March 19, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services


Dear Ms. Norwalk:

As Chair and on behalf of the Tribal Technical Advisory Group (TTAG), I appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services’ (CMS) proposed rule published on January 18, 2007 at 72 Federal Register 2236. As currently written, we oppose the proposed rule and would like to offer suggested regulatory language that we believe will address tribal concerns consistent with existing CMS policy.

Statements made by the Acting Administrator, Deputy Administrator and other CMS officials during the most recent meeting of the TTAG made it clear that it was CMS’s intent that this proposed rule have no effect on the opportunity of Indian Tribes and Tribal organizations to participate in financing the non-Federal portion of medical assistance expenditures for the purpose of supporting certain Medicaid administrative services, as set forth in State Medicaid Director (SMD) letters of October 18, 2005, as clarified by the letter of June 9, 2006. Unfortunately, we are convinced that, as written, the proposed rule would, in fact, negatively affect such participation. We discuss our concerns and offer proposed solutions below.

**Criteria for Indian Tribes to Participate**

The proposed rule attempts to make clear that Indian Tribes may participate by specifically referencing them in proposed section 433.50(a)(1). However, as currently proposed, an Indian Tribe would only be able to participate if it has “generally applicable taxing authority,” a criteria applied to all units of government referenced here. Although in principle Indian Tribes do enjoy taxing authority, as with all other matters about Indian Tribes, the law is complex and fraught with exceptions. To impose this requirement will burden each State with trying to understand the specific status of each Indian Tribe and to make decisions about the taxing authority of the Tribe – a complex matter often the subject of litigation between Indian Tribes and States. A requirement to make such determinations will almost certainly negatively affect the willingness of States to enter into cost sharing agreements with Indian Tribes since an error in the determination regarding this undefined term could have potentially negative effects for the State.

Since other provisions of the proposed rule address the limitations on the type of funds that may be used, other funds of the Indian Tribe, including funds transferred to the Tribe under a contract or compact pursuant to the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended,
should be acceptable without regard to whether they derive from “generally applicable taxing authority.” Accordingly, we propose the following amendment to the proposed language for section 433.50(a)(1)(i):

(i) A unit of government is a State, a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) that has generally applicable taxing authority, and includes an Indian tribe as defined in section 4 of the Indian Self-Determination and Education Assistance Act, as amended, [25 U.S.C. 450b].

Criteria for Tribal Organizations to Participate

We oppose this rule as currently written because we believe it will negatively affect the participation of tribal organizations to perform Medicaid State administrative activities. The CMS TTAG spent over two years working with CMS and the Indian Health Service (IHS) resulting in an October 18, 2005, SMD letter clarifying that tribes and tribal organizations, under certain conditions, could certify expenditures as the non-Federal share of Medicaid expenditures for Medicaid administrative services provided by such entities. However, the proposed rule does not reflect that the criteria approved by CMS recognizing tribal organizations as a unit of government eligible to incur expenditures of State plan administration eligible for Federal matching funds. As part of these comments, we have enclosed a copy of the SMD’s letter of October 18, 2005, and clarifying SMD letter dated June 9, 2006.

Under the proposed rule, participation will be available only if two conditions are satisfied:

(1) the unit that proposes to contribute the funds is eligible under the proposed amendment to 42 C.F.R. § 433.50(a)(1); and
(2) the contribution is from an allowable source of funds under the newly proposed section 447.206.

Most tribal organizations will not meet the proposed standard for criteria (1). The basic participation requirement in proposed 433.50(a)(1) sets a new standard for the eligibility of the unit that will exclude many tribal organizations by imposing a requirement that there be “taxing authority” or “access [to] funding as an integral part of a unit of government with taxing authority which is legally obligated to fund the health care provider’s expenses, liabilities, and deficits. . . .” The new proposed rule at 433.50(a)(1) provides:

(i) A unit of government is a State, a city, a county, a special purpose district, or other governmental unit in the State (including Indian tribes) that has generally applicable taxing authority.
(ii) A health care provider may be considered a unit of government only when it

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1 The October letter contained the incorrect footnote that said ISDEAA funds cannot be used for match. But the SMD letter dated June 9, 2006, corrected this error. “[T]he Indian Health Service has determined that ISDEAA funds may be used for certified public expenditures under such an arrangement [MAM] to obtain federal Medicaid matching funding.”

2 The language in proposed 447.206(b) that provides an exception for IHS and tribal facilities from limits on the amounts of contributions uses language consistent with the October 18, 2005, SMD Letter (“The limitation in paragraph (c) of this section does not apply to Indian Health Service facilities and tribal facilities that are funded through the Indian Self-Determination and Education Assistance Act (Pub. L. 93-638”).
is operated by a unit of government as demonstrated by a showing of the following:

(A) The health care provider has generally applicable taxing authority; or

(B) The health care provider is able to access funding as an integral part of a unit of government with taxing authority which is legally obligated to fund the health care provider’s expenses, liabilities, and deficits, so that a contractual arrangement with the State or local government is not the primary or sole basis for the health care provider to receive tax revenues.

In the explanation of the proposed rule, the problem is exacerbated in the discussion of section 433.50. Many tribal organizations are not-for-profit entities. The explanation of the rule suggests that not-for-profit entities “cannot participate in the financing of the non-Federal share of Medicaid payments, whether by IGT or CPE, because such arrangements would be considered provider-related donations.”

None of these criteria: taxing authority; governmental responsibility for expenses, liabilities and deficits; nor a prohibition on being a not-for-profit are limitations contained in the October 18, 2005 SMD letter. None of these criteria are consistent with the governmental status of tribal organizations carrying out programs of the IHS under the Indian Self-Determination and Education Assistance Act (ISDEAA), which is the basis of the SMD letters.

The proposed rule imposes significant new restrictions on a state’s ability to fund the non-federal share of Medicaid payments through intergovernmental transfers (IGTs) and certified public expenditures (CPEs). Furthermore, we believe there is no authority in the statute for CMS to restrict cost sharing to funds generated from tax revenue. CMS has inexplicably attempted to use a provision in current law that limits the Secretary’s authority to regulate cost sharing as the source of authority that all cost sharing must be made from state or local taxes. The proposed change is inconsistent with CMS policy as outlined in the October 18, 2005 and the June 9, 2006 SMD letters.

Based on the comments made by Leslie Norwalk during the TTAG meeting February 22, 2007, it is clear that the proposed rule regarding conditions for inter-governmental transfers was not intended by the Department to overturn any part of the SMD letters of October 18, 2005, and June 9, 2006. This was further confirmed by Aaron Blight, Director Division of Financial Operations, CMSO, on a conference call held with the CMS TTAG policy subcommittee as well as the second day of the CMS TTAG meeting held on February 23.

We therefore suggest that the regulations be amended to include the criteria contained in the October 18, 2005 SMD letter as a new (C) to 433.50(a)(1)(ii), as follows:

(C) The health care provider is an Indian Tribe or a Tribal organization (as those terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act (ISDEAA); 25 U.S.C. 450b) and meets the following criteria:

(1) If the entity is a Tribal organization, it is—

   (aa) carrying out health programs of the IHS, including health services which are eligible for reimbursement by Medicaid, under a contract or compact entered into between the Tribal organization and the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, and
(bb) either the recognized governing body of an Indian tribe, or an entity which is formed solely by, wholly owned or comprised of, and exclusively controlled by Indian tribes.

(2) The cost sharing expenditures which are certified by the Indian Tribe or Tribal organization are made with Tribal sources of revenue, including funds received under a contract or compact entered into under the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, provided such funds may not include reimbursements or payments from Medicaid, whether such reimbursements or payments are made on the basis of an all-inclusive rate, encounter rate, fee-for-service, or some other method.

The caveat to paragraph (2) above regarding the source of payments was added to expressly address a new limitation that CMS proposed on February 23, 2007, with regard to approving the Washington State Medicaid Administrative Match Implementation Plan to exclude any “638 clinics that are reimbursed at the all-inclusive rate from participation in the tribal administrative claiming program.” No such exclusion was ever contemplated by CMS when it sent the SMD letters referred to earlier. Such an exclusion would swallow the rule that allows Indian Tribes and Tribal organizations to participating in cost sharing.

This new requirement could be interpreted as undermining the commitment made in the SMD letters, which had no such limitation, notwithstanding hours of discussion among CMS, Tribal representatives, and IHS about how reimbursement for tribal health programs is calculated. There was an understanding that the all-inclusive rate does not include expenditures for the types of activity covered by Administrative Match Agreements and therefore avoids duplication of costs. CMS well knows that most IHS and tribal clinics are reimbursed under an all-inclusive rate. We have to hope that instead this is another instance in which the individuals responding to Washington State were simply “out-of-the-loop” regarding the extensive discussions with the TTAG prior to the issuance of the SMD letter.

We appreciate the challenges that face a large bureaucracy like CMS in making sure that all of its employees are equally well informed. Given that this request to Washington State reflects yet another breakdown in internal communication, we believe that the caveat at the end of the (C)(2) is essential (or some other language that makes clear that the form of Medicaid reimbursement received by an Indian Tribe or Tribal organization will not disqualify it from participating in cost sharing).

We appreciate the opportunity to comment and appreciate thoughtful consideration of these comments.

Sincerely,

Valerie Davidson, Chair
Tribal Technical Advisory Group

Cc:    Herb Kuhn
Dr. Charles Grim
CMS Tribal Affairs Staff
Aaron Blight
Dear State Medicaid Director:

A number of States and Tribal organizations have asked whether expenditures that are certified by Tribal organizations can be used to fulfill State matching requirements for administrative activities under the Medicaid program. In considering this question, the Centers for Medicare & Medicaid Services (CMS) took into account the fact that Tribal organizations may have governmental responsibilities when operating on behalf of Tribal governments. Additionally, CMS considered the possible occurrence of duplicate payment when the same entity is paid under an agreement to perform Medicaid State administrative activities and as a provider for Medicaid services. This letter describes CMS’ policy regarding the conditions under which Tribal organizations can certify expenditures as the non-Federal share of Medicaid expenditures for Medicaid administrative services directly provided by such entities.

Pursuant to Federal law, the Indian Self-Determination and Education Assistance Act (ISDEAA), Public Law 93-638, as amended, permits Indian Tribes to directly operate health programs that furnish covered Medicaid services under a contract or compact with the Indian Health Service (IHS). Several States have contracted with Tribes to perform certain allowable Medicaid administrative functions and, as units of government, the Tribes certify actual expenditures related to these activities to the State. The activities performed include, among other things, outreach and application assistance for Medicaid enrollment and activities that ensure appropriate utilization of Medicaid services by Medicaid beneficiaries. The contract language ensures that expenditures certified for administrative costs do not duplicate, in whole or in part, claims made for the costs of direct patient care. The State uses the certified expenditures in its Federal financial participation (FFP) claims for State Medicaid administration activities.\(^1\)

Section 1903(w)(6)(A) of the Social Security Act (the Act) specifies that the Secretary may not restrict a State's use of funds where such funds are derived from State or local taxes (or funds appropriated to State teaching hospitals) transferred from, or certified by, units of government within a State as the non-Federal share of Medicaid expenditures, regardless of whether the unit of government is also a health care provider under the State plan, unless the transferred funds are derived from donations or taxes that would not otherwise be recognized as the non-Federal share. Under this provision, only certified public expenditures from units of government are protected.

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\(^1\) Federal funds may not be used to meet State matching requirements, except as authorized by Federal law. Although Federal IHS funds awarded under ISDEAA may be used to meet Tribal matching requirements, that authority does not include State matching requirements. As a result, Tribal expenditures certified for this purpose must be funded through non-ISDEAA sources.
Regulations at 42 CFR section 433.51 permit certified public expenditures from public agencies, specifically including Indian Tribes, to be used as the non-Federal share of expenditures. However, these regulations do not address Tribal organizations.

It is not the intent of this letter to expand the scope of transactions protected under section 1903(w)(6)(A) of the Act or the regulations at 42 CFR section 433.51. However, it is CMS’ position that when federally recognized Indian Tribes coalesce for a common purpose, that collective effort should be afforded the same rights, privileges, protections, and exemptions as the individual Tribes themselves. This status extends to Tribal organizations formed solely by, wholly owned by or comprised of, and exclusively controlled by Indian Tribes, as currently defined in section 4(e) of ISDEAA. This section defines “Indian Tribe” to mean any Indian Tribe, band, nation, or other organized group or community, including any Alaska Native village or a regional or village corporation as defined in, or established pursuant to, the Alaska Native Claims Settlement Act, which are recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Some Indian Tribes, either alone or jointly with other Indian Tribes, operate health programs indirectly through separate Tribal organizations. The organizational structure of the Tribal organizations, as well as the designation of authority and responsibilities by the Tribes to the Tribal organizations, varies among Tribes and Tribal organizations. When the IHS enters into an ISDEAA contract or compact with a Tribal organization, the IHS engages in a detailed process of certifying that the Tribal organization meets the ISDEAA statutory requirements. The governing body of the Tribal organization must be composed solely of members of Indian Tribes. Each Tribe represented by the Tribal organization must have passed a resolution authorizing the Tribal organization to act on its behalf. ISDEAA requires that the contracting or compacting Tribal organization compute its costs in accordance with the cost principles for State, local, and Indian Tribal governments contained in the Office of Management and Budget (OMB) Circular A-87. Additionally, ISDEAA requires that the Tribal organization comply with the provisions of the Single Audit Act (31 U.S.C., Chapter 75). Therefore, reliance on the IHS certification process for approval of ISDEAA contracts and compacts will prevent duplication of some of the efforts necessary to determine—by CMS standards—whether an entity is a unit of government.

Some Tribal organizations that receive IHS funding do not operate solely on behalf of Tribal governments. A Tribal organization that is not formed wholly by Indian Tribes, as discussed above, may be authorized to act on behalf of Tribal governments, may receive IHS grant funds on behalf of such governments, and may be accorded the rights of such governments for many purposes. However, unless a Tribal organization is either the recognized governing body of an Indian Tribe, or an entity which is formed solely by, wholly owned by or comprised of, and

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2 See Dille v. Council of Energy Resource Tribes, 801 F.2d 373 (10th Cir. 1986).
exclusively controlled by Indian Tribes, as defined above, it is not a unit of government for Medicaid purposes.

Because of the variations in the organization, nature, function, responsibilities, and fiscal arrangements between Tribes and Tribal organizations, CMS has developed a set of criteria for use in analyzing whether a Tribal organization is acting as a unit of government and incurs expenditures of State plan administration that are eligible for Federal matching funds. All of these criteria must be met for recognition of certified public expenditures for administration of the State plan by a Tribal organization. If you choose to enter into a contractual arrangement for certification of expenditures for Medicaid administrative activities by a Tribal organization which meets the criteria set forth below, please ensure that your agreements are structured such that you do not contract out any Medicaid administrative functions that Federal or State law and regulations require that the State government itself perform. Assure that the activities covered by the contract are not already being offered or provided by other entities or through other programs and will not otherwise be paid for as a Medicaid administrative cost. In addition, if the Tribal organization is also a direct provider of health care services, the contract language must ensure that activities that are integral parts or extensions of direct medical services, such as patient follow-up, patient assessment, patient education, or counseling, are not included in the claims for Medicaid administration. Finally, the costs of any subcontracts by the Tribal organization to non-governmental entities are not to be included in the FFP claims for which certification is made.

CRITERIA FOR RECOGNITION OF TRIBAL ORGANIZATION EXPENDITURES AS THE NON-FEDERAL SHARE OF MEDICAID ADMINISTRATION CLAIMS:

1. The Tribal organization is carrying out health programs of the IHS, including health services which are eligible for reimbursement by Medicaid, under a contract or compact entered into between the Tribal organization and the IHS pursuant to the ISDEAA (P.L. 93-638), as amended.

2. The Tribal organization is either the recognized governing body of an Indian Tribe, or an entity which is formed solely by, wholly owned by or comprised of, and exclusively controlled by Indian Tribes, as defined in Section 4 of the ISDEAA (P.L. 93-638), as amended.

3. The Tribal organization has contracted with the State Medicaid agency to perform specified State Medicaid administrative activities and certify as public expenditures only its actual costs (computed in accordance with applicable provisions of OMB Circular A-87) of allowable administrative activities performed pursuant to its contract with the State Medicaid agency.
4. The expenditures for allowable administrative activities which are certified by the Tribal organization are made with Tribal sources of revenue other than Medicaid revenues or ISDEAA funds.

Attached is a list of Tribal organizations with current ISDEAA Title I contracts or Title V compacts that have been identified by IHS as meeting the criteria listed above (Attachment A). This list is subject to change as new Tribal organizations contract or compact with IHS on a yearly basis. In addition to the attached list of Tribal organizations, for those Tribal organizations which are the recognized governing body of an Indian Tribe, please refer to the Department of the Interior’s list of federally Recognized Tribes. The most recent listing, a copy of which is attached (Attachment B), was published on December 5, 2003, in the Federal Register (67 Fed. Reg. 68180). Proof of current ISDEAA contractor status should be included in the agreement approval process established by each State.

Prior to claiming FFP for expenditures for which a Tribal organization certifies the funds, the State must submit a written statement to the jurisdictional CMS regional office, certifying that the State reviewed the organization and that it meets all of the criteria specified in this letter. Please note that the source of funds used by Tribal organizations to represent expenditures eligible for FFP must be documented to CMS upon its request.

If you have questions regarding this matter, please contact Mr. Ed Gendron at (410) 786-1064.

Sincerely,

/s/

Dennis G. Smith
Director

Attachments

cc:

CMS Regional Administrators

CMS Associate Regional Administrators for Medicaid and State Operations

Martha Roherty
Director, Health Policy Unit
American Public Human Services Association
Title I Contractors
Tribal Organizations

Title I Tribal Organizations*

Alamo Navajo School Board, Inc.
Albuquerque Area Indian Health Board
All Indian Pueblo Council, Inc.
California Rural Indian Health Board (CRIHB)
Central Valley Indian Health, Inc.
Chapa-De Indian Health Program, Inc.
Consolidated Tribal Health Project, Inc.
Cook Inlet Tribal Council, Inc.
Eight Northern Indian Pueblo Council
Fairbanks Native Association
Feather River Tribal Health, Inc.
Great Lakes Inter-Tribal Council
Healing Lodge of Seven Nations
Indian Health Council
Lake County Tribal Health Consortium, Inc.
Mariposa, Amador, Calaveras, Tuolumne (MACT) Indian Health Board, Inc.
Northern Valley Indian Health
NW Portland Area Indian Health Board
Ramah Navajo School Board, Inc.
Sierra Tribal Consortium
Sonoma County Indian Health
Southern Indian Health Council
South Puget Intertribal Planning Agency
Toiyabe Indian Health Project
Ukpeagvik Inupiat Corporation
United Indian Health Services
United South and Eastern Tribes, Inc.
United Tribes Technical College
Valdez Native Tribe

* This list will be updated periodically.
Title V Compactors
Tribal Organizations

**Title V Tribal Organizations**

Alaska Native Tribal Health Consortium (ANTHC)
Aleutian Pribilof Islands Association, Inc.
Arctic Slope Native Association, Ltd.
Bristol Bay Area Health Corporation
Chugachmiut
Copper River Native Association
Council of Athabascan Tribal Governments
Eastern Aleutian Tribes, Inc.
Ketchikan Indian Community
Kodiak Area Native Association
Maniilaq Association
Metlakatla Indian Community
Miami Health Consortium
Mount Sanford Tribal Consortium
Native Village of Eklutna
Northeastern Tribal Health System
Norton Sound Health Corporation
Riverside-San Bernadino County Indian Health, Inc.
Seldovia Village Tribe
Southcentral Foundation
SouthEast Alaska Regional Health Consortium (SEARHC)
Tanana Chiefs Conference, Inc.
Yakutat Tlingit Tribe
Yukon-Kuskokwim Health Corporation

* This list is updated periodically.
Friday,
December 5, 2003

Part III

Department of the Interior

Bureau of Indian Affairs

Indian Entities Recognized and Eligible To Receive Services From the United States Bureau of Indian Affairs; Notice
DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

Indian Entities Recognized and Eligible To Receive Services From the United States Bureau of Indian Affairs

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Notice.

SUMMARY: Notice is hereby given of the current list of 562 tribal entities recognized and eligible for funding and services from the Bureau of Indian Affairs by virtue of their status as Indian tribes. This notice is published pursuant to section 104 of the Act of November 2, 1994 (Pub. L. 103–454; 108 Stat. 4791, 4792).

FOR FURTHER INFORMATION CONTACT: Daisy West, Bureau of Indian Affairs, Division of Tribal Government Services, MS–320-MIB, 1849 C Street, NW., Washington, DC 20240. Telephone number: (202) 513–7641.

SUPPLEMENTARY INFORMATION: This notice is published in exercise of authority delegated to the Assistant Secretary—Indian Affairs under 25 U.S.C. 2 and 9 and 209 DM 8.

Published below is a list of federally acknowledged tribes in the contiguous 48 states and in Alaska. The list is updated from the notice published on July 12, 2002 (67 FR 46328).

Several tribes have made changes to their tribal name. To aid in identifying tribal name changes, the tribe’s former name is included with the new tribal name. We will continue to list the tribe’s former name for several years before dropping the former name from the list. We have also made several corrections. To aid in identifying corrections, the tribe’s previously listed name is included with the tribal name.

The listed entities are acknowledged to have the immunities and privileges available to other federally acknowledged Indian tribes by virtue of their government-to-government relationship with the United States as well as the responsibilities, powers, limitations and obligations of such tribes. We have continued the practice of listing the Alaska Native entities separately solely for the purpose of facilitating identification of them and reference to them given the large number of complex Native names.


Aurene M. Martin, Principal Deputy Assistant Secretary—Indian Affairs.

Indian Tribal Entities Within the Contiguous 48 States Recognized and Eligible To Receive Services From the United States Bureau of Indian Affairs

Absentee-Shawnee Tribe of Indians of Oklahoma
Agua Caliente Band of Cahuilla Indians of the Agua Caliente Indian Reservation, California
Ak Chin Indian Community of the Maricopa (Ak Chin) Indian Reservation, Arizona
Alabama-Coushatta Tribes of Texas
Alaska-Quassarte Tribal Town, Oklahoma
Alturas Indian Rancheria, California
Apache Tribe of Oklahoma
Arapaho Tribe of the Wind River Reservation, Wyoming
Aroostook Band of Micmac Indians of Maine
Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation, Montana
Augustine Band of Cahuilla Mission Indians of the Augustine Reservation, California
Bad River Band of the Lake Superior Tribe of Chippewa Indians of the Bad River Reservation, Wisconsin
Bay Mills Indian Community, Michigan
Bear River Band of the Rohnerville Rancheria, California
Berry Creek Rancheria of Maidu Indians of California
Big Lagoonz Rancheria, California
Big Pine Band of Owens Valley Paiute Shoshone Indians of the Big Pine Reservation, California
Big Sandy Rancheria of Mono Indians of California
Big Valley Band of Pomo Indians of the Big Valley Rancheria, California
Blackfeet Tribe of the Blackfeet Indian Reservation of Montana
Blue Lake Rancheria, California
Bridgeport Paiute Indian Colony of California
Buena Vista Rancheria of Me-Wuk Indians of California
Burns Paiute Tribe of the Burns Paiute Indian Colony of Oregon
Cabazon Band of Mission Indians, California (previously listed as the Cabazon Band of Cahuilla Mission Indians of the Cabazon Reservation)
Cachil DeHe Band of Wintun Indians of the Cachil DeHe Band of Wintun Indians of the Cachuma Reservation, California
Confederated Tribes of the Warm Springs Reservation of Oregon
Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians of Oregon
Confederated Tribes of the Siletz Reservation, Oregon
Confederated Tribes of the Umatilla Reservation, Oregon
Confederated Tribes of the Colville Reservation, Washington
Confederated Tribes of the Grand Ronde Community of Oregon
Confederated Tribes of the Siletz Reservation, Oregon
Confederated Tribes of the Umatilla Reservation, Oregon
Confederated Tribes of the Warm Springs Reservation of Oregon
Confederated Tribes and Bands of the Yakama Nation, Washington (formerly the Caddo Indian Tribe of Oklahoma)
Confederated Tribes of the Umatilla Reservation, Oregon
Native Village of Napakiak
Native Village of Nelson Lagoon
Nenana Native Association
New Koliganek Village Council
(formerly the Koliganek Village)
New Stuyahok Village
Newhalen Village
Newtok Village
Native Village of Nightmute
Nikolai Village
Native Village of Nikolski
Ninilchik Village
Native Village of Noatak
Nome Eskimo Community
Nondalton Village
Noorvik Native Community
Northway Village
Native Village of Nuiqsut (aka Nooiksut)
Nulato Village
Nunakuyarmiut Tribe (formerly the
Native Village of Toksook Bay)
Native Village of Nunapitchuk
Village of Ohogamiut
Village of Old Harbor
Orutsararmuit Native Village (aka
Bethel)
Oscarville Traditional Village
Native Village of Ouzinkie
Native Village of Paimut
Pauloff Harbor Village
Pedro Bay Village
Native Village of Perryville
Petersburg Indian Association
Native Village of Pilot Point
Pilot Station Traditional Village
Native Village of Pitka’s Point
Platinum Traditional Village
Native Village of Point Hope
Native Village of Point Lay
Native Village of Port Graham
Native Village of Port Heiden
Native Village of Port Lions
Portage Creek Village (aka Ohgsenakale)
Pribilof Islands Aleut Communities of
St. Paul & St. George Islands
Qagan Tayagungin Tribe of Sand Point
Village
Qawalangin Tribe of Unalaska
Rampart Village
Village of Red Devil
Native Village of Ruby
Saint George Island (See Pribilof Islands
Aleut Communities of St. Paul & St. George Islands)
Saint Paul Island (See Pribilof Islands
Aleut Communities of St. Paul & St. George Islands)
Village of Salamatoff
Native Village of Savoonga
Organized Village of Saxman
Native Village of Scammon Bay
Native Village of Selawik
Seldovia Village Tribe
Shageluk Native Village
Native Village of Shaktoolik
Native Village of Sheldon’s Point
Native Village of Shishmaref
Shoonaq’ Tribe of Kodiak
Native Village of Shungnak
Sitka Tribe of Alaska
Skagway Village
Village of Sleetmute
Village of Solomon
South Naknek Village
Stebbins Community Association
Native Village of Stevens
Village of Stony River
Takotna Village
Native Village of Tanacross
Native Village of Tanana
Native Village of Tatitlek
Native Village of Tazlina
Telida Village
Native Village of Teller
Native Village of Tetlin
Central Council of the Tlingit & Haida
Indian Tribes
Traditional Village of Togiak
Tuluksaq Native Community
Native Village of Tuntutulik
Native Village of Tununik
Twin Hills Village
Native Village of Tyonek
Ugashik Village
Unkumute Native Village
Native Village of Unalakleet
Native Village of Unga
Village of Venetie (See Native Village of
Venetie Tribal Government)
Native Village of Venetie Tribal
Government (Arctic Village and
Village of Venetie)
Village of Wainwright
Native Village of Wales
Native Village of White Mountain
Wrangell Cooperative Association
Yakutat Tlingit Tribe

[FR Doc. 03–30244 Filed 12–4–03; 8:45 am]

BILLING CODE 4310–4J–P
Center for Medicaid and State Operations

June 9, 2006

SMDL#06-014

Dear State Medicaid Director:

On October 18, 2005 The Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Director (SMD) letter containing guidance for participation by Tribal organizations in arrangements that use certified public expenditures by a “unit of government” to fulfill the non- federal matching requirements for administrative activities under the Medicaid program. The letter set forth criteria under which a Tribal organization may be considered as a unit of government that can certify expenditures as the non-Federal share of Medicaid administration claims. The letter contained the following footnote:

“Federal funds may not be used to meet State matching requirements, except as authorized by Federal law. Although Federal HHS funds awarded under ISDEAA [the Indian Self-Determination and Education Assistance Act, or Pub.L. 93-638] may be used to meet Tribal matching requirements, that authority does not include State matching requirements. As a result, Tribal expenditures certified for this purpose must be funded through non-ISDEAA sources.”

Although the footnote correctly states the applicable principles of law, after further review, we have determined that the conclusion in the last sentence would not apply when the full financial benefit and responsibility has been assigned to the tribal organization. The Indian Health Service (IHS) and CMS are issuing this joint SMD letter to clarify that footnote.

When a State assigns to a tribal organization the full right to the federal matching share, without any diminution, along with the full responsibility for establishing the non-federal share through certified public expenditures, the State effectively drops out of the financial equation. What remains is a funding arrangement under which federal matching funds are directly available to the tribal organization based on the tribal organization’s expenditures. This is effectively a tribal matching obligation, rather than a contribution to a larger State matching obligation.

Based on this analysis that such an arrangement effectively results in a tribal matching obligation, the Indian Health Service (IHS) has determined that ISDEAA funds may be used for certified public expenditures under such an arrangement to obtain federal Medicaid matching funding. The net required contribution by the Tribal organization cannot exceed the non-Federal share of such expenditures; thus the State must pass through to the Tribal organization the full amount of Federal Medicaid matching funding received based on the certified expenditures.

It is important to note that ISDEAA funds may only be used to fund activities permissible under the ISDEAA. This includes activities authorized under the Snyder Act, 25 U.S.C. 13, and the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. §1601 et seq. Thus, any Medicaid administrative activities that are funded with ISDEAA funds must also be permissible activities under the Snyder Act or the IHCIA.
The October 18, 2005 State Medicaid Director letter also contained four criteria for recognition of Tribal organization expenditures as the non-Federal share of Medicaid administration claims. The fourth criterion, stating that expenditures for allowable administrative activities which are certified by the Tribal organizations must be made with Tribal sources of revenue other than Medicaid revenues or ISDEAA funds is amended to delete the reference to ISDEAA funds, which may now be used as outlined in this letter. Additionally, a fifth criterion is hereby added. The fourth and fifth criteria now read as follows:

4. Expenditures for allowable Medicaid administrative activities which are certified by the Tribal organization are made with funds derived from Tribal sources of revenue other than Medicaid revenues.

5. Expenditures made with funds derived from ISDEAA agreements may be certified by the Tribal organization only to the extent that the State passes the entire amount of Federal Medicaid matching funding to the Tribal organization.

Tribes, as well as Tribal organizations, which certify Medicaid administration expenditures made with funds derived from ISDEAA agreements, must receive the full amount of Federal Medicaid matching funding.

If you have questions regarding this matter, please contact Ed Gendron at CMS on 410-786-1064 or Carl Harper at HIS on 301-443-3216.

Sincerely,

/s/ Dr. Charles Grim, D.D.S., M.H.S.A.  
Director  
Indian Health Service

/s/ Dennis G. Smith  
Director  
Center for Medicaid and State Operations

Cc:

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CMS Associate Regional Administrators  
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Joy Wilson  
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