

# TRIBAL USE OF MEDICAID TO SUPPORT CHILDREN'S MENTAL HEALTH SERVICES

## Fact Sheet

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## Tribal Use of Medicaid to Support Children's Mental Health Services

### Introduction

Medicaid is a federal entitlement health insurance program that was established with the enactment of Title XIX of the Social Security Act in 1965. Administered by the Centers for Medicare and Medicaid Services (CMS), it supports health and long-term care services, including children's mental health services, for low-income Americans who meet the financial criteria and belong to one of the categorically eligible groups. Medicaid is the largest payer of behavioral health services in the United States.

Each state, U.S. territory, and the District of Columbia administer Medicaid programs with federal funds. Though tribes cannot currently administer Medicaid directly through the federal government, there are a number of ways in which tribes can and do provide Medicaid-funded services. It is important that tribes and tribal organizations serve in this role, as they are better positioned to understand and respond to the needs of their populations in a culturally appropriate and clinically effective manner. Many tribes that are building and expanding Systems of Care are utilizing Medicaid as a funding mechanism to support children's mental health services that are culturally responsive. This briefing paper provides an overview of the federal Medicaid program, tribal provider type options, tribal-state relations, and culturally appropriate Medicaid billable children's mental health programming.

### Federal Medicaid Program

States are required to develop a state plan. Each state plan is unique and serves as the contract between the state and the federal government, describing eligible groups of people, covered services, applicable limitations, and the payment methodology of each service. State Medicaid programs are generally required to cover the following services as a minimum:

- Inpatient and outpatient hospital services; physician, nurse practitioner, and midwife services; nursing facility and home health care for individuals 21 and older; family planning; lab and x-ray services; early and periodic screening, diagnosis, and treatment (EPSDT) for children under 21<sup>1</sup>; and rural health clinic/federally qualified health center services (Kaiser Commission on Medicaid and the Uninsured, June 2010).

A state may elect to expand its Medicaid program beyond the legally required minimums, offer various optional services, and/or limit benefits for certain groups, excluding children.

States are required to provide Medicaid services to the following populations:

- Families that meet the eligibility requirements of the state's Aid to Families with Dependent Children in effect on July 16, 1996, and now Temporary Assistance to Needy Families; certain elderly and disabled Social Security Income recipients; infants born to Medicaid-eligible pregnant women; children under age 6 and pregnant women whose family income is at or below 133% of the federal poverty level; children age 6 and older in families with incomes at or below 100% of the federal poverty level; recipients of Title IV-E foster care and adoption assistance; certain people with Medicare; and special protected groups (Centers for Medicare and Medicaid Services, 2005).
- In 2014, the Affordable Care Act (ACA) will expand Medicaid eligibility for children ages 6–18 years who are at or below 138% of the federal poverty level. This expansion was **not** affected by the Supreme Court ruling since it is under a separate section of ACA. The Supreme Court did not address this provision.

States are required to serve all eligible populations within their service areas that meet the above criteria, including American Indian and Alaska Native (AI/AN) peoples. Upon approval from CMS, states may increase the income level eligibility requirements above the minimum federal standards. States may also elect to cover optional populations. An example of this would be expanding coverage to low-income children whose family income is above the federal poverty level stipulated in the mandatory eligibility rules.

The federal share for each of the different Medicaid program components is calculated using match rates established by law. The Social Security Act specifies these rates, which apply to administration, training, and other special Medicaid categories. Another factor in determining the federal share of Medicaid program expenditures is referred to as the Federal Medical Assistance Percentage (FMAP) and is calculated by comparing a state's per capita income to that of the national

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<sup>1</sup> Federal language regarding EPSDT requires that states provide necessary health care, diagnostic services, treatment, and other measures described to correct or ameliorate defects and physical and mental illnesses and conditions identified in the screening, whether or not such services are covered under the state Medicaid plan.

average. Depending on which state is seeking reimbursement, the FMAP ranges from 50%–83%. These rates are published annually in the *Federal Register* and may be found online at <https://www.federalregister.gov>.

Per the Indian Health Care Improvement Act of 1976, the FMAP for Medicaid services provided by the Indian Health Service (IHS) and Public Law 93-638 (638) IHS-contracted tribal facilities (excluding urban Indian programs<sup>2</sup>) is 100%. In an effort to facilitate payment to IHS and tribal facilities that rendered Medicaid-eligible services, the federal government negotiated with Medicaid to establish rates for inpatient and outpatient services. For an IHS or tribal facility to receive payment at the IHS published rates, it must become a Medicaid provider and be on the IHS facility list.

IHS and tribal 638 contracted facilities bill for Medicaid services through the state Medicaid authority in the state where they reside. States pay these rates using all federal dollars, as the FMAP rate for IHS and tribally contracted IHS facilities is 100%. This is a much better FMAP rate than what states get when services are furnished to AI/AN people via non-IHS or non-638 contracted facilities. The 100% FMAP rate results in full reimbursement.

### **Tribal Medicaid Provider Types: Options for Tribes**

Tribes can choose to enroll with Medicaid under any "provider type" for which they qualify. The term "provider type" is descriptive of the services the program renders and is also specific to the payment methodology that Medicaid uses for the service. Many tribal programs may provide a broad array of services and typically have multiple enrollment numbers specific to each category of service. Tribes may enroll as one or more of the three main types: an IHS facility, a Federally Qualified Health Center (FQHC), and/or a community mental health center.

- **IHS Facility Provider Status:** To be paid at the IHS encounter rates, a tribal facility must be on the IHS facility list and be either IHS or a tribal organization operating under a 638 contract or Public Law 106-260 compact (a type of self-governance agreement). The IHS facility list is comprised of those facilities owned or leased and operated by the IHS or a 638 tribe or tribal organization.
- **Federally Qualified Health Center:** Non-tribal providers are usually required to have a community health center grant from the Health Resources and Services Administration (HRSA) to qualify as an FQHC. However, tribal facilities and urban Indian programs are deemed to be FQHCs under federal rules and qualify to enroll as such without a HRSA grant. Certain services are mandatory for FQHC coverage (physician, physician assistant, nurse practitioner, psychologist, and licensed clinical social worker) and are paid as cost-based encounter rates. Second to the IHS facility provider type, FQHC enrollment is the best option for maximizing reimbursement. For urban Indian programs that cannot meet the IHS facility provider status, FQHC enrollment is the best option fiscally.
- **Community Mental Health Center:** If a tribal program is interested in providing Medicaid eligible services not included in the state under the IHS encounter rate or FQHC provider type, it must enroll with Medicaid as an additional provider type(s). Other provider types for behavioral health have different enrollment requirements, and payment is based on the Medicaid fee schedule for all providers. This fee schedule is much less generous than the IHS encounter rate or FQHC encounter rate.

### **Tribal-State Relations**

A number of tribal programs have successfully established and strengthened positive working relationships with state Medicaid officials, thereby improving tribal use of Medicaid to support children's mental health services. Tribes with Systems of Care experience have cited a number of strategies that helped with this endeavor. These include becoming familiar with federal Medicaid policy and the applicable state plan(s); developing relationships with state Medicaid directors and officials; educating state Medicaid officials on the cost savings associated with the 100% FMAP provision; working on policy changes such as state plan amendments to increase tribal access where needed; and others. Additionally, each CMS regional office employs one Native American contact who is available to provide training and technical assistance to tribal programs, serving as liaison between CMS and tribal communities. They may answer questions about eligibility, coverage, reimbursements, enrollment, and may help facilitate conversations between tribal programs and Medicaid officials at different levels. Contact and other information about the CMS Native American contacts and Tribal Technical Advisory Group members may be found online at: <http://www.cmsttag.org/>.

### **Medicaid and Culturally Appropriate Services**

A common area of interest and need for technical assistance among tribes building and expanding Systems of Care in children's mental health is billing Medicaid for culturally appropriate services. It is important to note that a cultural activity by itself is not billable, but services that reflect the cultural context of the population being served may be Medicaid

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<sup>2</sup>It is important to note that a federal exception exists regarding ineligibility of urban Indian programs not qualifying for 100% FMAP (also referred to as Federal Financial Participation, or FFP). The Tulsa Clinic and Oklahoma City Clinics in Oklahoma are eligible to receive 100% FFP. Urban Indian programs may still enroll with Medicaid under a different provider category. The most common provider type used by urban Indian programs is the FQHC.

billable. There exist a number of examples of culturally appropriate children's mental health service programming in Indian Country. One such example is a group therapy session in which young men make drums with a traditional teacher who is partnered with a billable mental health professional who co-facilitates the session and completes the proper clinical documentation for each participant. Another example is structuring certain subsistence activities as therapeutic events. It is important to remember that all state plans are different, each addressing and covering optional services differently. Information pertaining to what a state plan covers that could support culturally appropriate service delivery may be found under "rehabilitative" services.

### **Conclusion**

Medicaid is the largest payer of behavioral health services. In light of the socioeconomic situation faced by most tribes and the limited availability of reliable mental health funding, Medicaid is absolutely critical to the sustainability of tribal children's mental health programs. Tribal programs may increase access to and use of Medicaid by becoming familiar with applicable federal and state policies, establishing relationships with state Medicaid officials, and building services that reflect community culture and needs.

### **Additional Resources**

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