The Effects of Across State Border Issues on Young American Indian/Alaska Native Medicaid and CHIP Beneficiaries and Their Health Care Providers: Three Case Studies

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Executive Summary

Many young American Indians and Alaska Natives (AI/ANs) travel across State borders for various purposes, such as attending boarding school, obtaining behavioral health services, and participating in various other activities. When they are enrolled in either Medicaid or the State Children's Health Insurance Program (CHIP) and require health care while outside the State where they are enrolled in Medical Assistance, obtaining health care can be difficult for the beneficiary and receiving reimbursement can be difficult for providers. Medicaid and CHIP are administered jointly by the federal government and States. The federal government sets some overall requirements for the programs and contributes substantial funding to underwrite the costs of the programs, but States have the flexibility to develop their own policies around eligibility, benefits, and the level of reimbursement for services. Given the significant variations in State policies, it can be difficult for Medicaid beneficiaries to obtain health care services when they travel outside of their home State, largely because health care providers are concerned about their inability to receive payment for services provided to Medicaid beneficiaries that are enrolled in a different State. The unique political circumstances of AI/ANs, recognized in the Constitution, legislation, treaties, and court cases, have contributed to the development of a dedicated health care system and special regulations that affect the delivery of health care services to them. This health care system and the special regulations that affect health care for AI/ANs add another layer of complexity to the Across State Border (ASB) issues that any Medicaid beneficiary, regardless of age or political distinction, must surmount to obtain health care outside of their permanent residence.

In order to describe the delivery of health care to young Medicaid beneficiaries when they travel across State borders, 28 interviews were conducted at three sites: an Indian boarding school in North Dakota and two substance abuse treatment facilities in South Dakota and New Mexico that

serve Native youth. The major findings from the case studies included six primary issues, presented here in the order of their frequency of their occurrence:

- States seem cautious to qualify out-of-state health care providers to receive reimbursement for their services.
- Under the current system, patient persistence against every challenge and setback is the best strategy to ultimately become qualified as a multi-state Medicaid/CHIP provider and ensure reimbursement for services provided to out-of-state Medicaid/CHIP beneficiaries.
- The lack of an OMB Rate for Youth Regional Treatment Centers (YRTCs) impedes these institutions' ability to receive reimbursement for the services they provide to AI/AN youth.
- States sometimes have conflicting eligibility requirements that leave AI/AN youth without health care benefits when they temporarily reside in another State.
- Personal relationships with State Medicaid offices can facilitate solutions to issues that arise. The lack of a central point of contact in some States can prevent issues from being resolved.
- The varied requirements of third-party clearinghouses among the States can deter a facility from seeking to become a multi-State Medicaid provider.

The underlying assumption among all the respondents in the three case studies was that the ASB issues represent an ongoing and important concern for institutions that serve young AI/AN Medicaid/CHIP beneficiaries and the young people themselves.

Introduction

The Centers for Medicare and Medicaid Services (CMS) is a primary partner to the Indian Health Service (IHS), tribal clinics, and urban Indian centers in their mission to provide health care for AI/ANs. CMS sponsors research to evaluate the impact of its programs and policies on beneficiaries and providers in order to better understand issues such as access to Medicaid and CHIP. As part of the effort by CMS to respond to Congressional interest in Medicaid and CHIP coverage for children who frequently change their State of residence, CMS awarded a contract to Kauffman & Associates, Inc. (KAI), an American Indian and woman-owned firm, to study ASB issues that affect the use of Medicaid and CHIP services by AI/AN children and adolescents. As part of this contract, KAI wrote a literature review about ASB issues and their effect on Indian Country, conducted three site visits to AI/AN-serving institutions to document their issues, and made recommendations for potential policy changes. Reports that summarize the results of each of these activities are available in separate documents.

The current document describes the findings from the second activity, the three site visits. In May and June 2010, researchers from KAI conducted case studies of three institutions that serve AI/AN young people who are Medicaid and CHIP beneficiaries and who cross State borders to either attend boarding school or receive substance abuse treatment. These three case studies took place at the Circle of Nations Wahpeton Indian School in North Dakota, the New Sunrise Regional Treatment Center (NSRTC) in New Mexico, and the Aberdeen Area Youth Regional Treatment Center (AAYRTC) in South Dakota (AAYRTC is often called "Chief Gall"). The case studies consisted of site visits, interviews with staff, a review of documents, and subsequent data analysis. Appendix 1 presents the methods KAI used to conduct the case studies.

Circle of Nations Wahpeton Indian School

The Circle of Nations Wahpeton Indian School is located in Wahpeton, ND, less than a mile from North Dakota's border with Minnesota. This privately incorporated, inter-tribal, and off-reservation boarding school serves AI/AN youth in the fourth through eighth grades. Chartered by the Sisseton-Wahpeton Sioux Tribal governing body, the school receives the bulk of its funding from the Bureau of Indian Education (BIE). It offers a State-approved course of instruction and is fully accredited with commendation by the North Central Association (NCA). Figure 1 presents a map that identifies the school's location in the southeastern corner of North Dakota.

Figure 1. Location of Circle of Nations Wahpeton Indian School.

An Act of Congress created the Wahpeton Indian School in 1904, and the school subsequently opened its doors to students in early 1908. It was the last off-reservation Indian boarding school founded by the U.S. Government. For many years after its inception, the school offered a year-round program that emphasized agricultural, vocational, and domestic skills. Until 1993, the Bureau of Indian Affairs (BIA) administered the school, but in July of that year, Wahpeton Indian School converted to tribal grant status. The following year, the school adopted "Circle of Nations" as its name.

Background

- **Student Population, Including Out-of-State Students**—In school year 2009-2010, a total of 154 students from 11 States matriculated at Circle of Nations. Of these 154 students, 125 students came from outside of North Dakota, and 29 students were residents of North Dakota.
- **Home States of Students**—Staff at the school estimated that in a given year the school has enrolled residents from as many as 21 different States. Since 2003, students at Circle of Nations have been residents of Arizona, California, Colorado, Indiana, Idaho, Illinois, Iowa, Kansas, Louisiana, Nebraska, Michigan, Minnesota, Montana, North Carolina, North Dakota, Oregon, South Dakota, Utah, Washington, Wisconsin, and Wyoming.
- **Students' Gender and Age**—About 47% (*n*=73) of the student body was male, and about 53% (*n*=81), female; students' ages ranged between 10 and 15 years.
- **Tribal Background of Students**—Students at Circle of Nations were enrolled in 33 different Tribes.
- **Medicaid Eligibles among Students**—Staff from the school reported that almost all the members of its student body in 2009-2010 were eligible for Medicaid or CHIP with only a negligible number of students enrolled in private health insurance.
- **School Lunch Eligibles among Students**—All students at the school were eligible for the National School Lunch Program.
- **School Program**—Circle of Nations provides a comprehensive curriculum appropriate for the developmental stages of its students. The school provides students with comprehensive array of adjunct services, including special education, counseling, library and other information services, athletics, social and recreational activities, psychological assistance, and

mentoring. The school has two separate dormitories, one for boys and one for girls, and provides intensive residential and case management services. Classrooms and the library have computers with Internet access for student use. A health clinic with nursing staff is open daily.

Findings

Fourteen interviews took place to collect information about ASB issues at Circle of Nations, including interviews of six current staff persons at Circle of Nations, three consultants at the school, four service providers from private non-affiliated enterprises, and one employee at an IHS service unit. During their interviews, respondents described the students' characteristics, services provided to the students through Circle of Nations, services provided to students through other institutions in the community, and the respective ASB issues related to Medicaid for Circle of Nations and these other organizations. Respondents also offered suggestions to address Circle of Nations' Medicaid- and CHIP-related ASB issues.

The Characteristics of Students at Circle of Nations—In the interviews, participants commented on common characteristics of students who attend Circle of Nations. Respondents consistently mentioned various adversities that were common features of the life histories of many young people who attended the school, including poverty, family trauma and dysfunction, sexual and other physical abuse, personal and familial substance abuse, and transience. These backgrounds had contributed to serious challenges for many students, including hopelessness, learning disorders, antisocial behaviors, impulse control disorder, and suicidal ideation. As one participant observed, "These are very complicated kids." This same respondent, however, also reported later in the interview, "They teach you a lot. The resiliency is amazing." Despite the difficulties students encountered, multiple respondents identified different prosocial behaviors among the youth. As one participant observed:

> "We volunteer at the food pantry. In the wintertime, they'll load up a bus full of kids and shovels, and they'll go to the community and shovel out driveways. Sandbag, we've sandbagged for years here when it floods. These children get out, and they just pour their heart into this stuff."

According to participants, students from the school won first, second, and third places at a science fair held in Albuquerque, NM during the school year; more than 20 students were taking piano lessons; about 40 youth were taking Tae Kwon Do lessons; and the chess team was second in the State at the time of the site visit.

Potentially Medicaid-Eligible Services Provided at the School—Circle of Nations is not qualified as a Medicaid-provider in North Dakota or any State. As described in the background section, Circle of Nations is an academic institution, but many of the adjunct services it provides are therapeutic. As one respondent reflected, "We are technically a school that's providing therapeutic services." Another participant extolled Circle of Nations' ability to address the students' needs, "They have such a handle on dealing with the issues that the kids come there with." The school enjoys consultation on a weekly basis by a psychiatrist and several times a week by a psychologist and a counseling social worker. The school also employs a counselor. The psychologist supervises interns from the University of North Dakota who, without cost to Circle of Nations, counsel students. The team provides a variety of different services, including therapeutic counseling, prescriptions and monitoring of psychotropic medications, case management, crisis intervention, placement as necessary in psychiatric and chemical dependency facilities, classroom presentations, and prevention groups. One participant suggested that if Circle of Nations is responsible for the physical health of its students, Medicaid funding should be available at the very least for its medical infrastructure, including the nursing services.

ASB Issues that Prevent Qualification as a Multi-State Medicaid Provider—A respondent estimated that Circle of Nations spent eight months over the last five years trying to become qualified as a Medicaid provider in various States where their students most typically reside. The process proved too daunting, and staff at the school eventually abandoned the effort. A number of different ASB issues stood in Circle of Nations' way. For instance, a respondent who had participated in the application procedures complained about the complexity of working with multiple clearinghouses in multiple States:

> "We have to go through a third-party clearinghouse, and the clearinghouse we might be using—let's say for the State of North Dakota—might not be the same clearinghouse in Montana. It's just not logistically feasible to do it. It's a nightmare."

The residency of out-of-state students also was a significant problem:

> "(We contact) the administration of each State to see if we would qualify and once they find out that the child is no longer residing in their State, the automatic reaction is, "They're not eligible, because they're no longer our State resident."

States would assert that since the students were residents in North Dakota for nine months out of the year, they were no longer residents of the State where they were enrolled in Medicaid. Moreover, this participant noted the compounding conundrum that "the parents need to confirm on a monthly basis they're still eligible for the program, and most of our parents are transient." Unfortunately for the out-of-state students at Circle of Nations, they are not eligible for Medicaid in North Dakota, either. This same participant observed:

> "We approached (North Dakota to enroll our out-state-students in Medicaid). They will not do it, because they are not the residents of North Dakota . . . because their parents are not residents of this State, which is one of their issues for eligibility."

ASB Issues for Medicaid Providers Who Serve School Youth—Several Medicaid-qualified providers in the area offer support services for students at the school and participated in this study. One of these providers is Prairie St. John's Psychiatric Center, a private provider in Fargo, ND, which receives referrals of students from Circle of Nations for causes such as suicidal ideation and destructive aggression. Prairie St. John's, which has a 39-bed intensive inpatient unit for children and adolescents, provides intensive therapeutic services that seek to stabilize patients. One respondent who worked at Circle of Nations noted about the school's use of Prairie St. John's, "We had 14 psychiatric hospitalizations this year." Another participant noted, "Other years, we've had way, way more." A respondent who worked at Prairie St. John's believed that most of the students from Circle of Nations who required psychiatric hospitalization at the institution were from South Dakota; however, South Dakota resists payment to Prairie St. John's for South Dakota's Medicaid beneficiaries at the school:

> "We take Minnesota Medicaid, and then we take North Dakota Medicaid. We've been unable to secure South Dakota Medicaid. We are able to take Montana Medicaid as well. If they have Minnesota or North Dakota Medicaid—those agreements have, especially on the kids, have been very easy to work with and secure the payments. With South Dakota being the one that we would really like to secure."

The respondent noted that Prairie St. John's had tried to secure South Dakotan Medicaid several times when South Dakotan AI/AN students from Circle of Nations were hospitalized, but each attempt has proven unsuccessful.

A local pharmacy, Wahpeton Drug and Gifts, fills prescriptions for students at Circle of Nations. A respondent from the drug store observed that the store fills prescriptions for students every week during the school year, reporting that, "We do lots of the C2s and the psych meds."[2] The

pharmacy wanted Circle of Nations' business and sought to qualify as a Medicaid provider in the State that had residents who attended Circle of Nations. The key informant from the store recalled:

> "It was a little bit of a hassle to be a provider for some of the States, because they didn't understand. Like Nebraska didn't understand why someone in North Dakota would need to be a provider for their Medicaid system, but once we explained it to them, and they could figure that out, then I mean it wasn't a problem."

Respondents from Circle of Nations described Wahpeton Drug as "marvelous" for its efforts to serve the students at the school.

When students require medical intervention that the nurses at the school clinic cannot address, redress of the problem involves various considerations, such as the seriousness of the problem, the urgency of the need for care, and whether there is a third party payer. Circle of Nations uses St. Francis Hospital, across the border in Breckenridge, MN, for care after clinic hours and for emergency cases. A respondent suggested, "This last year now, we didn't have too awful many. I would say probably maybe…..no more than maybe 10, 12 kids." The respondent from St. Francis suggested that providing emergency services for youth at Circle of Nations at one time was more complicated than it currently is. The participant reported:

> "Two, three years ago we did develop a plan with (Circle of Nations) that they take and give us a copy of what—the parents or whoever is their guardian—they fill out their form with, insurance information and everything, and we get that . . . and we keep it in a separate book. So that's why if they come to the hospital, then we have that information right away. So that helps us for our billing purposes."

The participant expressed the belief that this practice had largely resolved its billing issues related to serving the students from the school.

Circle of Nations and the Area IHS Clinic—The staff at Circle of Nations did not believe that the IHS services in their area were a solution to their ASB issue. Staff has the option to drive their AI/AN students the nearly 60 miles to the Woodrow Wilson Keeble Memorial Health Care Center, the IHS clinic in Sisseton, South Dakota. Circle of Nations staff reported that they typically only use this option for uninsured youth in need of hospitalization; as one participant reported use of the facility, "(The health problems) are usually pretty big." Another respondent employed by the school commented on the difficulty of having students seen at the IHS clinic:

> "My understanding is IHS—they're supposed to be able to see or help any Native American person. You know and I understand that the IHSs are stretched in their areas, too, but we get all of these kids from these . . . different states, we try to take them down to IHS at times, and it's tough to get them in through that system even sometimes."

Recommendations by Participants to Address ASB Issues—During the course of their interviews, respondents offered suggestions to increase Medicaid ability to help students from Circle of Nations. One of the participants employed by Prairie St. John's recommended that CMS standardize the program so that it is "automatically funded from one state to the next." Another respondent summarized suggestions to address Circle of Nations' problem to qualify as a Medicaid provider with the proposition, "So the . . . things for you to help us is definition of residence (and) the e-billing issue. . . ."

Summary of ASB Findings from Circle of Nations Site Visit

The primary ASB issue identified across the interviews among knowledgeable participants at Circle of Nations, Wahpeton Drug, and Prairie St. John was the apparent reluctance of States to make favorable dispositions of ASB concerns. This resistance included qualifying beneficiaries who

are out-of-state to receive services. It also included qualifying providers who are out-of-state to receive reimbursement. Conflicts in the Medicaid eligibility requirements between States can leave a young Medicaid beneficiary from one State temporarily resident in a second State without Medicaid benefits from either the home or host States. Similarly, States generally seem reluctant to qualify providers in other States to receive reimbursement for services for their Medicaid beneficiaries who are out-of-state and temporarily resident in another State. Another issue identified by one participant was the difficulties that service providers face when they have to interact with the e-billing systems of multiple States. Under the current system, the general consensus among participants was that success in dealing with ASB issues requires determination and persistence.

New Sunrise Regional Treatment Center

Located about 60 miles west of Albuquerque in San Fidel, NM, New Sunrise Regional Treatment Center has been in existence since early 1988. NSRTC treats substance abuse and coexisting problems in AI/AN adolescents between the ages of 13 and 18. NSRTC is a part of IHS's Acoma-Canoncito-Laguna (ACL) Service Unit that serves the three Tribal groups in the immediate area: the Acoma Pueblo (population 3,500), the Laguna Pueblo (5,500), and the Canoncito Navajos (1,100). Figure 2 presents the location of NSRTC.

Figure 2. Location of New Sunrise Regional Treatment Center.

NSRTC was founded shortly after Congress passed the Anti-Drug Abuse Act of 1988, P.L. 99-570, which authorized the Indian Health Service (IHS) to construct YRTCs for treatment of alcohol and substance abuse among AI/AN youth.

Background

- **NSRTC Census Population, Including Out-of-State Residents**—From October 1, 2009, the start of the Federal fiscal year, to May 4, 2010, a total of 44 American Indian (AI) adolescents enrolled in NSRTC to obtain treatment. NSRTC typically treats 90 to 100 young people each year, about 10% of whom are from outside New Mexico.
- **Age of Gender of Residents**—The mean age of the residents at NSRTC between October 1, 2009 and May 4, 2010 was 15.6 years. Typically, about a third of NSRTC's clients are female and two-thirds, male; the facility maintains a total of 24 beds, 8 for females and 16 for males.
- **Catchment Area of the Facility**—The facility, as a regional treatment center, focuses its services on youth from New Mexico, Arizona, Colorado, and Texas. NSRTC also serves a portion of Utah, though the facility has received few referrals of residents from that State over the years.
- **Tribal Background of Residents**—Between October 1, 2009 and May 4, 2010, the YRTC served AI youth from New Mexico, Colorado, and Texas; taken together, these 44 adolescents were enrolled in 20 Tribes.
- **The Program at NSRTC**—At any given time, about 18 to 20 adolescents are undergoing a 90-day treatment program at the facility. About 90% of the facility's staff is AI. The facility is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and licensed by the State of New Mexico.

Findings

Eight current staff persons at NSRTC took part in key informant interviews. Participants described the characteristics of residents at NSRTC and the components of the program. They also discussed the facility's budget, prior activities to qualify the facility as a Medicaid provider in New Mexico and other States, and ASB issues related to Medicaid. Respondents also volunteered suggestions to address the YRTCs' ASB issues.

Characteristics of the Residents at NSRTC—Respondents described the background of residents at NSRTC. Participants observed that NSRTC, as a regional treatment center, serves AI/AN adolescents from New Mexico, Arizona, Colorado, Utah, and Texas, but it has also provided treatment for youth from California, Nevada, Oklahoma, Nebraska, and Iowa. Most residents come from New Mexico; concerning the origins of the other residents, a respondent volunteered, "We have about 20% from Colorado, and about 5% from Arizona, and maybe 2 or 3% from Texas."

To become a resident at NSRTC, a young person must provide evidence of enrollment in a Tribe or be able to demonstrate lineal descent. One participant offered that "community programs, schools, hospitals, probation officers, the courts, (and) families" refer residents to the facility. Youth at NSRTC are either male or female and between the ages of 13 and 18; one respondent reported that the facility has received referrals for younger youth (10- to 12-year-olds) which it has had to decline because of age restrictions. According to oral reports and written documentation, NSRTC has qualified as a Medicaid provider for New Mexico, Colorado, and Arizona. If residents of any of those States arrive at NSRTC as Medicaid-eligible but are not enrolled in Medicaid, staff from NSRTC aggressively pursues their enrollment. As one staff person observed, "We do whatever possible to get them on (Medicaid.)" If a resident does not come from New Mexico, Colorado, or Arizona, however, NSRTC does not make an effort to enroll the youth since NSRTC is on the

campus of the ACL Service Unit, and residents have ready access to medical care whether or not a third party pays for it. About 96% to 98% of residents are enrolled in Medicaid; a respondent indicated that NSRTC rarely sees CHIP beneficiaries.

Participants reported that most residents who attend NSRTC present for marijuana abuse, alcohol abuse, or a combination of the two. Clients also often have co-occurring symptoms, such as depression, anger, or anxiety. One respondent indicated, "I would say the majority of our residents (come) with some sort of abuse, neglect issues."

NSRTC's Program—According to respondents, NSRTC's treatment services include assessments, treatment planning and review, chemical dependency education and counseling, academic education, family education and therapy, psychological/psychiatric services, recreational therapy, cultural/traditional awareness, nursing/health services, social skills services, discharge planning, and 12-Step Support Groups. Among the culturally sensitive services that NSRTC provides are sweat lodge, talking circles, storytelling, traditional agricultural activities, traditional food preparation, traditional crafts, a cultural awareness program, and local Tribal celebrations. A respondent commented concerning the cultural content of NSRTC's program, "Just to help them connect with their culture—it's just incredibly important." The residents also continue their education while at NSRTC with an educational program accredited by the North Central Association and accredited by the State of New Mexico.

NSRTC's Current Budget, Including Medicaid Funding—NSCRTC's funding derives from two sources, recurring funds from the congressional appropriation under P.L. 99-570 and third-party payments. A respondent reported that, dependent on the year, NSRTC's annual budget is between $3.2 and $3.6 million, and that almost half of those funds are third party payments by Medicaid. A negligible number of residents, perhaps "one out of a hundred," as two participants indicated, qualify for payments from private health insurance, but participants did not speak well of

private insurance payments. One respondent observed, "Private clients don't pay much. They'll pay for some of the days over fourteen."

NSRTC's Medicaid ASB Experience—NSRTC has only sought to qualify as a Medicaid provider for the three States that account for most of its client base: New Mexico, Colorado, and Arizona. The facility has not applied to other States to qualify as a Medicaid provider because an insufficient number of residents come from those States to warrant the burden of preparing an application. As one participant mentioned, "We don't get that many of them, so we haven't really pursued it."

About 14 years ago, NSRTC hired a staff person who specializes in third-party payments who prepared the applications for New Mexico, Colorado, and Arizona and continues to carry out all the facility's activities related to Medicaid reimbursement. NSRTC has had two staff persons trained as Presumptive Eligibility/Medicaid On-Site Application Assistance (PE/MOSSA) Determiners.[1] These individuals can work with residents from New Mexico to assist in their enrollment in Medicaid. In addition, New Mexico has an out-stationed eligibility worker onsite at the ACL Service Unit who can make an immediate determination of eligibility for any resident from New Mexico who arrives at NSRTC.

After the facility qualified as a Medicaid provider in its home State, it sought to become qualified in Arizona and New Mexico. As one respondent described, "After becoming Medicaid eligible, some years later we went into Arizona, became Arizona eligible, and then we eventually went to Colorado and became eligible to bill for Colorado." Staff at NSRTC during the interviews described various hurdles that the differences in regulations among the States posed to the facility as it endeavored to transact Medicaid-related business, such as variations in the determinations of eligibility and different approaches to communicate about various challenges. While most of these issues, one respondent reported, were easily resolved, sometimes the barriers could be more

daunting, particularly when staff at NSRTC did not have personal relationships with employees in State offices:

> "You know we always have issues with state regulations, but it's pretty straightforward. And each one offers an eligibility line either on the website or by telephone. I have tried over the years to have some key people in these places that have been real helpful to me and can be of assistance. We find that with Colorado it's very difficult. We don't have that contact. We're here, and we can't be over there to get that assistance, and it is frustrating."

The daily rates that New Mexico, Arizona, and Colorado paid NSRTC also illuminated another aspect of the ASB issues that the facility faced. A respondent recollected, and written documentation from the respective States verified, that NSRTC receives $300 per day for Medicaid beneficiaries from New Mexico; $325, from Arizona; and $1,906, from Colorado. Staff at NSRTC recognized that the daily rate for Colorado represented a special success for the facility. According to one respondent, NSRTC received assistance from CMS to have Colorado give NSRTC the OMB Rate for a psychiatric non-hospital base facility. When asked about the process that NSRTC staff employed to obtain the OMB Rate for Colorado, this respondent replied:

> "When we had negotiated with the state of Colorado . . . when we got the OMB rate because of the designation they gave us, one of the beautiful things about negotiating with them is that we brought in CMS at the same time to sit down with the State of Colorado. And so they approved the rate that they gave us, which was the all-inclusive rate, and it was through CMS's encouragement and blessing that we came up with that rate."

The great difference between New Mexico's and Arizona's rates, on the one hand, and Colorado's, on the other, pointed to a problem that staff from NSRTC had identified in the

disparate treatment that YRTCs receive from the several States. A participant in an interview observed:

> "Colorado and some of the States . . . we're the same facility, but they'll look at you differently depending on what their state designations are. We're looked at as a substance abuse facility in this State. Colorado looks at us as a psychiatric non-hospital base facility. We still see the same type of diagnosis, but our State, I think, look at us because we're licensed in that, don't want to move off the dime on that one there."

Recommendations by Participants to Reduce ASB Issues—Several respondents from NSRTC thought that the creation of an OMB rate for the YRTCs would rectify the problems that NSRTC faced in its attempt to negotiate, as a Federal facility, the obstacles implicit in the different regulatory requirements of the several States. One respondent observed, "The biggest fix would be . . . just give us the money, reimburse us for the OMB rate." This participant was perplexed at the failure to adopt an all-inclusive rate for YRTCs since services provided to AI/ANs through an IHS facility is a 100% Federal Medical Assistance Percentage (FMAP). As this participant observed, "It's a federal pass-through money, anyway."

Summary of Findings from New Sunrise Regional Treatment Center Site Visit

Staff at NSRTC identified several ASB issues that hindered the effective use of the program. One challenge was the complexity of the process to complete an application. Even though NSRTC receives referrals from multiple States, it determined that the application process to become a qualified provider in another State was too daunting to warrant the preparation of an application if sufficient numbers of young people from a given State did not seeks services at NSRTC. This situation meant that the facility regularly cannot bill for many Medicaid eligibles, a circumstance that results in a loss of income for NSRTC and its programs. A significant issue for respondents at

NSRTC was the lack of uniformity among States in their designations for what a YRTC is. For example, Colorado designated NSRTC as a psychiatric non-hospital base facility, and New Mexico determined that it was a substance abuse treatment facility. These dichotomous determinations for the exact same set of services resulted in wildly different daily rates, neither one of which approximated the true per resident daily rate at the facility. All knowledgeable informants recommended the adoption of an OMB rate for YRTCs to resolve this problem. A final issue for staff at NSRTC was simply the lines of communication. When staff at NSRTC worked with Medicaid in their home State, they established relationships inside the State office that permitted them to resolve issues. When staff worked with out-of-state Medicaid programs, such personal relationships were more difficult to establish and complicated the process of resolving problems. As at Circle of Nations, the sensibility at NSRTC was that patient persistence was necessary to succeed in coping with ASB issues and receiving remuneration for services.

Aberdeen Area Youth Regional Treatment Center

The Aberdeen Area Youth Regional Treatment Center (AAYRTC) provides residential alcohol and drug abuse treatment services for AI adolescents. Located near Mobridge, SD, AAYRTC is situated on the southeastern corner of the Standing Rock Indian Reservation and in the north central section of South Dakota. Commonly called "Chief Gall" in honor of the 19th century battle leader of the Hunkpapa Lakota, AAYRTC overlooks the Grand River near the point where the river flows into the Missouri. Figure 3 provides a map that graphically depicts the location of AAYRTC.

Figure 3. Location of AAYRTC.

Founded by the Standing Rock Sioux Tribe in August 1996, AAYRTC became a service unit of the Aberdeen IHS Area Office in May 1997 and accepted its first group of AI adolescents for treatment in October 1997. Though that original cohort of residents was exclusively male, AAYRTC serves both adolescent males and females. Since 2004, CARF has accredited the treatment program at AAYRTC.

Background

- **AAYRTC Census Population, Including Out-of-State Residents**—For the five completed fiscal years prior to the case study (FY 2005 to FY 2009), this facility served an average of 63 adolescents a year. In FY 2008, 19% (*n*=15) of youth at AAYRTC came from out-of-state; the figure in FY 2009 was 3% (*n*=2).
- **AAYRTC's Residential Capacity**—AAYRTC maintains a total of 18 beds; however, the number of counselors on staff dictates the institution's maximum capacity. With a counselor to client ratio of 6 to 1 and two counselors in the facility's employ at the time of the site visit, AAYRTC's maximum capacity in May 2010 was 12 residents.
- **Gender Ratio at AAYRTC**—Adolescents who receive treatment at the facility tend more often to be male (e.g., in FY 2009, 57% [*n*=37] of clients were male and 43% [*n*=28], female).

- **Age of Residents**—The average age at entry into treatment in FY 2009 was 15.75 years.
- **Drug of Choice**—In FY 2009, alcohol was the drug of choice of 52% (*n*=34) of the adolescents treated in the facility, and marijuana was the drug of choice for 42% (*n*=27) of the youth.
- **Other Presenting Diagnoses**—AAYRTC has a dual diagnosis treatment capability. In FY09, the most frequent co-occurring diagnosis was major depression, with 41% (*n*=16) of youth having received this diagnosis.

Findings

One former and five current staff persons at AAYRTC participated in key informant interviews concerning the impact of ASB issues on Medicaid and CHIP reimbursement at the facility. The interviews addressed a range of concerns, including the characteristics of residents at AAYRTC, the financial underpinning of the program, the history of Medical Assistance at the facility, ASB issues related to Medicaid and CHIP, and the consequences of inadequate funding for the program. During the interviews, participants also offered several suggestions to redress ASB issues.

Characteristics of the Residents at AAYRTC—During the course of their interviews, participants referenced various characteristics of the adolescents that AAYRTC serves. The YRTC has drawn clients from across the nation, but it endeavors as a regional treatment center to focus on residents of South Dakota, North Dakota, Nebraska, and Iowa. Prospective clients must prove either enrollment in a recognized Tribe or lineal descent from AI/AN forbearers, and they must have received a diagnosis of substance abuse from a clinician. According to oral reports by a participant, "between 75 and 80% of the individuals" who come to AAYRTC are enrolled in Medicaid. Respondents reported that adolescents at the facility often present with co-occurring disorders, including attention-deficit hyperactivity disorder, bipolar disorder, and suicidal ideation.

According to one participant, most of the residents, including youth as young as 12 years, arrive at AAYRTC with a history of sexual activity. Another respondent reported that many of both female and male residents have reported a history of sexual abuse.

AAYRTC's Program—Respondents indicated that treatment at AAYRTC generally requires between 60 and 120 days and includes individual, group, and family counseling; substance abuse and dual diagnosis assessments, education, and treatment; academic education through a South Dakota State Certified Alternative Education Program; attendance at 12-Step meetings; 12-Step work and relapse prevention; adventure therapy experience; health promotion and disease prevention; psychological counseling; life skills development; leadership development; aftercare planning; and follow-up contacts. AAYRTC primarily serves adolescents from South Dakota, North Dakota, and Nebraska but also has treated youth from Montana and Iowa. AAYRTC has served adolescents from 19 Federally-Recognized Tribes; according to the participants, AAYRTC integrates culturally sensitive activities, such as sweat lodge, Native crafts, and Native music, into all phases of its program.

AAYRTC's Current Budget, Including Medicaid Funding—Almost all the funding that underwrites AAYRTC and its activities derives from the facility's annual Federal appropriation; despite focused efforts to improve its receipts from Medical Assistance, AAYRTC generates only marginal revenue from Medicaid. One participant in the study recollected about the first years of the YRTC's existence: "When we first started out, the only thing that we were operating on was the actual 570, Public Law 99-570, dollars, with a little bit under two million dollars at that time." According to another respondent, this original funding stream, which is currently $2,059,685, is "the account that we do most of our everyday business, all the activities." Another fund of $90,416 allows AAYRTC to cover "supplies to run the facility and for the upkeep." AAYRTC is an approved Medicaid provider in its home State. AAYRTC realized only $32,067.50 in revenues from Medicaid

in the last fiscal year. One respondent noted that residents referred to AAYRTC from the State of South Dakota typically have had previous treatments that depleted their Medicaid funding for treatment at AAYRTC; this fact accounts for why its Medicaid revenues even from its home State have been a relatively small part of the institution's budget.

AAYRTC's Medicaid ASB Experience—Staff from AAYRTC has undertaken considerable efforts over the years to qualify the facility as a Medicaid provider in North Dakota, Nebraska, Iowa, and Wyoming. AAYRTC has encountered different obstacles in each of the States where it has applied to qualify as a Medicaid provider. One respondent noted that Nebraska asked the facility to have:

> " . . . a full-time psychologist on board, a licensed marital family therapist, and then . . . 24-hour access to a psychiatrist. So once we met all of that criteria, then they told us that we had to provide culturally relevant treatment to that population, which we did. But they were just looking for ways, from my perspective, of not paying us or approving for reimbursement for any of the Nebraska youth."

The North Dakota application also failed to make AAYRTC an approved Medicaid provider in that State. The participant who described the problems the Nebraska application encountered also described the disposition of the North Dakota submission:

> "With the state of North Dakota, they basically told us that they did not pay for alcohol and substance abuse treatment outside the state of North Dakota system and what we had to qualify there, was a co-occurring disorder that had to accompany this alcohol substance abuse diagnosis and basically we did that. Once we got a full-time psychiatrist on-board and we also had a licensed marital family therapist on-board as well. . . . It's been quite a challenge and has been quite a challenge to get the proper staffing levels for Chief Gall instituted to meet the criteria.

AYRTC has also encountered problems even with the basic process of obtaining an application package to qualify as a Medicaid provider. AAYRTC requested an application package from Wyoming, but YRTC staff never received a response from the State to this request. AAYRTC has recently commenced a process to resubmit applications to qualify as a Medicaid provider in these States.

The Effect of ASB Impediments on AAYRTC's Programming—The respondents offered a variety of opinions about the ways that the lack of Medicaid reimbursement from States outside of South Dakota affected AAYRTC. One participant noted the inequity inherent in the failure of States to support the costs of their Medicaid beneficiaries' treatment:

> "Well, you know basically when the clients do come from different States . . . I mean basically we're just paying it directly out of our budget. . . . I mean, we're flipping the bill, basically. And there are a lot of costs involved."

Another respondent offered the opinion that the level of care at AAYRTC had become stagnant. He estimated that the facility was annually losing between $300,000 and $500,000 of receivables as the result of States outside of AAYRTC. With that level of additional funding, the informant noted:

> "We could have added the 24-hour nursing onsite and . . . recruited maybe a licensed social worker and definitely been able to compete with better RTC's in offering competitive salaries with regard to licensed addiction counselors."

Other respondents similarly observed that additional funding would afford the ability to hire a cultural educator, a recreational specialist, or a mental health specialist and afford the facility the ability to offer more opportunities to the residents, such as taking them to more AA meetings in Mobridge.

Effect of ASB Issues on Medical Care for Residents—Across State Border issues at AAYRTC also affect AI adolescent Medicaid and CHIP beneficiaries in need of medical care. The IHS maintains two facilities within a relatively lengthy driving distance, a clinic at McLaughlin and a hospital at Fort Yates, so obtaining medical services for the residents at AAYRTC is not an insurmountable obstacle, but it nevertheless presents challenges. As one key informant noted:

> "The hospital, the IHS hospitals are in McLaughlin and Fort Yates. Since we have limited staff, it's always hard to try to get the staff lined up in addition to take residents to the different clinics that are so far away when we're close to Mobridge right here, you know just a few miles down the road. Where if they did (have useable health coverage), we could take them right next door here."

As this key informant inferred, a resident with South Dakota Medicaid who has a medical condition that needs attention while at AAYRTC has a less complicated interaction with the health care system than does a resident with out-of-state Medicaid. Another respondent specifically commented on this circumstance when she observed:

> "We get kids like from Montana, Wyoming, all those different states you've seen, and say they have to go to the doctor. We can't take them to the doctor in Fort Mobridge. Their Medicaid is no good. . . . We had a young man who had an emergency and had to go to Mobridge clinic, and he had (South Dakotan) Medicaid. It was really nice. We didn't have to go all the way to Fort Yates and sit there and wait. We could take him right across the bridge into Mobridge Emergency Room, and they were back like within 45 minutes."

The respondent observed that the Fort Yates Hospital is a 50-minute drive from AAYRTC, so the trips to and from the hospital, in combination with the wait at the hospital, exacted a stressful toll on both the adolescent and the accompanying staff person.

Recommendations by Participants to Reduce ASB Issues—During the course of the interviews, participants identified a number of activities and policy changes that might redress some of the ASB issues that YRTCs face. One respondent recommended the need for persistence in the face of the obstacles that States place in the pathway to recognition as a Medicaid provider:

> "I think you have to be very adamant and very consistent in what you're doing and the follow-through part of it on the process. And not taking the "no" or the "no responses." And answer and keeping up with it, I guess, is the biggest part."

Another participant recommended the need to qualify as a Medicaid provider at the highest possible level of care in the YRTC's home State before applying to other States to qualify as a Medicaid provider:

> "I would say for them to work with the State that they're located in and get the highest level of care qualified . . . and then branch out to the neighboring States that they expect to . . . receive referrals from. It seems a fairly successful model and one that Desert Visions in Sacaton, AZ focused on. They qualified in Arizona first and then (applied) to qualify themselves in California and New Mexico as well."

Several times during their interviews, both of these respondents expressed the belief that an OMB rate for YRTCs would resolve the problems that these institutions face in negotiating their ASB reimbursement problems.

Aberdeen Area Youth Regional Treatment Center Site Visit: Summary of ASB Findings

Consistent with findings from the Circle of Nations case study, respondents from AAYRTC described reluctance on the part of States to qualifying an out-of-state institution as a Medicaid provider. Respondents explained that States would set up roadblocks to their qualification, and when AAYRTC had addressed the States' concerns, States would present new issues not previously identified. One State had gone so far as to simply refuse to send an application to initiate the process. Consistent with the recommendations of staff at NSRTC, knowledgeable staff at AAYRTC called for the establishment of an OMB Rate for all YRTCs as a means to resolve their issues.

Conclusion

The site visits to Circle of Nations, NSRTC, and AAYRTC lend themselves to various conclusions. The necessity inherent in the present system that a health care provider in one State must qualify as a Medicaid provider for every State where a potential client might be enrolled was a recurrent theme in various ways across the 3 sites. If policies were implemented to reduce the burden on providers qualified in one State to qualify in other States, this reform might facilitate the ability to provide services to out-of-state Medicaid/CHIP beneficiaries. Consistent policies among the States for youth enrolled in one State's Medicaid or CHIP program to receive health care in another State would resolve situations where no State assumes responsibility for health care of these young people. Third party clearinghouses in the several States have different e-billing protocols; this variability hinders the ability of some relatively small institutions that serve clients from multiple States to establish relationships with Medicaid programs in the various States.

Successful navigation of the current system appears to rely on the personal characteristics of individuals within institutions. Some comments from respondents, for instance, suggested the need for personal relationships in State Medicaid offices to resolve problems; the establishment in State Medicaid offices of central points of contact for out-of-state providers might relieve some of the need to cultivate such relationships to work out problems. The tenacity of individuals within an institution to pursue remedies to ASB problems often resulted in success, so another recommendation to institutions seeking to address ASB challenges would be to identify staff who are experienced in Medicaid/CHIP and who have established a record of success in navigating these problems.

Finally, the most AI/AN-specific solution to the problems that the YRTCs face is the establishment of an OMB Rate. Such an all-inclusive rate would relieve these institutions of the need to negotiate with multiple States and permit them to realize a more reliable funding stream without the need to negotiate State-to-State variability in eligibility requirements and reimbursement rates.

Footnotes

[1]New Mexico sponsors a program called, Medicaid On-Site Application Assistance (MOSAA). The program allows staff in an eligible agency or organization to receive training to give Medicaid applications to children and pregnant women, gather the information required to determine eligibility, and conduct an eligibility interview. Unlike Presumptive Eligibility, acceptance in the program is not immediate, but once the local Income Support Division office has approved an application, the application can result in 12 months of Medicaid eligibility for children; coverage for pregnant women (which includes two months of post-partum care); and one year of family planning Medicaid coverage for women.

[2]C2 is one of the categories of drugs known as "controlled substances." A C2 drug is also known as a Schedule II substance or C-II drug. Such drugs are considered to have a high potential for abuse.

Appendix I

Methods

The examination of policies and practices related to ASB issues for AI/AN Medicaid and CHIP beneficiaries suggested the need for in-depth examination of different aspects, conditions, and nuances of a number of interrelated questions. Given the number and complexity of issues, a case study approach is the most appropriate method to understand them. Case studies are empirical inquiries that may employ qualitative or quantitative methods to explore ongoing complex social phenomena within their real-life context and boundaries.

In April 2010, CMS sought the advice of members of the ASB Subcommittee of the Tribal Technical Advisory Group (TTAG) concerning prospective sites for the case studies. With input from these TTAG members, CMS asked researchers from KAI to conduct case studies at Circle of Nations, NSRTC, and AAYRTC. In late April 2010, a team of three researchers from KAI made preliminary visits to Circle of Nations and AAYRTC to present the study to officials in those institutions. Research staff from KAI subsequently recruited NSRTC by phone.

After KAI received the consent from each of these institutions to participate, staff scheduled site visits for Circle of Nations on May 24 and 25, 2010, AAYRTC on May 26, 2010, and NSRTC on June 7 and 8, 2010. During each of these site visits, an experienced qualitative researcher collected data in face-to-face key informant interviews with staff at all the facilities and, in the case of Circle of Nations, from vendors who provide various health care services to the Medicaid/CHIP beneficiaries at the school. During each of the site visits, the researcher also collected assorted printed materials that described aspects of the respective programs and reports that documented the residents' demographic data. The researcher toured the facilities and made observations of activities in the institutions. In addition, this same researcher, between June 11 and 21, 2010, interviewed by

telephone five key informants who for different logistical reasons were unavailable for interviews during the site visits to AAYRTC and Circle of Nations.

After obtaining a respondent's written informed consent, the researcher digitally recorded the interview and subsequently transcribed the interview for analysis. One of six respondents from AAYRTC declined to allow the interview to be digitally recorded but did permit the researcher to take written notes of the responses to questions; no other participants declined to have their interviews recorded. The researcher also wrote field notes at the conclusion of each interview.

Questions in the interviews were semi-structured and moved from the general to the specific. The researcher from KAI asked open-ended questions that encouraged participants to explain their experiences with AI/AN youth who were enrolled in Medicaid/CHIP in another State. At various points in the data collection, participants volunteered voluminous data with prompting from just a relatively few questions. In addition, during the course of the interviews, various respondents offered comments that prompted the researcher to ask spontaneous questions for clarification or elucidation. With the exception of these caveats, four fully developed interview protocols with both questions and prompts, one each respectively for the administrators and line staff at the treatment facilities and school, guided the collection of data from participants. Each interview lasted 45 minutes to an hour-and-a-half.

A total of 28 individuals participated in the three case studies. The criterion for participation in the study was that a respondent needed to be generally knowledgeable about (1) Medicaid/CHIP issues at the organization, (2) Medicaid/CHIP issues as they apply to AI/AN youth beneficiaries who crossed State borders and required access to health care, or (3) the programmatic issues at the institution. No Institutional Review Boards reviewed the project; participants were adult key informants exempt from human subject provisions under 45 CFR 46.101(b)(2), since they were

professionals giving opinions on matters related to their expertise, and their contribution to the project could not place them at any personal risk.

Prior to traveling to the facilities, the KAI researcher who conducted the site visits explained these criteria to the officials at each of the facilities to ensure the inclusion of appropriate participants. The Acting Directors of AAYRTC and NSRTC recruited respondents at those two institutions. The Director of Health Services at Circle of Nations recruited participants at the school. None of the respondents received an incentive for participation in the study. Since Circle of Nations is not a governmental institution, it was offered and accepted an incentive of $1,000.00 to participate in the case study.

As Table 1 depicts, 18 of the respondents in the study were female and 10 of the respondents, male.

Table 1

Participants' Genders by Case Study Site and Study Sample

Group	Circle of Nations	NSRTC	AAYRTC	Total
Males	5	3	2	10
Females	9	5	4	18
Total	14	8	6	28

The researcher who visited the sites and conducted the interviews also analyzed the data. He employed a systematic approach to the analysis of the data and the verifiability of the findings. Steps included the execution of a transcript based upon the digital recording; creation of a word processing file for the text; and the analysis of the data using a qualitative software package, NVivo8. The analysis considered both verbal and non-verbal reactions of the participants and included

words, context, internal consistency, and the frequency, extensiveness, intensity, and specificity of comments. When the researcher who conducted the analysis needed clarification about a point that a respondent made, he contacted the participant (n=4) by email with follow-up questions. In each case, the respondents supplied their responses to these questions in return emails.