MEMORANDUM OF AGREEMENT
BETWEEN THE INDIAN HEALTH SERVICE AND
THE HEALTH CARE FINANCING ADMINISTRATION

I. Purpose

The purpose of this memorandum of agreement (MOA) is to establish the roles and responsibilities of the Health Care Financing Administration (HCFA) and the Indian Health Service (IHS) in implementing a change in payment policy for Medicaid services provided on or after July 11, 1996, to American Indian and Alaska Native (Al/AN) individuals through health care facilities owned and operated by AI/AN tribes and tribal organizations with funding authorized by Title I or III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended), hereafter "638."

II. Policy

The United States Government has a historical and unique legal relationship with, and resulting responsibility to, AI/AN people. A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage maximum participation of AI/ANs in the planning and management of those services. The health care delivery system for AI/AN tribes with this unique government-to-government relationship consists of IHS-owned and operated health care facilities, IHS-owned facilities that are operated by Al/AN tribes or tribal organizations under 638 agreements (contracts, grants, or compacts), and facilities owned and operated by tribes or tribal organizations under such agreements.

AI/AN individuals are entitled to equal access to state, local, and Federal programs to which other citizens are entitled. Under the provision of its approved medical assistance plan, the state Medicaid agency is responsible for meeting the cost of services provided therein for all individuals, regardless of race or national origin, who apply and are found eligible. Many IHS and tribally owned health care facilities provide such Medicaid services to AI/AN individuals, and states reimburse the facilities accordingly.

Prior to July 11, 1996, if such services were provided by a health care facility operated by the IHS or by a tribe or tribal organization under a 638 agreement, HCFA interpretation of the controlling statute, section 1905(b) of the Social Security Act (the Act), 42 U.S.C. 1396d, provided the state with 100-percent Federal medical assistance percentage (FMAP), or 100-percent Federal reimbursement, only for payments made by the state for services rendered through an IHS-owned or leased facility. If such services were provided

through a tribally owned and operated facility, the state received an FMAP of 100 per centum less the state percentage, which, depending on the state, could range from 50-percent to 83-percent of the amount the state paid the facility.

A recent amendment to 638 added a new subsection that affects this payment policy. Upon request of a tribe or tribal organization, new section 105(1) requires the Secretary of Health and Human Services, through the IHS, to enter into a lease with a tribe or tribal organization that holds title to or leasehold or trust interest in a facility used by such tribe or tribal organization for administration and delivery of 638 health care services. An IHS lease of any tribally owned facility in which 638 health services are provided would then make the state entitled to the 100-percent FMAP for services provided through the facility. Without this change in policy, states would have had a strong financial incentive to encourage tribes to request that IHS enter into leases of tribal facilities. These requests could have resulted in the processing and signing of possibly hundreds of mandatory leases.

To address state financing concerns, to encourage tribal self-determination in program operation and facility ownership, and to eliminate the processing of numerous leaseback requests, HCFA reevaluated its original interpretation of section 1905(b). In light of the above amendment to 638 and underlying Federal Indian policy, HCFA concluded that the statutory language in this context permits an interpretation that tribal facilities operating under a 638 agreement are functioning as IHS facilities in performing obligations set forth under that agreement. Thus, as of July 11, 1996, the Secretary approved HCFA's proposal to adopt an interpretation that section 1905(b) allows 100-percent FMAP for Medicaid services furnished to Medicaid eligible AI/ANs by any tribal facility operating under a 638 agreement. This means that the state will be reimbursed for 100 percent of the amount it pays to any 638 facility for services provided to Medicaid eligible AI/ANs only, and services provided to Medicaid eligible non-Indians will continue to be reimbursed at the state's usual FMAP. The IHS has concurred in this new interpretation and in the revised policy.

It is the policy of both the IHS and HCFA to assure quality health care for Al/AN people. Section 1902(a)(9) of the Act requires a state plan for medical assistance to provide that the state agency shall be responsible for establishing and maintaining health standards for private or public institutions in which Medicaid beneficiaries receive care or services. Section 1911 of the Act provides that an IHS-owned or leased facility, whether operated by the IHS or a tribe or tribal organization, shall be eligible for reimbursement for Medicaid services provided under a state plan so long as it meets all the conditions and requirements generally applicable to such facilities under the Medicaid statute. IHS and tribes have worked towards meeting strong quality of care standards including, where appropriate, accreditation of IHS and tribal facilities by recognized accreditation bodies. For Medicaid

reimbursement in the past, IHS-owned or leased facilities were certified by HCFA as meeting standards of care, and tribally owned health care facilities were certified by the states, where required. In implementing 100-percent FMAP for tribal 638 facilities, HCFA and IHS acknowledge that these facilities must meet all conditions and
requirements applicable under the Medicaid statute and will encourage either state certification or accreditation by a recognized accreditation body, such as JCAHO, for all tribal facilities that participate in their programs.

Current Medicaid regulations require a state plan to provide that an IHS facility meeting state requirements for Medicaid participation must be accepted on the same basis as any other qualified provider. However, when state licensure is normally required, the regulations provide that the IHS facility need not obtain such a license but must meet all applicable standards for licensure. With the new interpretation that tribally owned and operated 638 facilities are "IHS facilities," such 638 facilities must meet all applicable standards for licensure but need not obtain a state license.

Prior to July 11, 1996, many 638 facilities participated in state Medicaid programs as FQHCs or other types of providers under the state plan. In implementing 100-percent FMAP for 638 facilities, a tribally operated facility may: (1) continue to operate as an FQHC under the state plan and receive the FQHC reimbursement rate; (2) if it so qualifies, operate as any other provider type recognized under the state plan and receive that respective reimbursement rate; or (3) choose to be designated as an IHS provider. If the facility chooses to be designated as an IHS provider for purposes of the payment policy and this MOA, it will receive the IHS payment rate for services to AI/ANs; however, at state option, the IHS payment rate may not be available for services to non-Indian Medicaid beneficiaries as the state will not receive 100-percent FMAP for services to non-Indians.

III. Implementation

A. To assist HCFA in the implementation of this revised policy, IHS shall, within the limits of its authorities and resources:

1. Negotiate with the tribes and tribal organizations to include in any 638 agreement tribal quality of care standards necessary to meet state licensure, accreditation, or certification requirements, if any (which may be met through accreditation by a recognized accreditation body, such as JCAHO).

2. Develop and maintain a list of IHS-operated facilities and Indian health care facilities operating under a 638 agreement, including the following information: (1) whether each such facility is IHS-owned or leased or tribally owned; (2) the name and location of each such

facility; (3) the type of each such facility; (4) whether each such facility is operated under its own Medicaid provider number and, if so, state that number; and (5) each such facility's accreditation body and status.

3. Provide HCFA with the list in A2 at least once per fiscal year.

4. Inform all facilities identified in A2 above that valid Medicaid claims shouldinclude all information the state requires from any similar facilities serving the general Medicaid population and receiving reimbursement under the state plan.

5. Continue to provide technical assistance to tribes and tribal organizations to maintain and maintain tribal quality of care standards necessary to meet state licensure, accreditation, or certification requirements.

6. Promptly share with HCFA any problems arising from this policy change.

B. HCFA shall, within the limits of its authorities and resources:

1. Revise its payment policy to provide 100-percent FMAP with respect to amounts expended by the state for Medicaid services to eligible AUANs received through tribally owned facilities operating under a 638 agreement, as identified in the IHS list in A2 above, as well as for Medicaid services received through IHS-owned or leased facilities.

2. Provide technical assistance to states and AI/AN tribes and tribal organizations to assure smooth implementation of this new payment policy.

3. Provide assistance to the tribes/tribal organizations and states in developing the method for reimbursement of facilities identified in A2 above with the understanding that each such tribe/tribal organization shall have the option to choose among the provider types for which it qualifies that are recognized under the state plan.

4. Upon receipt of the list in A2 from IHS, provide the states with that list at least once per fiscal year.

5. Provide technical assistance to facilitate the tribes' and tribal organizations' attainment and maintenance of tribal quality of care standards necessary to meet state licensure, accreditation, or certification requirements.

6. Promptly share with IHS any problems arising from this policy change.

C. Nothing contained herein shall be construed as abrogating or limiting the rights of AI/ANs presently established under any treaty, statute, or regulation.

IV. Effective Dates

The payment policy change specified in this MOA is effective for services provided on or after July 11, 1996. Agency responsibilities set forth in this MOA shall become effective beginning on the date of the day after the latest signature date below.

_____/S/_____12/19/96
Michael H. Trujillo, MD
Director
Indian Health Service

_____/S/_____12/19/96
Bruce C. Vladeck
Administrator
Health Care Financing Administration