

MEDICAID SERVICES MANUAL  
TRANSMITTAL LETTER

March 24, 2020

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: CODY L. PHINNEY, DEPUTY ADMINISTRATOR */Cody L. Phinney/*

SUBJECT: MEDICAID SERVICES MANUAL CHANGES CHAPTER 3000 –  
INDIAN HEALTH

**BACKGROUND AND EXPLANATION**

Revisions to Medicaid Services Manual (MSM) Chapter 3000, Section 3003.1 – Health Services are being proposed to allow the opportunity for Tribal or Tribal Organization outpatient health clinics to enroll as Federally Qualified Health Centers (FQHCs). This service model will promote greater access to specialty and related services outside of the four walls of the tribal clinics for Medicaid eligible American Indian/Alaska Native (AI/AN) recipients.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: Federal, State and Tribal Governmental Agencies.

Financial Impact on Local Government: Unknown at this time.

These changes are effective March 25, 2020.

<b>MATERIAL TRANSMITTED</b>	<b>MATERIAL SUPERSEDED</b>
MTL 12/20 MSM Ch 3000 – Indian Health	MTL 22/14 MSM Ch 3000 – Indian Health

<b>Manual Section</b>	<b>Section Title</b>	<b>Background and Explanation of Policy Changes, Clarifications and Updates</b>
<b>3003.1</b>	<b>Health Services</b>	To include new policy for tribal organizations selecting to be recognized as Tribal FQHCs.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL  
TABLE OF CONTENTS

INDIAN HEALTH PROGRAM

3000	INTRODUCTION .....	1
3001	AUTHORITY .....	1
3002	DEFINITIONS.....	1
3003	POLICY .....	1
3003.1	HEALTH SERVICES.....	1
3003.2	TRIBAL GOVERNMENTS.....	4

	MTL 22/14
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 3000
MEDICAID SERVICES MANUAL	Subject: INTRODUCTION

3000 INTRODUCTION

Medically necessary (as defined in Medicaid Services Manual (MSM) Chapter 100 (Medicaid Program) services are reimbursable when the services are provided by an Indian Health Program to an eligible American Indian or Alaskan Native (AI/AN) Medicaid or Nevada Check Up recipient. Indian Health Programs may be operated by the Indian Health Service (IHS), Tribal Organization, or an Urban Indian Organization – (I/T/U).

Numerous public laws guide federal and state interactions with tribal governments and AI/ANs. A basic understanding of these laws is essential to help facilitate the collaborative relationship between the Division of Health Care Financing and Policy (DHCFP) and the tribes within the State of Nevada. Below is a brief summation of these laws.

**WORCESTER V. GEORGIA (1832):** The Supreme Court of the United States held that the federal government, and not state governments, had exclusive “authority over American Indian Affairs”.

**GENERAL ALLOTMENT ACT OF 1877**

The Act authorized the President of the United States to partial reservation lands into general allotments. Federal trust land owned or possessed by an AI/AN may be exempt from Medicaid estate recovery.

**SNYDER ACT OF 1921**

The Act made the federal government responsible for the health care of AI/ANs.

**INDIAN CITIZENSHIP ACT OF 1924**

The Act granted AI/ANs dual citizenship.

**INDIAN REORGANIZATION ACT OF 1934**

The Act reversed the General Allotment Act. The Act reinstated self-governance and returned tribal lands to respective tribal governments.

**INDIAN SELF-DETERMINATION AND EDUCATION ASSISTANCE ACT OF 1975**

Prior to this Act, the federal government managed, coordinated, and provided health care services for AI/ANs. The Act authorized tribal governments to establish contracts and compacts with the federal government. In general, tribal governments may plan, conduct and administer their own public programs – to include Indian Health Programs.

	MTL 22/14
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 3000
MEDICAID SERVICES MANUAL	Subject: INTRODUCTION

#### INDIAN HEALTH CARE IMPROVEMENT ACT OF 1976

The Act authorized 100% federal reimbursement to states for medical services provided to AI/ANs when provided through the Indian Health Service (IHS) and/or tribal organizations.

#### AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009

The Act established:

- Guidelines surrounding the enrollment of AI/ANs in Medicaid Managed Care Organizations (MCO);
- Prohibitions of state Medicaid agencies from charging AI/AN premiums and cost shares for services provided through Indian Health Programs or tribal organizations to AI/ANs;
- Protections of certain properties held by AI/AN from federal or state recovery; and
- Mandates that states seek ongoing advice from Indian Health Programs on issues that are likely to have a direct effect on Indian Health Programs.

#### PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

The Act reauthorized and made permanent the Indian Health Care Improvement Act.

	MTL 22/14
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 3001
MEDICAID SERVICES MANUAL	Subject: AUTHORITY

3001 AUTHORITY

- Public Law (PL) 49-43: General Allotment Act of 1877
- PL 67-85: Snyder Act of 1921
- PL 68-175: Indian Citizenship Act of 1924
- PL 73-383: General Allotment Act of 1934
- PL 93-638: Indian Self-Determination and Education Act of 1975
- PL 94-437: Indian Health Care Improvement Act of 1976
- Social Security Act (SSA), Title XIX (Grants to States for Medical Assistance Programs), Chapter 1905 (Definitions), Section (b)
- SSA, Title XIX, Chapter 1911 (Indian Health Service Facilities)
- SSA, Title XIX, Chapter 1916A (State Option for Alternative Premiums and Cost Sharing)
- SSA, Title XIX, Chapter 1917 (Liens, Adjustments and Recoveries, and Transfers of Assets)
- SSA, Title XIX, Chapter 1932 (Provisions Relating to Managed Care)
- United States Code (USC), Title 25 (Indians), Chapter 14 (Miscellaneous), Subchapter II (Indian Self-Determination and Education Assistance)
- USC, Title 25 (Indians), Chapter 18 (Indian Health Care)
- Code of Federal Regulations, Title 42 (Public Health), Chapter IV (Centers for Medicare & Medicaid Services, Department of Health and Human Services), Section 431.110 (Participation by Indians Health Service Facilities)
- Johnson v. McIntosh (1823)
- Worcester v. Georgia (1832)
- United States v. Wheeler (1978)

	MTL 22/14
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 3002
MEDICAID SERVICES MANUAL	Subject: DEFINITIONS

3002 DEFINITIONS

A. American Indians and Alaskan Natives (AI/AN)

In accordance with 25 USC, Section 1602: “The term [eligible] Indians or Indian, unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) hereof, except that, for the purpose of Sections 1612 and 1613 of this title, such terms shall mean any individual who:

1. Irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band or other organized group of Indians, including those tribes, bands or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member, or
2. Is an Eskimo or Aleut or other Alaska Native, or
3. Is considered by the Secretary of the Interior to be an Indian for any purpose, or
4. Is determined to be an Indian under regulations promulgated by the Secretary.”

B. Children, Eligible

“Any individual who:

1. has not attained 19 years of age;
2. is the natural or adopted child, stepchild, foster child, legal ward or orphan of an eligible Indian; and
3. is not otherwise eligible for health services provided by the Indian Health Service (IHS), shall be eligible for all health services provided by IHS on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age.”

C. Indian Descent, Eligible

Indian descendants may be eligible for Indian health services if:

1. They are verifiable descendants of an enrolled tribal member – as established by each tribe;
2. The recipient belongs to an Indian community which may be verified by tribal

	MTL 22/14
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 3002
MEDICAID SERVICES MANUAL	Subject: DEFINITIONS

record or census number; and

3. The recipient lives within the established contract health service delivery area.

D. Indian Health Programs

Indian Health Programs include the IHS, Tribal Organizations and Urban Indian Organizations (I/T/U):

1. Indian Health Service: IHS is a federal agency within the Department of Health and Human Services (DHHS).
2. Tribal Organizations: Tribal Organizations are operated by tribal governments.
3. Urban Indian Organizations: Urban Indian Organizations are nonprofit organizations.

E. Pregnant Woman, Non-Indian, Non-Spouse, Eligibility

During the period of her pregnancy through postpartum – a non-Indian, non-spouse pregnant woman with an eligible Indian child is eligible for tribal organization health services on the same basis and subject to the same rules that apply to eligible Indians.

F. Sovereignty, Trust Relationship

Federally recognized tribes are sovereign governments. They may establish their own governments, establish tribal membership guidelines and create and enforce their own laws.

G. Tribes, Federally Recognized

Any Indian tribe, band, nation, or other organized group or community, which the Federal government recognizes as eligible for programs and services provided by the United States to AI/AN.

	<b>MTL 12/20</b>
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 3003
MEDICAID SERVICES MANUAL	Subject: POLICY

3003 POLICY

It is the policy of the DHCFP to follow State and Federal laws, uphold the tribal-state consultation process, and promote Indian Health Programs (IHP).

3003.1 HEALTH SERVICES

A. The DHCFP reimburses Indian Health Services (IHS), Tribal organizations and Tribal Federally Qualified Health Centers (FQHCs) at an outpatient encounter rate.

1. Encounter visits are limited to healthcare professionals as approved under the Nevada Medicaid State Plan. Each healthcare professional is considered an independent (i.e., separate) outpatient encounter.
2. Service Limits: Eligible Indians may receive up to five face-to-face IHS and/or Tribal Organization outpatient encounter/visits per day, per recipient, any provider.
3. Medical Necessity: In order to receive reimbursement, all services must be medically necessary as defined in the Medicaid Services Manual (MSM), Chapter 100 – Medicaid Program.
4. Tribes or Tribal organizations that choose to be recognized as a Tribal FQHC may receive reimbursement for services furnished by an enrolled Medicaid non-IHS/Tribal provider to AI/AN Medicaid recipient's when requested by a Tribal FQHC provider (refer to CMS SHO #16-002). Covered services include those in the Medicaid State Plan.
  - a. The Tribal FQHC and the offsite non-IHS/Tribal provider must have a written agreement in place that designates that the non-IHS/Tribal provider is a contractual agent furnishing services as part of the Tribal FQHC.
  - b. The written agreement between the non-IHS/Tribal provider and the Tribal FQHC provider must include:
    1. The Tribal FQHC provider makes a specific request for specific services to the non-IHS/Tribal provider;
    2. The non-IHS/Tribal provider must send information about the recipients care to the Tribal FQHC;
    3. The Tribal FQHC continues to assume responsibility for the recipient's care; and



	MTL 12/20
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 3003
MEDICAID SERVICES MANUAL	Subject: POLICY

4. The Tribal FQHC incorporates the recipient's information into their medical record.
- c. Both the Tribal FQHC and non-IHS/Tribal provider must be enrolled in Nevada Medicaid.
- d. There must be an established relationship between the recipient and the Tribal FQHC provider.
- e. The following services are not eligible:
  1. Services that are self-requested by the recipient.
  2. Services in which the Tribal FQHC does not remain responsible for the recipient's care.
  3. Services requested by a non-IHS/Tribal provider.
    - a. The provider could furnish and bill for services via their own Medicaid provider type but would not be eligible for reimbursement through the Tribal FQHC.

B. Primary Care Provider (PCP)

In accordance with the American Recovery and Reinvestment Act of 2009, the DHCFP supports eligible Indians in selecting an Indian Health Program as their PCP. These recipients may select an Indian Health Program as their PCP, whether they are enrolled in managed care or fee-for-service (FFS). Indian Health Programs that become PCPs for eligible Indians do not have to be, but may be, enrolled with either of the Managed Care Organizations (MCOs). Services which are referred out by PCPs must follow the service limitation and prior authorization requirements set forth by the applicable benefit plan (i.e., managed care or FFS).

C. Managed Care Enrollment

Eligible Indians are exempt from mandatory enrollment in managed care. In situations where Indians voluntarily enroll in managed care, they may access health care services from Indian Health Programs without restriction. Health care services provided to Indians through the IHS and/or tribal organizations may be reimbursed FFS or through the MCO.

D. Prior Authorizations

1. Medically necessary services provided by the IHS and/or Tribal Organizations do not require prior authorization when:

	MTL 22/14
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 3003
MEDICAID SERVICES MANUAL	Subject: POLICY

- a. The service is provided to an eligible Indian; and
- b. The service is provided through IHS or a Tribal Organization.

E. Program Funding

1. Premiums and Cost Sharing

- a. Adults – Age 21 and older: Eligible Indians may not be charged premiums or cost shares when they receive medical services through an Indian Health Program.
- b. Children – Age 20 and younger: Eligible Indian children may not be charged premiums or cost shares for covered Nevada Medicaid and/or Check Up services – regardless if the services are provided through an Indian Health Program, FFS providers or an MCO.

1. Federal Medical Assistance Percentage (FMAP)

The FMAP for services provided by the IHS or Tribal Organizations to eligible Indians is 100 percent. This percentage does not apply to non-emergency transportation services.

2. The FMAP for medical services provided by Urban Indian Organizations to eligible Indians is the established state percentage.

3. Rates

- a. IHS and Tribal Organization Clinics – Provider Type 47 (PT 47): PT 47s are paid the federally established Outpatient Per Visit Rate (i.e., encounter rate). The rate is adjusted annually by the federal government. The rate is posted on the Federal Register.
- b. Tribal Organization Inpatient Hospitals – Provider Type 51 (PT 51): PT 51s are paid the federally established Inpatient Hospital Per Diem Rate. The rate is adjusted annually by the federal government. The rate is posted on the Federal Register.
- c. IHS Inpatient Hospitals – Provider Type 78 (PT 78): PT 78s are paid the federally established Inpatient Hospital Per

	MTL 22/14
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 3003
MEDICAID SERVICES MANUAL	Subject: POLICY

Diem Rate. The rate is adjusted annually by the federal government. The rate is posted on the Federal Register.

F. Facility Licensure and Accreditation

1. IHS and Tribal Organizations:

- a. Licensure: Facility licensure is not required.
- b. Accreditation: In accordance with the Indian Health Care Improvement Act, to assure nondiscrimination, Indian Health Programs must follow the same provider enrollment criteria as other similar Medicaid provider types. The DHCFP does not require tribal clinics to be accredited.

G. Staff Licensure and Certification

Health care professionals do not have to be licensed in the State of Nevada if:

1. They provide services at an Indian Health Program; and
2. They are currently licensed in another state.

H. Transportation

1. Non-emergency transportation is not a covered IHS benefit. Indian Health Programs may enroll with the DHCFP's Non-Emergency Transportation (NET) broker (see MSM Chapter 1900).
2. Ambulance, Air or Ground – Provider Type 32: While emergency medical transportation is not a covered IHS benefit, qualified Indian Health Programs may enroll as a Provider Type 32 (see MSM Chapter 1900).

3003.2 TRIBAL GOVERNMENTS

A. Consultations

The DHCFP will consult with Tribes and Indian Health Programs on Medicaid State Plan Amendments (SPAs), waiver requests, waiver renewals, demonstration project proposals and/or on matters that relate to Medicaid and Nevada Check Up programs.

1. The notification will describe the purpose of the SPA, waiver request, waiver renewal, demonstration project proposal and/or on matters relating to Medicaid and

	MTL 22/14
DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 3003
MEDICAID SERVICES MANUAL	Subject: POLICY

Nevada Check Up programs and will include the anticipated impact on Tribal members, Tribes and/or Indian Health Programs.

2. The notification will also describe a method for Tribes and/or Indian Health Programs to provide official written comments and questions within a time-frame that allows adequate time for State analysis, consideration of any issues that are raised and the time for discussion between the State and entities responding to the notification.
3. Tribes and Indian Health Programs will be provided a reasonable amount of time to respond to the notification. Whereof, 30 days is considered reasonable.
4. In all cases where Tribes and/or Indian Health Programs request in-person consultation meetings, the DHCFP will make these meetings available.
5. The tribe-state consultation process allows for an expedited process for notification of policy changes due to budget cuts prior to changes being implemented. The Centers for Medicare and Medicaid Services (CMS) requires Medicaid SPAs, waiver requests and waiver renewals, which fall within this category to have a notification process prior to these documents being submitted to CMS. Due to this, the State is instituting an expedited process which allows for notification to the Tribes and Indian Health Programs of at least one week notice prior to the changes being implemented as agreed upon in the tribe-state consultation process or two weeks prior to the submission of the SPAs, waiver requests and/or waiver renewals, whichever date precedes.