DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
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Center for Medicaid and State Operations

Dear State Health Official:

This letter is one of a series that provides guidance on the implementation of the American Recovery and Reinvestment Act of 2009 (Recovery Act), Public Law 111-5. Section 5006 of the Recovery Act provides protections for Indians in Medicaid and the Children's Health Insurance Program (CHIP). The amendments made by this section take effect on July 1, 2009. This letter provides a brief overview of these provisions to assist you with implementation of these new provisions for Indians in your programs.

In keeping with the Department of Health and Human Services (HHS) Tribal consultation policy and the new provisions in the Recovery Act, the Centers for Medicare & Medicaid Services (CMS) collaborated and consulted with the Tribal Technical Advisory Group (TTAG) and the Indian Health Service (IHS) to solicit advice on implementing these provisions. The Tribal Affairs Group and the Center for Medicaid and State Operations within CMS jointly hosted two All Tribes Calls on June 5, 2009 and June 12, 2009 to consult on implementation of section 5006 of the Recovery Act. Two face-to-face consultation meetings were held in Denver on July 8, 2009 and July 10, 2009 to solicit advice and input from federally-recognized tribes, Indian health providers and Urban Indian Organizations on these provisions. An All States Call was held on June 10, 2009, with the State Medicaid and CHIP programs to describe the CMS tribal consultation process on the Recovery Act provisions and solicit feedback and questions from the States.

Premiums and Cost Sharing Protections Under Medicaid and CHIP

The Social Security Act (the Act) allows States to impose enrollment fees, premiums, cost sharing and similar charges under certain conditions on Medicaid participants under title XIX and CHIP participants under title XXI of the Act. The Medicaid provisions are at section 1916 of the Act for nominal premiums and cost sharing and at section 1916A of the Act for alternative premiums and cost-sharing, as authorized by the Deficit Reduction Act of 2005 (DRA), Public Law 109-171.

Section 5006(a) of the Recovery Act amends sections 1916 and 1916A of the Act, to exempt American Indian and Alaska Native (AI/AN) applicants and participants from Medicaid premium and cost sharing requirements under certain circumstances and to assure that Indian health providers, and those providing Contract Health Services (CHS) under a referral from an Indian Health Provider, will receive full payment. Premiums and cost sharing exemptions for AI/ANs under CHIP are not affected. These provisions take effect on **July 1, 2009**.

Specifically, the Recovery Act:

- Excludes Indians from payments of enrollment fees, premiums, or similar charges if they are furnished an item or service directly by the IHS, an Indian Tribe, Tribal Organization, or Urban

Indian Organization or through referral under CHS for which payment may be made by Medicaid.

- Excludes Indians from payment of a deductible, coinsurance, copayment, or similar charge for any item or service covered by Medicaid if the Indian is furnished the item or service directly by the IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under CHS.
- Prohibits any reduction of payment that is due under Medicaid to the IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization or to a health care provider through referral under CHS for furnishing an item or service to an Indian. The State must pay these providers the full Medicaid payment rate for furnishing the item or service. Their payments may not be reduced by the amount of any enrollment fee, premium, deduction, copayment, or similar charge that otherwise would be due from the Indian.

Definitions

In administering the Recovery Act's cost sharing provisions related to Indians, CMS will use the following definitions:

- "Indian Health Care Provider" means an Indian Health Program or an Urban Indian Organization. An Indian Health Program is defined at 42 C.F.R. §136.1 as the health service program for Indians administered by the IHS within HHS. This definition also encompasses facilities known as I/T/Us (Indian Health Service Providers/Tribal Health Service Providers/Urban Indian Health Programs or Organizations).
- "Indian" has the meaning found at 42 C.F.R. §136.12 that is used by IHS and includes both American Indians and Alaska Natives. It includes individuals who are enrolled as a member of a federally-recognized tribe, individuals of Indian descent belonging to the Indian community served by the local Indian facilities and programs, and individuals who are regarded as an Indian by the community in which he or she lives.

Indian Health Service is responsible for the CHS Program, which provides for medical/dental care provided away from an IHS or tribal health care facility. The State Medicaid program will need to work closely with Indian Health Service and Indian tribes that operate CHS programs within the State to determine what documents will be used by the CHS for referrals to non-Indian health care providers under the program. The State will need to educate non-Indian health care providers about what documents are used to identify CHS referrals so that providers will know that cost sharing is to be waived.

For more information about the CHS program, the State may access reference materials about CHS on the Indian Health Services web pages at http://www.ihs.gov/NonMedicalPrograms/chs/.

Exemption of Certain Property from Resources for Medicaid and CHIP Eligibility

Section 5006(b) of the Recovery Act amends Medicaid law under title XIX of the Social Security Act (the Act) and CHIP law under title XXI of the Act to require States to exclude certain types of Indian-specific property from being considered as "resources" when determining Medicaid or CHIP eligibility for an individual who is an Indian. These resource exclusions become effective **July 1, 2009.**

Basically, the Recovery Act requires States to exclude resources in two categories:

- Property connected to the political relationship between Indian tribes and the Federal government;

and

- Property with unique Indian significance.

The following resources must be excluded:

1. Property, including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including any federally-recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior.
2. For any federally-recognized Tribe not described in paragraph (1), property located within the most recent boundaries of a prior Federal reservation.
3. Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights.
4. Ownership interests in or usage rights to items not covered by paragraphs (1) through (3) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

Attached is additional guidance on consideration of income and conversion of resources for Medicaid eligibility of Indians. It is important to note that the Recovery Act's provisions did not change the treatment of income for Medicaid or CHIP eligibility purposes. Income that was protected under previous laws or rules will still be protected, and income that was counted under previous laws or rules will still be counted.

<u>Continuation of Current Protections for Certain Indian Property from Medicaid Estate Recovery</u>

Certain AI/AN income, resources, and property have been exempt from Medicaid estate recovery since April 1, 2003. The specific exempted income, resources, and property are listed in the State Medicaid Manual at section 3810.A.7. Section 5006(c) of the Recovery Act amends section 1917(b)(3) of the Social Security Act to codify these exemptions.

The specific income, resources, and property exempted from Medicaid estate recovery for AI/AN are:

1. Certain income and resources (such as interests in and income derived from Tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;
2. Ownership interest in trust or non-trust property, including real property and improvements:
    a. Located on a reservation (any federally-recognized Indian Tribe's reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established by Alaska Native Claims Settlement Ac,t and Indian allotments) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or
    b. For any federally-recognized Tribe not described in (a), located within the most recent boundaries of a prior Federal reservation.
    c. Protection of non-trust property described in (a) and (b) is limited to circumstances when it passes from an Indian (as defined in section 4 of the Indian Health Care

Improvement Act (25 U.S.C. §1603)) to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a Tribe and non-Indians, such as spouses and step-children, that their culture would nevertheless protect as family members; to a Tribe or Tribal Organization; and/or to one or more Indians;

3. Income left as a remainder in an estate derived from property protected in 2 above, that was either collected by an Indian, or by a Tribe or Tribal Organization and distributed to Indian(s), as long as the individual can clearly trace it as coming from the protected property.
4. Ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally-protected rights, and income either collected by an Indian, or by a Tribe or Tribal Organization and distributed to Indians(s) derived from these sources as long as the individual can clearly trace it as coming from protected sources; and
5. Ownership interests in or usage rights to items not covered by 1-4 above that have unique religious, spiritual, traditional, and/or cultural significance or rights that support subsistence or a traditional life style according to applicable Tribal law or custom.

<u>New Rules Regarding Indians, Indian Health Care Providers, and Indian Managed Care Entities in Medicaid and CHIP Managed Care Programs</u>

AI/ANs who are eligible for Medicaid or CHIP may elect to enroll in Medicaid or CHIP managed care entities on a voluntary basis. They may be enrolled on a mandatory basis under a Medicaid or CHIP waiver or when certain conditions regarding participation by Indian Health Care providers are met in a program operating under State plan authority.

Section 5006(d) of the Recovery Act adds new subsection 1932(h) of the Act, which will apply consistent rules governing the treatment of Indians, Indian Health Care Providers (IHCPs), and Indian Managed Care Entities (IMCEs) that are part of a State's Medicaid or CHIP managed care program. The term Indian Health Care Providers (IHCPs) also encompasses facilities known as I/T/Us (Indian Health Service Providers/Tribal Health Service Providers/Urban Indian Health Programs or Organizations).

Under this provision, all contracts with Medicaid and CHIP managed care entities, which include Medicaid and CHIP managed care organizations (MCOs) and primary care case managers (PCCMs), must:

- Permit any Indian who is enrolled in a non-Indian managed care entity and eligible to receive services from participating IHCP, to choose that IHCP as his or her primary care provider, as long as that provider has capacity to provide the services;
- Require each managed care entity to demonstrate that there are sufficient IHCPs in the network to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers;
- Require that IHCPs, whether participating or not, be paid for covered Medicaid or CHIP managed care services provided to Indian enrollees who are eligible to receive services from such providers either (1) at a rate negotiated between the managed care entity and the IHCP, or

(2) at a rate not less than the level and amount of payment that would be made if the provider were not an IHCP; and

- Provide that the managed care entity must make prompt payment to all IHCPs in its network as required for payments to practitioners in individual or group practices under 42 C.F.R. §§ 447.45 and 447.46.

The rules governing payment to IHCPs will apply to States where the IHCP is part of a PCCM program reimbursed under fee-for-service (FFS).

CMS plans to develop regulations to address the application of the requirement for sufficient IHCPs in States where there are few or none available.

IHCPs, whether participating or not, that receive reimbursement as federally qualified health centers (FQHCs) are entitled to receive FQHC payment rates, including any supplemental payment from the State to make up the difference between the amount the managed care entity pays and what the IHCP/FQHC would have received under the State Plan.

IHCPs, whether participating or not, that do NOT receive reimbursement as FQHCs are entitled to receive the same payment as they would if the services provided to the Indian enrollee were provided under the State plan. Where the amount a subcontracting IHCP receives from a managed care entity is less than this, the State must make a supplemental payment to the IHCP to make up the difference between the amount the managed care entity pays and what the IHCP would have received under the State plan.

The term Indian Managed Care Entity (IMCE) means a managed care entity that is controlled by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which may also include the Indian Health Service.

In a Medicaid or CHIP managed care program, an IMCE may restrict its enrollment to Indians in the same manner as Indian Health Programs may restrict the delivery of services to Indians.

<u>Consultation on Medicaid, CHIP, and Other Health Care Programs Funded under the Act Involving Indian Health Programs and Urban Indian Organizations</u>

Section 5006(e) of the Recovery Act includes in statute the requirement for the Secretary of Health and Human Services (HHS) to maintain a Tribal Technical Advisory Group (TTAG) within the Centers for Medicare & Medicaid Services (CMS). The TTAG, initially established in accordance with a charter dated September 30, 2003, is now required to include a representative of Indian Health Services (IHS) and a representative of a national Urban Indian Organization.

The Recovery Act also amends the Social Security Act at section 1902(a)(73) for Medicaid and section 2107(e)(1)(C) for CHIP. Effective July 1, 2009, certain States are required to utilize a process for the State to seek advice on a regular, ongoing basis from designees of the IHS and Urban Indian

Organizations concerning Medicaid and CHIP matters having a direct effect on these IHS or Urban Indian Organizations. The consultation process must be followed by any State in which 1 or more Indian Health Programs or Urban Indian Organizations furnish health care services, even if no federally-recognized Indian tribes are located within the State. These States are required to solicit advice from federally-recognized Indian Tribes and federally-recognized Indian tribes, Indian health providers (including those operating programs through IHS agreements), and Urban Indian health providers prior to the State's submission of any Medicaid or CHIP State plan amendment, waiver request, or proposal for a demonstration project likely to have a direct effect on Indians, IHS, or Urban Indian Organizations. The consultation may include the appointment of an advisory committee or a designee of these IHS and Urban Organizations to the State medical care advisory committee required by 42 C.F.R. §431.12, both, or another method. Attached is a draft Medicaid State Plan template that a State may use for a State plan amendment to document its process for such consultation.

CMS has previously provided guidance on the consultation process with federally-recognized Indian Tribes, which may be found in the July 17, 2001 State Medicaid Director Letter, requiring State consultation with federally-recognized Indian Tribes for waivers. The process must now be expanded to include all IHS (including those Tribes operating programs through IHS agreements) and Urban Indian Organizations and must extend to Medicaid and CHIP State Plan amendments, as well as waiver proposals, amendments, and renewals. The above-referenced letter can be found on the CMS website at http://www.cms.hhs.gov/smdl/downloads/smd071701.pdf.
http://www.cms.hhs.gov/smdl/downloads/smd071701.pdf .

Because the requirement is to consult prior to submission of a State plan amendment or waiver, States should be prepared to begin the consultation process for proposals to take effect on or after July 1, 2009. For example, if a State is proposing a Medicaid or CHIP change to take effect on July 1, 2009, and the change is likely to have a direct effect on Indians, IHS, or Urban Indian Organizations, the State must notify and solicit advice from all the IHS providers, Urban Indian Organizations, and federally-recognized Indian Tribes in the State no later than August 1, 2009, since CMS must receive the State plan amendment by September 30, 2009.

Examples of changes that would have a direct effect on Indians, IHS, or Urban Indian Organizations include Medicaid or CHIP changes that are more restrictive for eligibility determinations, changes in payment rates or methodologies to Indian Health providers or for services reimbursed to Indian Health providers, reductions in covered services, changes in consultation policies, and proposals for demonstrations or waivers that may impact Indian people or Indian health providers.

Contact Information

If you have questions regarding this guidance, please contact Ms. Dianne E. Heffron, Acting Director, Family and Children's Health Programs Group, who may be reached at (410) 786-5647.

Sincerely,

Cindy Mann
Director
Center for Medicaid and State Operations

Enclosures

- Draft Medicaid State Plan Amendment Preprint
- Additional guidance for consideration of income and resources for Medicaid eligibility of Indians

cc:

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