

CMS TTAG Medicaid (Legislative Fixes) Priorities
March 15, 2023

Medicaid Priority #1: Authorize Medicaid reimbursements for Qualified Indian Provider Services

In 1976, Congress gave the Indian health system access to the Medicaid program in order to help address dramatic health and resources inequities and to implement its trust and treaty responsibilities to provide health care to American Indians and Alaska Natives (AI/ANs). In order to ensure that States not bear the increased costs associated with allowing Indian health care providers access to Medicaid resources, Congress provided that the United States would pay 100 percent of the costs for services received through Indian health care providers (100 percent FMAP). While Congress provided equal access to the Medicaid program to all Indian health care providers, in practice access has not been equal. Because States have the option of selecting some or none of the optional Medicaid services, the amount and type of services that can be billed to Medicaid varies greatly state by state. So, while the United States's trust and treaty obligations apply equally to all tribes, it is not fulfilling those obligations equally through the Medicaid program. To further the federal government's trust responsibility, and as a step toward achieving greater health equity and improved health status for AI/AN people, we request that Congress authorize Indian health care providers across all states to receive Medicaid reimbursement for a new set of Qualified Indian Provider Services. These would include all mandatory and optional services described as "medical assistance" under Medicaid and specified services authorized under the IHCA when delivered to Medicaid-eligible AI/ANs. This would allow all Indian health care providers to bill Medicaid for the same set of services regardless of the state they are located in. States could continue to claim 100 percent FMAP for those services so there would be no increased costs for the states for services received through IHS and tribal providers. Services received through Urban Indian Organizations would also be made eligible for 100 percent FMAP reimbursement in order to ensure there would be no increased costs to the states for services received through Urban Indian Organizations.

Legislative Language:

For Qualified Indian Provider Services:

Amend subsection 1905(a)(2) by striking the "and" before subparagraph (C) and inserting the following:

"and (D) Qualified Indian Provider Services (as defined in subsection (l)(4) of this section) and any other ambulatory services offered by an Indian Health Care Provider and which are otherwise included in the plan."

Add a new subsection 1905(l)(4) as follows:

"(A)(i) The term "Qualified Indian Provider Services" means all services described in paragraphs (1) through (29) of section 1905(a) and all services of the type described in the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) sections 1616, 1616l, 1621b, 1621c, 1621d, 1621h, 1621q, 1665a, 1665m1, when furnished to an individual as a patient of an Indian Health Care Provider (as defined in (B) of this subsection) who is eligible to receive services under the State plan and is eligible to receive services from the Indian Health Service."

"(ii) Notwithstanding any other provision of law, Qualified Indian Provider Services may be provided by authorized non-physician practitioners working within the scope of their license, certification, or authorized practice under federal, state, or tribal law."

CODIFY IN FEDERAL LAW THE DEFINITION OF IHCP FROM FEDERAL REGULATIONS AT 42 CFR 447.51 -- Amend Social Security Act Section 1905 (I)(4) by inserting the following as a new subparagraph (B):

“(B) The term “Indian Health Care Provider” means a health program operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act [25 U.S.C. 1603]) or inter-tribal consortium (as defined in section 5381 of title 25) or through an Urban Indian Organization (as defined in section 4 of the Indian Health Care Improvement Act) operating pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act or as a permanent program within the IHS direct care program.”

For 100 Percent FMAP for Services Provided by Urban Indian Organizations:

SEC. 1. EXTENSION OF FULL FEDERAL MEDICAL ASSISTANCE PERCENTAGE TO URBAN INDIAN ORGANIZATIONS.

Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by striking “Indian Health Care Improvement Act)” and inserting “Indian Health Care Improvement Act) or through an Urban Indian Organization (as defined in section 4 of the Indian Health Care Improvement Act) pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act or as a permanent program within the IHS direct care program.”

Medicaid Priority #2: Provide reimbursements for services furnished by Indian Health Care Providers outside of an IHS or Tribal Facility (Four Walls Issue)

The COVID-19 pandemic has increased the need for Indian health providers to see AI/AN patients in non-traditional settings outside of the traditional “four walls” of a clinic or other facility, but such services have always been an essential part of health care service delivery in Indian country. For example, many Alaska Native villages are too small or remote to have a brick-and-mortar clinic of their own, so clinic providers from larger villages in the region periodically travel to the smaller villages to provide services. Even in villages with clinics, access to care is enhanced when services are furnished in non-traditional settings, including schools, community centers, and patients’ homes. Further, at the height of the Covid-19 Public Health Emergency, many IHS and Tribal sites set up mobile units and outdoor triage centers to provide more outpatient care and to limit contagion risks within facilities. It is self-evident that, to maximize access and improve health outcomes, health care services should be furnished, and reimbursable, in whatever setting is most effective and appropriate under the circumstances. Yet, because of a cramped and antiquated interpretation of the Medicaid statute’s definition of “clinic services,” many of the offsite services Indian health providers have long furnished, and those they added in response to COVID-19, will no longer qualify for Medicaid reimbursement once a temporary grace period expires 9 months after the COVID-19 Public Health Emergency ends. Congress should amend the “clinic services” definition to ensure that reimbursements for services furnished by IHS and Tribal clinic services providers will be available wherever the service is delivered.

Legislative Language:

"Amend section 1905(a)(9) [42 U.S.C. 1396d(a)(9)] by inserting after “address”:

“and including such services furnished in any location by or through an Indian Health Care Provider as defined in (I)(4)(B)”

Medicaid Priority #3: Extension of 100% FMAP for Urban Indian Organizations

The current extension of 100% FMAP for Urban Indian Organizations expires in March 2023. Once it expires, States will once again be able to claim 100% FMAP for Medicaid-covered services furnished by the Indian Health Service, Indian Tribes, and Tribal Organizations, *but not* for those furnished by UIOs. TTAG requests the law be amended to permanently extend 100% FMAP to services furnished by UIOs.

Legislative Language:

SEC. 1. EXTENSION OF FULL FEDERAL MEDICAL ASSISTANCE PERCENTAGE TO URBAN INDIAN ORGANIZATIONS.

Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by striking “Indian Health Care Improvement Act)” and inserting “Indian Health Care Improvement Act) or through an Urban Indian Organization (as defined in section 4 of the Indian Health Care Improvement Act) pursuant to a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act or as a permanent program within the IHS direct care program.”