DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

May 29, 2009

ARRA #2
CHIPRA #3

Dear Tribal Leader:

On February 4, 2009, the President signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3. The law contains provisions that directly affect both the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act (the Act) and the Medicaid Program under title XIX of the Act. On February 17, 2009, the President signed into law the American Recovery and Reinvestment Act of 2009 (the Recovery Act) to jumpstart the economy, create or save millions of jobs, and modernize our Nation's health care, schools, and infrastructure.

I am writing to you today because both CHIPRA and the Recovery Act contain provisions that amend titles XIX and XXI of the Act and, when implemented, will have an impact on American Indian and Alaska Native (AI/AN) communities. You can view the State Health Official letter providing an overview of the CHIPRA provisions at http://www.cms.hhs.gov/SMDL/downloads/SHO041709.pdf and the Tribal Leader Letter of March 24, 2009, providing an overview of the Recovery Act provisions at http://www.indiancountryworks.org/ file/HHS%20letter%20to%20tribes.

The Centers for Medicare & Medicaid Services (CMS) is committed to implementing these provisions on a government-to-government basis through consultation with Tribal governments. The Center for Medicaid and State Operations (CMSO) has established a workgroup consisting of staff from CMSO, the Tribal Affairs Group (TAG), the Office of External Affairs, the Indian Health Services (IHS), and members of CMS' Tribal Technical Advisory Group (TTAG). This Tribal workgroup will serve as an important resource to CMSO in identifying and defining the issues as we move forward to provide detailed guidance both to Tribes and States on the CHIPRA and Recovery Act provisions.

While we appreciate the work of the TTAG, we know it is not a substitute for Tribal Consultation, and thus, we are planning opportunities for Tribal Consultation over the next several weeks. We are planning regularly scheduled conference calls with Tribal Leaders to listen to questions and implementation concerns. These calls will be held each Friday afternoon in June from 2:00 - 4:00 p.m. Eastern Time and are scheduled as follows:

Friday, June 5, 2009 **The Recovery Act**

- Section 5006(a-c) – Premium and cost sharing protections under Medicaid and exemption of certain Indian-specific property from consideration in determining Medicaid eligibility from Medicaid estate recovery.

Friday, June 12, 2009 **The Recovery Act**

- Section 5006(d-e) – Medicaid managed care protections for Indian health programs and Indian beneficiaries; consultation on Medicaid and CHIP with Indian health programs.

Friday, June 19, 2009 **CHIPRA**

- Sections 201-203 – Grants and enhanced administrative funding for outreach and enrollment; increased outreach and enrollment of Indians; State option to rely on findings from and express lane agency to conduct simplified eligibility determinations; facilitating cooperation and agreements between States and the IHS, Indian Tribes, Tribal Organizations, or Urban Tribal Organizations.
- Sections 211-213 – Verification of declaration of citizenship or nationality for purposes of eligibility for Medicaid and CHIP; reducing administrative barriers to enrollment; model of interstate coordinated enrollment and coverage process.

Friday, June 26, 2009 **CHIPRA**

- Sections 301-302 – Additional State option for providing premium assistance; outreach, education, and enrollment assistance.
- Sections 401-403 – Development of child health quality measures for children enrolled in Medicaid and CHIP; child health quality improvement activities for children enrolled in Medicaid or CHIP (childhood obesity demonstration project); child health quality improvement activities for children enrolled in Medicaid or CHIP; improved availability of public information regarding enrollment of children in CHIP and Medicaid; application of certain managed care quality safeguards to CHIP.
- Sections 501-503 – Dental benefits; mental health parity in CHIP plans; application of prospective payment system for services provided by federally qualified health centers and rural health clinics.

Thursday, July 2, 2009 **The Recovery Act**

- Sections 4201 – Medicaid provider for health information technology adoption and operations payments; implementation funding.

CHIPRA

- Section 505 – Clarification of coverage of services provided through school-based health centers.
- Sections 602-604 – Improving data collection; updated Federal evaluation of CHIP; access to records for the Inspector General and the General Accounting Office audits and evaluations.
- Section 611 – Deficit Reduction Act technical corrections.
- Section 621 – Outreach regarding health insurance options available to children.

CHIPRA - Information about sections not administered by CMS

- Section 401(e) and (g) – Child health quality improvement activities for Children Enrolled in Medicaid or CHIP; (e)(6) – child health quality improvement activities for children enrolled in Medicaid or CHIP.
- Section 402 – Improved availability of public information regarding enrollment of children in CHIP and Medicaid.
- Section 501 – Dental benefits.
- Section 506 – Medicaid and CHIP Payment and Access Commission.

The call in number for each week is 1-888-455-5059 and the pass code is Tribal Affairs. This is a toll-free number. The format for the call will include a brief overview of the provision by CMSO and then the lines will be open for questions and concerns. You may e-mail your questions prior to or after the call to tribalaffairs@cms.hhs.gov. We will either try to answer your question on the call or provide a response after the call.

In addition to the All Tribes Calls, CMS is scheduling a Tribal Consultation Session in conjunction with the Indian Health Summit, July 7-9, 2009 in Denver. The Session will be held Friday, July 10, from 8:30 a.m. – 1:00 p.m., at the Colorado State Bank & Trust Building, 1600 Broadway, 7th floor conference room. The Tribal Consultation Session will provide another opportunity for Tribal Leaders to ask questions and present their issues and concerns regarding these important CHIPRA and Recovery Act provisions. If you are planning to attend the July 10 Tribal Consultation Session, please send your name, title, and tribal affiliation to lois.serio@cms.hhs.gov on or before June 19th.

Please be assured that CMS is committed to working with Tribal governments in the implementation of the CHIPRA and Recovery Act provisions that amend titles XIX and XXI. We hope that you will be able to participate on the All Tribes Calls and to attend the July 10 Tribal Consultation Session in Denver.

I look forward to working with Tribal Leaders as we implement these provisions.

Sincerely,

Jackie Garner

Jackie Garner
Acting Director
Center for Medicaid and State Operations

cc:

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CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Ann C. Kohler
NASMD Executive Director
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Indian Specific Medicaid and CHIP provisions in the American Recovery and Reinvestment Act

Below is Section 5006 of the American Recovery and Reinvestment Act (ARRA). There are many other provisions of ARRA that will impact American Indians and Alaskan Natives and Indian Health Providers. A link to the entire legislation is: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h1enr.pdf.

SEC. 5006. PROTECTIONS FOR INDIANS UNDER MEDICAID AND CHIP.

(a) PREMIUMS AND COST SHARING PROTECTION UNDER MEDICAID.—
(1) IN GENERAL.—Section 1916 of the Social Security Act
(42 U.S.C. 1396o) is amended—
(A) in subsection (a), in the matter preceding paragraph
(1), by striking ‘‘and (i)’’ and inserting ‘‘, (i), and (j)’’; and
(B) by adding at the end the following new subsection:
‘‘(j) NO PREMIUMS OR COST SHARING FOR INDIANS FURNISHED ITEMS OR SERVICES DIRECTLY BY INDIAN HEALTH PROGRAMS OR THROUGH REFERRAL UNDER CONTRACT HEALTH SERVICES.—
‘‘(1) NO COST SHARING FOR ITEMS OR SERVICES FURNISHED TO INDIANS THROUGH INDIAN HEALTH PROGRAMS.—
‘‘(A) IN GENERAL.—No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services for which payment may be made under this title.
‘‘(B) NO REDUCTION IN AMOUNT OF PAYMENT TO INDIAN HEALTH PROVIDERS.—Payment due under this title to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care provider through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under such title, may not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deduction, copayment, cost

sharing, or similar charge that would be due from the Indian but for the operation of subparagraph (A).

''(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as restricting the application of any other limitations on the imposition of premiums or cost sharing that may apply to an individual receiving medical assistance under this title who is an Indian.''.

(2) CONFORMING AMENDMENT.—Section 1916A(b)(3) of such Act (42 U.S.C. 1396o–1(b)(3)) is amended—

(A) in subparagraph (A), by adding at the end the following new clause:

''(vii) An Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.''; and

(B) in subparagraph (B), by adding at the end the following new clause:

''(x) Items and services furnished to an Indian directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.''.

(b) TREATMENT OF CERTAIN PROPERTY FROM RESOURCES FOR MEDICAID AND CHIP ELIGIBILITY.—

(1) MEDICAID.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by sections 203(c) and 211(a)(1)(A)(ii) of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), is amended by adding at the end the following new subsection:

''(ff) Notwithstanding any other requirement of this title or any other provision of Federal or State law, a State shall disregard the following property from resources for purposes of determining the eligibility of an individual who is an Indian for medical assistance under this title:

''(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.’’.
(2) APPLICATION TO CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)), as amended by sections 203(a)(2),

203(d)(2), 214(b), 501(d)(2), and 503(a)(1) of the Children’s Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), is amended—
(A) by redesignating subparagraphs (C) through (I), as subparagraphs (D) through (J), respectively; and
(B) by inserting after subparagraph (B), the following new subparagraph:
‘‘(C) Section 1902(ff) (relating to disregard of certain property for purposes of making eligibility determinations).’’.
(c) CONTINUATION OF CURRENT LAW PROTECTIONS OF CERTAIN INDIAN PROPERTY FROM MEDICAID ESTATE RECOVERY.—Section 1917(b)(3) of the Social Security Act (42 U.S.C. 1396p(b)(3)) is amended—
(1) by inserting ‘‘(A)’’ after ‘‘(3)’’; and
(2) by adding at the end the following new subparagraph:
‘‘(B) The standards specified by the Secretary under subparagraph (A) shall require that the procedures established by the State agency under subparagraph (A) exempt income, resources, and property that are exempt from the application of this subsection as of April 1, 2003, under manual instructions issued to carry out this subsection (as in effect on such date) because of the Federal responsibility

for Indian Tribes and Alaska Native Villages. Nothing in this subparagraph shall be construed as preventing the Secretary from providing additional estate recovery exemptions under this title for Indians.''.

(d) RULES APPLICABLE UNDER MEDICAID AND CHIP TO MANAGED CARE ENTITIES WITH RESPECT TO INDIAN ENROLLEES AND INDIAN HEALTH CARE PROVIDERS AND INDIAN MANAGED CARE ENTITIES.—

(1) IN GENERAL.—Section 1932 of the Social Security Act (42 U.S.C. 1396u–2) is amended by adding at the end the following new subsection:

''(h) SPECIAL RULES WITH RESPECT TO INDIAN ENROLLEES, INDIAN HEALTH CARE PROVIDERS, AND INDIAN MANAGED CARE ENTITIES.—

''(1) ENROLLEE OPTION TO SELECT AN INDIAN HEALTH CARE PROVIDER AS PRIMARY CARE PROVIDER.—In the case of a non-Indian Medicaid managed care entity that—

''(A) has an Indian enrolled with the entity; and

''(B) has an Indian health care provider that is participating as a primary care provider within the network of the entity,

insofar as the Indian is otherwise eligible to receive services from such Indian health care provider and the Indian health care provider has the capacity to provide primary care services to such Indian, the contract with the entity under section 1903(m) or under section 1905(t)(3) shall require, as a condition of receiving payment under such contract, that the Indian shall be allowed to choose such Indian health care provider as the Indian's primary care provider under the entity.

''(2) ASSURANCE OF PAYMENT TO INDIAN HEALTH CARE PROVIDERS FOR PROVISION OF COVERED SERVICES.—Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall require any such entity, as a condition of receiving payment under such contract, to satisfy the following requirements:

''(A) DEMONSTRATION OF ACCESS TO INDIAN HEALTH CARE PROVIDERS AND APPLICATION OF ALTERNATIVE PAYMENT ARRANGEMENTS.—Subject to subparagraph (C), to—

''(i) demonstrate that the number of Indian health care providers that are participating providers with

respect to such entity are sufficient to ensure timely access to covered Medicaid managed care services for those Indian enrollees who are eligible to receive services from such providers; and

‘‘(ii) agree to pay Indian health care providers, whether such providers are participating or nonparticipating providers with respect to the entity, for covered Medicaid managed care services provided to those Indian enrollees who are eligible to receive services from such providers at a rate equal to the rate negotiated between such entity and the provider involved or, if such a rate has not been negotiated, at a rate that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a participating provider which is not an Indian health care provider.

The Secretary shall establish procedures for applying the requirements of clause (i) in States where there are no or few Indian health providers.

‘‘(B) PROMPT PAYMENT.—To agree to make prompt payment (consistent with rule for prompt payment of providers under section 1932(f)) to Indian health care providers that are participating providers with respect to such entity or, in the case of an entity to which subparagraph (A)(ii) or (C) applies, that the entity is required to pay in accordance with that subparagraph.

‘‘(C) APPLICATION OF SPECIAL PAYMENT REQUIREMENTS FOR FEDERALLY-QUALIFIED HEALTH CENTERS AND FOR SERVICES PROVIDED BY CERTAIN INDIAN HEALTH CARE PROVIDERS.—

‘‘(i) FEDERALLY-QUALIFIED HEALTH CENTERS.—

‘‘(I) MANAGED CARE ENTITY PAYMENT REQUIREMENT.—To agree to pay any Indian health care provider that is a federally-qualified health center under this title but not a participating provider with respect to the entity, for the provision of covered Medicaid managed care services by such provider to an Indian enrollee of the entity at a rate equal to the amount of payment that the entity would pay a federally-qualified health center that is a participating provider with respect to

the entity but is not an Indian health care provider for such services.

‘‘(II) CONTINUED APPLICATION OF STATE REQUIREMENT TO MAKE SUPPLEMENTAL PAYMENT.—Nothing in subclause (I) or subparagraph (A) or (B) shall be construed as waiving the application of section 1902(bb)(5) regarding the State plan requirement to make any supplemental payment due under such section to a federally-qualified health center for services furnished by such center to an enrollee of a managed care entity (regardless

of whether the federally-qualified health center is or is not a participating provider with the entity).

‘‘(ii) PAYMENT RATE FOR SERVICES PROVIDED BY CERTAIN INDIAN HEALTH CARE PROVIDERS.—If the amount paid by a managed care entity to an Indian health care provider that is not a federally-qualified health center for services provided by the provider to an Indian enrollee with the managed care entity is less than the rate that applies to the provision of such services by the provider under the State plan, the plan shall provide for payment to the Indian health care provider, whether the provider is a participating or nonparticipating provider with respect to the entity, of the difference between such applicable rate and the amount paid by the managed care entity to the provider for such services.

‘‘(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as waiving the application of section 1902(a)(30)(A) (relating to application of standards to assure that payments are consistent with efficiency, economy, and quality of care).

‘‘(3) SPECIAL RULE FOR ENROLLMENT FOR INDIAN MANAGED CARE ENTITIES.—Regarding the application of a Medicaid managed care program to Indian Medicaid managed care entities, an Indian Medicaid managed care entity may restrict enrollment under such program to Indians in the same manner as Indian Health Programs may restrict the delivery of services

to Indians.
‘‘(4) DEFINITIONS.—For purposes of this subsection:
‘‘(A) INDIAN HEALTH CARE PROVIDER.—The term ‘Indian health care provider’ means an Indian Health Program or an Urban Indian Organization.
‘‘(B) INDIAN MEDICAID MANAGED CARE ENTITY.—The term ‘Indian Medicaid managed care entity’ means a managed care entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C)) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of 1 or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.
‘‘(C) NON-INDIAN MEDICAID MANAGED CARE ENTITY.—The term ‘non-Indian Medicaid managed care entity’ means a managed care entity that is not an Indian Medicaid managed care entity.
‘‘(D) COVERED MEDICAID MANAGED CARE SERVICES.—The term ‘covered Medicaid managed care services’ means, with respect to an individual enrolled with a managed care entity, items and services for which benefits are available with respect to the individual under the contract between the entity and the State involved.
‘‘(E) MEDICAID MANAGED CARE PROGRAM.—The term ‘Medicaid managed care program’ means a program under sections 1903(m), 1905(t), and 1932 and includes a managed care program operating under a waiver under section 1915(b) or 1115 or otherwise.’’.

(2) APPLICATION TO CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(1)), as amended by subsection (b)(2), is amended—
(A) by redesignating subparagraph (J) as subparagraph (K); and
(B) by inserting after subparagraph (I) the following new subparagraph:
‘‘(J) Subsections (a)(2)(C) and (h) of section 1932.’’.
(e) CONSULTATION ON MEDICAID, CHIP, AND OTHER HEALTH CARE PROGRAMS FUNDED UNDER THE SOCIAL SECURITY ACT

INVOLVING INDIAN HEALTH PROGRAMS AND URBAN INDIAN ORGANIZATIONS.—
(1) CONSULTATION WITH TRIBAL TECHNICAL ADVISORY GROUP (TTAG).—The Secretary of Health and Human Services shall maintain within the Centers for Medicaid & Medicare Services (CMS) a Tribal Technical Advisory Group (TTAG), which was first established in accordance with requirements of the charter dated September 30, 2003, and the Secretary of Health and Human Services shall include in such Group a representative of a national urban Indian health organization and a representative of the Indian Health Service. The inclusion of a representative of a national urban Indian health organization in such Group shall not affect the nonapplication of the Federal Advisory Committee Act (5 U.S.C. App.) to such Group.
(2) SOLICITATION OF ADVICE UNDER MEDICAID AND CHIP.—
(A) MEDICAID STATE PLAN AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 501(d)(1) of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), (42 U.S.C. 1396a(a)) is amended—
(i) in paragraph (71), by striking ''and'' at the end;
(ii) in paragraph (72), by striking the period at the end and inserting ''; and''; and
(iii) by inserting after paragraph (72), the following new paragraph:
''(73) in the case of any State in which 1 or more Indian Health Programs or Urban Indian Organizations furnishes health care services, provide for a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this title that are likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations and that—
''(A) shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations; and
''(B) may include appointment of an advisory committee

and of a designee of such Indian Health Programs and Urban Indian Organizations to the medical care advisory committee advising the State on its State plan under this title.''.

(B) APPLICATION TO CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(1)), as amended by subsections (b)(2) and (d) (2), is amended—

(i) by redesignating subparagraphs (B), (C), (D), (E), (F), (G), (H), (I), (J), and (K) as subparagraphs (D), (F), (B), (E), (G), (I), (H), (J), (K), and (L), respectively;

(ii) by moving such subparagraphs so as to appear in alphabetical order; and

(iii) by inserting after subparagraph (B) (as so redesiganted and moved) the following new subparagraph:

''(C) Section 1902(a)(73) (relating to requiring certain States to seek advice from designees of Indian Health Programs and Urban Indian Organizations).''.

(3) RULE OF CONSTRUCTION.—Nothing in the amendments made by this subsection shall be construed as superseding existing advisory committees, working groups, guidance, or other advisory procedures established by the Secretary of Health and Human Services or by any State with respect to the provision of health care to Indians.

(f) EFFECTIVE DATE.—The amendments made by this section shall take effect on July 1, 2009.