Tribal Self-Governance Advisory Committee to IHS (TSGAC)

**Legislative Priorities under Medicaid**

**Summary**

April 23, 2018

**The TSGAC is working to identify needed changes in federal Medicaid law that will help advance the federal trust responsibility to American Indians and Alaska Natives (AI/ANs)**[[1]](#footnote-1) **and Indian Tribes by improving access to comprehensive health services, particularly through Indian health care providers**[[2]](#footnote-2) **(IHCPs), for low- and moderate-income AI/ANs across all states.** In doing so, the TSGAC is—

1. Identifying the preferred end state with regard to federal Medicaid law; and
2. Developing a strategy to achieve the preferred end state, such as identifying which components might be phased in, advocating for certain components to be at state option and others to be required under federal law, etc.

Problem Statement

Low- and moderate-income AI/ANs have differing access—and often times no access—to Medicaid coverage and services depending on their state of residence. This is a result of (a) the great variance across states in Medicaid eligibility criteria (for AI/ANs and others) based on household income and other factors, (b) the inconsistency in the set of services for which IHCPs are authorized to receive Medicaid reimbursement under different State Plans, and (c) the lack of capacity of urban Indian health programs resulting from, in part, lower payment rates for Medicaid covered services provided by urban Indian health programs.[[3]](#footnote-3)

Approach and Recommended Elements

This initiative aims to build on the existing IHCP status and federal funding infrastructure to ensure access to a comprehensive set of health care services for low- and moderate-income AI/ANs across all states. The following primary legislative initiatives are proposed:

1. Create an IHCP-specific set of services.
	* Define in federal law a comprehensive set of health care services as Qualified Indian Provider Services (QIPS).
	* Indicate that QIPS are authorized for payment under Medicaid as QIPS when provided by an IHCP to IHS-eligible persons.
2. Enable states to extend Medicaid eligibility to AI/ANs.
	* Establish in federal law an AI/AN-specific “optional” Medicaid eligibility category.
	* Permit states to adopt a Medicaid eligibility category for AI/ANs, with the income threshold up to either (a) 100% FPL or (b) 138% FPL.
3. Extend 100% federal funding (100% FMAP)[[4]](#footnote-4) to services provided to AI/ANs by urban Indian health programs in addition to services provided to AI/ANs by IHS/Tribal providers.

Further, in advancing these provisions in federal law, this initiative seeks to:

1. Clarify in federal law and regulations that state Medicaid programs are permitted to implement policies specifically targeting AI/ANs and IHCPs, without risk of violating civil rights protections or Medicaid standards pertaining to state-wideness and comparability[[5]](#footnote-5);
2. Continue current authorities for states to apply the federal OMB rates as a Medicaid payment methodology for IHCPs, as well as to allow states to engage with Tribes to structure alternative payment methodologies and rates for IHCPs; and
3. Address the “four walls” limitations on IHCP “clinic” services.

Next Steps

* Continue to define and refine the preferred end-state with regard to federal Medicaid law.
* Broaden circulation of recommendations and feed-back from Tribes and others.

Conclusion

Implementing these provisions—and thereby strengthening the Medicaid program infrastructure for AI/ANs and IHCPs under federal law across all states—will heighten access to a comprehensive set of health care services for low- and moderate-income AI/ANs nationally by (a) creating greater uniformity in program eligibility, (b) enabling greater consistency in the breadth of services for which IHCPs are authorized to receive reimbursement, and (c) providing consistency in 100% federal funding across all IHCPs for services provided to AI/ANs.

1. For purposes of this initiative, AI/ANs are Indian Health Service (IHS)-eligible persons defined under 42 CFR § 447.51 as “any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12.” [↑](#footnote-ref-1)
2. Pursuant to 42 CFR 447.51, “Indian health care provider” is defined as “a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).” [↑](#footnote-ref-2)
3. In turn, the lower payment rates are, in part, due to states contributing significant state funding for Medicaid services provided to AI/ANs by urban Indian health programs, as the 100% FMAP provision does not apply to these providers. [↑](#footnote-ref-3)
4. FMAP refers to the Federal Medical Assistance Percentage and is the share of program health care service expenditures funded by the federal government under Medicaid. [↑](#footnote-ref-4)
5. “State-wideness” means that changes to Medicaid policies must apply to enrollees throughout the state, not just in certain areas. “Comparability” means that comparable services must be available to all Medicaid enrollees, regardless of their eligibility category, so states cannot change covered services for just one group of enrollees. [↑](#footnote-ref-5)