Medicaid Services Manual
Transmittal Letter

January 28, 2025

To: Custodians of Medicaid Services Manual

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Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 3000- Indian Health Program

Background And Explanation

Revisions to Medicaid Services Manual (MSM) Chapter 3000 – Indian Health Program are being proposed to address the reimbursement methodology for pharmacy services for Tribal Health Clinics (THC) operating under the Indian Self-Determination and Education Act of 1975 (PL 93-638). These changes will allow THCs to receive one encounter per prescription filled and will not be limited to a certain number of prescriptions per day.

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: The proposed changes affect Medicaid-enrolled THCs operating under the PL 93-638 delivering pharmacy services. The only provider type (PT) this would impact is Indian Health Programs and Tribal Clinics (PT 47).

Financial Impact on Local Government: No financial impact is currently anticipated for local government.

These changes are effective February 1, 2025, pending Centers for Medicare and Medicaid Services (CMS) approval of the State Plan Amendment (SPA).

Material Transmitted	Material Superseded
MTL 01/25 Chapter 3000-Indian Health Program	MTL 12/20 Chapter 3000-Indian Health Program

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3003.1	**Health Services**	To revise the pharmacy services reimbursement methodology for tribal health clinics.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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INDIAN HEALTH PROGRAM

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 (IHP) to an eligible American Indian or Alaskan Native (AI/AN) Medicaid or Nevada Check Up recipient. IHPs 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 IHP.

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 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 IHP s 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 IHP s on issues that are likely to have a direct effect on IHP s.

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

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

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 (IHS 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 (CFR), Title 42 (Public Health), Chapter IV (Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (DHHS)), Section 431.110 (Participation by Indians Health Service Facilities)
- Johnson v. McIntosh (1823)
- Worcester v. Georgia (1832)
- United States v. Wheeler (1978)

3002 DEFINITIONS

A. 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 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 IHSs 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 record or census number; and

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

D. IHPs

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

1. Indian Health Service: IHS is a federal agency within 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.

3003 POLICY

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

3003.1 HEALTH SERVICES

A. DHCFP reimburses IHSs, 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 with the exception of pharmacy services.

3. Pharmacy Services: IHSs and Tribal 638 pharmacies will receive one encounter paid per prescription filled and will not be limited to a certain number of prescriptions per day. Pharmacies reimbursed using the all-inclusive rate will not be eligible for a dispensing fee.

4. Medical Necessity: In order to receive reimbursement, all services must be medically necessary as defined in the MSM, Chapter 100 – Medicaid Program.

5. 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

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.

The provider could furnish and bill for services via their own Medicaid provider type (PT) 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, DHCFP supports eligible Indians in selecting an IHP as their PCP. These recipients may select an IHP as their PCP, whether they are enrolled in managed care or fee-for-service (FFS). IHPs that become PCPs for eligible Indians do not have to be, but may be, enrolled with either of the 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 IHPs 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:

   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 IHP.

   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 IHP, 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 – (PT 47): PT 47 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 (PT 51): PT 51 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 – (PT 78): PT 78 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.

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, IHPs must follow the same provider enrollment criteria as other similar Medicaid PTs. 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 IHP; and

2. They are currently licensed in another state.

H. Transportation

1. Non-emergency transportation is not a covered IHS benefit. IHPs may enroll with DHCFP's Non-Emergency Transportation (NET) broker (see MSM Chapter 1900).

2. Ambulance, Air or Ground – (PT 32): While emergency medical transportation is not a covered IHS benefit, qualified IHPs may enroll as a PT 32 (see MSM Chapter 1900).

I. Community Health Representatives (CHR)

1. CHRs are frontline public health workers who improve access to healthcare in American Indian/Alaskan Native communities and help strengthen community capacity. CHR's provide supports in areas such as outreach, education, social support, and advocacy services that improve the health and wellness of American Indian and Alaskan Native people. CHR services must be related to disease prevention and chronic disease management that follow current national guidelines, recommendations, and standards of care, including but not limited to, the United States Preventive Services Task Force (USPSTF) A and B recommended screenings. CHRs may only provide services to recipients (individually or in a group) through a Tribal Health Clinic (THC) operating under the Indian Self-Determination and Education Act of 1975 (PL 93-638).

2. CHR Provider Qualifications

   a. Completion of the IHSs CHR Training and;

   b. Must be supervised by a Physician, Physician Assistant (PA), Advanced Practice Registered Nurse (APRN), Dentist, Licensed Clinical Social

Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Professional Counselor (LCPC), Nurse Midwife, and Nurse Anesthetist operating through a Nevada Medicaid enrolled THC under the Indian Self-Determination and Education Act of 1975 (PL 93-638).

3. Coverage And Limitations

a. Covered services:

1. Guidance in attaining health care services.

2. Identify recipient needs and provide education from preventive health services to chronic disease self-management.

3. Information on health and community resources, including making referrals to appropriate health care services.

4. Connect recipients to preventive health services or community services to improve health outcomes.

5. Provide education, including but not limited to, medication adherence, tobacco cessation, and nutrition.

6. Promote health literacy, including oral health.

b. Non-covered services:

1. Delegate the CHR to perform or render services that require licensure.

2. Transport a recipient to an appointment.

3. Make appointments not already included within the CHR visit/service (i.e. receptionist duties or front desk support).

4. Deliver appointment reminders.

5. Employment support including but not limited to resume building and interview skills.

6. Coordinate and participate in community outreach events not related to individual or group Medicaid recipients.

7. Case management.

8. Accompanying a recipient to an appointment.

9. Provide child-care while the recipient has an appointment.

10. Application assistance for social service programs.

11. Mental health/alcohol and substance abuse services, including peer support services.

c. Service Limitations

1. Services provided by a CHR are limited to four units (30 minutes per unit) in a 24-hour period, not to exceed 24 units per calendar month per recipient. If medically necessary, additional services can be provided.

2. When providing services in a group setting, the number of participants must be at a minimum of two and a maximum of eight.

d. For a list of covered procedure codes, please refer to the IHS and Tribal Clinics (PT 47) Billing Guide.

3003.2 TRIBAL GOVERNMENTS

A. Consultations

DHCFP will consult with Tribes and IHPs 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 Nevada Check Up programs and will include the anticipated impact on Tribal members, Tribes and/or IHPs.

2. The notification will also describe a method for Tribes and/or IHPs to provide official written comments and questions within a timeframe 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 IHPs 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 IHPs request in-person consultation meetings, 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. 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 IHPs 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.