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Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-2393-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicaid Program; Medicaid Fiscal Accountability Proposed Regulation
File Code: CMS-2393-P

Dear Administrator Verma:

On behalf of the Northwest Portland Area Indian Health Board (NPAIHB), I submit the following comments on the Centers for Medicare and Medicaid Services (CMS) *Medicaid Program: Medicaid Fiscal Accountability Regulation,* published in the Federal Register on November 18, 2019.

Established in 1972, the NPAIHB is tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638, representing the 43 federally-recognized Indian Tribes in Idaho, Oregon, and Washington on specific health care issues. NPAIHB works closely with the IHS Portland Area Office, operating a variety of important health programs on behalf of our member tribes, including the Northwest Tribal Epidemiology Center.[1]

NPAIHB appreciates CMS's goal of strengthening the fiscal oversight and integrity of the Medicaid program to ensure that federal Medicaid dollars are spent in ways that support direct needs of Medicaid beneficiaries, as stated in the proposed rule. However, given the scope and complexity of the proposed changes we are concerned with potential negative impacts the proposed changes could have on AI/AN Medicaid beneficiaries access to care and the providers entrusted to delivering care to AI/AN Medicaid beneficiaries.

[1] A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.L. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

I. Background

The Indian health system has been chronically underfunded for decades, leading to a large gap in the health care needs of American Indian/Alaska Native (AI/AN) people. In 1976, the opportunity to close this gap was realized with Congressional authorization for the Indian Health Service (IHS) to bill Medicare and Medicaid for services. Medicaid is a critically important component of the Indian health funding stream, and allows many IHS and Tribal health programs the ability to begin to address some of the chronic health disparities faced by Indian people in the United States. Any change to Medicaid is a concern to IHS and Tribal health programs.

The proposed rule establishes new reporting requirements for states to provide CMS with certain information on supplemental payments to Medicaid providers, including supplemental payments approved under either Medicaid state plan or demonstration authority. In addition, the proposed rule would establish requirements to ensure that state plan amendments proposing new supplemental payments are consistent with the proper and efficient operation of the state plan and with efficiency, economy, and quality of care. Lastly, the proposed rule addresses the financing of supplemental and base Medicaid payments through the non-federal share, as well as the requirements on the non-federal share of any Medicaid payment.

II. Specific Comments

A. State Share of Financial Participation (§ 433.51)

Under §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)).

Under §433.51 (b)(1) , the only permissible source of IGTs from tribes would be funds derived from local taxes. This is too restrictive and could prevent tribes from providing a non-federal match. NPAIHB requests that CMS conduct tribal consultation on the proposed rule changes as to IGTs and the impact on tribes.

B. Payments funded by Tribal CPEs (§ 447.206).

CPEs described in §433.51(b)(2), are important to tribes to provide the non-federal match for Medicaid programs. In Washington, many tribes participate in the CPE process for both

outpatient substance use disorder services for non-American Indian/Alaska Native Medicaid beneficiaries and for Medicaid Administrative Claiming. A streamlined CPE process has been set up by the Washington Health Care Authority (HCA). HCA sends the tribes a report and certification form and the tribes sign and return the form to HCA. NPAIHB recommends that any CPE processes that have been established by states, and vetted by tribes in the state, should continue without any impact by these proposed rules. In addition, NPAIHB requests tribal consultation on the impact to tribes related to the rule changes.

C. State Plan Requirements (§ 447.201)

Section 447.201 would establish that a state plan may not provide for variation in Fee For Service (FFS) payment for Medicaid services based on a beneficiary's "eligibility category, enrollment under a waiver or demonstration project or FMAP rate available for services provide to an individual in the beneficiary's eligible category." However, in the preamble, CMS highlights that states are allowed to set higher payment rates where such rates reflect actual increases in the cost of providing care to certain beneficiaries, e.g., increased costs associated with paying a provider with higher qualifications for furnishing care. CMS further states that 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 for an increased FMAP."[2] NPAIHB requests tribal consultation on the restriction as to no "variation" on FFS and how this may impact tribes.

D. Reporting on Supplemental Payments (§ 447.288(c))

Under § 447.288(c), states will be required to report provider-level payment information for Medicaid supplemental payments. This is in contrast to current practices where states report aggregate data across all providers.[3] States must also report provider-level payment information for state plan services and demonstration programs, as well as identify the specific authority and source of the non-federal share for these payments. CMS indicated these changes are intended to yield greater insights into how supplemental payments are administered and whether they are consistent with Medicaid program standards requiring "efficiency and economy" of care. NPAIHB is concerned that these proposed changes would disturb the tribal-state-federal partnership and create barriers to access to care from needed health care providers. It is anticipated that supplemental payments made through section 1115 demonstrations such as uncompensated care pools and delivery system reform incentive payments (DSRIP) would also be considered supplemental payments subject to the new proposed reporting requirements.

In Washington, tribes are participating in a DSRIP which is known as the Washington State Medicaid Transformation Project (MTP). The MTP provides an opportunity to enhance the Indian Health Delivery System. With the American Indian Health Commission for Washington State (AIHC), over the past three years, IHCPs have worked to address the impacts of Medicaid

[2] 84 Fed. Reg. 63744.
[3] §§ 447.272 and 447.321

Transformation on programs and services for Native people. The IHCP Projects Plan honors Tribal sovereignty and the government to government relationship. IHCPs design and implement their own culturally appropriate delivery system reform project. The IHCPs, made up of 29 Tribes and 2 Urban Indian Health Programs, require unique funding mechanisms and activities to support sovereignty and self-determination, key foundational elements for health. Tribes are concerned about the reporting requirements being imposed on states that have an impact on tribes. NPAIHB requests that tribal consultation be conducted on the reporting requirements and impact on tribes.

III. Request for Tribal Consultation

According to CMS Tribal Consultation Policy, Section 7.1. "[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] NPAIHB requests that CMS honor the government-to-government relationship, and this policy, and conduct tribal consultation on the CMS Medicaid fiscal accountability proposed rule.

For additional information please contact Sarah Sullivan, Health Policy Analyst at (503) 228-4185 or ssullivan@npaihb.org.

Sincerely,

Nickolaus D. Lewis
Chair, Northwest Portland Area Indian Health Board
Councilman, Lummi Nation

4 Centers for Medicare and Medicaid Services Tribal Consultation Policy, dated December 10, 2015.