

Tribal Technical Advisory Group

to the Centers for Medicare and Medicaid Services

National Indian Health Board 101 Constitution Ave NW, #8B02 Washington, DC 20001 (202) 742-4262 (202) 742-4285 fax www.nihb.org

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Dennis Smith, Director,
CMSO
7500 Security Boulevard
Baltimore, MD 20244-1850

Dear Mr. Smith:

The tribal representatives to the CMS Tribal Technical Advisory Group have asked me to write to request your assistance in promptly clarifying that funds transferred or certified by Indian Tribal organizations may be used by states as their share of Medicaid administrative expenditures -- just as states may now use funds transferred or certified by Indian Tribes for this purpose. We believe that this clarification is consistent with CMS Medicaid regulations, with established federal policy to encourage self-determination by Indian Tribes, and with established practice in several states. This clarification would facilitate outreach and enrollment activities by Tribal organizations that would increase participation by eligible American Indians and Alaska Natives in their state Medicaid programs.

Under CMS regulations, state Medicaid programs must use non-federal public funds as the state share of Medicaid expenditures in order to claim federal matching funds. For this purpose, public funds include funds "transferred from other public agencies (including Indian tribes) to the [state Medicaid agency] and under its administrative control, or certified by the contributing public agency as representing [allowable Medicaid expenditures]." 42 CFR 433.51(b). The regulation does not define the term "public agency," although it clearly includes Indian Tribes. The question on which we are seeking clarification is whether the term "public agency" also includes Tribal organizations that have been authorized by an Indian tribe to carry out programs, functions, or activities on behalf of their Tribe.

Neither the Medicaid statute nor your agency's Medicaid regulations are silent on this issue. While they do not expressly endorse such a policy, they most certainly do not prohibit it. The Indian Self-Determination and Education Assistance Act (ISDEAA), P. L. 93-638, defines the term "Indian tribe" to include organizations that have been authorized by resolutions adopted by federally-recognized Tribes. It also expressly allows Tribal organizations to use federal funds provided under a Self-Determination contract to meet matching requirements under federal programs.

The federal government's policy of equating Tribes and authorized Tribal organizations is straightforward: as a practical matter, Tribes can only determine their own futures if they have the managerial flexibility to do so by delegating various functions to Tribal organizations. In the case of health care, many Tribes have elected to authorize Tribal organizations to act on their behalf. Although national data are unavailable, in the state of California, the majority of the Tribal Health Programs (16 out of 30), serving about 80 percent of the Indian Medicaid beneficiaries in the state, are run by Tribal organizations rather than Tribes. As a consequence,

unless current CMS policy is clarified, only 20 percent of Indian Medicaid enrollees in California will be able to benefit from outreach and other administrative activities.

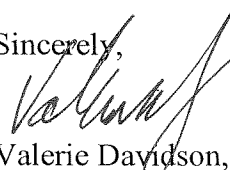
A number of state Medicaid programs currently use funds transferred or certified by Tribal organizations in paying for administrative costs. With the approval of their CMS Regional Offices, these states claim federal matching payments for these expenditures. The amounts involved in these transactions are very small in the context of overall Medicaid expenditures, but they are significant to the Tribes and states affected. Other states, including California, are interested in entering into such arrangements with Tribal organizations but have not gone forward pending CMS approval.

We understand that CMS is currently concerned about the use by some states of “creative financing” mechanisms that use illusory expenditures to bring federal Medicaid matching payments into their treasuries. We want to emphasize that neither the Tribal organizations nor the federal self-determination funds that they spend or certify for Medicaid administrative functions are illusory. Tribal organizations enter into Self-Determination contracts with the Indian Health Service, which monitors their performance. The ISDEAA expressly authorizes the use of Self-Determination funds received by either Tribes or Tribal organizations as state share of Medicaid and other federal matching programs. And CMS retains the authority to disapprove any administrative matching arrangements that prove to be abusive.

CMS clarification that Indian tribes include Tribal organizations for purposes of claiming federal Medicaid matching payments would advance two important federal policy objectives. It would promote federal Indian self-determination policy and it would increase participation of eligible American Indians and Alaska Natives in Medicaid, helping to reduce health disparities. At the same time, it would not compromise the fiscal integrity of the Medicaid program. We urge your prompt attention to this matter.

We further recommend that CMS write a “Dear State Medicaid Director” letter strongly encouraging states to contract with Tribes and Tribal organizations for outreach and access activities, and to facilitate their reimbursement under federal financial participation. This request was discussed in past meetings between the interim TTAG and CMS. It is our understanding that other tribes would like to engage in MAM activities, however some states may not be willing to move forward without formal authorization from CMS. A “Dear State Medicaid Director” letter would clarify this issue for all parties concerned.

Sincerely,



Valerie Davidson, Chair
CMS Tribal Technical Advisory Group

cc: Richard Strauss, Director
Division of Financial Management Finance Systems & Budget Group
Jim Frizzera, Team Leader, Non-Institutional Reibursement Team