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DATE: February 5, 2010

TO: Tribal Health Directors and Delegates

FROM: Jim Roberts, Policy Analyst

SUBJECT: SMDL #: 10-001 ARRA Protections for Indians in Medicaid & CHIP

I am providing you a State Medicaid Director Letter that issues guidance to the States on the new Indian provisions that were pass in the American Recovery and Reinvestment Act of 2009 (ARRA). Section 5006 of ARRA (P.L. 111-5) provides protections for Indians in Medicaid and the Children's Health Insurance Program (CHIP).

The amendments made by this section became effective on July 1, 2009 and cover: (1) Premium and Cost-Sharing Protections Under Medicaid; (2) Exemption of Certain Property from Resources for Medicaid and CHIP Eligibility; (3) Continuation of Current Protections for Certain Indian Property from Medicaid Estate Recovery; (4) New Statutory Requirements Regarding Indians, Indian Health Care Providers, Indian Managed Care Entities in Medicaid, and CHIP Managed Care Programs, and (5) Consultation on Medicaid, CHIP, and Other Health Care Programs.

A summary of each item is as follows:

1. This new Section 5006 prohibits imposition of an enrollment fee, premium or similar charge, and deduction, copayment, cost sharing or similar charge against an Indian who receives an item or service covered by Medicaid from an Indian Health Provider or from another provider to whom the Indian was referred by the contract health services program of an Indian Health Provider.
2. Requires States to exclude certain types of Indian-specific property from being considered as "resources" when determining the eligibility of an Indian for Medicaid. This requirement is modeled on a policy established in 2001 by CMS which excluded certain types of Indian property from Medicaid estate recovery rules. The description of the excluded property, which appears in CMS's State Medicaid Manual, was used to write the new Indian property exclusion amendment.
3. States must now exclude certain property from estate recovery to encourage otherwise eligible Indians to enroll in Medicaid, but to enable them to protect their Indian-specific property from confiscation after death. ("Estate recovery" refers to a provision in the Medicaid law which requires States to seek recovery from the estate of a deceased Medicaid beneficiary to reimburse the State and Federal Governments for the costs of Medicaid-funded health care.
4. Section 5006(d) adds amends Medicaid and CHIP statutes to apply consistent rules governing the treatment of Indians, Indian health care providers, and Indian Managed Care Entities (IMCEs) in a State Medicaid or CHIP managed care programs. The new provisions expressly recognize that an IMCE may restrict its enrollment to Indians in the same manner as Indian health programs may restrict the delivery of

services to Indians. Indians who are eligible for Medicaid or CHIP may elect to enroll in managed care entities for this purpose, including primary care case management programs on a voluntary basis. They may be enrolled on a mandatory basis under a Medicaid or CHIP waiver or in an I/T/U managed care entity.

Under section 5006(d), all contracts with Medicaid and CHIP managed care entities must permit any Indian who is enrolled in a non-Indian MCE and eligible to receive services from a participating I/T/U provider. It also requires MCEs to demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services. Finally, 5006(d) requires that I/T/U providers, whether participating in the network or not, be paid for covered Medicaid or CHIP managed care services provided to Indian enrollees who are eligible to receive services from such providers either:

i. At a rate negotiated between the managed care entity and the I/T/U provider, or;
ii. If there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider, and;
iii. Provide that the managed care entity must make prompt payment to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under federal regulations.

5. Requires the Secretary of Health and Human Services (HHS) to maintain a Tribal Technical Advisory Group (TTAG) within CMS. Effective July 1, 2009, certain States are required to utilize a process for the State to seek advice on a regular, ongoing basis from designees of the Indian health programs and Urban Indian Organizations concerning Medicaid and CHIP matters having a direct effect on Indians, Indian health programs or Urban Indian Organizations.

I have attached a copy of the State Medicaid Director Letter which includes additional details on each of items covered under this guidance. If you should have any questions, feel free to contact me at (503) 228-4185 or by email jroberts@npaihb.org.

`DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL#: 10-001
ARRA #: 6

January 22, 2010

Re: ARRA Protections for Indians in Medicaid and CHIP

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the American Recovery and Reinvestment Act of 2009 (Recovery Act), Public Law 111-5. Section 5006 of the Recovery Act provides protections for Indians in Medicaid and the Children's Health Insurance Program (CHIP). The amendments made by this section were effective on July 1, 2009. This letter provides a brief overview to assist States with implementation of these new provisions for Indians in your programs.

Section 5006 of the Recovery Act provides certain premium and cost-sharing protections under Medicaid and exemption for certain Indian-specific property from consideration in determining Medicaid eligibility and from Medicaid estate recovery. It also provides certain Medicaid managed care protections for Indian health programs and Indian beneficiaries and establishes new requirements for consultation on Medicaid and CHIP with Indian health programs. The new provisions are described in greater detail below.

Premium and Cost-Sharing Protections Under Medicaid

The Social Security Act (the Act) allows States to impose enrollment fees, premiums, cost-sharing and similar charges under certain conditions on Medicaid participants under title XIX and CHIP participants under title XXI of the Act. The Medicaid provisions are at section 1916 of the Act for nominal premiums and cost-sharing and at section 1916A of the Act for alternative premiums and cost-sharing, as authorized by the Deficit Reduction Act of 2005 (DRA), Public Law 109-171. CHIP provisions can be found at section 2103(e) of the Act.

Section 5006(a) of the Recovery Act amends sections 1916 and 1916A of the Act, to preclude States from imposing Medicaid premiums or any other Medicaid cost sharing on Indian applicants and participants served by Indian health providers and to assure that Indian health providers, and providers of contract health services (CHS) under a referral from an Indian health provider, will receive full payment. These provisions apply to the Medicaid program. Premiums and cost-sharing exemptions for Indians under CHIP are not affected. These provisions became effective **July 1, 2009**. Specifically, section 5006(a):

- Exempts Indians from payment of enrollment fees, premiums, or similar charges if they are furnished an item or service by an Indian health care provider; Indian Health Service (IHS); an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U)) or through referral under CHS. We consider this condition to be met if the individual meets the definition of Indian below.
- Exempts Indians from payment of a deductible, coinsurance, copayment, or similar charge for any item or service covered by Medicaid if the Indian is furnished the item or service directly by an Indian health care provider, I/T/U or through CHS.
- Prohibits any reduction in payment that is due under Medicaid to the I/T/U or to a health care provider through referral under CHS for furnishing an item or service to an Indian. The State must pay these providers the full Medicaid payment rate for furnishing the item or service. Their payments may not be reduced by the amount of any enrollment fee, premium, deduction, copayment, or similar charge that otherwise would be due from the Indian.

Definitions

For purposes of ensuring compliance with the cost-sharing provisions under the Recovery Act, CMS will use the following definitions in reviewing State plans:

- Indian Health Care Provider means a health care program, including CHS, operated by the 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).
- Indian means an individual, defined at title 25 of the U.S.C. sections 1603(c), 1603(f). 1679(b) or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization–I/T/U) or through referral under Contract Health Services.

State Medicaid programs are encouraged to work closely with I/T/Us and Contract Health Services programs within the State to implement the exemption of Indians from Medicaid enrollment fees, premiums, or other similar charges and for exemption from deductibles, coinsurance payments, copayments, or similar charges. In addition, States are encouraged to inform non-I/T/U providers who participate in CHS about the absence of cost-sharing.

Exemption of Certain Property from Resources for Medicaid and CHIP Eligibility

Section 5006(b) of the Recovery Act amends the Medicaid statute by adding section 1902(ff) of the Act and the CHIP statute by adding section 2107(e)(1)(C) of the Act to require States to exclude certain types of Indian-specific property from being considered as "resources" when determining Medicaid or CHIP eligibility for an individual who is an Indian. These resource exclusions became effective **July 1, 2009.**

In general, the Recovery Act requires States to exclude resources in two categories:

- Property connected to the political relationship between Indian Tribes and the Federal government; and
- Property with unique Indian significance.

The following resources must be excluded:

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.

Enclosed is additional guidance on consideration of income and conversion of resources for Medicaid eligibility of Indians. It is important to note that section 5006(b) did not change the treatment of income for Medicaid or CHIP eligibility purposes. Income that was protected under previous laws or rules will be protected still and income that was counted under previous laws or rules will be counted still.

<u>Continuation of Current Protections for Certain Indian Property from Medicaid Estate Recovery</u>

Section 5006(c) of the Recovery Act amends section 1917(b)(3) of the Act to specify in the Act that certain Indian income, resources, and property are exempt from Medicaid estate recovery. These provisions have been in the State Medicaid Manual since April 1, 2003 and can be found at section 3810.A.7.

The specific income, resources, and property exempted from Medicaid estate recovery for Indians include:

1. Certain income and resources (such as interests in and income derived from Tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations.
2. Ownership interest in trust or non-trust property, including real property and improvements:

   a. Located on a reservation (any federally-recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by Alaska Native Claims Settlement Act and Indian allotments) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or
   b. For any federally-recognized Tribe not described in (a), located within the most recent boundaries of a prior federal reservation.
   c. Protection of non-trust property described in (a) and (b) is limited to circumstances when the property passes from an Indian (as defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. section 1603)) to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a Tribe and non-Indians, such as spouses and step-children, that their culture would nevertheless protect as family members; to a Tribe or Tribal Organization; and/or to one or more Indians;
3. Income left as a remainder in an estate derived from property protected in section 2 above, that was either collected by an Indian, or by a Tribe or Tribal Organization and distributed to Indian(s), as long as the individual can clearly trace it as coming from the protected property.
4. Ownership interests left as a remainder in an estate 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, and income either collected by an Indian, or by a Tribe or Tribal Organization and distributed to Indians(s) derived from these sources as long as the individual can clearly trace it as coming from protected sources; and.
5. Ownership interests in, or usage rights to, items not covered by 1-4 above that have unique religious, spiritual, traditional, and/or cultural significance or rights that support subsistence or a traditional life style according to applicable Tribal law or custom.

<u>New Statutory Requirements Regarding Indians, Indian Health Care Providers, Indian Managed Care Entities in Medicaid, and CHIP Managed Care Programs</u>

Section 5006(d) of the Recovery Act adds a new section 1932(h) to the Medicaid statute and section 2107(e)(1)(J) to the CHIP statute, which will apply consistent rules governing the treatment of Indians, Indian health care providers–I/T/Us, and Indian Managed Care Entities (IMCEs) in a State Medicaid or CHIP managed care program. The term Indian Managed Care Entity (IMCE) means a managed care entity that is controlled by the IHS, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which may also include the IHS. The new statutory provision expressly recognizes that an IMCE may restrict its enrollment to Indians in the same manner as Indian health programs may restrict the delivery of services to Indians.

Indians who are eligible for Medicaid or CHIP may elect to enroll in managed care entities for this purpose, including primary care case management (PCCM) programs on a voluntary basis. They may be enrolled on a mandatory basis under a Medicaid or CHIP waiver or in an I/T/U managed care entity.

Under section 5006(d), all contracts with Medicaid and CHIP managed care entities, which include Medicaid and CHIP managed care organizations (MCOs) and PCCMs, must:

- Permit any Indian who is enrolled in a non-Indian MCE and eligible to receive services from a participating I/T/U provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services;
- Require each managed care entity to demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers;
- Require that I/T/U providers, whether participating in the network or not, be paid for covered Medicaid or CHIP managed care services provided to Indian enrollees who are eligible to receive services from such providers either (1) at a rate negotiated between the managed care entity and the I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider; and
- Provide that the managed care entity must make prompt payment to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under federal regulations at 42 CFR sections 447.45 and 447.46.

The Centers for Medicare & Medicaid Services intends to issue forthcoming regulations to address the application of the requirement for sufficient I/T/Us in States where there are few or none available.

Under prior provisions of law, I/T/U providers that receive reimbursement as federally qualified health centers (FQHCs) pursuant to a contract from a managed care entity also receive a supplemental payment from the State to make up the difference between the amount the managed care entity pays and what the I/T/U FQHC would have received under the State Plan.

The new provision provides a supplemental payment from the State to all I/T/U providers for services furnished to managed care enrollees, whether the provider is an FQHC or not, and without regard to whether the provider has a contract with the managed care entity. The supplemental payment must make up the difference between the amount paid by the managed care entity and the applicable rate under the State plan.

<u>Consultation on Medicaid, CHIP, and Other Health Care Programs Funded under the Act Involving Indian Health Programs and Urban Indian Organizations</u>

Section 5006(e) of the Recovery Act codifies in statute, at section 1902(a)(73) and section 2107(e)(1)(C) of the Act, the requirement for the Secretary of Health and Human Services (HHS) to maintain a Tribal Technical Advisory Group (TTAG) within CMS. The TTAG, initially established in accordance with a charter dated September 30, 2003, is now required to include a representative of IHS and a representative of a national Urban Indian Organization.

Additionally, effective July 1, 2009, certain States are required to utilize a process for the State to seek advice on a regular, ongoing basis from designees of the Indian health programs and Urban Indian Organizations concerning Medicaid and CHIP matters having a direct effect on Indians, Indian health programs or Urban Indian Organizations. The consultation process must be followed by any State in which one or more Indian health programs or Urban Indian Organizations furnish health care services, even if no federally-recognized Indian Tribes are located within the State. These States are required to specifically solicit such advice prior to the State's submission of any Medicaid or CHIP State plan amendment, waiver request, or proposal for a demonstration project likely to have a direct effect on Indians, Indian health programs, or Urban Indian Organizations. The consultation may include the appointment of an advisory committee or a designee of these IHS (including those programs operated by federally-recognized Tribes under P.L. 93-638 authority) and Urban Organizations to the State medical care advisory committee required by Federal regulations at 42 CFR 431.12, both, or another method. Also, enclosed is the Medicaid State plan template that a State must use for a State plan amendment in order to document its process for such consultation. CMS is sharing, in draft, the SPA template under the guidelines of the Paperwork Reduction Act (PRA) currently under OMB review. Until the PRA process is completed, States are not obligated to use the recommended template. After CMS obtains the necessary PRA clearance number from OMB, States will be required to complete the SPA template.

Previously, CMS has provided guidance on the consultation process with federally-recognized Indian Tribes, which may be found in the July 17, 2001, State Medicaid Director Letter, requiring State consultation with federally-recognized Indian Tribes for waivers. The letter will be revised to address additional requirements in Section 5006(e) of the Recovery Act. The above-referenced letter can be found on the CMS Web site at: http://www.cms.hhs.gov/smdl/downloads/smd071701.pdf .

Examples of changes that would have a direct effect on Indians, Indian health programs, or Urban Indian Organizations include Medicaid or CHIP changes (submitted through State plan amendments, proposed waivers, waiver extensions, waiver amendments or waiver renewals) that are more restrictive for eligibility determinations, changes that reduce payment rates or changes in payment methodologies to I/T/U providers or for services reimbursed to I/T/U providers, reductions in covered services, changes in consultation policies, and proposals for demonstrations or waivers that may impact Indians or I/T/U providers.

Implementation

This guidance is offered in order to assist States in planning for application of these provisions. Additional guidance will be forthcoming on this issue, and CMS will work with States to help them implement these provisions in a manner that is consistent with the statute.

In keeping with the HHS Tribal consultation policy and the new provisions in the Recovery Act, CMS collaborated and consulted with the TTAG and IHS to solicit advice on implementing these provisions. The Tribal Affairs Group and the Center for Medicaid and State Operations, within CMS, jointly hosted two All Tribes Calls on June 5 and 12, 2009, to consult on implementation of section 5006 of the Recovery Act. Two face-to-face consultation meetings were held in

Denver on July 8 and 10, 2009, to solicit advice and input on these provisions from federally-recognized Tribes, Indian health providers, and Urban Indian Organizations. An All States Call was held on June 10, 2009, with the State Medicaid and CHIP programs to describe the CMS Tribal consultation process on the Recovery Act provisions and to solicit feedback and questions from States.

Contact Information

We hope you find this information helpful in your efforts to implement the provisions of the Recovery Act. If you have questions regarding this guidance, please send an email to CMSOCHIPRAQuestions@cms.hhs.gov or contact Ms. Victoria Wachino, Director, Family and Children's Health Programs Group, who may be reached at (410) 786-5647.

Sincerely,

/s/

Cindy Mann
Director
Center for Medicaid and State Operations

Enclosures

cc:

CMS Regional Administrators

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

Ann C. Kohler
NASMD Executive Director
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Director for Health Policy
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Christine Evans, M.H.P.
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Alan R. Weil, J.D., M.P.P.
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Dr. Yvette Roubideaux
Director
Indian Health Service

Valerie Davidson
Chairman
Tribal Technical Advisory Group

Stacy Bohlen
Executive Director
National Indian Health Board

Additional Guidance for Consideration of Income and Resources for Medicaid Eligibility of Indians

In order to be eligible for Medicaid or the Children's Health Insurance Program (CHIP), an individual must have countable income and resources at or below the maximum amounts established by the State plan. The following rules, in accordance with Federal regulations at 42 CFR 435.601(b), generally apply to eligibility for Medicaid and CHIP:

- Income is defined for Medicaid and CHIP purposes as anything that an individual receives (e.g., wages, self-employment income, interest, dividends, Social Security payments) that the individual can use to pay for the family's basic necessities.
- Resources are defined as cash or anything an individual owns (e.g., checking or savings accounts, real estate, personal property, stocks, bonds) that the individual can convert to cash to pay for the family's basic necessities.
- Any income not spent during the month of receipt is considered as resources in the following months. It is counted or excluded as a resource depending on the form that it takes (e.g., cash, checking account, stocks, property).
- Certain types of income and resources are not counted for Medicaid and/or CHIP eligibility, such as the home property in which the family lives.

If an individual does not have the legal right, authority, or power to liquidate resources or to use income or resources that the individual owns, that income or resource is not counted for Medicaid or CHIP eligibility because the individual is not free to access and spend it.

- For example, if an Indian has a restricted Individual Indian Money (IIM) Account with money held in trust for the individual's use, but that individual must be authorized by someone else to access the money, and that access may be denied, the money in the IIM is considered to be inaccessible and so is excluded from consideration as a resource for Medicaid or CHIP eligibility.

Resources include an individual's right to harvest or extract natural resources from land that the individual owns or for which the individual has an ownership interest (e.g., mineral rights, fishing rights, timber rights). If the individual cannot sell those rights or that ownership interest, or those rights or that ownership is specifically excluded by statute, those resources are not accessible and are not counted for Medicaid or CHIP eligibility.

- For example, if a Tribe holds rights to extract natural resources from a geographical area, those rights are not owned by any individual and cannot be sold by any Tribal member, even if an individual exercises those rights to extract and sell natural resources from the property (e.g., oil, gas, gravel, timber). Therefore, the mineral/timber rights are not counted as a resource for any Tribal member's Medicaid or CHIP eligibility.

If a resource is sold or exchanged, the proceeds are still considered resources, not income. Therefore, if natural resources (e.g., gravel, timber, fish, oil) are sold by the owner of the property or by the owner of rights for use of that geographical area, the money received from that sale is also considered as a resource in the determination of Medicaid or CHIP eligibility.

However, if the rights for use of the natural resources are excluded as a resource (such as because the individual cannot sell the ownership interest), the money received for the sale of natural resources extracted or harvested from that area is also excluded as a resource during the month of receipt. If the individual retains money from the sale of the natural resources and does not spend it, the money is considered for Medicaid or CHIP resource eligibility in the months following the month of receipt depending on the form the money takes (e.g., countable in a checking account or cash, excludable in certain property such as a home). If the individual sells the resource and then spends the money or uses it to purchase another resource that is also considered exempt under Medicaid and CHIP rules, eligibility may not be affected.

- For example, if a Tribal member or Tribe exercises federally-protected mineral rights and sells minerals extracted in that designated area, money received from the sale of the minerals is not income but is considered to be an excluded resource in the month that the money is received.
- If the money from the sale of the minerals is not spent by the end of the month it is received (e.g., to pay for the family's food or other personal or business expenses), the money is either counted or excluded as a resource based on the type of resource in which the money is retained after the month of receipt.
    - For example, if the money is deposited and retained in the individual's checking account, it is counted as a resource along with all other money in the checking account after the month the money is received. If the money is spent to purchase a car and the State's Medicaid program excludes motor vehicles as a resource, it is excluded from consideration as a resource for Medicaid or CHIP eligibility.

Certain types of Tribal per capita payments and other types of Tribal income are excluded from consideration as income per Public Law 98-64 (the Per Capita Act) and 45 CFR section 233.20(a)(4)(ii)(e). This law and implementing regulations specify that per capita distribution of all funds held in trust by the Secretary of Interior for members of an Indian Tribe are excluded from consideration as income and resources for federal means-tested public benefits programs (e.g., Medicaid and CHIP).

However, also according to Public Law 98-64, local Tribal funds that a Tribe distributes to individuals on a per capita basis, but which have not been held in trust by the Secretary of Interior (e.g., Tribally managed gaming revenues), are not excluded from income and resources. Therefore, those funds are considered as countable income in the month of receipt. Any per capita payments from gaming revenues that are retained after the month of receipt are counted or excluded based on the type of resource in which the money is retained.

- For example, if a Tribal member receives a quarterly check from the Tribe as the individual's per capita payment from the casino owned by Tribe, the money is considered as the individual's countable income in the month that the check is received.
- Any money from a per capita casino payment that the individual still has after the month of receipt is counted or excluded based where the money is. If it is retained in a countable resource (e.g., cash, checking or savings account), it is counted for Medicaid and CHIP eligibility. If it is converted to an excludable resource (e.g., personal property like a refrigerator), it is excluded for Medicaid and CHIP eligibility.

DRAFT DRAFT

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:

1.4 State Medical Care Advisory Committee **(42 CFR 431.12(b))**
There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.

Tribal Consultation Requirements
Section 1902(a)(73) of the Social Security Act requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA) Consultation is required concerning Medicaid matters having a direct impact on these Indian health programs . Please indicate below whether the State, as part of its consultation process, appoints an advisory committee or appoints a designee of the Indian health programs and Urban Indian Organizations to the State medical care advisory committee, both of these, or something else.

__/ State appoints a tribal advisory committee.
__/ State appoints a designee of the IHS, Tribes or Tribal organizations operating health programs under the ISDEAA, and/or Urban Indian organizations operating health programs under the IHCIA to the State medical care advisory committee.
__/ Other. Specify:
__/ Not applicable because the State does not have at least one Indian Health Program or Urban Indian Organization furnishing health care services.

TN No: Approval Date Effective Date _____

Supersedes TN No.
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-XXXX**. The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.