Tribal Technical Advisory Group
To the Centers for Medicare & Medicaid Services
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Submitted via http://www.regulations.gov

February 1, 2020

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2393-P, P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicaid Fiscal Accountability Regulation, CMS-2393-P

Dear Administrator Verma,

On behalf of the Tribal Technical Advisory Group (TTAG) to the Centers for Medicare & Medicaid Services (CMS), I write to comment on the proposed rule issued by the CMS concerning supplemental payments under Medicaid. The TTAG advises CMS on Indian health policy issues related to Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and any other health care program funded in whole or in part by CMS. In particular, TTAG focuses on providing policy advice designed to improve the availability of health care services to American Indians and Alaska Natives (AI/ANs) under these federal health care programs, and those operated by the Indian Health Service (IHS), Indian Tribes, Tribal organizations, and urban Indian organizations (collectively I/T/Us). While we support the effort to ensure fiscal accountability and transparency in Medicaid administration, the TTAG is concerned that the proposal goes beyond these purported goals by uprooting past and current policies on which Medicaid programs for AI/ANs are built and financed.

The proposed rule constitutes a significant departure from longstanding CMS interpretations. Specifically, the TTAG is concerned that states utilizing Medicaid Administrative Matching (MAM) and doing the same through a Certified Public Expenditure (CPE) mechanism could potentially be impacted by the rule. CMS has already addressed this issue when it released guidance in October of 2005 (SMDL #05-004)[1] as to whether expenditures that are certified by Tribal organizations can be used to fulfill state matching requirements for administrative activities under the Medicaid program. In addition, the proposed rule would significantly diminish the objectivity of current regulations by affording CMS far too much discretion in approvals and in disallowing Medicaid expenditures. Our recommendations on this proposed rule are intended to promote policy that CMS has embraced in past State Medicaid Director letters and to clarify any ambiguity about the ability of Tribes and Tribal organizations to provide for financial participation in the Medicaid program.

I. Background

Through the Medicaid Fiscal Accountability Regulation (MFAR) proposed rule, CMS is requiring states to provide detailed data on payments, including supplemental and disproportionate share

[1] CMS, Center for Medicaid and State Operations, Dear State Medicaid Director Letter (Oct. 18, 2005), https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/smd101805.pdf

hospital (DSH) payments, Medicaid utilization data, and provider taxes and donations. CMS will also implement new reviews of supplemental payment methodologies and tax waivers and periodically seek authorization for their renewal. Supplemental payments approved under either a Medicaid state plan or demonstration authority and applicable upper payment limits (UPL)[2] will also have to be reported.

The TTAG fears that the rule could adversely affect how states currently finance their share of the cost of their Medicaid programs through taxes on health care providers, contributions from local governments and spending incurred by public providers. If states can no longer rely on that funding to the same extent and are unable to generate other funding, such as through higher taxes, states could be forced to reduce their total Medicaid spending and make damaging cuts in the areas of eligibility, benefits and provider payments. Given the scope and complexity of the proposed changes, we are concerned with potential negative impacts to AI/AN Medicaid beneficiaries, access to care, and the providers entrusted to delivering care to AI/AN Medicaid beneficiaries.

We urge CMS to promote policies that it has embraced in past State Medicaid Director letters and to clarify any ambiguity about the ability of Tribes and Tribal organizations to provide for financial participation in the Medicaid program.

II. Impact of the Proposed Rule

1) State Share of Financial Participation (§ 433.51)

Under section 433.51, CMS proposes to replace the term "public funds" with "state or local funds" to more clearly define allowable sources of the non-federal share in alignment with the Social Security Act, section 1903(w) (permitting states to cover the state share of Medicaid payments with revenue generated from health care-related taxes). Permissible "state or local funds" for the purposes of the state share include: state general fund dollars appropriated directly to Medicaid (subsection (b)(1)); intergovernmental transfers (IGTs) from units of government (including Indian Tribes) derived from state or local taxes (or funds appropriated to state university teaching hospitals), and transferred to the State Medicaid agency (subsection (b)(2)); and certified public expenditures (CPEs) which are certified by a unit of government within a State as representing expenditures eligible for Federal Financial Participation (FFP), and which meet the requirements of § 447.206 (subsection (b)(3)).

Both IGTs and CPEs are important to Tribal governments and Tribal organizations to assist in financing the Medicaid administrative activities in several states. CMS has issued sub-regulatory guidance affirming that Tribal governments and Tribal organizations can certify expenditures such as the non-Federal share of Medicaid expenditures for administrative services provided by such entities.[3] In accordance with this policy, we are pleased to see that Tribal governments are included as a unit of government, yet we are concerned that the proposed rule does not address situations in

[2] Institutions subject to the UPL requirement include hospitals, nursing facilities, and freestanding non-hospital clinics.
[3] SMDL #05-004; SMDL #06-014.

which a Tribal government does not or is unable to exercise its taxing authority for the purposes of intergovernmental transfers. Limiting the contribution from IGTs to only Tribes with taxing authority is too restrictive in this context, and could prevent Tribes from providing a non-federal match. The TTAG therefore requests that CMS conduct Tribal consultation on the proposed rule changes as to IGTs and the impact on Tribes.

2) State Plan Requirements (§ 447.201)

Section 447.201 would establish that a state plan may not provide for variation in FFS payment for Medicaid services based on a beneficiary's eligibility category, enrollment, or available federal match. However, there is no discussion about whether and how the OMB rate for Indian health care would be accounted for. CMS notes that states are allowed to set higher payment rates where such rates reflect actual increases in the cost of providing care to certain beneficiaries. For example, increased costs associated with paying a provider with higher qualifications for furnishing care. Where payment rates impact Medicaid access, states must then increase rates to "rectify the access problem for all Medicaid beneficiaries, not only those for whom the statute provides an increased FMAP." CMS states that the proposed change would codify the current practice by prohibiting variations in payment rates based solely on federal financial participation (FFP). The proposed change would be consistent across FFS and managed care.

As drafted, the proposed regulatory provision could be understood to prohibit states from making payments to Indian Health Service (IHS) and Tribally owned or operated facilities at the all-inclusive rates for inpatient and outpatient services, if other facilities are paid on a different basis. That differentiation in payments is common among states, and it has been the long-standing position of the Department of Health & Human Services (HHS) that payment to those facilities at the published all-inclusive rate is appropriate for both the Medicare and Medicaid programs. This could have significant financial impacts in states with many IHS and Tribally owned or operated facilities paid at the all-inclusive rates for inpatient and outpatient services.

Furthermore, the proposed revision gives too much discretion to CMS. Under these proposed changes, CMS essentially has to approve, or, on a state-by-state basis, determine whether states are seeking to reimburse services at a justifiable rate. Additionally, states would have to submit a plan every three years to CMS, which would be administratively burdensome. The TTAG requests that CMS conduct Tribal consultation in order to clarify this provision's impact on Tribes.

3) Payments Funded by Certified Public Expenditures to Unit of Government Providers (§ 447.206)

This section would codify longstanding policies, including standards to document Medicaid expenditures that government units may certify through a CPE for a FFP claims made by state and non-state government providers as defined at section 447.286 and limited to actual incurred costs. It would establish annual cost reporting and audit protocols with only certified amounts being usable for FFP claims. It also sets forth detailed health care-related indices for calculation interim payment rates and a detailed reconciliation process.

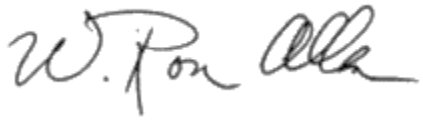
TTAG is concerned that the proposed definition for "non-state governmental provider" could be used to preclude certain local government structures from qualifying as permissible CPE entities, contrary to historical practice. Specifically, the requirement that a provider must have access to and exercise administrative control over directly appropriated state funds and/or local tax revenue may exclude Indian Tribes, Tribal organizations, or certain local hospital authorities that have been created as unique and express units of government. The TTAG requests that CMS conduct Tribal consultation on the impact of the proposed definition change.

III. Request for Tribal Consultation

According to section 7.1 of the CMS Tribal Consultation Policy, "[u]pon identification of a policy that has Tribal implications and a substantial direct effect on Indian Tribes or on the relationship between Tribes and the federal government, CMS will initiate consultation regarding the policy."[4] TTAG thus requests that CMS honor the government-to-government relationship between Tribes and the United States, as well as this policy, and move forward only after conducting Tribal consultation on the proposed Medicaid Fiscal Accountability Regulation.

We thank you for the opportunity to provide our comments and concerns on the rule. If you should have any questions, please contact Carolyn Hornbuckle, Chief Operations Officer at the National Indian Health Board, at chornbuckle@nihb.org.

Sincerely,



W. Ron Allen, TTAG Chairperson
Chairman, Jamestown S'Klallam Tribe

cc: Kitty Marx, Director
CMCS Division of Tribal Affairs
Centers for Medicare and Medicaid Services

[4] CMS, Tribal Consultation Policy (2015), https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSTribalConsultationPolicy2015.pdf