IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

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Submitted Electronically: Seema.verma@cms.hhs.gov

May 23, 2019

Administrator Seema Verma
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20101

RE: Comments on the State of South Dakota's 1115 Demonstration Application, "Improving Indian Health in South Dakota"

Dear Administrator Verma:

On behalf of the Tribal Self-Governance Advisory Committee (TSGAC) to the Indian Health Service (IHS), I am writing to submit comments to the Centers for Medicare and Medicaid Services (CMS) regarding South Dakota's proposed new 5-year section 1115 demonstration to "reimburse Federally Qualified Health Centers (FQHCs) in the demonstration with 100% Federal Financial Participation (FFP) for services provided to American Indians."

The waiver proposes to create a new alternative service delivery model that is represented as increasing access to primary care services for American Indians and Alaska Natives (AI/ANs) from FQHCs and Urban Indian programs. However, the waiver does not change the FQHC system or create a new delivery or payment model that does not already exist today. All the waiver does is increase federal financial participation (FFP) by allowing South Dakota to claim 100% FFP for services provided to AI/ANs by FQHCs and Urban Indian programs. Most importantly, nothing in the waiver indicates that the savings to the State from 100% FMAP claiming be used to increase access to services for AI/ANs—for example, by building the infrastructure of Indian health facilities or by funding an expansion of Medicaid eligibility.

As a result, the TSGAC requests that CMS not approve South Dakota's waiver. It does not promote the objectives that Congress intended when providing 100% Federal Medical Assistance Percentage (FMAP) for services received through Indian Health Service (IHS) and Tribal health facilities under section 1905(b) of the Social Security Act (SSA). The waiver is not necessary since South Dakota already operates an "alternative service delivery model" through its existing structure of FQHC providers. AI/ANs can already access services at FQHCs. Approval of the waiver would not create a service delivery model that does not exist today, or increase access to such services. The waiver only creates a new financing scheme that would allow the State to claim 100% FFP/FMAP for services provided by non-Tribal FQHCs and shifts this cost to the federal government.

In fact, in a recent CMS response to a section 1115 waiver demonstration proposed by the State of North Carolina, CMS took the position that the 100 percent FMAP rule could not be waived by a

Section 1115 waiver. CMS stated, "Section 1115(a)(i) waiver authority extends only to provisions of section 1902 of the Act, and does not extend to provisions of section 1905 of the Act, such as section 1905(b)." It would not—and does not—now appear to be supportable for CMS to waive portions of SSA section 1905.

It is important to acknowledge that the TSGAC supports the State of South Dakota continuing to work with Tribes in order for the State to claim 100% FFP/FMAP for services to eligible AI/ANs "received through" facilities of the IHS; however, this should be done under the existing CMS State Health Official letter (SHO #16-002) and apply to individuals eligible for IHS services as defined at 42 C.F.R. Part 136. And, we believe that this authority should be exercised for the purpose of strengthening the Tribal and IHS health systems in order to provide improved access to care for AI/ANs. The TSGAC also supports the expansion of 100% FMAP to those Urban Indian Health Programs that are funded under the Indian Health Care Improvement Act (IHCIA) (however, not as a part of this waiver).

Congress Intended 100% FMAP to Support IHS Facilities

In 1976, Congress amended the Social Security Act to authorize the IHS and Tribes to bill Medicaid, a provision that Congress described "as a much-needed supplement to a health care program which for too long has been insufficient to provide quality health care to the American Indians."[1] Section 1905(b) of the SSA requires the federal government to match state expenditures at the FMAP rate, including 100% FMAP for state expenditures on behalf of "IHS eligible" Medicaid beneficiaries for covered services "received through" an IHS facility, whether operated by the IHS or by a Tribe or Tribal organization (as defined in section 4 of the Indian Health Care Improvement Act).[2]

Congress authorized 1905(b) to supplement inadequate IHS appropriations as part of the federal trust responsibility and, at the same time, recognized that "it would be unfair and inequitable to burden a State Medicaid program with costs which normally would have been borne by the Indian Health Service."[3] By providing 100% FMAP for services "received through" IHS and Tribal facilities, Congress ensured that states would not have to bear any such costs. Section 1905(b) allows Congress to provide critical resources to the Indian health system while not shifting this responsibility to the states.

At the same time, Congress stipulated that the Medicaid funding received by the IHS and paid for entirely by the federal government under 1905(b) is to be utilized to make facility improvements necessary to achieve compliance with Medicaid standards as prescribed in State Medicaid Plans. Initially, the Act required that Medicaid and Medicare payments be placed into a special fund for improvements of IHS facilities [§ 401(c)(1)]. Subsequent amendments to the IHCIA now allow Tribal health programs to bill Medicaid directly and eliminate the use of the special fund. However, the requirement that funds be used to maintain and improve facilities to achieve compliance with Medicaid standards—among expanded uses of the reimbursements from improvements to reduce health deficiencies—still exists in current law. The IHCIA further stipulates that reimbursements received from Medicare, Medicaid, or CHIP shall be credited to the IHS operating unit generating

[1] House Report No. 94-1026-Part III at 21 (May 12, 1976), reprinted in U.S.C.A.A.N. 2796.
[2] Sec. 1905(b) of SSA; 42 U.S.C. § 1396d(b).
[3] Senate Report 94-133, Indian Health Care Improvement Act.

these resources and be used for such purposes needed for maintaining compliance with the standards of the federal programs described above.[4]

CMS' long-standing interpretation of section 1905(b) is that 100% FMAP is available for amounts expended for services under the following circumstances:

1) The service must be furnished to a Medicaid-eligible AI/AN;
2) The service must be a "facility service";
3) The service must be furnished by an IHS/Tribal facility or by its contractual agent as part of the facility's services; and
4) The IHS/Tribal facility must maintain responsibility for the provision of the service and must bill the state Medicaid program directly for the service.

CMS' recent reinterpretation of 1905(b) permits a wider scope of services for which states can claim 100% FFP/FMAP.[5] However, services must still be linked to an IHS/Tribal facility. Under CMS' new interpretation, Medicaid services provided to AI/ANs that are "received through" a Tribal provider, but are delivered by a non-Tribal provider under a written care coordination agreement, can qualify for 100% FFP/FMAP. The purpose of CMS' revised policy interpretation of 1905(b) is to enable IHS facilities to expand the scope of services they are able to offer to their AI/AN patients while ensuring coordination of care in accordance with best medical practice standards.

It was the intent of Congress to provide 100% FMAP so as not to burden the states with the federal responsibility to pay for the cost of care "received through" IHS facilities, and to provide additional resources for making improvements in IHS facilities in order to achieve compliance with the applicable conditions and requirements of Medicaid. As a result, the Tribal 100% FMAP rule must only be made available for services received through the Indian health system. Only in this way can CMS ensure that federal funds flowing into the Indian health system will achieve and maintain compliance with the Medicaid conditions of participation as Congress intended. For this reason, the TSGAC strongly objects to the State's proposal to establish an "alternative" delivery system to serve AI/ANs that is divorced from the Indian health providers but nonetheless is funded by the Tribal 100% FMAP rule for Indian health facilities.

The South Dakota demonstration waiver would provide significant additional Medicaid funds to the State with no guarantee that these resources be used to support the Indian health system or address IHS/Tribal facility deficiencies, as Congress intended. The waiver states that it is intended to increase access to services for AI/ANs who do not have convenient access to IHS providers in the State. But the waiver does not actually provide additional access to providers, or additional resources to Indian health providers. AI/ANs already have access to FQHCs and Urban Indian programs in the State. The waiver does not increase their access to FQHC or Urban Indian clinics. Nor does the waiver provide any new resources for FQHCs or Urban Indians clinics to serve AI/ANs. The waiver would appear to reimburse FQHCs under the State's standard cost-based reimbursement methodology. There is nothing in the waiver stipulating that any additional resources would be provided for expanded care to AI/ANs. Billing by Urban Indian clinics is not even mentioned.

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[4] 25 U.S.C. § 1641.

[5] CMS State Health Official Letter #16-002 (Feb. 26, 2016), Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives, https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf.

All of the cost savings in the waiver would flow directly to the State, and there is no assurance that any resources would flow back to the Indian health system, or make any improvements in the facilities of the IHS in order to achieve compliance with the applicable conditions and requirements of Medicaid, as Congress intended when it amended the Social Security Act sections 1905(b) and 1911(xx).

Budget Neutrality

CMS requires states to demonstrate that projects authorized under section 1115 of the SSA are budget neutral. A budget neutral demonstration project requires that Medicaid costs to the federal government must not be greater than what the federal government's Medicaid costs would likely have been absent the demonstration. The South Dakota demonstration waiver simply states that budget neutrality to the federal government is satisfied by claiming that these costs are the responsibility of the federal government under the federal trust responsibility citing the IHCIA's Declaration of National Indian Health Policy (25 U.S.C. § 1602) as the authorization for 1905(b).[6]

While the TSGAC does not disagree with South Dakota's foundational principle that the federal government has a duty and obligation to fund the health needs of AI/ANs, we note that the State conflates the Declaration with the authorization for 100% FMAP. The IHCIA is not the authorizing statute for 100% FMAP; it is the Social Security Act. Because of this, the requirements of the SSA, which authorizes 100% FMAP, would still mandate that covered services be "received through" an IHS facility.

South Dakota further reasons that there would not be increased federal expenditures than what would otherwise have been spent, since the federal government would be responsible under the "federal trust doctrine" and 1905(b) to pay all of the costs for Medicaid-eligible services at the FQHC facilities. South Dakota's proposed demonstration effectively would allow 100% FFP/FMAP for services rendered by FQHC providers eligible under the demonstration—with no requirement that covered services be "received through" IHS facilities. This will increase the costs of Medicaid services, which would no longer be linked to a requirement that they be "received through" IHS facilities, and result in increased Medicaid expenditures to the federal government.

When Congress authorized the IHS and Tribal facilities to participate in Medicaid as a new class of provider, it did not negate a state's existing obligation to provide Medicaid services to all eligible individuals, including AI/ANs as citizens of a state. Prior to the enactment of 1905(b), states paid the state share of Medicaid for all AI/ANs, whether served by Tribal or non-Tribal facilities. Section 1905(b) did not alter that, but it did provide 100% FMAP to offset the cost to states of authorizing a new class of providers to bill Medicaid, as well as to direct additional resources to the chronically underfunded IHS. The change outlined in this demonstration would contradict this principle.

Conclusion

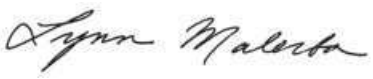
The TSGAC commends the State in identifying health disparities experienced in Indian country in the State of South Dakota and its commitment to exploring innovative ways of addressing these disparities. **Unfortunately, the proposed waiver will not achieve its stated aim of reducing health disparities for AI/ANs, in large part because of a failure to reach a mutually agreeable approach supported by the State and Tribes.**

[6] See page 13 of the waiver.

As a result, we urge CMS not to approve this demonstration waiver since it will simply allow the State to claim additional cost savings with no direct benefit to the Indian health system and it fails to meet the budget neutrality requirements for 1115 waivers. In fact, this waiver will result in additional Medicaid expenditures to the federal government by allowing all Medicaid services provided to AI/ANs by non-Tribal FQHCs to be claimed at 100% FFP/FMAP.

We hope that our comments and recommendations are not construed as an unwillingness to support efforts by the State of South Dakota, or any other state, to improve access to health care for AI/ANs. Our comments are intended to uphold the federal trust responsibility and to ensure that resources associated with 100% FMAP continue to be invested in maintaining and improving the Indian health system in order to better serve the health care needs of AI/ANs. If you have any questions or wish to discuss these comments further, please contact me at (860) 862-6192 or via email at lmalerba@moheganmail.com. Thank you.

Sincerely,



Marilynn "Lynn" Malerba
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cc: Kitty Marx, Director, Division of Tribal Affairs/IEAG/CMCS
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TSGAC Members and Technical Workgroup