, as a part of its Medicaid plan, to establish an MFCU or to demonstrate to the Secretary that establishment of MFCU would not be cost effective because minimal fraud exists and that beneficiaries will be protected from abuse and neglect without a MFCU. A MFCU is required to be separate and distinct from the state Medicaid agency. Most states house the MFCU in the Attorney General's office, where a team of attorneys, investigators and auditors investigate and prosecute provider fraud as well as patient abuse or neglect. While the authority of the MFCU is limited to provider fraud and patient abuse or neglect, states also have a process for preventing and detecting individual fraud perpetrated by persons seeking Medicaid eligibility through fraudulent methods

### ***Survey and Certification***

Each state is required to operate a survey and certification entity charged with certifying health care facilities (hospitals, nursing homes, home health agencies, etc.) for participation in Medicare and Medicaid. Under section 408 of the Indian Health Care Improvement Act, IHS and tribal facilities are exempt from state licensure, but must meet applicable standards for such licensure.

### ***Contracting***

All Medicaid agencies contract for a significant number of professional services to assist them in managing their program. Contract management and procurement rules therefore become a very desirable skill for agency staff; for each contract area, one or more positions will be responsible for adequately and completely describing the work product in the Request for Proposals (RFPs), managing the public process for advertising and awarding the contract and managing the

ongoing work of each selected contractor. Some contracts will require a higher level of work effort, particularly if there are legal requirements attached, such as provider audits where the final product may entail appeals, hearings, or sanctions against affected providers.

Common areas for contracting include:

- *MMIS*. Selecting a fiscal intermediary is the largest and most complex contract for any State. Developing the detailed requirements analysis for the RFP will entail work by most of the agency policy and technical staff. A single manager should lead the process, organizing the efforts of the staff and assuring that timelines are met. Ongoing management of the entity selected will require constant interface by a large number of staff who will each be responsible for his or her area of expertise.
- *Utilization review*. States generally contract for the services of a Quality Improvement Organization (QIO) to manage inpatient care, including psychiatric hospitals and residential programs; these entities are certified by CMS. Medicaid will generally define the types of conditions that may need prior authorization for hospital admissions, define length of stay, and require justification for any extended stays beyond expectations.
- *Disability determinations*. Many Medicaid agencies will contract with subject matter experts to conduct a disability determination for clients applying for Medicaid based on disability; additionally, SSI may contract with a state Medicaid agency for these determinations.
- *Third-party liability*. Medicaid is the payer of last resort (excluding IHS and tribal health programs) and, as such, must assure that any other liable party pays for health care services before Medicaid will pay. Clients are responsible for reporting insurance coverage changes, as well as incidents for which another party should pay, such as a car accident or work-related injury, but this reporting is not always reliable. Many states pay a contractor to pursue possible payers through review of claims for conditions likely to indicate liability and matching various data files.
- *Liens and estate recovery*. States must pursue liens and estate recoveries for certain Medicaid clients (as defined in state law and regulations) to repay Medicaid for the costs of care provided (subject to federal protections from Medicaid estate recovery of certain Indian property provided in section 1917(b)(3)(B) of the Social Security Act). Some agencies contract for this service. The Navajo Nation will need to consider its policy approach toward these issues, within federal parameters.
- *Prescription drugs*. There are several key areas related to prescription drugs for which a state may contract:
  - *Drug Utilization Review (DUR)*. Federal law at section 1927 of the Social Security Act requires that states have methods in place to conduct prospective and retrospective review of drug utilization clients, prescriptive activities of physicians and others authorized to prescribe drugs, and education efforts for both. These legal requirements would need to be extended to the Navajo Medicaid agency. It should be noted that Section 1927(g) of the Social Security Act refers specifically to “states” rather than to Medicaid agencies.



- *Drug rebates.* Medicaid is required to receive rebates from pharmaceutical manufacturers for all prescribed drugs provided to Medicaid clients; a program may manage this function in-house or contract for this service.
- *Dispensing fees.* Medicaid pays a dispensing fee for every prescribed drug dispensed, as well as multiple levels of fees depending on the dispensing activity, such as compounding drugs. The dispensing fee is generally determined by surveying pharmacies in the state to determine the cost for these services. The agency may perform the survey in-house or under contract.
- *Audits.* Medicaid programs are required to conduct provider audits to determine if payments have been correctly made. A state Medicaid program will need to have audit regulations in place in order to provide guidelines for providers on recoupment of overpayments determined by an audit and to provide an appeals process. Most Medicaid agencies contract for audit services, which must be more intensely managed by the state in order to assure that due process for providers is in place. Providers must be given the opportunity to respond to audits and to negotiate repayments of funds due. The agency must also manage any sanctions the state adopts under regulations. Federal regulations require states to return federal funds to CMS when an overpayment is discovered, so it is important for the state to have adequate protections in place. Medicaid agencies generally conduct desk audits of providers on records coming to the state's attention from the MMIS Surveillance and Utilization Review Subsystem (SURS), issue contracts with accounting firms for provider audits (including the new RAC requirements), and must link activities with the Medicaid Fraud Unit.

These requirements are extensive and there are many requirements that would need to be extended to a Navajo Medicaid agency so that it would have the same authorities as a state. Certain sections of the Social Security Act and regulations refer specifically to states rather than Medicaid agencies and would need to be addressed. Additionally, these requirements will necessitate significant professional resources and experienced personnel in order to be in compliance with all federal regulations and policies. The Navajo Nation would need to commit staff resources and, perhaps, obtain outside legal and regulatory consulting services well in advance of program implementation to develop the infrastructure necessary to operate the health care purchasing system desired. As noted previously, it is likely that this start-up process would take 5 years of intense effort. This 5-year timeline is based on assumptions that the Navajo Nation (after enactment of authorizing legislation by Congress) would take: 2 years to make policy choices on eligibility, covered services, provider payment, and other aspects of program design then enter into contracts with experts to develop the formal Medicaid State plan, including engaging in necessary public notice/consultation; 1 year to obtain necessary review and approval from CMS on the plan; and another 2 years to develop a contract and contract with an entity to carry out systems design, testing, and implementation activities, obtain infrastructure to support the system and staff, conduct staff hiring and training, conduct provider outreach and enter into provider participation agreements, and conduct beneficiary outreach and enrollment activities. Additional time may be required for startup if the Navajo Nation, for example, requires additional time to respond to additional information requests that CMS may have during the Medicaid plan approval process or if the Navajo Nation encounters unforeseen issues with developing program and administrative details, finding appropriate contractors, acquiring suitable space and staff, and other elements necessary to support implementation.

2.2. *Range of Potential Start-Up Costs for the Medicaid Agency*

Costs that would be incurred during the planning and start-up period for a Navajo Nation Medicaid agency are difficult to estimate because costs would vary depending on the number of years that the Navajo Nation would require to prepare for implementation, whether the Nation chose to rely on internal staff or outside contractors for much of the planning and development, and whether the Nation decides to contract claims adjudication with another state.

In this section, a very general estimate range of these potential costs is presented under the assumption that five years would be required for planning and start-up of the Navajo Nation Medicaid agency. Table 2.2 provides a summary of cost components and the potential range of costs that might be incurred over the start-up phase of the Navajo Nation Medicaid agency.

**Table 2.2. Start-up Assumptions and Costs**

Cost Component	Assumptions	Component Costs over 5-year Start-Up Timeframe
Personnel Costs	Number of Staff Required: 30 to 50 Average Annual Cost Per Staff: \$60,000 (salary & benefits) Average Annual Personnel Costs: \$1,800,000 to \$3,000,000*	\$9,000,000 to \$15,000,000
Contract Costs (costs could be lower if the Nation is able to partner with another state to host their systems)	MMIS: \$81,000,000 to \$120,000,000** Eligibility System: \$36,000,000 to \$100,000,000 Professional Services: \$5,000,000	\$122,000,000 to \$225,000,000
Infrastructure (office space, computer hardware and software, telephone equipment and services, supplies, etc.)	Average Annual Costs: \$650,000***	\$3,250,000
<b>Total Start-Up Costs</b>	—	<b>\$134,250,000 to \$243,250,000</b>

\*These costs are based on data from the Navajo Nation pay scale classifications 51-77, step A

\*\*If the Navajo Nation decided to contract claims adjudication with another state, rather than building their own MMIS, these costs could be lower.

\*\*\*These costs are supported by information for IHS Navajo Area Office based on rates paid by local tribal providers.

***Costs of Personnel for Start-Up Period***

The Navajo Nation would need to hire core staff during the start-up period for design and development of the Medicaid agency program components, including eligibility rules; benefit package; provider participation requirements; payment/fee schedules; policies and procedures; program integrity; outreach, marketing, and enrollment processes and systems; Medicaid state plan; and Navajo Nation laws and regulatory infrastructure to provide the framework for the Medicaid program. An estimate of the number of core staff that would be required during start-up might be approximately 30 to 50, with 5-year salary and benefits in the range of \$9 million to \$15 million during the planning and start-up period.

### ***Contract Costs***

Contract costs account for the largest category of start-up expenditures. These include contracts to design and implement the Navajo Nation Medicaid Management Information System (MMIS) and an Eligibility and Enrollment system. An MMIS typically costs in the range of \$81 million to \$120 million to purchase. An eligibility and enrollment system may cost in the range of \$36 million to \$100 million to purchase. However, these costs could be lowered if the Nation is able to partner with another state to host these systems functions. Other contracts might be needed for the Navajo Nation to obtain professional services that are not available within the Nation. For example, professional expertise might be contracted to assist in design of quality assurance policies and procedures. Actuarial services might be needed to estimate the potential costs of specific benefit package alternatives that might be considered. Legal services might be obtained to assist in drafting laws and regulations necessary to support the Medicaid agency. Training services might be contracted to provide staff with knowledge and skills necessary prior to implementation of the Medicaid program. Over the 5-year start-up period, these other contract costs could total \$122 million to \$225 million, depending on the types and scope of the professional services required.

### ***Other Start-Up Costs***

Other start-up costs include office space and furnishings, telephone equipment and services, computer hardware and software, travel costs, and supplies. The costs of this component of start-up costs are difficult to estimate since there would be substantial variance in costs depending on location of office space; lease or purchase decisions for space, telephone, and computer hardware; and other decisions. For purposes of the estimate of start-up costs, an assumption is made that these costs would average \$650,000 each year for the 5-year start-up period, for a total of \$3.2 million over 5 years.

### ***Federal Financial Participation in Start-Up***

The Federal Government pays 50 percent of most administrative costs incurred by states in operating their Medicaid program and a higher share of costs for some specific administrative components. Specifically, federal financial participation is 90 percent for approved design, development, and implementation of an MMIS system and an eligibility and enrollment system (at least through 2015).

However, federal financial participation is not available until a Medicaid system is fully operating statewide. We estimate that total start-up costs would probably be between \$134.2 million and \$243.2 million over a 5-year start-up period. Whether the Navajo Nation would be responsible for these costs has not been determined. Congress could authorize funding for start-up costs along with passage of the legislation to create the Navajo Nation Medicaid agency. If Congress authorized Federal Financial Participation for administrative costs at a rate of 60 percent, then the remaining 40 percent of these costs would be in the range of \$53.7 million to \$97.3 million for planning and development of the Medicaid agency.

## Section 3: Issues, Assumptions, and Results of Cost Estimations

### 3.1. Overview

Costs for operating a Navajo Nation Medicaid agency were estimated and are reported in this section. These estimates assumed, hypothetically, that the Navajo Nation Medicaid agency was fully operational in 2010. The use of 2010 as the base year for a fully operational Navajo Nation Medicaid agency permits the use of 2010 data to develop assumptions and cost estimates and makes use of data available from a number of sources, including:

- 2010 Census data.
- States of Arizona, New Mexico, and Utah 2010 data on Medicaid enrollment, expenditures, and payments to IHS, tribal, and other providers on behalf of beneficiaries residing in the Navajo reservation.
- 2010 FMAP rates for each state and formula for calculating a Navajo Nation FMAP.
- CMS Office of the Actuary report on 2010 spending.
- Medicaid budgets and program spending, by category, for several small population states and U.S. territories.

In addition, site visits and discussions with the state Medicaid Agencies of New Mexico, Arizona, and Utah were conducted and produced useful information for structuring the cost estimates and developing the assumptions that were used to produce these estimates.

FY 2010 was used as the base year for these cost estimates. The 2010 estimates are made under Medicaid policies that were in place in that year. As such, the estimates do not address the many changes in Medicaid policy and the expansion of Medicaid that would occur when the Affordable Care Act is fully implemented in 2014. Given the efficiencies made in the Medicaid program by the Affordable Care Act that streamline and simplify Medicaid eligibility and benefits, and if the Navajo Nation chooses to contract with a state for its systems, the Nation's administrative costs could be reduced from 8 percent to the 3-5 percent range in future years. Where appropriate, we have included consideration and models brought about by federal and state Affordable Care Act implementation efforts over the past several years that could assist the Navajo Nation in streamlining its systems and policy development time and costs. Such models would include, for example, the model hospital presumptive eligibility application, eligibility and enrollment systems enhancements, the model streamlined eligibility application and the state plan amendments posted to the CMS website at Medicaid.gov.

In the following sections of this chapter, the assumptions made to generate the cost estimates are discussed, a baseline model Navajo Nation Medicaid agency is described, and estimates of the costs of a Navajo Nation Medicaid agency, had it been fully operational in 2010, are presented. The final section discusses the limitations of the cost estimation methodology and the estimates produced and issues that could substantially affect actual costs if a Navajo Medicaid agency were established at some future time.

### 3.2. *Issues and Assumptions for Estimating the 2010 Cost of a Navajo Medicaid Agency*

Establishing and operating a Medicaid agency is a highly complex enterprise. Federal requirements are very detailed, and a substantial number of internal decisions must be made to establish the parameters and operational foundations for the program. To date, the Navajo Nation has not determined the eligibility requirements that it would use for its Medicaid program, nor has it finalized the benefit package, provider payment schedules, or any special waiver programs that might expand eligibility, services, and/or access to and use of benefits. Therefore, the Medicaid program model assumptions that have been made to permit estimates of the costs of a Navajo Medicaid agency are very simplistic ones. However, these assumptions do provide an initial baseline that can then be used to test the sensitivity of costs to changes in these assumptions about the characteristics of a Navajo Medicaid agency.

The key assumptions required for the cost estimates include:

- *Eligibility.* Who is eligible to enroll in the Navajo Nation Medicaid program, and what are the eligibility criteria?
- *Enrollment “take up.”* Of those determined to be eligible, what proportion are likely to actually enroll in Medicaid?
- *Benefit package.* What services will be covered by the Navajo Medicaid agency?
- *Payment rates.* How much will the Navajo Nation Medicaid agency pay providers for services?
- *FMAP.* What will be the federal match for claims costs and for administrative costs incurred by the Navajo Nation Medicaid agency?
- *Distribution of services provided and claims costs between IHS/tribally-operated providers and non-IHS/tribal providers.* What proportion of services and associated claim costs are provided to Navajo Nation Medicaid enrollees by IHS/tribal providers for which the Navajo Nation Medicaid agency can be reimbursed at 100 percent FMAP?
- *Administrative costs.* What is the administrative costs-to-claims cost ratio?

Each of these assumptions is discussed in this section.

#### ***Eligibility Assumptions***

- *Population Base.* The legislative language authorizing this study indicates that the Navajo Medicaid agency would serve Indians living within the boundaries of the Navajo reservation.

2010 Census data was used to identify Indians who lived within the boundaries of the Navajo reservation. This resulted in a total population of 176,322 persons living within the Navajo reservation who self-identified as Indian either alone or in combination with another race.

- *Medicaid Eligible Population.* After reviewing Medicaid eligibility criteria of several small states, the baseline eligibility criteria for estimating the costs of Navajo Medicaid

were set at the following levels: all infants/children under age 19 who reside in households with annual income less than or equal to 185<sup>2</sup> percent of the Federal Poverty Level; all pregnant women with annual incomes less than or equal to 185 percent FPL;<sup>3</sup> all adults of the ages of 19 to 64 with household income less than or equal to 133 percent FPL; and all adults of the age of 65 and over with income less than or equal to 133 percent FPL. Table 3.1 summarizes the number of people eligible for enrollment in the Navajo Medicaid program, based on these criteria.

**Table 3.1. Number of Medicaid Eligible Indian Residents of Navajo Medicaid Service Area, Applying Eligibility Criteria**

Population Category	Total Eligible on Income Criterion
Infants/children ages 0-18, income less than or equal to 185 percent FPL	43,795
Pregnant women, income less than or equal to 185 percent FPL	1,571
Adults, ages 19-64, income less than or equal to 133 percent FPL	25,115
Adults, ages 65+, income less than or equal to 133 percent FPL	1,226
Infants, children and adults with disabilities	15,283
<b>Total eligible</b>	<b>86,990</b>

Applying these criteria, 86,990 Indian residents on the Navajo Nation reservation, would be eligible to enroll in the Navajo Medicaid program. This would represent 49 percent of the total 176,322 Indian population of the Navajo Medicaid agency service area.

*Enrollment “Take up” Rate.* It is hard to predict the take-up rate that should be expected. Although the number of eligible individuals who are participating in Medicaid nationally has historically been in the 65 – 70 percent range among low income parents and adults, the participation rate among eligible children averages 87 percent and exceeds 90 percent in many states. Because Indians have access to IHS care for primary, preventive, and a range of routine specialty services at no out-of-pocket costs, an outreach and education campaign will be important in order to emphasize the advantages and importance of full health coverage through Medicaid. If the Nation invests in these efforts concurrently when establishing the Medicaid agency, the take-up rate will likely be higher than the national average, although it may take a number of years to achieve such rates. The cost estimates for Navajo Medicaid were prepared under four “take up” rate assumptions: (1) 65 percent of Medicaid eligibles enroll; (2) 80 percent of Medicaid eligibles enroll; (3) 95 percent of Medicaid eligibles enroll; and (4) a hybrid, similar to what many states experience, where 90 percent of Medicaid-eligible children and 70 percent of other

<sup>2</sup> If coverage is expanded up to 200 percent FPL, similar to other states that operate CHIP, an additional 3,000 children would be potentially eligible for Medicaid.

<sup>3</sup> No data source was found to estimate the number of pregnant Indian women residing on the Navajo reservation with income levels below the income criterion. An estimate was made based on the 2010 Census number of infants under age 1 residing in households with income less than 185 percent of the FPL.



Medicaid eligibles enroll. Table 3.2 presents the estimated number of persons eligible and enrolled into Navajo Medicaid under each assumption at the end of a five-year period after outreach and enrollment begins. Past experience in Indian Country with new health benefits, even with aggressive outreach, shows slower starts and more gradual slopes for take up for various reasons.

**Table 3.2. Number Enrolled in Navajo Medicaid under Alternative “Take up” Assumptions**

Population category	Enrollment under 65 percent “take up”	Enrollment under 80 percent “take up”	Enrollment under 95 percent “take up”	Enrollment under hybrid 90% Children/ 70% Others “take up”
Infants/children, ages 0-18, income less than or equal to 185 percent FPL	28,467	35,036	41,605	39,416
Pregnant women with income less than or equal to 185 percent FPL	1021	1,257	1,492	1,100
Adults, ages 19-64, income less than or equal to 133 percent FPL	16,325	20,092	23,859	17,581
Adults, ages 65+, income less than or equal to 133 percent FPL	797	981	1,165	858
Infants, children, and adults with disabilities	9,934	12,226	14,519	10,698
<b>Total enrolled</b>	<b>56,544</b>	<b>69,592</b>	<b>82,640</b>	<b>69,653</b>

*Benefit Package/Payment Rates/Average expenditures per Medicaid enrollee.* The Navajo Nation has not yet developed a benefit package or made decisions about the payment levels that will be used to pay providers of services. The new Alternative Benefit Program (ABP) may be helpful in developing a benefit package for the Navajo Nation. APBs provide states an alternative to providing all of the mandatory and selected optional benefits under the traditional Medicaid program. States have the option to enroll state-specified groups in these new benefit packages. Individuals in the new adult eligibility expansion group up to 138 percent of the federal poverty level must receive benefits through an APB. However, certain subpopulations will be exempt from mandatory enrollment in these programs (e.g., those with special health care needs).

An ABP must cover the following 10 essential benefits included in the Affordable Care Act:

- Ambulatory patient services (outpatient care provided without being admitted to a hospital)
- Emergency services
- Hospitalization
- Maternity and newborn care (before and after the baby’s birth)
- Mental health and substance use disorder services (including behavioral health treatment)
- Prescription drugs

- Rehabilitative and habilitative services and devices to help people with injuries, disabilities or chronic conditions gain or recover mental and physical skills)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services.

CMS can provide technical assistance to help the Nation establish its ABP.

Average cost per Medicaid enrollee is determined by the generosity of the benefits that are provided, average number of services used, and payment rate. The averages were provided by the States of Arizona, New Mexico and Utah and are included in table 3.4. The assumptions used to develop an average cost per Medicaid enrollee for the cost estimates are:

- Average expenditures for health services per enrollee, by category of enrollee, were drawn from the 2011 Actuarial Report on the Financial Outlook for Medicaid.
- Average health services cost per enrollee for the States of Arizona, New Mexico, and Utah were then examined to assess whether the national average expenditures per enrollee are comparable and to identify potential limitations of using national expenditures data for these estimates.

Table 3.3 presents the national average Medicaid expenditures for health services, for each eligibility category assumed for the Navajo Medicaid program. Table 3.4 presents average expenditures for health services per enrollee by Arizona, New Mexico, and Utah Medicaid programs.

**Table 3.3. National Medicaid Spending Per Enrollee For Health Services, by Category, 2010\***

Population category	Average Medicaid Expenditures
Infants/children, ages 0-18	\$2,717
Pregnant women	\$4,314**
Adults, ages 19-64	\$4,314
Adults, ages 65+	\$15,495
Infants, children, and adults with disabilities	\$16,963
<b>U.S. Average, all enrollees</b>	<b>\$6,775</b>

\*Data drawn from C Truffer, JD Klemm, CJ Wolfe, and KE Rennie, *2011 Actuarial Report on the Financial Outlook for Medicaid*, Office of the Actuary, CMS, HHS.\*\*No separate average expenditure estimates for this eligibility category as this category is included in the average for adult Medicaid enrollees ages 19-64.

**Table 3.4. Average 2010 Medicaid Spending for Health Services, Per Indian Enrollee Residing on the Navajo Reservation, for States of Arizona, New Mexico, and Utah**

State	Average Medicaid Expenditures
Arizona	\$5,359
New Mexico	\$3,946
Utah	\$4,172
Three State Average	\$4,492

National per capita Medicaid spending in 2010 was \$6,775, compared to approximately \$4,500 per capita health spending for Indians residing on the Navajo reservation as reported by New



Mexico, Arizona, and Utah Medicaid for 2010. There are a number of reasons for the lower per capita costs for Indian Medicaid beneficiaries in the Navajo area. The age-mix of the Indian population is younger than the average U.S. population, with more lower-cost infants and children proportionately and proportionately fewer higher-cost Indians over the age of 65. Limited long-term care services are available within the Navajo reservation, and these services are typically very costly on an annual basis. In addition, the highly rural nature of the Navajo Nation, transportation barriers, and limited availability of health resources in the area are consistent with lower health care utilization levels than the national average.<sup>4</sup> Additionally, IHS and tribal providers might have under-billed for Medicaid services due to their lesser familiarity with services covered and billing procedures to obtain payment for those services under Medicaid.

Because we do not have information on the specific covered services that would be offered by the Navajo Nation Medicaid program, the cost estimates have been developed using average expenditures for each eligibility category derived from the national actuarial data.

- *Navajo Nation FMAP.* The formula for calculating the FMAP is  $(1 - 0.45 \times (\text{state per capita income squared divided by U.S. per capita income squared}))$ , with a maximum of 83 percent for the federal match rate. Using 2010 Census data, the FMAP for claims costs incurred by the Navajo Nation Medicaid agency is calculated to be 93 percent (before application of the current statutory maximum).<sup>5</sup>

The FFP for Medicaid administrative costs is 50 percent, with higher match rates for specific types of administrative costs. Data on match rates for a range of administrative costs reported by states suggest that, on average, the Navajo Nation Medicaid agency could obtain (and is likely to request) approximately a 60-percent federal match overall on administrative costs.

- *Distribution of Claims Costs between IHS/tribal Providers that are 100 percent FMAP and Non-IHS/tribal Providers that would be reimbursed at the 83-percent FMAP rate.* Medicaid revenues reported by IHS providers serving Indians living on the Navajo reservation, and state Medicaid payments to IHS were examined to obtain information on the proportion of claims dollars that would be subject to the 100 percent FMAP under a Navajo Medicaid agency. These data support an assumption that 17-33 percent of claims were paid at 100 percent FMAP in 2010.<sup>6</sup> While Indians may use primarily IHS and tribal facilities for routine primary care, tests, procedures, and preventive services, higher cost laboratory and radiology services, specialist physician services, more advanced surgical services, and long-term care services may be more likely to be obtained at non-IHS/tribal facilities. Given this situation, the 33 percent of claims cost

<sup>4</sup> Bonito, AJ, CR Eicheldinger, and NF Lenfestey, Health Disparities: Measuring Health Care Use and Access for Racial/Ethnic Populations: Final Report, Part 2, RTI International, Contract No. 500-00-0024, Task No. 8, Centers for Medicare & Medicaid Services, Baltimore, MD, April 31, 2005.

<sup>5</sup> Navajo Nation per capita income in 2010 was \$9,948, while U.S. per capita income was \$26,059. Applying the FMAP formula yields 93 percent, which is above the 83-percent maximum FMAP permitted.

<sup>6</sup> Data on the distribution of claims paid to IHS and non-IHS providers were not provided by the Arizona Medicaid program.

paid at 100 percent FMAP (as reported by NM) is a reasonable assumption for purposes of this report.

- *Estimates of Administrative Costs of a Navajo Nation Medicaid Agency.* Review of published Medicaid budget and expenditures data from a number of states suggests that the average incurred administrative costs are approximately 5 percent of claims costs, with smaller states incurring higher administrative costs relative to claims costs. Since the Navajo Nation Medicaid agency would be similar to the smallest states in terms of estimated number of Medicaid enrollees, we have assumed administrative costs would average approximately 8 percent of claims costs in 2010 (although they may be higher in the first years of implementation).

### 3.3. *Summary of Assumptions for Estimating the 2010 Costs of a Navajo Nation Medicaid Agency*

The assumptions that underlie the estimate of 2010 costs of a Navajo Nation Medicaid agency, had it been fully operational in that year, are presented below.

#### ***Baseline Assumptions for 2010 Cost Estimate***

- *2010 Population.* The population that would be served by the Navajo Medicaid agency includes all Indians residing within the boundaries of Navajo reservation. In 2010, this population is estimated to be 176,322.
- *Eligibility Rules for Enrollment in Navajo Medicaid.* The eligibility assumptions include the following eligibility categories:
  - Infants and Children, ages 0 to 18, living in households with incomes less than or equal to 185 percent FPL.
  - Pregnant women, incomes less than or equal to 185 percent FPL.
  - Adults, ages 19 to 64, incomes less than or equal to 133 percent FPL.
  - Adults, ages 65+, incomes less than or equal to 133 percent FPL.
  - Individuals of all ages who qualify for assistance based on disability.

*Number of Persons Eligible for Enrollment in the Navajo Medicaid Program in 2010.* We estimate that a total of 86,990 persons, as noted in Table 3.1 above, would be eligible to enroll in the Navajo Medicaid program, under the eligibility rules assumptions presented above.

- *Number of Persons Enrolled in the Navajo Medicaid Program in 2010, under alternative “take up” assumptions.* Separate enrollment estimates are calculated assuming “take up” rates of 65 percent, 80 percent, and 95 percent of eligible persons and a hybrid consisting of 90 percent eligible children and 70 percent eligible adults.

These assumptions produce the following numbers of enrollees in 2010:

- 65 percent of eligible persons enrolled in Medicaid: 56,544 enrolled.
- 80 percent of eligible persons enroll in Medicaid: 69,592 enrolled.
- 95 percent of eligible persons enroll in Medicaid: 82,640 enrolled.

- 90 percent of eligible children and 70 percent of eligible adults enrolled in Medicaid: 169,653.
- *Average Claims Costs per Eligibility Category.* The estimates presented in this report use the CMS national 2010 estimates of per capita costs for each eligibility category.

*FMAP for Navajo Nation Medicaid Agency.* The FMAP for the Navajo Nation Medicaid agency is assumed to be 83 percent in 2010. This FMAP is applied to claims for services provided by non-IHS/tribal health providers; 100 percent FMAP is applied to services provided by IHS/tribal health providers.

- *Distribution of Claims Costs between IHS/tribal health providers and non-IHS/tribal providers.* The assumption is that 33 percent of 2010 claims costs will be for services provided by IHS/tribal providers and 67 percent of claims costs will be for services provided by non-IHS/tribal providers.
- *Administrative Costs.* The assumption is that Navajo Nation Medicaid agency administrative costs are 8 percent of claims costs in 2010 and an average federal payment rate (FFP) of 60 percent is assumed for these costs.

*3.4. Estimated 2010 Total, Navajo Nation, and Federal Costs of a Navajo Nation Medicaid Agency*

The estimated costs of a Navajo Nation Medicaid agency, had it been fully operational in 2010, is shown in Table 3.5 for alternative enrollment “take up” assumptions.

**Table 3.5. Estimated Costs of Navajo Medicaid Agency under Alternative Enrollment Assumptions, 2010**

<b>Enrollment Levels and Cost Categories</b>	<b>Alternative 1: 65 Percent of Eligible Persons Enrolled</b>	<b>Alternative 2: 80 percent of Eligible Persons Enrolled</b>	<b>Alternative 3: 95 percent of Eligible Persons Enrolled</b>	<b>Alternative 4: Hybrid 90% Children/ 70% Others Enrolled</b>
Number of Enrollees	56,544	69,592	82,640	69,653
Claims Costs	\$333,035,440	\$409,882,631	\$486,742,471	\$382,447,990
Administrative Costs	\$26,642,835	\$32,790,610	\$38,939,398	\$30,595,839
<b>Total Program Costs</b>	<b>\$359,678,275</b>	<b>\$442,673,241</b>	<b>\$525,681,869</b>	<b>\$413,043,829</b>
Navajo Nation Cost Share	\$48,589,871	\$59,801,876	\$71,015,727	\$55,799,162
Federal Government Cost Share	\$311,088,404	\$382,871,365	\$454,666,142	\$357,244,667

Based on the assumptions in Table 3.5, the average cost per Medicaid beneficiary for the Navajo Nation is estimated to be \$5,890. This average is based on the potential number of enrollees and the estimated claims costs. This amount is less than the national average Medicaid costs of \$6,775 but higher than the state average Medicaid costs for Indians residing on the Navajo reservation enrolled in each of the respective state Medicaid programs: \$3,946 (New Mexico); \$4,173 (Utah); and \$5,359 (Arizona).

### 3.5. *Discussion and Limitations of the Cost Estimates*

The cost estimates presented above represent very general approximations of the potential costs of a Navajo Nation Medicaid agency. The Navajo Nation could make very different decisions about eligibility rules and benefits that would produce significantly different estimates of potential costs. In addition, the cost estimates rely on data sources with some limitations that may affect the accuracy of the results.

The estimates for FY 2010 are based on historical data and policies and are expected to change in the future. The Affordable Care Act would be fully implemented and would become the new regulatory framework for Medicaid, affecting eligibility, benefits, administrative requirements, and costs. Also, health care costs are likely to continue rising. These changes (and others that may not be anticipated) could increase and/or decrease the costs of a Navajo Nation Medicaid agency, and it is impossible to predict with accuracy the potential future costs or distribution of those costs, as the economy, health care system, and regulations change.

## Section 4: Other Feasibility Considerations

Cost is only one important consideration for assessing the feasibility of a policy change. The feasibility of a Navajo Nation Medicaid agency may also be affected by a number of other factors, including:

- Availability of professional and management staff needed to design, implement, and manage the Medicaid agency.
- Contracting for a MMIS and other services.
- Legal and regulatory issues.
- Provider network and payment issues.
- Impacts on residents of the Navajo reservation.

Each of these issues is discussed in this section.

### 4.1. *Recruitment and Retention of Professional and Management Staff*

- The Navajo Nation is in a highly rural location and spread out over a large geographic area with many areas of very low population density. Recruiting and retaining professional and management staff to support and manage the diverse functions necessary to operate the Medicaid agency can be very challenging in rural areas, generally, and even more so in Indian Country. To estimate the number of staff a Navajo Nation Medicaid agency might need to employ, the Medicaid budgets for several low-population states were reviewed. Detailed budgets were available online for Wyoming, North Dakota, and Alaska; more generalized budget information was available for South Dakota, Vermont, and the Territories of Guam and the Virgin Islands.
- Wyoming (population 563,626) provides Medicaid to 82,000 people; it employs 84 people to manage Medicaid and 50 people to determine eligibility (Wyoming has separate Medicaid enrollment staff from other public assistance programs).
- Alaska (population 710,231) provides Medicaid to 150,000 people; it employs 84 people to manage Medicaid and 526 people to determine eligibility for Medicaid and other programs.
- South Dakota (population 814,180) provides Medicaid to 114,000 people; it employs 149 people to manage Medicaid and 319 people to determine eligibility for Medicaid and other assistance programs.
- North Dakota (population 672,591) provides Medicaid to 62,257 people; it employs 68 people to manage Medicaid.
- Hawaii (population 1,360,301) contracts with Arizona for claims adjudication in its MMIS, still employs 239 positions for health care policy and eligibility for the 214,000 people on Medicaid in that state; it also employs 45 people to perform disability determinations for SSI, and another 7 positions work in Arizona on the MMIS.

Based on the experience of these other states, it seems likely that the Navajo Nation Medicaid agency would employ approximately 85 to 100 staff members to support the functions of the agency and 50 or more eligibility workers to conduct outreach, eligibility determinations, and enrollment functions. These staff functions include policy and management, skilled medical professionals, eligibility determination supervisors and fieldworkers, electronic systems managers and technical staff, accountants and auditors, fraud and abuse detection and prevention staff, hearings and appeals staff, and support staff.

#### *4.2. Contracting for MMIS and Other Services*

If Congress authorizes a Navajo Nation Medicaid agency, procuring a certified MMIS will be a costly and complex challenge. System design and development is a lengthy process requiring highly skilled policy and technical personnel. It could be a challenge for the Nation to recruit and retain appropriate personnel because the market for skilled IT professionals is relatively tight at this time due to competition from the extensive technology work occurring nationally with Health Insurance Marketplaces, electronic health record development, and the number of MMIS builds occurring across states. Design, development, CMS negotiations, bidding for a system, and implementation of a system could take, at a minimum, two years to complete.

One alternative that would increase the feasibility of establishing the Navajo Nation Medicaid agency would be for the Navajo Nation to contract with another state currently operating a MMIS system to adjudicate claims for the Nation. This would enable the Nation to make the policy choices in design of its own benefit package and payment mechanisms and have the MMIS of another state to perform the implementation functions to adjudicate the claims. Currently, two smaller-population states have chosen to contract with other states for claims adjudication. As noted above, the State of Hawaii contracts with the State of Arizona and the Virgin Islands contracts with the State of West Virginia for claims adjudication.

While the Navajo Nation Medicaid agency, as the contracting entity, would need to provide some support to the system, the demands are significantly less than designing and operating a new MMIS system exclusively by and for the Navajo Nation. Hawaii pays for approximately half of Arizona's annual MMIS operating costs (\$6.5 million) as well as for 6.7 full-time positions located in Arizona. Arizona reported during the site visit to the Medicaid agency that the negotiation of the contract between the two states took a year. Ongoing cooperation between the two states on systems upgrades and maintenance is necessary in order to align their requirements to use the same set of code. The MMIS is capable of adjudicating claims for a multitude of different programs (many states pay claims through their MMIS for a variety of programs other than Medicaid), so segmenting different clients, providers, and payment mechanisms is entirely possible. It is important to note that, while Arizona adjudicates claims, Hawaii actually issues checks to providers for those claims approved for payment.

#### *4.3. Statutory and Regulatory Framework*

Currently, the Medicaid statute does not permit the creation of a Navajo Nation Medicaid agency with the same authorities as state Medicaid agencies. Creation of such an agency would provide for the implementation of the programs described in this report.



Feasibility of a Navajo Nation Medicaid agency would be affected by the magnitude and complexity of the federal statutory and regulatory requirements and the Navajo Nation would need to develop its own laws and regulations to provide a framework under which a Medicaid agency would operate. Thus, establishing a Navajo Nation Medicaid agency would be a substantial undertaking in which a high degree of cooperation would be necessary among Congress, federal agencies, states, and providers. Feasibility would depend upon an agreement between the United States and the Navajo Nation, on a specific plan to implement a Navajo Nation Medical Assistance program/Medicaid agency.

### ***Navajo Nation – Medical Assistance Program Operation***

If the Navajo Nation were designated a state for purposes of operating its own Medicaid agency, it would likely enact laws to authorize its own Medicaid program as required by all state participants in the program. Some of these laws will involve regulation of eligibility, benefits, payments, administration, and quality control; all elements of a Medicaid plan that involve technical subject matters, jurisdiction over providers and suppliers to regulate medical, dental, drug, durable medical equipment, health, nursing home, long-term care, and rural health centers. The Nation would also have to establish laws to address other activities such as compliance and auditing of records, professional liability insurance; and the expansion of judicial civil procedures to cover non-Navajo persons, entities and individuals who are providers or suppliers. An extremely high degree of involvement by the Navajo Nation will be necessary to regulate providers.

**Jurisdiction.** If the Navajo Nation should be treated as a “state” under Title XIX, it would, like all states, have to comply with all Section 1902’s requirements.

**Equal Protection and Due Process.** Overlapping geographic jurisdiction of Navajos and other Indians who are citizens of the three states listed above would need to be addressed. Section 1902 of Title XIX requires the recipient of federal financial assistance to comply with federal civil rights laws, which would require compliance with federal standards for due process and equal protection. It should be noted that the Navajo Nation has enacted its own Civil Rights Act, and has procedures for hearings.

#### *4.4. Potential Impacts on Indians Living within the Boundaries of the Navajo Nation*

*A Navajo Nation Medicaid agency would offer a number of positive benefits to Indians who live within the boundaries of the Navajo Nation. These benefits include:*

- A standardized eligibility and benefits Medicaid program for Indian residents of the Navajo Nation, regardless of their state of residence
- A Medicaid program tailored to the preferences and needs of Navajos and other Indians residing within the Navajo Nation boundaries, which may include enhanced ability to cover traditional healing and other culturally based services, either explicitly or under other general categories of services.

While these positive benefits are evident and could be highly valued by Indian residents living within the boundaries of the Navajo Nation, there are also some potential negative effects on

current Medicaid enrollees. Initially (unless Congress provided otherwise in authorizing legislation), all current Indian Medicaid enrollees who reside within the boundaries of the Navajo Nation would lose their Medicaid enrollment status with the state programs and be required to reenroll in the Navajo Nation Medicaid agency program. It is likely that some Indian Medicaid enrollees would not immediately enroll in the Navajo Nation Medicaid program due to transportation and other logistical difficulties, reluctance to complete the paperwork, or lack of awareness that they are losing their state Medicaid status and the implications for their health care coverage and benefits. This could result in gaps in coverage for some people, loss of anticipated Medicaid revenues by IHS and tribal health programs, and an increased staff burden in assisting patients to enroll with the new agency as quickly as possible.

In addition, if the Navajo Nation Medicaid agency were required to cost-share with the Federal Government for administrative and claims costs incurred, even at a low level, these costs would need to be paid through taxation or other revenue mechanisms by the Nation, if Congress does not finance these costs. To the extent that revenues from taxes or other sources could be diverted from other current uses of Navajo Nation revenues, there could be varying impacts on different categories of residents and enterprises operating within the boundaries of the Navajo Nation. Identifying and measuring such potential impacts was beyond the scope of this study.



## Section 5: Impacts on the States of Arizona, New Mexico, and Utah and on the Federal Budget

The creation of a Navajo Nation Medicaid agency could have impacts on the States of Arizona, New Mexico, and Utah and on federal costs. This section discusses and provides estimates of the potential magnitude of those impacts.

### 5.1. Impacts on States

Potential impacts on the Navajo Nation Medicaid agency on the States of Arizona, New Mexico, and Utah include:

- Reduction in the number of individuals who otherwise would be expected to enroll in state Medicaid programs.
  - Reduction in state Medicaid costs associated with those enrollees.
  - Potential reduction in the state FMAP due to potential increase in state average per capita income when Navajo Nation residents are excluded from calculation of state average per capita income.
  - Transitional costs of the policy change.
- *Enrollment and Claims Costs.* Reduction in the number of state Medicaid enrollees and reduction in state Medicaid costs associated with those enrollees are summarized, for FY 2010, in Table 5.1 below.

**Table 5.1. Estimated Impact of Navajo Medicaid Agency on State Medicaid Enrollments and Claims Costs**

State	Estimated Change in FY2010 Enrollment*	Estimated Change in FY2010 Claims Costs**	Estimated Total Change in Costs	FY2010 FMAP Rate***	Change in State Costs	Change in Federal Costs
Arizona	-53,429	-\$286,326,225	-\$294,916,012	65.75%	-70,779,842.91	-224,136,169.21
New Mexico	-35,301	-\$139,299,048	-\$143,478,020	71.35%	-27,318,214.94	-116,159,804.69
Utah	-6,679	-\$27,863,244	-\$29,813,671	71.68%	-8,398,511.25	-21,415,160.21

\*Assumes all eligible people enroll in Navajo Nation Medicaid, thus reducing potential state financial liability for eligible residents.

\*\*Number of Indian enrollees who would move to Navajo Medicaid times the average Indian claims costs for AZ (\$5,359), NM (\$3,946), and UT (\$4,172).

\*\*\*Regular and enhanced rates were published for FY 2010. Rates noted are the regular rates.

- *Change in State FMAP.* If the population of each state were reduced by the proportion of people living on Navajo Nation reservation within that state for calculating the state FMAP rate, this could have implications for the FMAP and the resulting cost share for Medicaid (and certain other programs) that is the responsibility of the state. This may be a significant impact to the extent that a high proportion of the low-income population of a state is accounted for by residents of the Navajo reservation. Table 5.2 shows the estimated change in per capita income if the Navajo Nation population was removed for the state for

purposes of calculating the FMAP, the original FY2010 FMAP, and the recalculated FMAP excluding the Navajo Nation population.

**Table 5.2. Impact of Navajo Nation Medicaid on Per Capita State Income and FMAP**

State	FY2010 Per Capita Income*	FY2010 Per Capita Income* Excluding Navajo	FY2010 Original FMAP**	FY2010 FMAP Excluding Navajo
Arizona	\$31,975	\$32,326.74	65.75%	65.00%
New Mexico	\$29,244	\$29,912.94	71.35%	70.03%
Utah	\$29,077	\$29,118.93	71.68%	71.60%
United States	\$36,653	--	--	--

\*The FMAP calculation is based on Bureau of Economic Analysis per capita income data, which are then used by CMS to create a 3-year weighted average, which is presented in this column.

BEA income includes both money income and imputed estimates of the value other resources. Calculation of the impact of excluding the Navajo population from state population on per capita income required adjusting Census money income to parallel the BEA definition of per capita income.

\*\*The Federal Government published both an FMAP and an enhanced FMAP for FY2010. The non-enhanced FMAP is used for these estimates.

Per capita income increases for all three states when the Navajo Nation population is removed from the state for purposes of calculating average income. Arizona's per capita income increases by 1.1 percent, New Mexico's per capita income increases by 2.2 percent, and Utah's income increases by 0.14 percent. The impact on FY2010 FMAP for each state is negative, although the decrease in the FMAP is relatively small. However, even small changes in the FMAP affect a state's Medicaid costs. For illustration, if New Mexico's Medicaid claims costs were \$100,000,000, then a change in the FMAP of 1.32 percentage points would result in the state share increasing by \$1,320,000.

- *Change in Number of Eligibility Workers Employed.* The Navajo Nation is a large geographic area, and each of the states employs eligibility workers to conduct outreach, eligibility determinations, and enrollment assistance to residents of the Navajo reservation. The State of New Mexico Medical Assistance Program estimates that eligibility determination staff would be reduced by 14 (2 fewer line managers, 11 fewer eligibility workers, and 2 fewer clerks) if the Navajo Nation were to take over Medicaid eligibility determination within the Navajo reservation. Total savings for the estimated reductions in staff would be approximately \$698,000 in salaries and fringe benefits. If Arizona and Utah were to obtain similar savings on eligibility determination, proportional to their share of the total population of the Navajo reservation, then total savings for the three states would be approximately \$1,886,500.
- *Transitional Costs and Other State Concerns.* During site visits and discussions with Medicaid program staff at each state, there were discussions about how the creation of a Navajo Nation Medicaid agency would impact each state. The impact of the Navajo Nation Medicaid agency on state FMAP rates was raised by both Arizona and New Mexico. Utah staff members raised the issue of transitional costs (reprogramming computer systems, changing informational brochures and Web information, etc.). This was particularly a concern because these types of administrative costs are matched at a

50-percent rate by the Federal Government, and the state would be responsible for the additional costs.

Arizona Medicaid staff members expressed concerns about whether Indian residents of the Navajo reservation moved frequently and changed living arrangements and addresses and, to the extent that this is the case, how difficult it might be to be certain an applicant for Medicaid enrollment is a resident of the state and eligible for Medicaid. It was suggested that this might result in an increase in eligibility errors and the state might incur penalties for improper enrollments.

Finally, all three states were concerned that, if the Navajo Nation were to take over responsibility for enrolling and providing Medicaid services for Indian people residing within its boundaries, then other tribes within each state might request similar consideration from the Federal Government and/or from the state. This could create a more complex and costly system for Medicaid and increase program costs for the states.

## 5.2. *Federal Budget Impacts*

The impact of the Navajo Nation Medicaid agency on federal budgetary costs would depend on many factors and policy decisions that, at present, are unknown or undecided, including:

- Eligibility rules and number of people who would enroll in Navajo Medicaid.
- The benefits covered by Navajo Medicaid and payment rates.
- The Navajo Nation FMAP and proportion of claims costs subject to the regular FMAP and the 100 percent FMAP for IHS/tribal health claims.
- Navajo Nation Medicaid start-up and operating administrative costs and the applicable FMAP for different administrative component costs.

In addition, it would be necessary to know the impact of Navajo Medicaid on Arizona, New Mexico, and Utah state Medicaid costs and cost sharing with the Federal Government. While estimates of state impacts have been made and a cost estimate for a generic Navajo Nation Medicaid agency has been developed, these estimates are based on a series of assumptions that, if changed, could significantly affect total costs and/or the federal cost share for Navajo Medicaid.

It is highly unlikely that a Navajo Medicaid agency would be budget-neutral for the federal government for several reasons:

- The FMAP for the Navajo Nation Medicaid program would almost certainly be 83 percent, compared to FY 2010 FMAP of 65.75 percent for Arizona Medicaid, 71.35 percent for New Mexico Medicaid, and 71.68 percent for Utah Medicaid. Thus, the federal share of medical claims costs could be 12 to 17 percentage points higher due to the higher Navajo FMAP.
- The Navajo Nation is likely to work closely with IHS and tribal health programs to increase accessibility and expand services, and may establish a managed care-like eligibility approach with IHS and tribal health programs as the managed care network in

order to increase the proportion of Medicaid claims that are subject to 100 percent FMAP, thus further increasing the federal share of costs.

- Eligibility rules for Navajo Medicaid might be more generous and potentially cover more people than would be the case under current state policies. In addition, the proportion of eligible persons who actually enroll in Navajo Medicaid might be significantly higher due to increased outreach and marketing of the program and a higher comfort level for eligible Indians who would interact with Navajo-operated eligibility offices and staff.
- The Navajo Medicaid benefit package may be more expansive and provider payments may be higher than those of the three States.

In addition, it is possible that a Navajo Nation Medicaid agency could be authorized under different rules than states currently operate.



## Appendix A: Navajo Nation Feasibility Study Discussion Paper

### *Background*

There are a number of issues that underlie the cost estimates that were produced for the Navajo Nation Feasibility Study. While assumptions about these issues may be made in order to estimate potential costs to establish a Navajo Nation Medicaid program, specific decisions would need to be made prior to actual implementation of this program. These issues include the Medicaid Benefit Package, payment methodologies and levels for those services the IHS and tribal health and external providers would render, and the eligibility standards for all categories of potential Medicaid enrollees into the Navajo program.

This paper discusses each of these issues and others that the Navajo Nation would need to consider in order to move forward with a proposal to Congress to authorize and fund the Navajo Nation as a state Medicaid agency. An additional consideration for the Navajo Nation is whether the Nation wants to operate a Medicaid agency which would require extensive operational development, hiring and training employees, and ongoing management and quality oversight to ensure compliance with federal regulatory requirements. Alternatively, the Navajo Nation could contract the many required functions to another entity.

### Overview of Federal Requirements

#### *Eligibility System*

An automated eligibility system (application processing and information retrieval system or APIRS) is required in order to effectively and efficiently assist in the management of applications for assistance. The system is required to collect and maintain all identifiable information on client and applicants, interface with other systems for purposes of checking eligibility and sharing information. An eligibility system uses the same type of process as an MMIS system; an advanced planning document must be pre-approved and each subsystem must be approved in order to receive federal matching funds. Eligibility systems are generally tied to receipt of cash and other assistance and generally come under the purview of the Administration for Children and Families. 45 CFR Section 205.35-37.

On April 19, 2011, the Centers for Medicare & Medicaid Services announced enhanced funding for eligibility systems for purposes of Medicaid and CHIP applicants and recipients (90 percent for design and development and 75 percent for operations) that are certified by December 2015. The enhanced funding is intended to upgrade systems across the country to facilitate MAGI eligibility determinations and exchange of income and other eligibility information with the Health Insurance Marketplaces.

#### *Client Eligibility*

Who the Navajo Nation determines to be eligible for Medicaid and the financial eligibility criteria for each group of people is a critical element of program design. There are mandatory groups of eligible persons as well as optional groups of people from which to select. Additionally, the new group of adults with incomes up to 133 percent FPL (with a 5 percent

income disregard, so essentially 138 percent of the FPL) authorized under the Affordable Care Act effective January 1, 2014, could be included in the design. Aged, blind, and disabled people must generally be found eligible according to the Supplemental Security Income (SSI) rules related to income and assets. Other groups of people are found eligible based on income; on January 1, 2014, the income rules were simplified for most people through the use of the Modified Adjusted Gross Income (MAGI) method. The MAGI uses the adjusted gross income from IRS rules with a few exceptions.

An additional issue not yet considered is if Indians qualified to receive Navajo Nation Medicaid services would be mandated to receive services through IHS and tribal facilities on the reservation, basically a "managed care" type of scenario, or if Indians would be able to participate in the Medicaid program of Arizona, New Mexico, or Utah at their discretion. This decision has political ramifications for Navajos that need to be carefully researched. It was shared with us at Gallup Indian Medical Center (GIMC) that a significant number of Indians receive eligibility for Medicaid through GIMC patient registration and then self-select the non-Indian hospital across the street to receive their care.

If the Navajo Nation decides to limit free choice of providers of Indian beneficiaries, then its Medicaid program will need to include federal waivers of certain provisions of the Social Security Act, and it would be considered basically a managed care model. Managed care contains a significant number of patient protections and quality initiatives that should be considered in internal discussions. Managed Care rules are contained in 42 CFR Part 438.

The other option would be for the federal language authorizing the nation as a "state" to preclude residents of the reservation from being state residents, for Medicaid purposes, of Arizona, New Mexico, and Utah. Such a language structure may have other implications that need to be studied.

A state is required to make Medicaid eligibility determinations according to federal rules. These rules generally relate to the income and resource standards for the old AFDC program for families, the income and resource rules of the SSI program for aged, blind and disabled, and income-only rules for certain pregnant women and children.

As of January 1, 2014, however, states were required to use the modified adjusted gross income methodology (MAGI) to determine eligibility for most non-elderly and non-disabled individuals.

Some federal rules applicable to a Medicaid program (unless there is a waiver in place) include:

- Statewideness – The Medicaid plan (except for Targeted Case Management services) must be in effect throughout the state. The state must provide local eligibility offices as well. 42 CFR Section 431.450.
- Comparability – Services cannot be less in amount, duration, and scope than is available to other like individuals. SSA Section 1902(a)(10)(B).



- Advanced Directives – Each state must include in its state plan the state law regarding advanced directives. SSA Section 1902(w).
- Appeals for applicant and recipients – The state plan must provide for a hearing system to afford a hearing before the agency or an evidentiary hearing at the local level that may be appealed to the agency, and must meet due process rules under *Goldberg v. Kelly*, 397 U.S. 254 (1970). There are extensive requirements for recipient notice and the hearing process contained in 42 CFR Part 431 Subpart E.
- Residency – An applicant for Medicaid must be a resident of the state, but applicants cannot be required to be a resident of the state for a specific time period. 42 CFR Section 435.403 42 CFR Section 436.403.
- Citizenship and alien status – An applicant for Medicaid must provide proof of citizenship or national status in the U.S. 42 CFR Section 435.406-407, 42 CFR Section 436.406-407.
- Dependency and age – The Medicaid agency must use the AFDC definitions for dependency (of a child) and age; and the "popular usage method" for aged, blind and disabled persons. 42 CFR Section 435.500-522.
- Blindness and Disability – The Medicaid agency must use the same definitions of blindness and disability as the SSI program and use the same process; and the agency must determine disability under certain circumstances. 42 CFR Section 435.530-541.
- Financial eligibility methodologies – The Medicaid agency must establish financial eligibility rules; some are applicable to rules of cash assistance programs (AFDC, SSI), and follow rules about the financial responsibilities of relatives and other persons for the Medicaid applicant. 42 CFR Section 435.600-608.
- Assignment of Rights – The Medicaid agency must require an applicant to assign their rights to medical support and payment for medical care from any third party during application for Medicaid. The client must cooperate in establishing paternity and pursuing third parties unless there is good cause not to do so. 42 CFR Section 435.610.
- Institutionalized persons – The Medicaid agency must recognize a higher income level for persons in nursing facilities and intermediate care facilities for the mentally retarded (this income level will also apply to home and community-based waiver clients; most states use 300 percent of the SSI income standard). 42 CFR Section 435.622.

- Institutionalized income – When a Medicaid client is in an institution, the Medicaid agency must make a post eligibility decision on how their income is treated; most income must be contributed to the cost of care of the facility. There are also rules for income for the at-home spouse and any minor children as well as different rules for home and community-based waiver clients. 42 CFR Section 435.700-735.
- Out-stationed eligibility – The Medicaid agency must allow applications for low-income women, children, and infants at locations other than eligibility offices. Outstationing of eligibility workers at Federally Qualified Health Centers and IHS and tribal facilities is required. 42 CFR Section 435.904.
- Medicaid applications – There are specific requirements for the content of the Medicaid application, assistance with the application process, timely determination of eligibility, timely redeterminations and verification of social security numbers. 42 CFR Section 435.905-930.
- Income verification – There are specific rules about how income must be verified, use and sharing of this information, and the specific format for sharing. 42 CFR Parts 940-965.
- Presumptive eligibility (PE) for children and women – State Medicaid agencies are permitted to authorize certain qualified entities such as federally qualified health centers, hospitals, and schools to screen and temporarily enroll children and pregnant women in Medicaid or CHIP until a formal eligibility determination is made, and thereby provide immediate access to care. The client must still complete the application process, but services rendered while the client is “presumptively” eligible may be paid with Medicaid funds. 42 CFR Section 435.1001-1003.
- All states must implement hospital PE to include all qualifying hospitals willing to abide by state policies and procedures. In order to be considered a qualified entity, under the regulation at 42 CFR 435.1110(b)(1), the hospital must agree to make presumptive eligibility determinations consistent with state policies and procedures, and the state can and should exercise oversight to ensure proper administration of hospital PE. At a minimum, states must implement hospital PE to ensure that hospitals are able to make PE determinations for all of the populations included in §435.1102 and §435.1103 (that is, all MAGI-eligible groups: pregnant women, infants, and children, parents and caretaker relatives, the adult group, if covered by the state, individuals above 133 percent of the Federal Poverty Level under age 65, if covered by the state, individuals eligible for family planning services, if covered by the state, former foster care children, and certain individuals needing treatment for breast or cervical cancer, if covered by the state). States may allow hospitals to determine PE for other groups, such as the aged, blind, and disabled, and those whose eligibility is established by section 1115 waiver authority. States permitting hospital PE for other groups are responsible for providing information on relevant state policies and procedures

and information on how hospitals should fulfill their responsibilities in making presumptive eligibility determinations for such individuals.

- Federal Medicaid matching funds are not available for health care expenditures for inmates of public institutions, including persons living in an institution for mental diseases who are between the ages of 22 and 64. 42 U.S.C Section 1396d(a)(A), 42 CFR Sections 435.1009(a)(1), 435.1010, and 441.13(a).

### ***Eligibility Groups***

There are mandatory and optional groups of people eligible to be covered by Medicaid.

The federal government sets minimum guidelines for Medicaid eligibility but states can choose to expand coverage beyond the minimum threshold.

Some of the mandatory groups include:

- People receiving cash assistance, those eligible for but not receiving cash assistance (this includes SSI<sup>7</sup> and those who would have been eligible for the old AFDC program), and those ineligible for cash assistance because of rules that do not apply to Medicaid (these rules are financial in nature, such as deeming income of a stepparent, grandparent or siblings in the home to be counted for a child which might make them ineligible for cash; Medicaid does not use the same rules).
- People receiving SSI supplemental payments (a state may choose to make cash payments to aged, blind and disabled people to augment SSI payments).
- People ineligible for SSI, who otherwise meet criteria for the program for a variety of reasons listed in federal regulations.
- Children under age 19 and pregnant women meeting the AFDC standards.
- Pregnant women who were receiving Medicaid when the pregnancy terminated are eligible during pregnancy and for a 60-day post-partum period (133 percent FPL).
- Newborn children born to a woman on Medicaid for the first year of life (133 percent FPL).
- Children age one to five (133 percent FPL).
- Children age six to eighteen (133 percent FPL).
- Children under Title IV-E adoption assistance or foster care.
- Various groups of Medicare beneficiaries are eligible for subsidies for their Medicare premiums.

Optional groups of people are basically aged, blind, disabled, children, pregnant women, and family members of children. These groups include, but are not limited to:

- Individuals who would be eligible for cash assistance if not in institutions.
- Individuals receiving home and community-based services.
- Families who would be eligible for AFDC if child care costs were paid from earnings.

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<sup>7</sup> States have the option not to provide Medicaid eligibility to individuals on the basis of their receipt of SSI under §1902(f) of the Social Security Act. These are known as 209(b) states.

- Children under age 21 (or at state option 19 or 20) at state-determined income levels.
- Children up to age 21 under an adoption assistance agreement.
- Children under age 19 eligible under a CHIP Medicaid expansion.
- The spouse of an aged, blind, or disabled person receiving cash assistance.
- Medically needy categories of people.
- Persons with tuberculosis.
- Working disabled persons with income up to 250 percent FPL.
- Women diagnosed with breast or cervical cancer by a program funded under the CDC breast and cervical cancer early detection program with incomes up to 250 percent FPL.
- Children under age 19 living in the community who would qualify for institutional placement (including a psychiatric facility); parental income is not counted in determining financial eligibility.

For a full list of the optional and mandatory groups visit:

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf>

### ***Medicaid Waivers***

Although the Navajo Nation is not currently a provider of Medicaid home and community-based waiver services, the Nation may be interested in providing (or paying other providers to furnish) waiver services to members of the reservation in the future. State Medicaid data demonstrated that many Navajos residing on the reservation are currently receiving home and community-based services. These people would lose these services if the Navajo Nation operates its own Medicaid program and does not include home and community-based services under either a waiver or a state plan option.

Waivers are vehicles that states can use to test new or existing ways to deliver and pay for health care services in Medicaid and the Children's Health Insurance Program (CHIP). There are four primary types of waivers and demonstration projects:

*Section 1115 Research & Demonstration Projects:* Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The Navajo Nation may not currently seek an 1115 demonstration under the terms of section 1115(a)(1) of the Social Security Act, but the Navajo Nation could do so if the Congress were to establish a Navajo Nation Medicaid agency with the same authorities as states.

In general, Section 1115 demonstrations are approved for a 5-year period. Arizona has been operating its entire Medicaid program under an 1115 demonstration since the state's Medicaid program began on October 1, 1982.

As a matter of HHS policy, demonstrations must be "budget neutral" to the Federal Government. This means that during the course of the project, federal Medicaid expenditures will not be more than federal spending could have been without the waiver.

[Section 1915\(b\) Managed Care Waivers](#): This section of the Social Security Act permits states to apply for waivers to provide services through managed care delivery systems or otherwise limit people's choice of providers.

**Section 1915(b)** Waivers are one of several options available to states that allow the use of Managed Care in the Medicaid program. When using Section 1915(b) waivers, states have four different options:

**Section 1915(b)(1)** – Implement a managed care delivery system that restricts the types of providers that people can use to get Medicaid benefits.

**Section 1915(b)(2)** – Allows a county or local government to act as a choice counselor or enrollment broker in order to help people pick a managed care plan.

**Section 1915(b)(3)** – Use the savings that the state gets from a managed care delivery system to provide additional services.

**Section 1915(b)(4)** – Restrict the number or type of providers who can provide specific Medicaid services (such as disease management or transportation).

[Section 1915\(c\) Home and Community-Based Services Waivers](#): States can apply for waivers to provide long-term care services in home and community settings rather than institutional settings. Home and community-based waiver regulations are contained in 42 CFR Part 441.

The Section 1915(c) waivers are one of many options available to states to allow the provision of long-term care services in home and community-based settings under the Medicaid program. States can offer a variety of services under an HCBS Waiver program, including services not available to other Medicaid clients such as specialized medical equipment, home delivered meals, and home modifications for accessibility. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e., supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

[Concurrent Sections 1915\(b\) and 1915\(c\) Waivers](#): States can apply to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities, as long as all federal requirements for both programs are met.

States can provide traditional long-term care benefits (like home health, personal care, and institutional services), as well as non-traditional home and community-based "Section 1915(c)-like" services (like homemaker services, adult day health services, and respite care) using a managed care delivery system, rather than fee-for-service. They accomplish this goal by combining a Section [1915\(c\) waiver](#) with a Section [1915\(b\) waiver](#) (or other federal authorities). The managed care delivery system authority is used to either mandate enrollment into a managed care arrangement which provides HCBS services or simply to limit the number or types of providers which deliver HCBS services.

### *The Benefit Package*

Under federal law (Title XIX of the Social Security Act), there are some mandatory services required to be included in a states' Medicaid program. Some mandatory services, such as nursing facility services, are not offered by the Nation or IHS and therefore would need to be purchased by the Nation for its beneficiaries should the Nation become a state-like Medicaid agency.

There are also optional services that a state can choose to offer; generally this is because the state agrees to pay the full state share of the cost of those services. The Nation will need to determine which services the IHS and tribal health providers in the service units within the reservation boundaries will provide, and which services will be purchased from non-Indian providers (in some areas of the reservation there may be a combination of direct service provision and purchased services depending on the availability of providers). Additional details about services can be found at 42 CFR Parts 440 and 441.

A state can design additional standards for all services as well:

- Limits on services can be imposed (e.g., an adult will receive a pair of eyeglasses every two years).
- Services can be purchased only under certain conditions, or from certain providers, as defined by the state (e.g., mental health services are purchased only from a community mental health center, or an agency licensed by the state).
- Services can be inclusive of other health care professionals under the supervision of the covered provider (e.g., a physical therapy assistant under supervision of a physical therapist, a physician assistant or certified registered nurse anesthetist under the supervision of a physician).
- Children and pregnant women can receive services not available to other Medicaid clients (e.g., nutrition services, preventive and emergency dental services for pregnant women not available to other adults).
- A variety of waivers of federal rules can be approved to provide additional services not covered for other Medicaid clients based on a defined condition or functionality. Home and Community-based Waivers are commonly provided for elders (age 65+ with functional limitations that would qualify for nursing facility admission), the developmentally disabled, medically fragile children, children meeting the inpatient treatment standard for a psychiatric hospital, people with AIDS, people with FAS/D, people with traumatic brain injuries, etc. Waiver clients can receive services in their home (which may be an assisted living home or group home) that are different than the standard benefit package such as chore services, home modifications, home delivered

meals, specialized transportation, specialized equipment and devices, and personal care attendant services.

Examples of the mandatory and optional services follow:

Mandatory Medicaid Services include, but are not limited to:

- Inpatient hospital services.
- Outpatient hospital services.
- Federally Qualified Health Center (FQHC) services.
- Rural Health Clinic (RHC) services.
- Laboratory and x-ray services.
- Nursing facility services for persons age 21 and older.
- Early, Periodic, Screening, Diagnosis and Treatment Services for children under age 21.
- Family planning services and supplies.
- Physician services.
- Transportation.
- Tobacco cessation counseling for pregnant women
- Free-standing birth center services (when licensed or otherwise regulated by the state)

Optional Medicaid services include, but are not limited to:

- Ambulatory Surgery centers.
- Clinic services by or under the direction of a physician.
- Dental services.
- Physical therapy.
- Speech language and hearing pathology services.
- Prescribed drugs.
- Medical supplies.
- Durable medical equipment.
- Prosthetic devices.
- Orthotics.
- Eyeglasses.
- Dentures.
- Nutrition services.
- Inpatient psychiatric hospital services for individuals under age 21 (includes an accredited residential psychiatric treatment facility).
- Intermediate Care Facility for the mentally retarded.
- Hospice.

A comprehensive list of the mandatory and optional services may be found at:

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html>.



### *Provider Networks and Enrollment*

Medicaid providers are generally a facility type or a trained health professional; each is expected to meet some type of licensure or certification in order to be enrolled in Medicaid. Some types of certifications are linked to Medicare rules such as a home health agency. Each state is required to operate an entity that performs survey and certification for both Medicare and Medicaid purposes (Section 1864 of the Social Security Act, 42 CFR Section 488 and 489). A state may require certain types of facilities and programs to hold a state license; this function may be performed by the survey and certification program, a state program, or a combination of the two (e.g., the survey and certification program might license hospitals, home health agencies, and nursing homes while a state behavioral health agency might license substance abuse treatment facilities). A state may also require certain types of facilities (e.g., hospitals, ambulatory surgery facilities, behavioral health treatment facilities) to hold accreditation from a national body such as the Joint Commission.

Individual practitioners are required to be licensed or practice under someone who is licensed according to state licensure laws. Employees of IHS and tribal health facilities may be exempt from state licensure but must hold a valid license from a state in the United States. The state Medicaid agency will maintain an interface with health care licensing boards in order to verify licensure, monitor disciplinary actions by the boards, and report serious Medicaid infractions to the licensing body. Any entity or person banned from participation in Medicare must also be banned from participating in Medicaid. That criteria should take into account the available workforce to meet the demand for services, and if necessary, recognize a broader range of disciplines than a particular state has, to assure adequate access to care. For example, allowing primary care providers to deliver mental health and substance abuse services if appropriately qualified, if those providers are not recognized by one or more of the involved states and access to care is a concern.

The Nation may not want to operate numerous licensing bodies and would, in that case, need to establish interfaces with the licensing bodies of all three states in order to monitor the qualifications of providers. If the three states license/certify different types of providers (e.g., behavioral health providers may be defined differently by each state with some provider types, such as a substance abuse counselor, required to meet state-specific requirements, pass a state created examination, etc.) then there will be additional complexity for the Nation in establishing provider enrollment requirements. As an alternative, the Nation may accept licensure from the three states for mainstream health professionals (physicians, dentists, pharmacists, etc.) and establish its own criteria for other provider types such as mental health and substance abuse agencies, home and community-based agencies, personal care attendants, etc.

A state may choose to accept proof of provider enrollment with another state's Medicaid agency as the criteria for enrollment of an out-of-state provider with its own Medicaid program, or may seek verification of licensure, accreditation and certification (as the state may require for the provider type) in order to enroll an out-of-state entity as a provider.

- *Provider Agreement* – The Medicaid agency must enroll each provider under an agreement in which the provider consents to keep necessary records, release records regarding payment for services upon request, provide an NPI,

make required disclosures about ownership and change of ownership, and agree to follow a client's advanced directive. A provider agreement can be made effective when the provider meets the requirements of the state for its provider type (survey, certification, accreditation, licensure, etc.), retroactive to one year from the application date. 42 CFR Section 431.107-108, 42 CFR Section 455.400-470. Required disclosures are contained in 42 CFR Section 455.100-106.

- *Recipient and Provider Choice* – A Medicaid recipient may obtain a covered service from any provider qualified and willing to provide the service. Waivers may restrict clients to a provider under a managed care scenario or medical home structure (called primary care case management); these waivers cannot restrict freedom of choice of a provider of family planning services. Recipients who use Medicaid in excessive patterns or over use services may be "locked-in" by the state to one primary care provider and one pharmacy. 42 CFR Section 431.51.
- *Payment for Services out of state* – Medicaid must pay for services to a recipient provided out of state if there is a medical emergency, if the recipient's health would be endangered if required to travel back to the state for services, if the service is more readily available in another state, or it is general practice in a locality to use services in another state (note: the out-of-state service provider must enroll with Medicaid to receive payment). 42 CFR Section 431.52.

#### *Provider and Supplier Payment*

Payment for services is also regulated by the Federal Government, and Medicaid agencies must adopt laws and regulatory policy to govern payment for all services within these federal rules. While many services will be purchased by the Nation from the IHS and tribal health facilities at the IHS all-inclusive rates, other services will need to be purchased from non-Indian providers.

The Navajo Nation could include in its Medicaid planning all of the IHS and tribal health programs operating within reservation boundaries to assure that there is alignment across all of the Navajo health system provider community with the goals and direction of the project. Early inclusion to assure agreement with the structure being developed will present a united front if the Navajo Nation decides to approach Congress to proceed with the project.

The Navajo Nation will need to establish the payment rates and methodology for determining payment rates for all services, items, and supplies covered by the Navajo Nation Medicaid state plan. A description of these methods will need to be included in the state plan. A public hearing process is required for all payment methodologies except the IHS inpatient and outpatient rates, which are negotiated between IHS, CMS, and OMB before annual publication in the *Federal Register*.

### *IHS All-Inclusive Rates*

Each Medicaid agency determines the service array and structure of the all-inclusive rates. Hospital services are generally paid with the inpatient per day rates and outpatient encounter rates for standard hospital services except outpatient surgery, which is often reimbursed according to the Medicare Ambulatory Surgery Fee Schedule (this methodology groups procedures according to complexity and assigns a dollar value to each group), which is updated annually in the *Federal Register*.

Defining the number and types of outpatient encounter rates, and obtaining CMS approval of the state plan amendment describing those rates, should be of critical concern to the Nation. Because each state defines its rates differently—some states pay only one rate per day while others may pay multiple rates—the Nation will need to determine the number and type of encounters, and define the types of providers and services covered under each.

Professional services provided in institutional settings (hospitals and nursing homes) are paid in a manner described by the state. The Nation will need to determine what types of providers will be covered (physician, physician assistant, etc.) and the methodology for payment, which is generally either the state fee-for-service payment scale or the outpatient encounter rate. This decision should be made based upon the two methodologies compared to the complexity of services rendered by physicians and others, primarily in the hospital setting.

Options for consideration in structuring the outpatient encounter:

#### Medical (Clinic) Encounter

- Physician
- Podiatrist
- Physician assistant
- Nurse practitioner
- Vision services (with or without eyeglasses)
- Nutrition services
- Diabetes care and diabetes self-management
- Case manager

Dental Encounter – Dentists, dental hygienists and dental assistants and other approved positions as defined in the State Dental Practice Act.

Pharmacy Encounter – Prescription drugs

#### Behavioral Health Encounter

These services consist of two components: mental health encounters and substance abuse encounters

- Define covered mental health services – psychiatrists, psychologists, psychologist assistants, social workers/interns, marital and family therapists/interns, professional counselors/interns, qualified mental health associates, qualified behavioral aides, case managers and residential counseling services.

- Define covered substance abuse services – chemical dependency counselors, social workers and interns, case managers.

#### Rehabilitation Encounter

- Physical therapy
- Occupational therapy
- Audiology
- Speech therapy
- Respiratory care

#### Home Care Encounter

- Visiting nurses
- Physician assistant services
- Nurse practitioner services
- Personal care services
- Diabetes care and diabetes self-management
- Case management

Transportation – Some state Medicaid programs pay encounter rates for transportation, which can include the outpatient rate for non-emergency transportation, the inpatient encounter rate for ambulance services when a patient is admitted to the hospital.

#### *Payments to non-Indian providers*

Navajo Nation probably will purchase some services (as defined by the Nation) which are not provided by some or all of the IHS and tribal health organizations, as well as pay in other ways for services, items, and supplies furnished by IHS and tribal providers not included in the encounter rates. The Nation will need to develop methodologies for purchasing these services, items, and supplies which will likely include institutional payments to hospitals and nursing homes as well as a fee-for-service methodology for payments to medical professionals such as doctors, nurse practitioners, speech therapists, etc.; possibly a payment methodology for dental services, home health agency services, and home and community-based waiver services, and payments for medical supplies, durable medical equipment and other covered items.

Payment rates for institutional services are quite complex and will require highly skilled staff to complete this work, as the Navajo Nation will need facility cost reports from which to develop rate setting methodologies. A simpler solution could be to adopt, by regulation, the facility payment structure of the state where a non-Indian facility from which they wish to purchase care is located; the Nation would then have to obtain rate files from those states (with annual or other updates) to be loaded into the claims processing system. However, the huge managed care infiltration in Arizona and New Mexico could mean that fee-for-service rates for institutions are not readily available. Another alternative in these situations would be to adopt the Medicare payment structure (or a variation of it) for those facilities.

Many state Medicaid programs use the Medicare Resource Based Relative Value Scale (RBRVS) methodology, which has been in use for fee-for-service payments to practitioners for

decades. This methodology provides values for each CPT code based on complexity of the procedure, practice time, and geographically adjusted practice costs related to that procedure. All factors are updated annually and published in the *Federal Register*, so this system would be relatively easy to adopt. The amount paid can be manipulated by the unit value called a conversion factor, which is a dollar amount assigned to one relative value unit (for example a procedure assigned 2.5 relative value units would be paid \$75 if the conversion factor chosen is \$30). RBRVS covers professional services such as those rendered by physicians, nurse practitioners, therapy services, etc. The Nation will have to adopt other payment methodologies for services not included in the RBRVS such as dental, medical supplies and equipment, personal care, home health, etc. Laboratory services are required to be purchased by Medicaid programs at the Medicare fee schedule rates.

Payment for prescription drugs can also be complex as the multitude of drug codes have pricing changes occurring monthly. Medicaid also requires states to enter into drug rebate agreements with pharmaceutical companies in order to receive partial recoupment of the amounts Medicaid pays for drugs. Note that Medicaid only pays for drugs that are prescribed, but a Medicaid agency can arrange to pay for certain types of over-the-counter medications for which a qualified health professional writes a prescription, such as prenatal vitamins, folic acid, etc.

Federal regulations applicable to payment for services include:

- In general, Medicaid agencies must assure that payments are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least and to the extent that such care and services are available to the general population in the geographic area. 42 CFR Section 447.204.
- Payments must be made directly to the provider in most circumstances and cannot be reassigned to another entity. This general prohibition on reassignment of provider payments continues to permit the common practice of individual practitioners who are employed by a health care facility or program to routinely assign their payments to their employers as part of that employment arrangement. 42 CFR Section 447.10.
- Medicaid payment is payment in full for services (less any applicable cost sharing) and a provider must agree to accept Medicaid payment as payment in full in the provider agreement. 42 CFR Section 447.15.
- Payments are not to be made for any provider-preventable condition (e.g., hospital acquired infections). 42 CFR Section 447.26.
- Medicaid may be required to withhold the federal share of payments to a provider who has not repaid money owed to Medicare; Medicare may do likewise for payments owed to Medicaid. 42 CFR Section 447.30-31.

- Medicaid may make payment, at a reduced rate, to an inpatient facility during a recipient's temporary absence. 42 CFR Section 447.40.
- Medicaid must make timely payment for claims; 90 percent must be paid within 30 days and 99 percent within 90 days. 42 CFR Section 447.45.
- Cost sharing may be required from a Medicaid beneficiary for Medicaid services, but not for services provided directly by and IHS or tribal health program or through referral under Contract Health Services. 42 CFR Section 447.50-88.
- A claim may not be made for federal financial participation for any claims under investigation for fraud. 42 CFR Section 447.90.
- The Medicaid plan must set forth the methods of payment for each service covered. 42 CFR Section 447.201.
- The Medicaid agency must conduct audits to assure payments are appropriate. 42 CFR Section 447.202; Recovery Audit Contractors are covered under 42 CFR Section 455.500-518.
- The Medicaid agency must maintain documentation on establishment of payment rates. 42 CFR Section 447.203.
- The Medicaid agency must provide public notice and opportunity for comments on its methods and standards for setting payment rates. 42 CFR Section 447.205.
- Payment rates for hospitals and nursing facilities are the most complex and states must make a number of assurances to CMS in order to receive state plan approval. 42 CFR Section 447.250-256.
- Payments for services may not exceed the upper payment limits described by CMS. This section also describes limits on disproportionate share payments. 42 CFR Section 447.257.
- Swing beds are hospital beds in rural areas that can be used either for acute care or long-term care, depending on the needs of the community. Payment rates for these beds are limited under federal rules. 42 CFR Section 447.280.
- Disproportionate share hospital payments are described in depth in 42 CFR Section 447.296-299.
- Development of payment rates and upper limits for outpatient hospital, clinic, and other facilities are described in 42 CFR Section 447.300-325.

- FQHCs and rural health clinics are reimbursed under a prospective payment methodology which establishes the federal requirement that these providers be reimbursed at a minimum rate for services provided to Medicaid patients. The prospective payment system is described at Section 1902(bb) of the Social Security Act.
- Payment for drugs is described in 42 CFR Section 447.500-520.
- Utilization review requirements for hospitals, including mental hospitals, inpatient psychiatric services for children, including residential psychiatric treatment facilities, nursing facilities, intermediate care facilities for the mentally retarded, and prescribed drugs are extensive. Hospital stays must be reviewed for continued stay. 42 CFR Section 456.1-725.
- State Medicaid agencies must make electronic health record (EHR) incentive payments to certain providers (42 CFR Part 495).
- Medicaid is required to assure that all liable parties (insurance, worker's compensation, liable parties in an accident, etc.) pay for health care rendered to Medicaid clients before Medicaid pays; this is called third-party liability or TPL (42 CFR Section 447.20). TPL requirements include assignment of rights, identification and billing of all liable third parties, and required medical support orders through state child support enforcement agencies. The Medicaid agency can contract with a private entity to secure funding for health services for which there may be a liable party. Data exchanges are required with such entities as SSA, and workers compensation for accident reports. Paternity cooperation is required of Medicaid recipients and Medicaid must enter into a cooperative agreement with the child support enforcement agency.

#### *Automated claims processing system*

In order to claim federal financial participation in Medicaid, a state must have a CMS-certified Medicaid Management Information System (MMIS). A MMIS is a complex and expensive system that takes years to develop and implement, with federal approvals required for every step of the process. 42 CFR Section 433.110-131. One option for the Nation to consider would be contracting with another state to process claims through an existing MMIS; this would reduce the development time involved in purchasing a system and require a lesser level of staffing for the Nation in monitoring the system. The Nation would need to negotiate an agreement with another state for this purpose which would include sharing costs for annual operation of the system and staffing. The MMIS would adjudicate the claims and maintain information for required federal reporting while the Nation would still be responsible for making payment for approved claims and reporting payments to the IRS.



### *Other Medicaid requirements*

There are many additional requirements for a Medicaid agency that must be complied with in order to operate a Medicaid program:

Relations with outside agencies:

- 1) The state must designate state licensing agencies, state agencies that develop and enforce health standards for public and private institutions as well as other types of health care providers and the state survey agency (for health care facilities, contained in 42 CFR Section 431.610). Cooperative agreements are required with the vocational rehabilitation agency (states are also required to conduct disability determinations for Medicaid purposes for some clients), Title V agencies (maternal and child health and crippled children's program) contained in 42 CFR Section 431.615, the special supplemental food program for women, infants and children (WIC) contained in 42 CFR Section 431.635. The state must have written agreements in place with the state mental health authority (42 CFR Section 431.620), the state authority for mental health and mental retardation in regards to pre-admission screening and annual resident review (PASAAR) contained in 42 CFR Section 431.621, the child support enforcement agency, and CHIP (42 CFR Section 431.636). The state must coordinate with Medicare Part B (42 CFR Section 431.625) and contract for medical and utilization review of services. 42 CFR Section 431.630.

These requirements pose both a significant cost to the project (health professional licensing) as well as other complexities. Will the Nation need to have agreements and data matching with agencies in all three states, will the Nation seek to operate these programs within reservation boundaries, or seek exemption from some or all of these requirements?

- 2) Licensing of nursing home administrators – required. 42 CFR Section 431.700-715. Licensing of nursing home administrators is a federal requirement. If the Nation pursues congressional action, it might consider asking for the authority to use the licensing body of the state in which the one nursing home on Nation land operates. 42 CFR Section 431.700-715
- 3) Survey and Certification – Medicaid programs must certify that certain types of providers (hospitals, nursing homes, home health agencies, laboratories, medical supplies and equipment companies, etc.) meet the qualifying requirements for participation in Medicare and Medicaid through state survey and certification agencies. (42 CFR Parts 482-498).

### *Quality and Standards*

- 1) Medicaid law and regulation contain significant program integrity requirements ranging from assuring that eligibility determinations are accurate to fraud investigations. Numerous functions are required with mandatory reporting to CMS and often subsequent return of federal funds. These include:

- 2) Medicaid Eligibility Quality Control (MEQC) – Requires sampling of cases and corrective action plans to fix problems detected with eligibility determinations. 42 CFR Section 431.800-822.
- 3) Medicaid Quality Control (MQC) – Designed to identify deficiencies in the claims processing system, MQC requires sampling and corrective action plans to correct problems detected. 42 CFR Section 431.830-836.
- 4) Estimating Improper Payments (Payment Error Rate Measurement or PERM) – Congressional reports are required to be made estimating the cost of improper eligibility determinations and erroneous payments for Medicaid and CHIP fee-for-service and managed care payments. Errors in eligibility, claims processing, medical review, and errors in determining error rates are to be reported. Samples of eligibility cases and claims are chosen for review and funds must be returned to CMS for errors. 42 CFR Section 431.950-1002.
- 5) Medicaid Fraud Detection and Investigation Function – Each state must have criteria for identifying suspected fraud cases and procedures for investigating these cases as well as assure due process of law. 42 CFR Section 455.12-23.
- 6) Disclosure of information from contractors and providers – Information about ownership interests in health care businesses and the entity operating the MMIS as well as the criminal history of employees and contractors, subcontractors, and suppliers is required. 42 CFR Section 455.100-106.
- 7) Medicaid Integrity Program – CMS enters into contracts for an integrity audit program; the contractors will audit state Medicaid programs. 42 CFR Parts 200-238.
- 8) Independent audits of disproportionate share hospital (DSH) payments are required. 42 CFR Section 455.300-304.
- 9) Medicaid Recovery Audit Contractors (RAC) – states must enter into contracts with one or more CMS-certified RAC audit entities to identify underpayments, overpayments, and recover funds improperly paid. 42 CFR Section 455.500-516.
- 10) Utilization and Quality Control – Medicaid programs contract for utilization review and quality control for various services, including inpatient hospital services, nursing facilities, intermediate care facilities for the mentally retarded, psychiatric facilities for children, mental hospitals and prescription drug utilization for organizations meeting federal program requirements. 42 CFR Part 456.
- 11) Quality Improvement Organizations (QIO) – Perform quality of care reviews of services furnished under risk-basis contracts by health maintenance organizations (HMOs) and competitive medical plans (CMPs). QIOs are certified by CMS. Many states contract with QIOs for other purposes such as authorizing inpatient hospitalizations and length of

stay or psychiatric admissions to mental hospitals and residential treatment programs. 42 CFR Parts 475-480.

*Medicaid funding and federal match rates*

Funding for the non-federal share of Medicaid matching can come from many different places; some states require counties to contribute to the program and others tax health care providers to raise some of the money required for state match. State funds are required to cover at least 40 percent of non-federal share. 42 CFR Section 433.53.

State match rates are calculated by a formula that compares national per capita income over a rolling three-year period compared to state per capita income (income information is developed by the Bureau of Economic Analysis) over that same rolling three-year period. The match rate, which can range from a statutory minimum rate of 50 percent (for states that are not insular areas) to a statutory maximum rate of 83 percent, is claimed by the state from the federal government for payments made by the state to non-IHS/tribal health providers. The federal match rate provided to the state for state payments for services furnished to Indians through IHS and tribal health facilities is 100 percent. Administrative costs are matched at 50 percent, family planning and develop/design of an MMIS is 90 percent. Operation costs for MMIS, skilled professional medical personnel, Quality Improvement contracts, PASRR and Quality review of services are all at 75 percent federal match. 42 CFR Section 433.10-38

The state is required to develop a cost allocation plan, approved by the Cost Allocation Division within HHS, which delineates all costs incurred for the Medicaid program and related match rates. 42 CFR Section 433.34.

## Appendix B: Summaries of Meetings with Navajo Nation, State of Arizona, State of New Mexico, and State of Utah to Discuss Data and Related Issues Related to a Navajo Nation Medicaid Agency

*Navajo Nation Medicaid Site Visit, July 10-11, 2012: Summary and Key Findings*

### ***Background and Purpose of Site Visit***

The Centers for Medicare & Medicaid Services contracted with Econometrica, Inc. to conduct a study of the feasibility of the Navajo Nation taking over responsibility for developing and managing Medicaid on behalf of American Indians and Alaska Natives residing within the boundaries of the Navajo reservation.

A site visit was made to the Navajo Nation on July 11-12, 2012 to introduce the project approach, meet the Navajo Nation planning team and other stakeholders, and gather information on the Navajo Medicaid population, health care operations, and the expectations and concerns of the Navajo Nation about a Medicaid agency. The meeting also provided an opportunity to discuss and clarify the data request.

This report summarizes key findings and information from this meeting. The Agenda for the site visit is presented in Attachment A to this report. A list of participants is provided in Attachment B. The Navajo Nation data request is included as Attachment C.

### ***Meeting Overview***

We worked with Roz Begay, Program Evaluation Manager of the Navajo Nation Division of Health to arrange an agenda for the site visit team that covered all operational areas within the program and provided substantial information and valuable insights and data for understanding and constructing a model for estimating the costs and feasibility of the Navajo Nation assuming responsibility for Medicaid with the boundaries of the Navajo Reservation. Key information obtained from these meetings is presented in this section.

### ***Navajo Priorities and Expectations***

Ben Shelly, President, Navajo Nation

- 1) Tribal Identification cards
- 2) Replacement of Gallup Hospital; use of old hospital for VA
- 3) Improving Internet – placing fiber optics cable
- 4) Emergency medical transportation – want helicopter
- 5) Medical training for American Indians

Rex Lee Jim, Vice President, Navajo Nation

- 1) Want direct relationships with Federal Government, not with states
- 2) Want direct funding as much as possible

- 3) Self-determination relationship with the U.S. will support and enhance capacity of the Nation to deliver health care services
- 4) Want to engage in a meaningful dialog through tribal consultation that will lead to concrete action.
- 5) 85 percent of the \$2.5 million/billion that comes to the Nation goes off the reservation; want to reverse that trend.

Larry Curley, Health Director, Navajo Nation

- 1) Our underlying principles are sovereignty and control within our jurisdiction
- 2) Want an innovative program that meets Indian needs, not just a state program with a feather in it.
- 3) We are large, with a defined boundary that allows us to do things other tribes cannot; we are therefore geared towards an outcome that is unique for Indian country.

### ***Navajo Office of Vital Records and Identification***

The division has a memorandum of agreement (MOA) with Homeland Security for the tribal enrollment enhanced card and plans data sharing with schools, FBI, police departments, ICWA and court system. The division records name, birth date, blood quantum, date enrolled, census number, eye and hair color, weight, photograph and fingerprints. This card will bring together all the numbers and registration for all Navajos into one place; there are 306,290 individuals in their database. They began issuing cards this year at a cost of \$17; they had issued 234 as of visit in July 2012.

The database is a Progeny Sequel server (Microsoft) administered through contract. They are beginning to scan documents and anticipate going live 12/31/12 with active interfaces with multiple computer systems.

### ***Fort Defiance Hospital***

The Fort Defiance Hospital is a 255,000 square foot facility with 900 staff, 56 beds and a budget of \$45 million has been tribally operated for 18 months. The facility has an adolescent psychiatric unit and a psychiatric dual diagnosis unit.

Patient Registration staff appears very competent; they use Health eArizona to complete Medicaid applications for clients; successfully filter all uninsured clients through the unit. Benefit coordinators have good rapport with clients and are certified to perform presumptive Medicaid eligibility determinations for New Mexico.

Staff believe NM clients need to have face-to-face interview for Medicaid, however that is only required for clients seeking cash and other assistance; they have signed an agreement with NM to use the new laptop software that permits scanning of documentation as well as electronic signature for applications with all uploaded to the state's web portal.

Cross-state barriers described as physician referral patterns – physicians do not ask a client where they live before referring them for services and therefore often refer to out-of-state providers that will not be paid by Medicaid.

A potential billing issue relates to the fact that each state requires different types of enrollment with Medicaid, pays for different services at IHS rates, uses different claim forms, and requires different coding for claims. AZ and NM heavily managed care and have different rules for billing (either have to bill MCO or can bill state directly). States have different rules for behavioral health and long term care clients, as well as different management entities for those services.

### ***Gallup Hospital***

Gallup Indian Medical Center has the highest utilization in the Nation (followed closely by Shiprock) with 1,330 staff, 5,000 hospital admissions, 1,000 births and 250,000 outpatient visits per year. The hospital was built during the 1950's and opened in 1961. Replacement of the hospital is a very high priority.

GIMC has a committed and engaged patient registration and billing office staff; they see patients from AZ and NM and are enrolled with Medicaid in both states. They have an out-stationed eligibility worker from the State of New Mexico; their benefit coordinators track Medicaid applications to completion and go to community events to enroll clients in Medicaid.

A non-Indian hospital, Rehoboth McKinley Christian Hospital, is located across the street from GIMC and attracts clients with Medicaid and insurance because the facility is newer.

### ***Behavioral Health***

Navajo Nation providers render very limited behavioral health services. On the AZ side, they case manage Medicaid clients with a network of 66 providers; they are paid for case management. Very limited services in NM as well - there are six tribal health sites with services but only two are enrolled with Medicaid; there is one residential substance abuse treatment program for adolescents and adults in Shiprock but it cannot bill for services as it is not accredited. This program serves 2,224 clients (1,573 are male) with total revenue under \$15,000 as most clients are not eligible for Medicaid.

### ***IHS Area Office***

We met with the IHS Navajo Area office staff regarding data and agreed to send them a formal data request. A copy of CHS referrals and payments for the last two years was forwarded to us after the visit; Roz Begay was to seek like reports from the other service units who manage their own CHS funds.

### ***Feasibility Study***

Rich Hilton provided an overview of the study, methodology, and report. Rich Hilton described the project report, which will include:

Navajo Nation established a task force for the study; they met one time before the site visit. Concerns they expressed included:

- 1) Border towns – would like to include beneficiaries "in or near" the reservations as many Navajos live in border communities for work purposes but still use the health care system.
- 2) Possibility of a phase in of the project as there is much to consider and a significant work effort.
- 3) Consider direct care and CHS impact.
- 4) Navajos are not aware of this huge undertaking.
- 5) Internet problems will affect viability of the Health Insurance Marketplace.

Roz Begay agreed to establish contact with facilities not at the table to facilitate communication and data requests for the study.



*Attachment A: Site Visit and Meeting Agenda*

**Day One - July 11, 2012: Site Visit Schedule**

Location: Navajo Division of Health Cornbread Room; Window Rock, AZ

8:00 a.m. Introductory Meeting

- Open Meeting by Roselyn Begay, Program Evaluation Manager, NDOH
- Introductions
- Welcome Remarks by Mr. Larry Curley, Division Director, NDOH
- Update on the NN Feasibility Study by Kitty Marx, Director, CMS Tribal Affairs Group
- Project Team's objectives for initial visit to the Navajo Nation by Richard Hilton

8:45 a.m. Adjournment  
*(Transition to the Office of the President & the Vice President State Room)*

9:00 a.m. Discussion: Navajo Nation enrollment process and Navajo identification card, data sharing, and potential use of enhanced tribal identification card

- Tom Ranger, Division Director, Navajo Division of Human Resources
- Leonard Benally, Vital Statistics Manager, Navajo Office of Vital Records & Identification
- Special Remarks by Navajo Nation President Ben Shelly

10:15 a.m. Adjournment  
*(Transition to the TseHooTsooi Medical Center; Fort Defiance, AZ)*

10:30 a.m. Welcome Remarks & Introduction of Staff by Dr. Leland Leonard, Chief Executive Officer

- Demonstration on the use of Health-e-Arizona on-line application for medical assistance
- Discussion: Level of current Medicaid beneficiaries, electronic health record, billing and collection procedures, across state border issues and recommendations, data sharing, etc.

12:00 p.m. TseHooTsooi Medical Center will provide lunch

1:00 p.m. *(Transition to NDOH Cornbread Room for meeting with the Navajo Department of Behavioral Health Services)*

1:15 p.m. Discussion: Claims processing for Behavioral Health Services through the Arizona Tribal Regional Behavioral Health Authority and the New Mexico Optium Health, level of current Medicaid beneficiaries, information technology, across state border issues and recommendations, data sharing.

2:30 p.m. Adjournment

*(Transition to the Gallup Indian Medical Center; Gallup, New Mexico)*

3: 15 p.m. Welcome Remarks & Introduction of Staff by Mr. Bennie C. Yazzie, Chief Executive Officer, GIMC  
Discussion: Partnership between the Indian Health Service and New Mexico HSD Income Support Division for Medicaid enrollment and presumptive eligibility determination; third-party revenue cycle, across state border issues and recommendations, level of current Medicaid beneficiaries: data systems, billing and collection procedures; and IT upgrade necessary for transition to Navajo Medicaid program.

4:30 p.m. Adjournment

**Day Two - July 12, 2012: Meeting with Tribal Officials & the Task Force**

Location: Navajo Transportation Complex; Senator John Pinto Conference Room; Tse Bonito, NM.

Directions from Gallup, NM: Head North on US Hwy 491 for about 7.5 miles; go West on AZ Hwy 264 for about 16 miles; take North exit on N-54 Old Coalmine Road; and go about ½ mile the complex will be on the right side of road.

Facilitator: Albert Long, Senior Programs & Projects Specialist, NDOH

8:00 a.m. Open Meeting

- Invocation
- Introductions

8:30 a.m. Welcome Remarks by Navajo Nation Vice President Rex Lee Jim

8:45 a.m. Overview and debrief on the Site Visits by CMS officials and Project Team

9:00 a.m. Discuss the Feasibility Study Design by Project Team

- Obtain information and input on:
  - Most effective ways to collect data necessary for the study--discuss and select the data source preferred for the study: US Census 2000 or 2010, I.H.S. user population, tribal enrollment, or other data sources;
  - Amendment of Section 1115 Research and Demonstration Waiver provision to include federally recognized tribes;
  - Health care insurance coverage for American Indians/Alaska Natives as an entitlement provision, not discretionary funding provision - Universal health care for Indians;
- Refine the study design based on comments from the Navajo Nation Medicaid Feasibility Task Force;
- Finalize the Feasibility Study Fact Sheet prepared by Econometrica;
- Finalize the state Medicaid data items prepared by Econometrica;
- Plan the next steps.

12:00 p.m. Lunch

1:15 p.m. Reconvene and continue open-ended discussion

4:30 p.m.      Adjournment

*Attachment B: Participant List*

**Introductory Meeting**

Roz Begay, Program Evaluation Manager  
Al Long, Senior Program Specialist, Behavioral Health  
Dr. Madan Poudel, Health Services Administration  
Sylvia Etsitty-Haskie, Health Planning  
Roland Todacheenie, Third Party Coordinator, IHS Business Office  
Dr. Gayle Dine Chacon, Chief Medical Director  
Marie Begay, Public Health Analyst, IHS Contract Health Services  
Larry Curley, Director, Division of Health  
Tom Ranger, Division Director, Division of Human Resources  
Leonard Benally, Vital Statistics Manager, Navajo Office of Vital Records and Identification  
Ben Shelly, President, Navajo Nation  
Rex Lee Jim, Vice President, Navajo Nation

**Gallup Hospital**

Bennie Yazzie, Acting Chief Executive Officer  
Marcie Platero, Clinical Applications Coordinator (EHR, coding, billing)  
Dawn Dineyazhe, Clinical Applications Coordinator  
Andrea Mitchell-Thomas, Deputy Director Medical Records (Patient coding, medical files, ROI)  
Kathy Cody, Acting Business Office Manager  
Valerie Barker, Contact Representative, Patient Registration  
Evangeline Yazzie, Accounting Technician (Enrollment)  
Florinda Peters, Medical Support Assistant (Inpatient Scheduling)  
Financial Manager (Accounts Payable)  
Health System Administration  
Sandy Becenti, Health Resources Manager  
Louella Fallis, Utilization Review  
Carla Baha-Alchesay, Executive Management Team, Division of Public Health

**Behavioral Health**

Suzie Ashcroft, Clinical Director, NM Behavioral Health  
NM Behavioral Health  
Clinical Director, AZ Behavioral Health

**IHS Area Office**

Genevieve Notah, Associate Director, IHS Planning  
Roland Todacheenie, Third Party Coordinator, IHS Business Office  
Floyd Thompson, Executive Officer, IHS  
John Hubbard

**CMS**

Jim Lyon, COR, Navajo Nation Feasibility Study, Centers for Medicare & Medicaid Services  
Kitty Marx, Director, Tribal Affairs Group, Centers for Medicare & Medicaid Services

Cyndi Gillaspie, Technical Director, Consortium for Medicaid and Children's Health Operations,  
Centers for Medicare & Medicaid Services

**Econometrica**

Rich Hilton, Senior Research Associate, Navajo Nation Feasibility Study, Econometrica

Nancy Weller, Senior Research Associate, Navajo Nation Feasibility Study, Econometrica

*Attachment C: Navajo Nation Data Request*

**MEMORANDUM**

**Date:** July 26, 2012

**To:** Roselyn Begay, Navajo Division of Health  
Genevieve Notah, Indian Health Service, Navajo Area Office

**From:** Richard Hilton, Econometrica Project Team

**Subject:** Contract Health Services (CHS) Data Request for CMS Navajo Nation Feasibility Study;  
Contract No.: HHSM-500-2011-00015I; Order No.: HHSM-500-T0005.

This memorandum presents a data request that the “Medicaid” project team is submitting to the Navajo Nation Division of Health and the Navajo Area Office of the Indian Health Service (IHS). This data request will support the study funded by the Centers for Medicare & Medicaid Services (CMS) to assess the feasibility of having the Navajo Nation operate as a state under the regulations that guide the federal Medicaid program. This follows on the discussions that members of the Econometrica project team had with representatives of the Navajo Nation and IHS in Window Rock, Arizona, on July 11 and 12, 2012.

Based on the Window Rock discussions, we understand that the requested data will need to come from two sources. The IHS Area Office can supply data for Service Units (SUs) on the Navajo Reservation that remain operated directly by IHS. The Navajo Division of Health will be able to supply data obtained from the tribal health facilities currently operating on the reservation. For the purposes of the study, we would like the data from the two sources to be combined, allowing the study team to obtain a comprehensive picture of CHS payments within the Navajo Area region.

The study team’s data requests are as follows:

- The total number of CHS claims for Native Americans resident on Navajo trust lands and the city of Gallup for the years 2008, 2009, and 2010.
- The percentage of CHS claims that were state Medicaid claims for Native Americans resident on the Navajo reservation and the city of Gallup for the Years 2008, 2009, and 2010.
- The total amount of Medicaid payments obtained for Native Americans resident on Navajo trust lands and the city of Gallup for the years 2008, 2009, and 2010.
- The proportions of Medicaid beneficiaries for the years 2008, 2009, and 2010 that were male and female.

- The proportion of Medicaid beneficiaries for the years 2008, 2009, and 2010 that received benefits respectively from the Arizona, New Mexico, and Utah Medicaid programs.
- The proportion of Medicaid beneficiaries for the years 2008, 2009, and 2010 that fell into each of the following age cohorts: 0-5; 6-12; 13-21; 22-35; 36-65; 66+.
- The proportion of Medicaid claims for the years 2008, 2009, and 2010 that fell into each of the following service categories: Inpatient; Outpatient; Behavioral Health; Other.
- The proportion of Medicaid payments for the years 2008, 2009, and 2010 that fell into each of the following service categories: Inpatient; Outpatient; Behavioral Health; Other.
- For the years 2008, 2009, and 2010, the average per patient payment amount obtained by IHS-operated and tribal health facilities.

We understand that the data requests as listed above may not be specific enough to allow programming staffs to obtain the requested data. Members of the Econometrica project team will be available to “talk through” each request as needed to ensure that programming staff receive precise instructions. The Econometrica team, with CMS concurrence, will modify the data requests as needed to reflect the design and data specifications of the Navajo and IHS data systems.

All questions regarding this request should be directed to Dr. Richard Hilton of the Econometrica project team. Dr. Hilton’s e-mail address is [rhilton@econometricainc.com](mailto:rhilton@econometricainc.com). Dr. Hilton can also be reached on his direct telephone line at (301) 657-1035.



*Navajo Nation Medicaid Site Visit, August 28-29, 2012:  
Summary and Key Findings*

***Background and Purpose of Site Visit***

The Centers for Medicare & Medicaid Services contracted with Econometrica, Inc. to conduct a study of the feasibility of the Navajo Nation taking over responsibility for developing and managing Medicaid on behalf of American Indians and Alaska Natives residing within the boundaries of the Navajo Nation reservation.

A site visit was made to the Navajo Nation on August 28-29, 2012, to review project progress and gather additional information on the Navajo Medicaid population, health care operations, and the expectations and concerns of the Navajo Nation about a Medicaid agency. The meeting also provided an opportunity to discuss and clarify the data request.

This report summarizes key findings and information from this meeting. The Agenda for the site visit is presented in Attachment A to this report. A list of participants is provided in Attachment B. The Navajo Nation data request is included as Attachment C.

***Meeting Overview***

We worked with Roz Begay of the Navajo Nation to arrange an agenda for the site visit team. Key information obtained from these meetings is presented in this section.

***Update on Project Progress***

Nancy Weller provided an overview of the site visit with New Mexico Medicaid that covered the structure of the program, number of employees, costs for contracts, services and the Medicaid Fraud Unit as well as projected costs for the new MMIS and eligibility systems.

Site visits to Arizona and Utah Medicaid programs are planned for the second week in August.

Nancy Weller provided an overview of the legal issues related to a Medicaid program and distributed a list of Social Security Act provisions for the Nation to review as well as described federal law requirements for a Medicaid program. Electronic copies of the Social Security Act, Titles XIX and XXI and Medicaid regulations contained within 42 CFR were provided to the Nation staff.

***Discussion of Alternatives***

Nancy Weller presented alternatives to the Navajo Nation becoming a state Medicaid agency; these included: 1) Navajo Nation determining eligibility for Medicaid, including a description of the SPA and implementation issues from the State of Minnesota; 2) Navajo Nation contracting with a state for claims processing services with examples of Hawaii working with Arizona and the Virgin Islands with West Virginia; and 3) consolidating Medicaid funding from the three states with the Nation in order to purchase Medicaid covered services for Navajos living on the reservation. The Section 1115 waiver alternative was briefly discussed; Navajo Nation staff expressed concerns about having to work with the three states to secure waivers. Dr. Pendel

stated that Indian tribes should be able to request and be granted Medicaid waivers on the same basis as states.

Discussion ensued concerning Navajo Nation being a managed care organization for the three states, although it was noted that their position is for a government to government relationship which does not include Navajo Nation having a relationship with MCOs. Should the Nation choose to do business with any MCO, it would be merely for operational convenience. Section 5006 of the ARRA permits Indian MCOs. The nation is in fact in discussions with New Mexico for a pilot that would provide a bundled rate for home care services.

Navajo Nation brought up the subject of Medicaid in the Territories as they believe there is no match for the Territories even though the Territories have the lowest possible match and capped budgets. Kitty Marx agreed to reach out to the CMS Territory subject matter experts for more information.

PL 93-638 was discussed in terms of amending the law to allow tribes to "638" a Medicaid program.

#### ***Data Request***

Roz Begay stated that requested data was sent to Rich Hilton at Econometrica; binders contained printed reports of data were available to meeting participants. Notice was sent from the President requesting data by August 17th which was extended to August 24th. Requested data was received from Fort Defiance, Winslow, Sage Memorial, and Utah; Tuba City is deferring the data request to the AHCCCS information. Tuba City is in transition for systems and is currently using three (only partly on RPMS). All of the federal facilities (Chinle, Crownpoint, Gallup, Shiprock and Kayenta) use RPMS as do tribal facilities (Fort Defiance and Winslow); Utah and Sage Memorial do not use RPMS but export to the data warehouse in the required format. It was stated that Chinle has the bulk of Arizona Medicaid clients; Kayenta operates a small outpatient clinic and is building a hospital to be completed by 2015 for the 18,000 people they serve.

Genevieve Notah, IHS Area Office, discussed the User Population reports in the binder. The User Pop reports from IHS were reviewed; Genevieve Notah will request additional runs of the report to include community of residence, state of residence, age broken out by year, gender and service unit.

The data for the checkerboard communities needs to come from the IHS Albuquerque Data Center. Econometrica has had difficulty scheduling time with this office. Roz Begay said she would get a letter from the President to Albuquerque right after the meeting; Cherie Espinosa felt a call between the two Epidemiology centers would resolve the issue.

Navajo team members continue to have significant concerns about the number of residents that live in a different location than their mailing address. Leonard Benally of the Navajo Nation Vital Statistics and Information program will run a report of all enrolled Navajo clients by age and sex to include the city, state and zip of both their mailing address and physical address so that an estimate of the proportion of the population affected by this can be generated.

The Division of Economic Development confirmed that they use census data. The division is beginning an in-depth consumer survey using 6 people from Arizona State University focused on consumer preferences, spending habits and sources of income. Raw data should be available by the end of October. The group showed an interest in adding additional questions to the survey, but survey data will not be ready in time to contribute to the study report and does not currently pertain to areas that will add to the study.

Navajo team members expressed various concerns about the census data, particularly since detailed information is being gathered through the American Community Survey (ACS) which they characterized as "crude" sampling. The epidemiologist suggested that our team contact Jake Baker at the University of New Mexico regarding undercounting in rural areas by the census survey.

Several of the New Mexico facilities have signed on to the new eligibility software that includes an electronic signature pad.

Shiprock, in the four corners area, has difficulties billing Utah Medicaid although those problems are being worked on. Utah recently upgraded their system; their MMIS contractor is now adjudicating claims which used to be done by the state. Utah also started the tribes submitting claims within the past year. Utah has IHS and tribes use the HCFA 1500 claim form while Arizona and New Mexico use the UB claim forms.

#### ***Discussion of Draft Study Report***

A draft report from Econometrica is due to CMS by October 31st. Kitty Marx stated that a number of sections within CMS would need to review and comment on the report, including Tribal Affairs, Medicaid subject matter experts, and Financial Management, before it could be made available to the Navajo for review. They would need a few weeks to complete this review. Kitty Marx stated she would try to get the draft report to Navajo Nation after Thanksgiving so they will have time to review the report before the final face-to-face meeting tentatively scheduled for December 5-6th. Navajo leadership will be involved in that meeting.

#### ***Discussion of Navajo Nation Planning Process***

The Navajo Nation Task Force is working on the Medicaid Feasibility study as well as multiple interagency coordination activities for a variety of health options which include the Health Insurance Marketplace in Arizona and New Mexico, the possibility of the Nation becoming a managed care organization and creation of a "state like" entity for the nation. The Task Force's work will go beyond completion of the study; they plan to watch how Congress reacts to the report and will put together their proposal for Congressional action.

Problems identified include the severity of health disparities, resource allocation and silo structure of programs. The Nation wants to reduce disparities by increasing access to care and available funding. They want to develop a public health outreach system to screen, identify and manage health care problems, which entails changing the way Navajo people currently take care of their health – by seeking treatment only when they are sick. The Nation has 8 or 9 health care systems which don't communicate effectively with each other; with Medicaid covering 50

percent of the population they need to ensure better collection and use of data to support the health of the people.

Navajo Nation has a Public Health Infrastructure grant which will contribute to data gathering, analysis and use, focus care on prevention and early intervention and quality.

The Task Force is looking to changing the laws and policies of the nation to support the health care delivery changes they intend to make as well as the data warehouse; they plan to review all laws and policies with a goal to amend existing law and adopt new laws to support their long term goals.

The Nation's employee benefit plan health insurance has a Native Traditional Healing benefit that covers a capped dollar amount for services per year, uses a different claim form, and is signed by the healer but submitted by the client. Chinle, Fort Defiance, Shiprock and GIMC all employ traditional healers. Traditional healing must be a mandatory covered service for the Navajo Medicaid program.

The Navajo Nation overall vision is to create a seamless, on-stop shop providing equitable care across the board to address critical issues, health disparities and prevention. Health care will be integrated and coordinated to address the physical, mental and spiritual needs of the people.

The Task Force will review the services to be included in the Navajo Nation Medicaid state plan, develop their vision statements, fundamental position and alternatives to the Medicaid state concept. This information will be developed and available in September.

#### Fiscal Year

2010 is the study year from which estimates will be made. State requests were for state fiscal year (generally July 1 - June 30); IHS and tribal request was for whatever time period was most convenient but for three years of 2008, 2009 and 2010. Kathy Langwell of the study team stated that adjustments can be made to data to accommodate different time periods being used and this was passed on to the meeting attendees.

#### Match Funds

Federal law requires states to contribute a minimum of service costs and most administrative costs require a 50 percent match; the average blended match rate for many states is 62 percent FFP. Nancy explained the FMAP calculation and Kitty reminded them that 100 percent FFP would be available for three years for the new childless adult population eligible in 2014. The study will make estimates of match rates and costs both for startup and ongoing operation of the Navajo program as well as cost impact on the three states.

#### Consultation

The Navajo Nation inquired about the extent to which CMS had or will conduct consultations with states and other interested parties. Language of the law requires the report to include a summary of any consultation that occurred between the Secretary and the Navajo Nation, other Indian tribes, the States of Arizona, New Mexico and Utah and counties which include Navajo

Land and other interested parties. There is no plan to consult with other parties beyond the Navajo Nation and potentially affected states.

***Attachment A: Agenda***

***Day 1: August 28, 2012***

- 9:00 AM – 9:15 AM     Introductions
- 9:15 AM – 10:00 AM    Opening remarks from the Navajo Nation
- 10:00 AM – 10:15 AM    Overview of the project (Econometrica)
- AM
- 10:15 AM – 11:00 AM    Update on project progress (Econometrica)
- AM                      Data requests
- Site visit to NM Medicaid
- Plans for site visits to AZ and UT Medicaid
- Discussion about the project report (recommendations and opportunity to review and comment)
- 11:00 AM – 12:00 PM    Update from Navajo Nation on planning progress
- PM
- 12:00 PM – 1:30 PM    Lunch
- 1:30 PM – 2:00 PM     Discussion of start-up process for Medicaid program (Econometrica)
- 2:00 PM – 4:00 PM     Open discussion on issues
- Clarification on service delivery area and Navajo Trust Lands
- Clarification on fiscal year definition
- Clarification on match funds
- Clarification on tribal consultations
- Alternative arrangements of interest to the Navajo Nation
- 4:00 PM – 4:30 PM     End of day debriefing with project team, NNDOH, and CMS

***Day 2: August 29, 2012***

- 8:30 AM – 8:45 AM     Start-up to confirm agenda
- 8:45 AM – 10:30 AM    Review and discussion of data collected by NN to date
- 10:30 AM – 11:30 AM    Discussion with Office of Vital Records and Economic Development
- AM                      (as feasible)
- 11:30 AM – 12:00 PM    Final site visit debriefing
- PM                      Next steps
- Plan for ongoing dialogue
- Next meeting

*Attachment B: Participant List*

**Meeting Attendees:**

Roz Begay, Program Evaluation Manager  
Al Long, Senior Program Project Specialist, Behavioral Health  
Dr. Madan Poudel, Health Services Administration  
Sylvia Etsitty-Haskie, Health Planning  
Roland Todacheenie, Third Party Coordinator, IHS Business Office\*  
Dr. Gayle Dine Chacon, Chief Medical Director  
Marie Begay, Public Health Analyst, IHS Contract Health Services\*  
Ernie Yazzie, Planner, Performance Improvement, Public Health Infrastructure  
Erlanda Chicarello, Navajo Nation Employee Benefit Program  
Genevieve Notah, Associate Director, IHS Planning\*  
Leonard Benally, Vital Statistics Manager  
Brian Tagaban, Executive Director, Telecommunications Regulatory Commission  
Anita Genera, Performance Improvement Manager  
Cherie Espinoza, Navajo Nation Department of Justice, Human Services and Government Unit  
David Foley, Epidemiologist, Navajo Epidemiology Center  
Raymond Nopa - CFO, Navajo Division of Economic Development

Kitty Marx, Director, Tribal Affairs Group, Centers for Medicare & Medicaid Services  
Kristen Corey, Project Manager, Navajo Nation Feasibility Study, Econometrica  
Nancy Weller, Senior Staff Associate, Navajo Nation Feasibility Study, Econometrica



*Attachment C: Navajo Nation Data Request*

**MEMORANDUM**

**Date:** July 26, 2012

**To:** Roselyn Begay, Navajo Division of Health  
Genevieve Notah, Indian Health Service, Navajo Area Office

**From:** Richard Hilton, Econometrica Project Team

**Subject:** Contract Health Services (CHS) Data Request for CMS Navajo Nation Feasibility Study;  
Contract No.: HHSM-500-2011-00015I; Order No.: HHSM-500-T0005.

This memorandum presents a data request that the “Medicaid” project team is submitting to the Navajo Nation Division of Health and the Navajo Area Office of the Indian Health Service (IHS). This data request will support the study funded by the Centers for Medicare & Medicaid Services (CMS) to assess the feasibility of having the Navajo Nation operate as a state under the regulations that guide the federal Medicaid program. This follows on the discussions that members of the Econometrica project team had with representatives of the Navajo Nation and IHS in Window Rock, Arizona, on July 11 and 12, 2012.

Based on the Window Rock discussions, we understand that the requested data will need to come from two sources. The IHS Area Office can supply data for Service Units (SUs) on the Navajo Reservation that remain operated directly by IHS. The Navajo Division of Health will be able to supply data obtained from the so-called tribal health facilities currently operating on the reservation. For the purposes of the study, we would like the data from the two sources to be combined, allowing the study team to obtain a comprehensive picture of CHS reimbursements within the Navajo Area region.

The study team’s data requests are as follows:

- The total number of CHS claims for Native Americans resident on Navajo trust lands and the city of Gallup for the years 2008, 2009, and 2010.
- The percentage of CHS claims that were state Medicaid claims for Native Americans resident on Navajo reservation and the city of Gallup for the Years 2008, 2009, and 2010.
- The total amount of Medicaid payments obtained for Native Americans resident on Navajo reservation and the city of Gallup for the years 2008, 2009, and 2010.
- The proportions of Medicaid beneficiaries for the years 2008, 2009, and 2010 that were male and female.

- The proportion of Medicaid beneficiaries for the years 2008, 2009, and 2010 that received benefits respectively from the Arizona, New Mexico, and Utah Medicaid programs.
- The proportion of Medicaid beneficiaries for the years 2008, 2009, and 2010 that fell into each of the following age cohorts: 0-5; 6-12; 13-21; 22-35; 36-65; 66+.
- The proportion of Medicaid claims for the years 2008, 2009, and 2010 that fell into each of the following service categories: Inpatient; Outpatient; Behavioral Health; Other.
- The proportion of Medicaid payments for the years 2008, 2009, and 2010 that fell into each of the following service categories: Inpatient; Outpatient; Behavioral Health; Other.
- For the years 2008, 2009, and 2010, the average per patient payment amount obtained by IHS-operated and tribal facilities.

We understand that the data requests as listed above may not be specific enough to allow programming staffs to obtain the requested data. Members of the Econometrica project team will be available to “talk through” each request as needed to ensure that programming staff receive precise instructions. The Econometrica team, with CMS concurrence, will modify the data requests as needed to reflect the design and data specifications of the Navajo and IHS data systems.

All questions regarding this request should be directed to Dr. Richard Hilton of the Econometrica project team. Dr. Hilton’s e-mail address is [rhilton@econometricainc.com](mailto:rhilton@econometricainc.com). Dr. Hilton can also be reached on his direct telephone line at (301) 657-1035.

*Arizona Medicaid Site Visit, September 10, 2012: Summary and Key Findings*

***Background and Purpose of Site Visit***

The Centers for Medicare & Medicaid Services have contracted with Econometrica, Inc. to conduct a study of the feasibility of the Navajo Nation taking over responsibility for developing and managing Medicaid on behalf of American Indians and Alaska Natives residing within the boundaries of the Navajo Nation reservation.

Site visits to the States of New Mexico, Arizona, and Utah were conducted to obtain detailed information on:

- Eligibility categories
- Enrollments, by category
- Benefits
- Waivers
- Operational requirements, structure, staffing, contracts, and related issues
- Program costs, by category
- State concerns about effects of a Navajo Nation Medicaid program and similar policies

In addition, the site visits offered the opportunity to meet with each state's IT manager and staff to discuss and clarify the Medicaid data request that was sent in advance to each state and to determine the extent to which the state had the data capability to respond to the specific elements of the data request.

The site visit to the Arizona Health Care Cost Containment System (AHCCCS) offices in Phoenix, Arizona was conducted on September 10, 2012. This report summarizes key findings and information from these meetings. The Agenda for the site visit is presented in Attachment A to this report. A list of documents and other information provided to the project team during the site visit is provided in Attachment B. The Revised State Data Request is included as Attachment C.

***Key Findings***

- AHCCCS serves 1.3 million people and most of their eligibility categories are tied to minimum federally required income standards; Arizona has frozen their CHIP and childless adult Medicaid categories due to funding limitations.
- AHCCCS employs 552 people to manage the Medicaid program with an additional 1,585 staff working in the 13 field offices in the state determining eligibility for Medicaid and other assistance programs.

- AHCCCS performs all claims processing functions in-house instead of hiring a fiscal intermediary to perform these functions. The MMIS system went live in 1991 and there are no immediate plans to replace the system.
- AHCCCS adjudicates Medicaid claims for the State of Hawaii under an agreement between the two states with Hawaii paying nearly half of the annual operating costs of claims functions.
- External contractors are responsible for performing many of the required functions of the Medicaid program such as audits, quality monitoring, program integrity, third party liability and actuarial services.
- Arizona Medicaid is largely a managed care program; medical, behavioral health, long term care and Kid Care are the four categories of contractors. About 75 percent of American Indians opt out of managed care in order to receive services at IHS, Urban Indian and tribal health programs - approximately 98,000 individuals.
- AHCCCS pays IHS and tribal facilities up to five IHS outpatient encounter rates per day for covered services that includes medical, behavioral health, prescription drugs and outpatient hospital services. Detailed information is not required on the claim form so data reports will not reveal the specific services provided.
- Arizona is concerned about the impact on the state's FMAP rate if people on the Navajo Nation reservation are removed from the FMAP calculation since the per capita income for Navajo people is approximately 1/3 of the national average.
- Tribes in Arizona have expressed little interest in becoming managed care organizations and AHCCCS leadership believes the tribes could ultimately benefit by becoming Qualified Health Plans under the Affordable Care Act.

### ***Overview of Information Obtained, by Topic Area***

The AHCCCS Tribal Liaison coordinated the site visit, setting up the five hours of meetings with AHCCCS leadership, the Divisions of Business and Finance, Fee-for-service Management and Information Services in response to the Econometrica request for information.

### **State Data Request**

The Division of Fee-for-service Management is responsible for the development and implementation of policy for fee-for-service claims, which are predominately those services rendered to Native Americans receiving services under the American Indian Health Plan (AIHP) and required Medicaid services for aliens.

The Assistant Director of the Division of Fee-for-service Management is coordinating the data request submitted for the Navajo Nation Feasibility Study. The data request was reviewed for clarification of issues and it was indicated the provider data is close to completion with estimated delivery of all data in two weeks. There are some HIPAA concerns from AHCCCS legal services due to the remote nature and small populations of some locations on the reservation, as it may be potentially possible to identify specific individuals on Medicaid through age, gender, and community information.

Because of the way IHS and tribal health programs bill AHCCCS (using the UB04 claim form with one revenue code), there will not be any detail available in the data request about the type of service provided other than the client diagnosis code.

### **Arizona AHCCCS Structure**

An organizational chart was provided to outline the structure of agency administration and management. Arizona has always operated their Medicaid program under a waiver structure. Their budget of \$8.5 billion covers 1.3 million people covered under four managed care types: acute care (nine plans), The Arizona Long term Care System (ALTS - four plans), Kid Care and the Regional Behavioral Health Authorities (six plans and a Tribal Behavioral Health Authority consisting of Navajo Nation, Pasqua Yaqui Tribe, Gila River Tribe and White Mountain Apache Tribe). ALTS covers elderly, physically disabled, and developmentally disabled Medicaid clients.

AHCCCS employs 2,137 people to manage their Medicaid program (this number includes 1,585 eligibility workers, most of whom are employed in the Department of Economic Security in thirteen field offices; AHCCCS determines eligibility for long term care services and for SSI medical assistance). There are 113 employees in Information Services since AHCCCS does not hire a fiscal intermediary but manages the MMIS in-house, 111 positions in member services, 67 positions in the fee-for-service unit, 73 positions in managed care oversight, 57 positions in program integrity and fraud and 52 positions in budget and finance. There are 6.7 positions working on the Hawaii Medicaid component in Phoenix (and are paid by Hawaii Medicaid); additional employees work in Hawaii.

The Kid Care Program has been frozen since January 2010. Due to the economic downturn in recent years, AHCCCS has eliminated covered services for adults on Medicaid (well exams, podiatry, dental, vision services, speech therapy and occupational therapy), limited other services (inpatient hospital days and physical therapy) and frozen childless adult coverage and the Kid Care Program. In April of 2012, CMS approved a waiver permitting AHCCCS to make supplemental payments to IHS and tribal health facilities for the uncompensated care costs of the adult services eliminated as well as for childless adults either losing Medicaid coverage or those who would otherwise have been eligible for childless adult coverage had they applied.

The American Indian Health Plan (AIHP) is a term AHCCCS uses to describe those Native Americans who have opted out of the traditional managed care plan (approximately 96,000 people) in order to receive services from IHS, tribal health facilities, and Urban Indian programs (I/T/U). AHCCCS recently received approval from CMS to increase the three IHS encounters per day paid to IHS and tribal facilities to five per day.

Arizona is primarily a managed care state; AHCCCS estimated that 75 percent of Indians opt out of managed care in order to receive services directly from IHS, tribal and Urban Indian health care programs (I/T/U). Payment of claims for AIHP Medicaid clients referred from I/T/U facilities to non-Indian providers for services unavailable at IHS/tribal facilities also come under the auspices of fee-for-service as those services are paid at AHCCCS fee-for-service payment schedules.

### **Eligibility Categories and Determination Processes**

The Department of Economic Security performs eligibility determination for most Medicaid clients as well as other assistance programs. Individuals may also apply on-line for Medicaid using the Health-e-Arizona application which screens applicant information for potential eligibility.

AHCCCS covers Pregnant Women and newborns at 150 percent of the FPL, Children ages 1-6 at 133 percent of the FPL, children age 6-18 and parents of children at 100 percent of the FPL. CHIP children at 200 percent FPL (however the program enrollment is frozen), Working Disabled and Breast and Cervical Cancer at 250 percent FPL (disabled individuals under the "Freedom to Work" program must pay a monthly premium of \$35). Aged, blind and disabled people are covered at the SSI income standard (monthly income less than \$648 for an individual and \$1,048 for a couple); institutionalized and waiver clients are eligible at income levels below \$2,094 per month (300 percent of the SSI standard). Medicare Savings Program eligibility is set by the federal government at the required income levels of 100 percent FPL (QMB), 120 percent FPL (SLIMB), and 135 percent FPL (QI), respectively.

### **Contracts**

AHCCCS purchases services under contractual arrangements at a cost of \$12,457,900 annually, which includes \$7 million for program administration (audits, legal services, external quality review organizations, drug rebate services, printing, copying mailing, building and vehicle repair as well as school based services administration); \$1.1 million for MMIS consulting; \$1.8 million related to claims processing; \$2.2 million for fraud detection, actuarial services and third party liability.

### **MMIS**

Information Services performs all MMIS functions in house as well as manages computers, phones, peripherals, data base administration and operates a help desk. MMIS claims processing is done in the state data center; the division's total cost is approximately \$13.3 million annually. There are currently 113 staff, however 35 percent of the IS staff were eliminated in 2009 when Arizona suffered significant lost revenues when the recession hit. The State of Hawaii pays almost half of this cost (\$6,563,087).

The claims processing system is quite dated; it went live in 1991 however Arizona has managed to support many web based functions for providers such as electronic claims submission, claims look up and eligibility look up for clients. The IS Director feels that their success is due in large part to an experienced staff.

The MMIS uses one set of code for both states, and one of the challenges to fulfilling the Hawaii contract is the need to cooperate and negotiate for system changes. Hawaii has an estimated 1/20th of the resources as AHCCCS and contracts out many Medicaid required functions.

Eligibility determination processing is also accomplished on the state's main frame computer. The Health-e-Arizona software package for on-line Medicaid applications was considered for use during deliberations on the establishment of a state-based Health Insurance Marketplace. The state now participates in the federally facilitated Marketplace.

A tribe's ability to attract and retain qualified IT staff with the national impetus to health technology at this time was a concern for the IS director who feels that Health Insurance Marketplaces, ICD-10, 5010 transactions, and electronic health records across the country have attracted all the talent available and made IT positions very competitive.

**Medicaid provider enrollment and payment policy for IHS and tribal health programs**

IHS and tribal health providers may enroll with AHCCCS through completion of a provider agreement meeting federal standards (such as ownership disclosure); enrollment is possible as any of the one hundred different provider types that exist depending on the particular line of business and qualifications of the facility. The IHS facility list is used to verify the qualifications of programs applying for provider status as meeting federal requirements to receive the IHS inpatient and outpatient encounter rates. Provider Enrollment also contacts the IHS Area Office if there are questions to be resolved.

IHS and tribal health providers are exempt from prior authorization requirements for services as well as any state licensure or certification requirements. They have an attestation form in which the Tribal Chairman may sign to certify that the tribal program meets the specific requirements for the provider type for which they are enrolling. Medicare does not have a similar exemption, so if the provider type is required to be certified/licensed/accredited by Medicare (such as a home health agency or hospice), then proof must be submitted to show that Medicare requirements are met in order to enroll with AHCCCS as that type of provider.

IHS and tribal health programs bill most commonly under a hospital or clinic provider ID number; these services are billed using the UB04 claim form with revenue code 510 and a diagnosis code. They may also enroll and bill for services that are not covered by the IHS encounter rates such as home health, durable medical equipment, case management and non-emergency transportation and be paid for professional services rendered to inpatient hospital patients at the AHCCCS fee-for-service schedule; these services are billed on a HCFA 1500 claim form with detailed CPT/HCPCS billing and ICD-9 diagnosis codes.

AHCCCS does not audit IHS and tribal health programs unless an issue becomes apparent under the PERM.

CMS approved a state plan amendment expanding the three encounters available to an IHS or tribal health facility daily to five encounters. The outpatient encounter is defined to include outpatient hospital, clinic (medical) covered services, prescribed drugs, and behavioral health services delivered in either the outpatient hospital or other outpatient setting. Telemedicine services are included. The encounter rates are tied to the patient account number (as opposed to diagnosis code or other indicator).

AHCCCS provider enrollment staff travels to IHS and tribal facilities to train providers about billing Medicaid for services. Most of the I/T/U facilities submit electronic claims using the claims software provided on the AHCCCS web site. Provider training is often related to using the AHCCCS website, systems and policy changes, how to void and resubmit claims and covered services.



### **Policy and Issues Related to Establishment of a Navajo Nation Medicaid Program**

The Director stated a number of concerns related to the Navajo Nation operating a state Medicaid program that included the complexities of the Navajo population, the health care seeking behavior of Navajos living on and off the reservation, and the mobility of the Indian population moving between communities. These realities could make the residence of these people confusing to the multiple state agencies (including a potential Navajo Nation Medicaid state) from which the population can claim residency for the receipt of Medicaid.

A second concern was the lack of infrastructure in place in the Navajo Nation to support the many demands of operationalizing a Medicaid program, the lack of adequately skilled professionals to put policies in place, manage complex computerized systems and the possible lack of economy of scale to make the program financially viable.

The tribes in Arizona are well aware of the Navajo Nation initiative to become the "51st state" for purposes of Medicaid, so the third concern is that other tribes may have an expectation that similar consideration will be given to them. Many tribes are very small and it would not be realistic to expect that small tribes could take on such an endeavor. Of greater potential would be a national Medicaid Indian benefit structure that would provide a benefit package, eligibility levels and centralized payment for services provided by IHS and tribal health programs.

Arizona has similar concerns about other tribes in the state wanting the same benefits should an alternative approach be a three-state Section 1115 waiver to equalize benefits for the Navajo Nation for all Medicaid clients living on the reservation.

Tribes in Arizona have not expressed an interest in becoming a managed care organization. The director feels that tribes should strive to become a Qualified Health plan under the Affordable Care Act. The state has had many conversations with the tribes about becoming a QHP because very few of them have contracts with commercial carriers and those that do generally have policies that do not extend to the IHS.

The Arizona relationship with Hawaii has worked well but negotiating the original contract took well over a year. The two states must work cooperatively on use of the claims processing system; AHCCCS does not actually pay the Hawaii claims but runs claims through adjudication and then forwards files of approved claims to Hawaii, who issues the actual payments. Contracting with Hawaii was useful to Arizona in that most MMIS costs are split but there is likely little return on investment in expanding the relationship to an additional partner.

***Attachment A: ARIZONA SITE VISIT AGENDA***

***Monday, September 10***

- 10:00 a.m. Tom Betlach, AHCCCS Director  
Monica Coury, Assistant Director, Intergovernmental Relations Office
- 11:00 a.m. Jim Cockerham, Assistant Director, Division of Business and Finance
- 12:00 p.m. Rebecca Fields, Assistant Director, Division of Fee-for-Service and  
Claims
- 1:00 p.m. Bonnie Talakte, Tribal Relations Liaison
- 2:00 p.m. James Wang, Assistant Director, Information Services

***Attachment B: List of Documents and Data Reports Provided by AHCCCS During Site Visit***

- List of IHS/Tribal Health Facility Expenditures, FY 2009-2010
- Organizational chart for AHCCCS
- Eligibility Standards Desk Aid
- Provider Certification and Licensure Requirements
- Data sheets on Medicaid administrative costs, and contracted services and costs
- List of 2011-2012 SPAs

***Attachment C: List of Data Items for Discussion with State Medicaid Programs  
(Revised 8/20/12)***

- Total number of Medicaid enrollees within the reservation boundaries, including Gallup, and by race (Indians and non-Indians)
- Number of AI/AN Medicaid enrollees within the reservation boundaries, including Gallup, by
  - Gender, Age group (0 < 1, 1 < 6, 6 < 18, 18 and older), and Eligibility category
- Total number of claims submitted and paid, on behalf of AI/AN Medicaid enrollees living within reservation boundaries, including Gallup
- Total number of Managed Care Organization (MCO) encounters for Indian Medicaid enrollees living within reservation boundaries, including Gallup.
- Total Medicaid payments for Indians enrollees living within the reservation boundaries, including Gallup, and by
  - Gender, Age group (0 < 1, 1 < 6, 6 < 18, 18 and older), and Eligibility category
- Medicaid payments on behalf of Indian enrollees living within reservation boundaries, including Gallup, by
  - Type of service (e.g. hospital inpatient, hospital outpatient, physician, lab/radiology, SNF, therapy, behavioral health, etc.)
  - Location of provider (within reservation, including Gallup, outside reservation boundaries)
- Total Medicaid payments made to Indian Health Service and tribal health facilities located
  - Within the reservation boundaries,
  - Gallup, and
  - Outside the reservation boundaries
- FY2010 FMAP for state and changes in the FMAP for FY2011-2013
- FY 2010 Medicaid administrative/operating costs, total and by category

*New Mexico Medicaid Site Visit, August 7-8, 2012: Summary and Key Findings*

***Background and Purpose of Site Visit***

The Centers for Medicare & Medicaid Services have contracted with Econometrica, Inc. to conduct a study of the feasibility of the Navajo Nation taking over responsibility for developing and managing Medicaid on behalf of American Indians and Alaska Natives residing within the boundaries of the Navajo Nation reservation.

Site visits to the States of New Mexico, Arizona, and Utah were conducted to obtain detailed information on:

- Eligibility categories
- Enrollments, by category
- Benefits
- Waivers
- Operational requirements, structure, staffing, contracts, and related issues
- Program costs, by category
- State concerns about effects of a Navajo Nation Medicaid program and similar policies

In addition, the site visits offered the opportunity to meet with each state's IT manager and staff to discuss and clarify the Medicaid data request that was sent in advance to each state and to determine the extent to which the state had the data capability to respond to the specific elements of the data request.

The site visit to New Mexico Medical Assistance offices in Santa Fe, New Mexico was conducted on August 7<sup>th</sup> and 8<sup>th</sup>, 2012. This report summarizes key findings and information from these meetings. The Agenda for the site visit is presented in Attachment A to this report. A list of documents and other information provided to the project team during and after the site visit is provided in Attachment B. The Revised State Data Request is included as Attachment C.

***Key Findings***

- The New Mexico Medical Assistance Division (MAD) serves over 515,000 Medicaid recipients enrolled through 40 Categories of Eligibility (CoE).
- Over 180 managers and staff support and operate the New Mexico MAD. However, additional support services are provided by Human Services Department Divisions outside of the MAD. The Income Support Division is responsible for eligibility determinations for Medicaid and several other programs (e.g. SNAP, LIHEAP, and TANF). The Behavioral Health Services Division coordinates all behavioral health services for Medicaid and other Human Services Department Divisions. Legal and regulatory support is provided by the General Counsel. Therefore, the total program personnel needed to support and operate a stand-alone Medicaid program would be greater than the 180 personnel in the MAD.
- External contractors are responsible for performing many of the required functions of the Medicaid program. These external contractors include Medicaid Management

Information System (MMIS) design, implementation, and operations, Third Party Assessor, External Quality Review Organization, TPL and Program Integrity, and others.

- The cost for MMIS development is in the range of \$100 million; annual costs for MMIS operations are in the \$9-\$10 million range. A cost-effective option that might be considered if the Navajo Medicaid program were to be authorized would be contracting with another state for use of the MMIS. Currently, Arizona is providing MMIS services to the State of Hawaii and West Virginia is providing MMIS services for the U.S. Virgin Islands.
- The impact of a Navajo Medicaid program on the state would be a likely reduction in the FMAP with higher state costs for Medicaid and higher costs to other state income support programs for eligibility determinations (since Medicaid would no longer provide a cost allocation for the portion of Medicaid eligibility determinations that would become the responsibility of the Navajo Nation). In addition, there would likely be state costs associated with the transition to a Navajo Medicaid program.
- New Mexico MAD would not be in favor of a Section 1115 waiver to provide a different set of benefits and eligibility rules for Indians residing within the Navajo Nation reservation boundaries, whether New Mexico alone or coordinated among the three states. Such a waiver would be complex, involve significant costs to operate, and would likely lead other tribes to request similar treatment which would introduce even greater complexity and costs.

#### ***Overview of Information Obtained, by Topic Area***

The New Mexico Medical Assistance Division Deputy Director had arranged an agenda for the site visit team that covered all operational areas within the program and provided substantial information and valuable insights and data for understanding and constructing a model for estimating the costs and feasibility of the Navajo Nation assuming responsibility for Medicaid with the boundaries of the Navajo reservation. Key information obtained from these meetings is presented in this section.

#### **State Data Request**

The Program Information Bureau is responsible for managing the internal data bases for the New Mexico Medical Assistance Division. The meeting with the Bureau Manager and several staff focused on review of the Data Request that had been forwarded to New Mexico prior to the site visit. Review of the data request identified several items that required clarification and several other data elements that could be simplified without loss of detail. (Attachment C presents the revised data request that incorporates these changes.)

The Program Information Bureau manager and staff indicated that all of the requested data could be extracted from their internal data base (with the exception of the FMAP data request which was available and provided by another bureau). A specific programmer was assigned to the data request and it was agreed that all of the data request would be fulfilled by September 7, with some components being provided earlier as it was completed.

#### **Medicaid Assistance Division (MAD) Structure**

The site visit team gathered information about the structure and staffing of the New Mexico Medical Assistance Division to assist in understanding the operational requirements that the Navajo Nation would need to address and the potential operating costs that would be involved in

establishing and operating the Navajo Medicaid program. The New Mexico MAD managers and staff were very helpful in providing detailed organizational charts and substantive information on the responsibilities and processes managed by each department. In summary:

- MAD employs 180 people, in total. There is a director and two deputies who oversee nine bureaus as well as Healthcare Operations (tracks all external activities of the agency such as requests from audits, Legislature, CMS), the School Based Services unit, and the Native American Liaison.
- In addition, other services needed to support the Medicaid program are provided through other divisions of the Human Services Department (i.e. legal and regulatory services, eligibility determinations). These services would also be necessary for the Navajo Medicaid program to operate.
- The Medical Assistance Division has multiple programs serving Medicaid recipients in the state. Salud! is the managed care program serving women and children; CoLTS serves dual eligible recipients and those requiring long term care services; and the Behavioral Health Collaborative provides for managed behavioral health services. Indians are not required to enroll in Salud! (in fact 85 percent of them opt out of the program) but are required to enroll with CoLTS.
- The Client Services Bureau operates the call center for clients, oversees eligibility policy, performs marketing and outreach, and assists with testing the new eligibility system, which is a transfer solution from Michigan.
- The Program Administration Bureau is responsible for financial management for MAD, including budget, accounting, and budget projections, analysis to identify cost drivers, review of the cost allocation plan, reconciliation of HCFA 64, etc.
- The Program Information Bureau manages the data warehouse. MAD currently contracts for most of their technology needs, including their Local Area Network (LAN), with Xerox, the Fiscal Intermediary, but the Human Services Department is bringing these functions back into the Department as part of the new contract awarded in 2012.
- The Benefits Bureau manages services coverage policy and is responsible for coordinating the fee-for-serve program.
- The CoLTS Bureau is responsible for operating the managed care program for dual eligible and long term care clients. Participation in CoLTS is mandatory for Indian clients who are automatically enrolled and may not opt out.
- The Insure New Mexico Bureau operates the State Coverage Insurance (SCI) managed care program that covers 40,000 childless adults and parents not otherwise eligible for Medicaid with a commercial-like benefit package.
- The Contract Administration Bureau manages the Salud! and Behavioral Health managed care contracts;
- The Long Term Services and Supports Bureau manages waivers other than CoLTS (e.g., AIDS, TBI, medically fragile and developmentally disabled waivers, as well as self-directed personal care).
- The Quality Assurance Bureau manages audits, recoveries, program integrity, fraud detection, EQRO/QIO contracts, and mandated audits of MCOs.
- The Behavioral Health Collaborative was established under state law in 2005 to separate the funding for behavioral health services from physical health services. The Collaborative requires state agencies that purchase behavioral health services



(Corrections, Behavioral Health Services, Child Welfare, Medicaid and Aging) to pool their funding and purchase services from a statewide managed behavioral health care entity. The goals of this program include maximizing Medicaid funding, establishing a continuum of care, identifying and leveraging all BH funds, improving quality, and enabling improved data collection. Optum is the managed behavioral health contractor with responsibility for credentialing providers and subcontracting with providers for treatment. There are five Medicaid Behavioral Health regions in the state; a sixth region is virtual and is for AI/AN people.

### **Eligibility Categories and Determination Processes**

One of the important issues raised by representatives of the Navajo Nation about assuming responsibility for Medicaid within the reservation boundaries is the differences among the three states in eligibility rules and the perceived complexity of the application and determination processes. It was suggested by the Navajo Nation representatives that, in some cases, face-to-face applications were required and this was a substantial barrier to enrollment due to the long travel distances involved and the limited transportation available to many tribal members. During the meetings that focused on eligibility issues, these issues were discussed and the eligibility categories and determination processes currently in place were described.

#### *Eligibility Categories and Income Levels*

New Mexico Medical Assistance currently has over 515,000 recipients enrolled in 40 Categories of Eligibility (CoE). New Mexico Medicaid covers Children, Pregnant Women and Family Planning clients at 185 percent FPL, CHIP (a Medicaid expansion) children at 235 percent FPL, Working Disabled and Breast and Cervical Cancer at 250 percent FPL. Aged, blind and disabled are covered at the SSI income standard (monthly income less than \$648 for an individual and \$1,048 for a couple); institutionalized and waiver clients are eligible at income levels below \$2,094 per month. Medicare Savings Program eligibility is set by the Federal Government at the required income levels of 100 percent FPL (QMB), 120 percent FPL (SLIMB), and 135 percent FPL (QI), respectively. New Mexico has extensive income disregards for children and pregnant women that result in eligibility at significantly higher total income levels than those described above; they have conducted analysis and produced a report estimating how the current income disregards will translate to the Modified Adjusted Gross Income (MAGI) that took effect January 1, 2014 and only permitted a 5 percent income disregard.

#### *Application Process for Medicaid*

The New Mexico Human Services Department operates a consolidated application and determination process for multiple programs, including Medicaid. This permits individuals to complete one application that is used to determine eligibility for Medicaid, SNAP, LIHEAP, TANF, and other programs. While face-to-face applications are not required for Medicaid, in-person interviews are required for several other programs (e.g. LIHEAP). New Mexico MA program staff pointed out that Navajo Nation Medicaid enrollees would still be faced with the need to deal with the three separate states to apply for other income support programs that are operated by the states and separating out Medicaid alone would not provide significant time savings for those who would be covered by the Navajo Nation Medicaid program.

New Mexico has used eligibility kiosks in various locations to facilitate access to application for Medicaid, including sites on the Navajo reservation. However, they have experienced significant

problems with the kiosks in rural areas due to limited Internet availability and lack of experience with use of computer technology by some rural residents. New Mexico is currently rolling out desktop applications with software for laptops and electronic signature pads; users will be able to connect to the Xerox web portal, scan documents and upload the application and supporting documents to the web portal. A number of locations on the Navajo Nation have agreed to use of the laptop through contracts with the state; these include Tohatchi Health Center, Gallup Indian Health Center, Northern Navajo Medical Center, Dziłth-Na-O-Dith-Hle Health Center, Four Corners Regional Health Center, and Fort Defiance Indian Health.

New Mexico has contracted with Deloitte to transfer from Michigan, modify and implement a new eligibility system to take advantage of the short term FFP enhanced match; the estimated cost of this system is \$105 million.

### **Contracts**

New Mexico Medical Assistance contracts with outside vendors for a number of services, rather than conduct the activities as internal functions. These contracts include:

- Fiscal Intermediary/MMIS operations
- Third Party Assessor (TPA) conducts utilization review of FFS claims, establishes Level of Care for HCB waivers, PCA and institutionalized clients, and performs ad hoc audits on hospital length of stay.
- TPL and Estate Recovery contract.
- Fraud and Abuse contractor performs fraud and abuse detection activities on encounter data from MCOs.
- EQRO and Quality Improvement Organization contractors perform compliance audit, reviews performance measures and performance improvement initiative, assesses all waivers, and prepares ad hoc reports. Contractor also reviews compliance with laws, regulations and contracts, CMS protocols, and state oversight of waivers.

### **MMIS**

New Mexico is on their third MMIS contractor, XEROX (formerly ACS) which took over the system operated by First Health as a replacement and then a new system in 2002. The original ICD-10 deadline of October 1, 2013 forced New Mexico to either extend the existing contract past its August 31, 2013 expiration date or procure early in order to give a new contractor time to implement the ICD-10 changes; NM decided to re-procure early. Their procurement efforts were prolonged due largely to state procurement requirements. Additionally, they have had extensive negotiations with CMS regarding match rates for all services included in the contract. The final approval for design and development, operations and administration of the system for four years is \$105,862,691; of this amount \$9.2 million is at 90 percent FFP, \$62.1 million is at 75 percent FFP and the remainder at 50 percent FFP although the cost of HIPAA translation may be claimed retroactively at the higher match rate once they demonstrate successful operation.

MAD indicated that CMS scrutiny of the MMIS advanced planning document in regards to match rates was significantly greater than in the past and that the agency's legal staff needed to develop contract language defining the state's ownership rights to certain system components in order to receive 90 percent FFP.

MAD staff also indicated that the Medicaid Cost Allocation Plan, which details all functions and their match rates, has grown significantly more complex over time, expanding from ten pages to over a hundred pages, with greatly increased negotiations with CMS over content.

#### **Medicaid provider enrollment and payment policy for IHS and tribal providers**

New Mexico Medicaid requires only one provider enrollment number for each IHS and tribal health program. With their application the facility must provide a letter from CMS that the facility is authorized as an Indian organization qualified for 100 percent FMAP reimbursement. State licensure is not required.

MAD does not have written policy applicable to IHS/tribes; they indicate that they assume that whatever services are offered and provided under PHS/IHS policies are permissible and eligible for reimbursement under Medicaid.

The outpatient encounter rate is paid for covered services rendered by a qualified provider by diagnosis code and location; generally these services include medical, dental, vision and behavioral health covered codes. Pharmacy is paid at the state fee schedule.

All IHS and tribal services covered by OMB rates (inpatient and outpatient services provided in the facility) are billed on the UB claim form using revenue codes, although it was indicated that MAD would like to have them include procedure codes in the future. MCOs may have different billing rules for IHS and tribal programs, but the MAD staff was uncertain about this.

A representative of NM's Benefits Services Bureau who works extensively with the IHS/tribal health providers indicated that major issues for these providers include 1) RPMS problems, 2) federal guidelines, 3) managing accounts receivable, 4) lack of a business model, and 5) staff turnover.

#### **Policy and Issues Related to Establishment of a Navajo Nation Medicaid Program**

The New Mexico Medical Assistance Division Director met with the site visit team to discuss the potential impacts of a Navajo Nation Medicaid program on the State of New Mexico Medicaid program and to discuss alternatives that might be considered, other than a Navajo Medicaid program, and the potential impacts of these alternatives.

Some specific concerns about the impacts of the Navajo Nation Medicaid program on New Mexico were expressed in this meeting (and by MAD staff in other meetings). In particular, concerns were raised about the potential effect on the New Mexico FMAP rate if all Indians residing within the Navajo reservation in New Mexico were removed from the population used to calculate the FMAP. Due to the relatively low income levels of people residing on the Navajo reservation, it was seen as very likely that this change would result in higher costs to the state.

New Mexico staff also expressed concern about including the city of Gallup in the catchment area for a Navajo Nation Medicaid program. Some of the issues involved in such a plan include the following:

- Gallup is an Indian and non-Indian community made up of various tribes, not just Navajo
- Some Navajos don't use IHS. They use non IHS health care centers such as Rehoboth.
- There would be no freedom of choice if all Navajos in the Gallup area had to use the Navajo Nation Medicaid program.

- The distance of Navajo Nation Medicaid program offices may be farther than the regular ISD office for many clients.

Factors that might affect the feasibility and costs of a Navajo Nation Medicaid program were also discussed. These issues include the potential level of fixed costs necessary to start-up and operate a Medicaid program, difficulties the Navajo Nation might encounter in hiring and retaining staff with the appropriate training and experience to manage and operate the program, the relatively small numbers of people that would be covered by a Navajo Medicaid program which could limit the ability to negotiate prices with external providers, and the lower health status of the AI/AN population which would affect the ability to spread risk and costs over a larger and healthier population.

**Attachment A: NEW MEXICO SITE VISIT AGENDA*****Tuesday, August 7***

9:00 a.m.	<i>Mark's office</i>	Introductions and NM Program Overview	Mark Pitcock Theresa Belanger
10:00 a.m.	<i>Mark's office</i>	HMS Contract (TPL and Estate Recovery)	Frankie Vigil
10:30 a.m.	<i>Roy's office</i>	Recipient Eligibility	Roy Burt
11:30 a.m.	<i>Mark's office</i>	HealthInsight Contract (QIO)	Lesley Urguhart
12:00 p.m.	<i>TBD</i>	Lunch	
1:30 p.m.	<i>Linda's office</i>	Data Needs	Linda Gonzales David Sandoval
3:00 p.m.	<i>Angela's office</i>	TPA Contract and HCBS Waivers	Angela Medrano
4:00 p.m.	<i>Julie's office</i>	Issues and Alternatives	Julie Weinberg

***Wednesday, August 8***

9:00 a.m.	<i>Ark-North</i>	MMIS Fiscal Agent Contract & Systems	Mark Pitcock
10:00 a.m.	<i>Ark-North</i>	Program Administration and Costs	Paoze Her Lucinda Sydow Donna Sandoval
11:30 a.m.	<i>TBD</i>	Lunch	
1:00 p.m.	<i>Ark-South</i>	Miscellaneous Topics	Michael Aragon (1:15) Geri Cassidy (1:30)
2:00 p.m.	<i>Ark-South</i>	Provider Enrollment and Reimbursement	Robert Stevens Virginia Brooks
3:30 p.m.	<i>Ark-South</i>	Wrap-up	

***Attachment B: List of Documents and Data Reports Provided by New Mexico Medical Assistance Division During and After August 7-8, 2012, Site Visit (as of August 16)***

During Visit:

- Organizational Charts for Medical Assistance Division and Bureaus
- Data on timeliness of Medicaid eligibility approval processing (Email from Ted Roth via Penny Jimerson, 8//12)
- CMS letter approval of Implementation Advance Planning Document and award of MMIS Fiscal Agent takeover contract, dated 2/28/12.
- MAGI Conversion to Affordable Care Act Categories, 7/5/12
- Advance Planning Document: New Mexico Human Services Department MMIS Fiscal Agent Contract Procurement, May 20, 2010 (Revised June 22, 2010)
- Scope of Work for QIO Contract
- FMAP Rates and Methodology links – Historic and through 2013.
- New Mexico Native American MCO Opt-Out Report
- New Mexico Medical Assistance Eligibility Pamphlet, 2012
- List of Eligibility Categories and Income Guidelines 2012

Following Visit:

- Data Request description (based on discussions of the State Data Request and revised detail)
- IHS/Tribal Claims Denial Rates
- Report on Top 10 Reasons for Claims Denials, IHS and Non-IHS Providers
- Report on Top 10 Reasons for Claims Denials, by IHS Provider
- Qualifications/Credentials for CCSS Providers (email from Geri Cassidy)
- Navajo Area electronic PE/MOSAA Determiners (list of participants from Theresa Belanger)

***Attachment C: List of Data Items for Discussion with State Medicaid Programs  
(Revised 8/12/12)***

- Total number of Medicaid enrollees within the reservation boundaries, including Gallup, and by race (Indians and non-Indians)
- Number of Indian Medicaid enrollees within the reservation boundaries, including Gallup, by
  - Gender, Age group (0 < 1, 1 < 6, 6 < 18, 18 and older), and Eligibility category
- Total number of claims submitted and paid, on behalf of AI/AN Medicaid enrollees living within reservation boundaries, including Gallup
- Total number of Managed Care Organization (MCO) encounters for Indian Medicaid enrollees living within reservation boundaries, including Gallup.
- Total Medicaid payments for Indian enrollees living within the reservation boundaries, including Gallup, and by
  - Gender, Age group (0 < 1, 1 < 6, 6 < 18, 18 and older), and Eligibility category
- Medicaid payments on behalf of AI/AN enrollees living within reservation boundaries, including Gallup, by
  - Type of service (e.g. hospital inpatient, hospital outpatient, physician, lab/radiology, SNF, therapy, behavioral health, etc.)
  - Location of provider (within reservation, including Gallup, outside Reservation boundaries)
- Total Medicaid payments made to Indian Health Service and tribal health facilities located
  - Within the reservation boundaries,
  - Gallup, and
  - Outside the reservation boundaries
- FY2010 FMAP for state and changes in the FMAP for FY2011-2013
- FY 2010 Medicaid administrative/operating costs, total and by category



*Call with Utah Medicaid, October 18, 2012: Summary and Key Findings*

***Background and Purpose of Meeting***

The Centers for Medicare & Medicaid Services have contracted with Econometrica, Inc. to conduct a study of the feasibility of the Navajo Nation taking over responsibility for developing and managing Medicaid on behalf of American Indians and Alaska Natives residing within the boundaries of the Navajo Nation reservation.

Site visits to the States of New Mexico, Arizona, and Utah were conducted to obtain detailed information on eligibility categories; enrollments, by category; benefits; waivers; operational requirements, structure, staffing, contracts, and related issues; program costs, by category; and state concerns about effects of a Navajo Nation Medicaid program and similar policies. In addition, the site visits offered the opportunity to discuss and clarify the Medicaid data request that was sent in advance to each state. Utah satisfied the data request in advance of the call.

An in person site visit with Utah Medicaid was not feasible, so the interview was conducted by telephone. This summary provides highlights from the discussion.

***Attendees***

Nathan Checketts, Assistant Medicaid Director

Gail Rapp, Assistant Medicaid Director

Melissa Zito, Medicaid Tribal Liaison

Dr. Kristen Corey, Project Manager, Navajo Nation Feasibility Study

Nancy Weller, Senior Research Associate, Navajo Nation Feasibility Study

***Overview of Eligibility and Administration of Utah Medicaid***

Medicaid in Utah covers 373,954 people (in 2011) at a cost of \$1.97 billion. Utah Medicaid covers pregnant women and children up to age 6 at 133 percent of the federal Poverty Level (FPL), children up to age 18 at 100 percent FPL, parents and childless adults at 150 percent FPL and children at 200 percent FPL under the CHIP. Most of the Medicaid clients in Utah live in the four most populated counties; in these areas Utah operates mandatory managed care organizations. Managed care is optional for Medicaid clients living in other areas of the state.

Utah employs 191 staff to manage the Medicaid program with personal services costs at \$19.2 million annually. Utah just purchased a new eligibility system (\$70-80 million) and is replacing its MMIS at a cost of \$120 million. A significant cost for the program is the eligibility determination process.

American Indians may receive services at IHS and tribal facilities. IHS and tribal facilities enroll with Utah Medicaid and are paid for most services at the IHS encounter rate (called All Inclusive Rate or AIR in Utah). Encounter rate payments are made for Inpatient hospital care, outpatient medical services, behavioral health services, dental services and pharmacy. A facility may be paid up to five encounter rates per day per patient. If a tribal pharmacy enrolls in their Point of Sale program, the pharmacy will be paid at the fee schedule for prescription drugs rather than the encounter rate (Paiute is the only tribe enrolled this way).

Medicaid considers the Navajo reservation "frontier country" in that there are few individuals and services available to them. Utah estimates that about 10,000 Navajos are eligible for Medicaid in Utah. Utah Medicaid spent \$163 million on these clients according to the data submitted but only \$28 million (17 percent) was paid to tribal providers operating on the reservation. Utah has a special team working on Medicaid applications for Indian people.

***Issues Related to a Navajo Medicaid Agency***

Utah is concerned about what specifically the Navajo might be taking over and if the state would still need to continue to provide certain functions. Utah just purchased a new eligibility system and has unified eligibility for all programs; these functions are performed by state employees. Their goal is to assure that people will be able to walk through any door to access the new Health Insurance Marketplace with a seamless process. A main concern about the Navajo Nation is if the eligibility system they build will be able to interface with the Health Insurance Marketplace. They are also concerned that geography will be a barrier to Medicaid eligibility for Navajos - potentially creating chaos. Utah stated that the tribal facilities on the reservation have a good model for outreach and enrollment even though they have to work on eligibility for three states and that they were a CHIPRA grant recipient.

Utah did not feel that a Navajo Nation Medicaid program would impact their FMAP calculation since the population of the Nation is so small.

*Meeting with Navajo Nation to Present and Discuss Draft Study Findings, December 12, 2012:  
Meeting Summary*

***Background and Purpose of Site Visit***

The Centers for Medicare & Medicaid Services has contracted with Econometrica, Inc., to conduct a study of the feasibility of the Navajo Nation taking over responsibility for developing and managing Medicaid on behalf of American Indians and Alaska Natives residing within the boundaries of the Navajo Nation reservation.

A meeting was held in Phoenix, Arizona, on December 12, 2012, to present the draft study findings of the Navajo Nation Feasibility Study to representatives of the Navajo Nation. Navajo Nation officials were in Arizona for other meetings and requested that the meeting to review and discuss the draft study findings be held in that city, where leadership and Feasibility Study Task Force members were available. The meeting provided an opportunity to obtain feedback and comments on the study findings.

This Meeting Summary summarizes key findings and information from this meeting. The Agenda for the meeting is presented in Attachment A to this report. A list of participants is provided in Attachment B.

***Meeting Overview***

We worked with Roz Begay, Program Evaluation Manager of the Navajo Nation Division of Health, to develop the agenda for the meeting. An executive session was requested by CMS for the Navajo Nation leadership to meet with the team prior to the full day's meeting. Key information obtained from this meeting is presented in this section.

***Executive Session***

The Econometrica team gave an overview of the process and explained that we are still receiving comments from HHS on the draft report. The report will then have to go through HHS clearance before the final report to Congress is drafted; that report is due March 23, 2013. The purpose of this meeting is to consult with the Navajo Nation about the draft report, but since the report is not final and approved by CMS for dissemination, it may not yet be released. Econometrica brought printed copies of the report for today's meeting, but those copies were numbered and collected at the end of the meeting. Navajo Nation representatives indicated that they would provide comments on the study findings and report following the December 12 meeting.

Econometrica team members then provided a brief overview of the study components and findings.

Larry Curley asked if the report assumes that the current structure of Medicaid laws and regulations are in place.

The cost assumptions presume that the Medicaid Program as it is currently structured is in place for the Navajo Nation Medicaid agency, recognizing that if the Nation proceeds with the concept, Congress could make changes in the law authorizing the Navajo Nation program.

Dwight Witherspoon stated that the Council will want detailed information about the benefits to the people and how operating the Medicaid agency will improve the quality of health, particularly if the Nation is expected to contribute \$50–70 million a year for its operation.

Mr. Curley stated that the Nation is greatly concerned about generation of the match rate dollars.

Vice President Jim asked how the Nation will know if its comments are included in the report. Econometrica stated that Econometrica can respond to comments separately, explaining where comments were incorporated into the reports or why a specific comment could not be addressed.

Vice President Jim stated that the Nation kept pushing CMS about issuing the contract for the study, as they felt a comprehensive study would take more than a year to complete. In an ideal world, a government would honor treaties and trust responsibilities. The Nation hopes to offer more than what is offered by a state.

Kitty Marx stated that Congress could consider the Navajo Nation share of the Medicaid match funds. Startup and operational costs for Medicaid programs are significant, and states have considerably more options for raising matching dollars.

### ***Open Task Force Meeting***

Vice President Jim opened the meeting by stating that we need to understand that they are Navajos, a sovereign nation that needs to take the necessary steps to provide health care for its people. Many here are raised on the idea of self-reliance, and we need to apply the same principal to ourselves as a Nation.

Kitty Marx explained that the Navajo Nation Feasibility Study was authorized in the Indian Health Care Improvement Act reauthorization. This third visit to the Navajo Nation is to present the results of the study and get comments. Due to the short time period and comments still coming in from the Department, the report could not be sent on the schedule envisioned; since the contract for the report expires December 31st, the Nation will need to submit comments by the 19th of December.

Larry Curley, Director, Division of Health, stated that the process for the Navajo Nation Medicaid agency started years ago, and while they may not agree with the report, we do have an opportunity to comment. We want to maximize our opportunity to design our destiny.

Kathy Langwell explained that she had worked formerly in the Congressional Budget Office and used the process that the CBO employs in developing cost estimates, which is to establish a base year and estimate what the costs would have been if the program were in place at that time.

Econometrica offered a PowerPoint presentation highlighting the report. Nancy Weller explained the Medicaid requirements in current law and regulation, and Kathy Langwell explained the cost assumptions and cost estimates for startup, operation, and matching rates for the Navajo Nation Medicaid agency.

Larry Curley stated that he would like to see the Navajo Nation recommendations in a separate section of the report and not in an appendix that no one will ever read. He stated that “they want to be a Medicaid state because the culture of our people—we are a migrant people—the essence of who we are and how we want to address health disparities should be in the background section of the report.”

Roz Begay said that information went out about why “we believe we are a nation within the nation.”

Tom Christie stated that he wished to point out that jurisdictional issues have been addressed in one way or another. The Navajo Nation has full jurisdiction over tribal providers, but those off reservation or non-Indian providers will have contracts just as other states do. The Navajo Nation is treated as a state for operating environmental programs. Arizona contracts with Navajo Nation as a provider for long-term care and behavioral health management. He thinks that some hoops may not be as big to jump through as we think. Navajo Nation can write its own laws and do things in their own way.

Larry Curley stated that he did not know of any other agency of the federal government given one half of the funding needed and told to beg for the rest of the money needed to operate.

Roz Begay stated that the cost estimate was of concern and wanted to know if Medicaid recipients were identified by zip code. Econometrica assured her that the state data requests were made by specific zip codes identified as trust lands and the city of Gallup.

Larry Curley asked how long it might be before anyone in Congress has an opportunity to read the report after it is submitted.

Kathy Langwell suggested that working with Congressional representatives of the Navajo Nation could be effective.

Larry Curley commented that FY15 is probably the soonest that anything might happen, and Kathy agreed that it was a likely budget cycle assumption.

Larry Curley wondered if there were a Congressional hearing might someone ask CMS questions about the study.

Kathy Langwell stated that the feasibility study request for proposal did not ask for recommendations; we were to address only the feasibility of a Navajo Nation Medicaid agency, including start-up and operational requirements and costs. Contractors are not permitted to make recommendations on federal policy.

Larry Curley stated that from the Navajo Nation perspective, formidable is not something we shy away from. We have a sense of urgency about this because we feel the window is small and fading fast.

Dwight Witherspoon stated that the 2010 estimates can be very helpful to all involved.

Kathy Langwell replied that it would have been helpful to have multiple years of data and costs, but that was simply not possible in the time allowed.

Dr. Poudel stated that he felt the goal of the study was to fulfill the need of Congress and the Navajo Nation that better services need to be available. Cost control is the other issue. Is there anything to indicate that a Navajo Medicaid program would be more efficient or cost-effective?

Kathy Langwell replied that Navajo Nation could set eligibility levels more generously than any of the three states. They could generate more revenue for the IHS and tribal programs that benefit the population as a whole by bringing more dollars into the health system. It is, however, hard to estimate costs to the federal government without concrete information from the Nation on its plans for eligibility and benefits.

A comment was made that section 4.5 of the report, speaking to impact on residents, seems to be negative and suggests that the section could state that residents' experience would be enhanced by making the program more appealing, culturally appropriate, and accessible.

Gen Notah stated that, in terms of the distance Navajos face in applying for Medicaid, their goal is to make access to benefits easier.

Kathy Langwell stated that the states pointed out that the process for Medicaid application is the same as for a number of other programs, and clients will have to apply twice for benefits. She also agreed that section 4.5 could be amended.

Vice President Jim wrapped up the meeting by saying that the Navajo Nation Medicaid Program is worth pursuing. The leadership has an interest in expanding its jurisdiction, and the Navajo Nation is willing to stretch as far as possible.

*Attachment A: Meeting Agenda*

**Navajo Feasibility Study Task Force Meeting**

**Flinn Foundation Educational Conference Center  
1802 N. Central Avenue  
Phoenix, AZ 85004-1506**

**December 12, 2012**

**AGENDA**

8:30 – 9:30 am	Closed meeting between Navajo Nation Leaders, CMS and Econometrica, Inc.	
8:50 – 9:30 am	Registration, Pick Up Materials, and Meet & Greet	
9:30 am	Open Task Force Meeting Invocation Introductions	Roselyn Begay Navajo Division of Health
9:45 am	Overview of the Navajo Nation Feasibility Study Q & A	Larry Curley, Division Director Navajo Division of Health Kitty Marx, Director Office of Tribal Affairs, CMS
10:30 am	Overview of the Study Questions, Process and Data Collection Q & A	Econometrica, Inc.
11:15 am	Review the Draft Study Report: Steps to Starting a Medicaid Agency Q & A	Econometrica, Inc.
12:00 pm	Lunch on your own	
1:30 pm	Review the Draft Study Report: Cost Estimation Assumptions, Results and Limitations Q & A	Econometrica, Inc.
2:15 pm	Review the Draft Study Report: Other Feasibility Issues, Alternatives and State Impacts Q & A	Econometrica, Inc.
3:00 pm	Additional Q & A and Navajo Input	
3:30 pm	Next Steps	
4:30 pm	Closing Prayer and Adjournment	



*Attachment B: Participant List*

**Meeting Attendees:**

Rex Lee Jim, Vice President, Navajo Nation  
Larry Curley, Health Director, Navajo Nation Division of Health  
Roz Begay, Program Evaluation Manager, Navajo Nation Division of Health  
Dr. Gayle Dine Chacon, Chief Medical Director  
Dr. Madan Poudel, Health Services Administration  
Walter Phelps, Navajo Nation Council Delegate  
Dwight Witherspoon, Navajo Nation Council Delegate  
Genevieve Notah, Associate Director, IHS Planning  
Philine Herrera, Director, Health Education, Navajo Nation Division of Health  
Mae-Gilene Begay, Navajo Nation Division of Health  
Tom Christie, Attorney, Navajo Nation Division of Health  
Ramona Antone-Nez, Navajo Nation Division of Health, Navajo Epi. Center  
Harry Tom, Navajo Nation Division of Health  
Cherie Espinosa, Department of Justice  
Ralph Roanhorse, Employee Benefits Program  
Eulanda Ciccarello, Employee Benefits Program  
Harry Bowman, Senior programmer  
Herman Shorty  
Ruth White  
Theresa Galvan  
Adele King  
Vernon Livingston

Kitty Marx, Director, Tribal Affairs Group, Centers for Medicare & Medicaid Services  
Johanna Davis-Joyce, Director of Health Programs, Econometrica  
Kathryn Langwell, Sundance Research Institute, Cost Estimation Task Leader, Navajo Nation Feasibility Study  
Nancy Weller, Senior Staff Associate, Navajo Nation Feasibility Study, Econometrica

