2021 HOUSE HUMAN SERVICES

HB 1407

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1407
1/27/2021

Relating to medical assistance tribal health care coordination agreements; to provide for a legislative management report; and to provide a continuing appropriation.

Chairman Weisz opened the hearing at 10:39 a.m.

Representatives	Attendance
Representative Robin Weisz	P
Representative Karen M. Rohr	P
Representative Mike Beltz	P
Representative Chuck Damschen	P
Representative Bill Devlin	P
Representative Gretchen Dobervich	P
Representative Clayton Fegley	P
Representative Dwight Kiefert	P
Representative Todd Porter	P
Representative Matthew Ruby	P
Representative Mary Schneider	P
Representative Kathy Skroch	P
Representative Bill Tveit	P
Representative Greg Westlind	P

Discussion Topics:

- Tribal government money distribution
- Biennial report

Rep. Scott Louser, District 5 (10:39) introduced the bill.

Rep. Jon Nelson, District 14 (10:42) testified in favor.

Caprice Knapp, North Dakota Medicaid Director (10:56) testified and submitted testimony #3796.

Lorraine Davis, Founder & CEO NATIVE Inc. (11:02) testified in favor and submitted testimony #3807.

Rep Gretchen Dobervich, District 11 (11:04) introduced Nathan Davis, District 1 Council Representative Turtle Mountain Band of Chippewa Indians.

Nathan Davis, District 1 Council Representative Turtle Mountain Band of Chippewa Indians (11:07) testified in favor and submitted testimony #3795.

Cynthia Monteau, Three Affiliated Tribes (11:19) testified in opposition and submitted testimony #3835.

Scott Davis, Executive Director North Dakota Indian Affairs Commission (11:24) testified neutral and submitted testimony #3806.

Brad Hawk, North Dakota Indian Affairs Commission (11:35) answered questions.

Additional written testimony: #3619, #3710

Chairman Weisz adjourned at 11:36 a.m.

Tamara Krause, Committee Clerk

Testimony

House Bill 1407 – Department of Human Services

House Human Services Committee

Representative Robin Weisz, Chairman

January 27, 2021

Chairman Weisz, members of the House Human Services Committee, my name is Caprice Knapp, Director of the Medical Services Division for the Department of Human Services (Department). I am here today to testify on House Bill 1407, which makes changes to section 50-24.1-40 of North Dakota Century Code as it relates to Tribal Care Coordination agreements.

As you are aware, last session section 50-24.1-40 was added to the North Dakota Century Code. That section allows for a tribal health care organization to enter into a signed care coordination agreement with a provider enrolled in Medicaid. If an agreement is signed between a provider and a tribal health care organization, the State will be able to claim 100% FMAP funding on covered services received through IHS/Tribal 638 facilities that have care coordination agreements with non-IHS/Tribal providers. These covered services, and their subsequent bills, must be processed through the Department's normal payment system often referred to as the MMIS. MMIS will capture the billing and this information will be used in federal reporting to claim the 100% as opposed to regular FMAP.

Section 1 of the bill notes that any savings captured from the 100% versus regular FMAP will be captured and placed in a tribal health care coordination fund. Subsequently, 90% of that savings will be distributed to the tribal entity and 10% will remain with the State.

The Department is neutral on this part of the bill but offers the following for consideration and would be happy to propose changes in an amendment.

First, the proposed bill strikes through language that was added that would require the tribes to submit audit reports to the State every two years. The Department recommends that Section 3 (a) (2) and (3) shown in lines 14-21 as well as Section 3 (c) (d) and (e) show in lines 25-30 on page 2 and lines 1-7 on page 3 not be struck and remain in the bill.

Medicaid routinely audits payments, and this is in alignment with other program integrity activities. We also reached out to South Dakota Medicaid and they confirmed that they as well audit these tribal care coordination payments. There are two types of audit that Medicaid would want to conduct: audit that the care coordination activities are valid and audit that the correct FMAP was used. Tribal health care organizations would be audited, and the Department already has a tribal liaison staff to conduct these audits.

Second, Section 4a requires the Department to compile a report on how the dollars in the fund (due to the 10 percent savings) are distributed. However, the Department requests clarity on how the legislature expects these funds to be spent. The bill does describe that funds should be spent on essential services of public health or enhancement of community health representative programs or services. The Department requests clarity in those functions and if the dollars spent should be targeted toward a specific population or sub-population.

This concludes my testimony. I would be happy to answer any questions.

#3807

HB1407 Testimony presented by CEO, Lorraine Davis, Native American Development Center & Native Community Development, Inc. dba NATIVE, Inc.

Good Morning Chairman and Members of the Committee,

My name is Lorraine Davis, I am the founder and CEO of NATIVE, Inc. and the Native American Development Center. I support HB1407. This is a great opportunity for the state and tribes to work together to improve the lives of all tribal members living on and off the reservations.

So often, we are referred to as American Indians or Native Americans when we live off the reservation, however, we are still tribal people geographically residing off the reservation boundaries. As Tribal members living off the reservations, we fall through the cracks, even become invisible not only by our tribes but by society. We are unfairly misperceived by mainstream society's perceptions of us and the ways that we should be served. We have a lot to offer with the right systematic structure in place in our state.

I know this is not specific matter for the State Government to address, however, coordinated care services for tribal members across the state and tribal boundaries is a great opportunity for the State and Tribes to not only improve healthcare to our tribal members but to improve "culturally responsive" coordinated care services amongst tribal members even while living off the reservations. This bill is the beginning of healthcare disparity prevention for Native Americans so desperately needed when reviewing healthcare statistics and the social determinants of health. Our work addresses the social determinants of health of not only Native American but all Americans with low to moderate income levels living in urban areas within North Dakota. My hope is that the State and Tribes come to a fair negotiation in determining the percentages on the return on investment and include a strategy that includes funding streams to provide coordinated care services tribal members living off reservations. The majority of Native Americans live in the Bismarck metropolitan area with approximately 9,000 in population, this is twice the size of Fargo-Moorhead and Grand Forks.

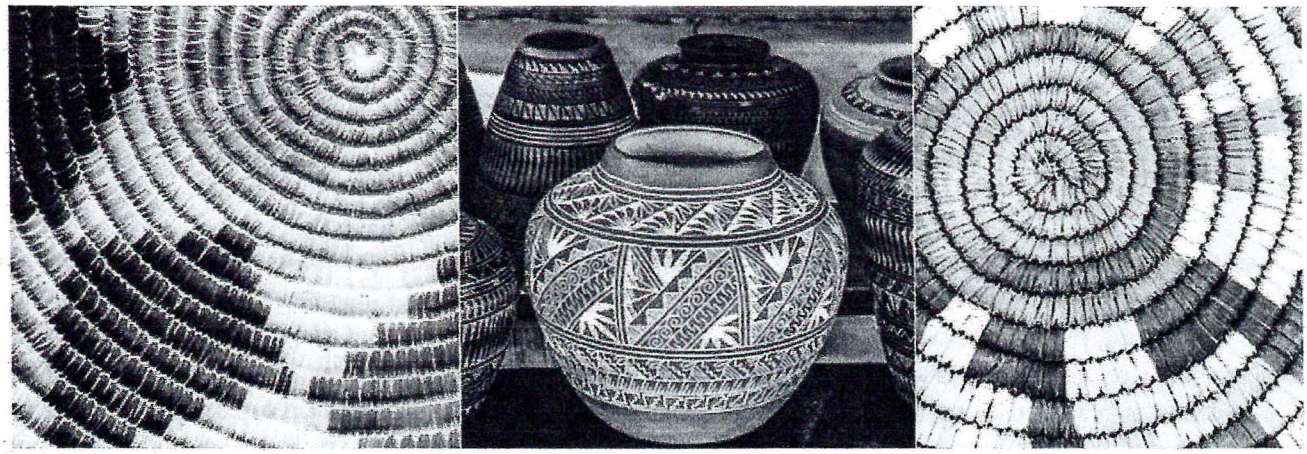
Native American Development Center & NATIVE, Inc. | 2403 East Thayer Ave. Bismarck ND 58501
P: (701) 595-5181, dial 4 | C: (701) 214-7911 | Email: lorraine@ndnadc.org
NADC Facebook: @ndnativecenter | Twitter: @nativamerdevctr | Website: www.ndnativecenter.org
NATIVE, Inc. Facebook: @NDNATIVEINC | Twitter: @NATIVE_INC | Website: www.ndnadc.org

Indian Health Service

The Federal Health Program for American Indians and Alaska Natives

The Indian Health Service continues to work closely with our tribal partners to coordinate a comprehensive public health response to COVID-19.

Community Health Representative



COVID-19 RESOURCES

Visit our Covid-19 Resources page for recordings and resources for IHS Community Health Representatives.

STAY CONNECTED

Join our CHR LISTSERV list to stay informed.

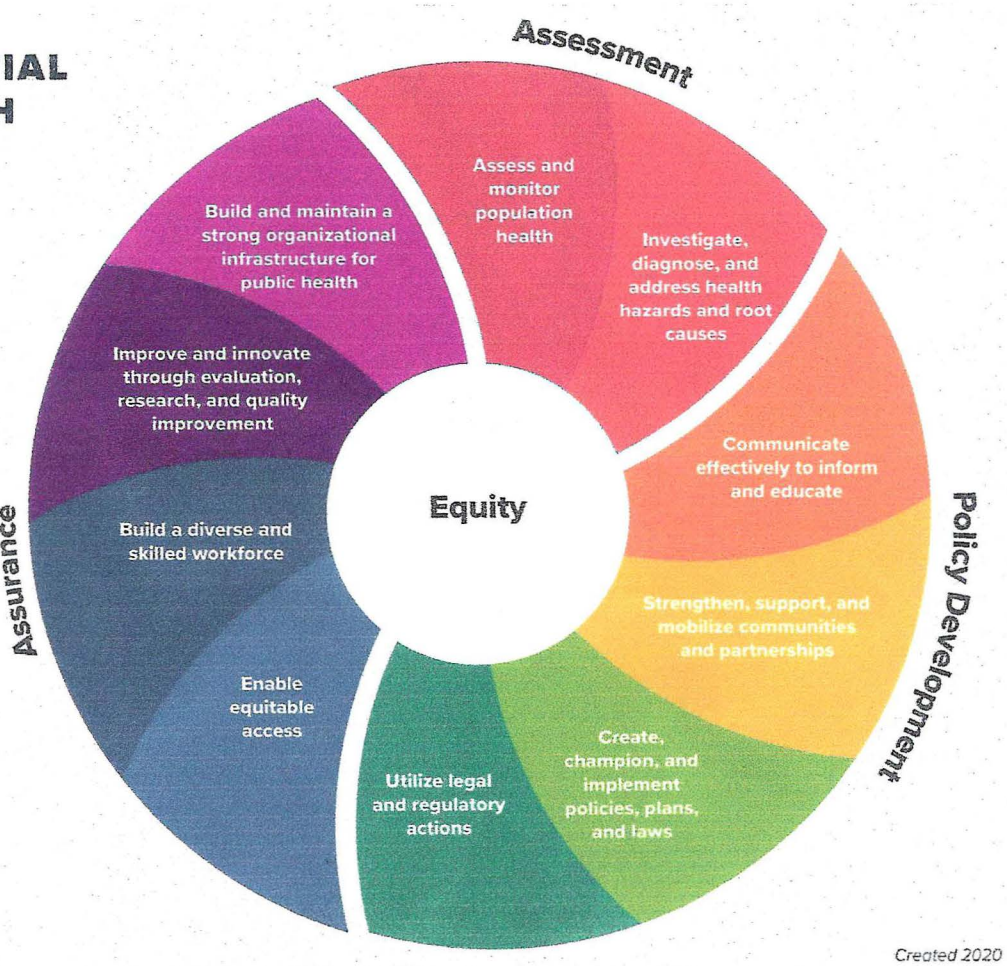
The Community Health Representative (CHR) Program is a unique concept for providing health care, health promotion, and disease prevention services. CHRs have demonstrated how they assist and connect with the community, and their work has become essential to the spectrum of Tribal community-oriented primary health care services. CHRs are great advocates, in part, because they come from the communities they serve and have tribal cultural competence. Their dedicated work has assisted many to meet their healthcare needs. The health promotion and disease prevention efforts that CHRs provide have also helped people from the community improve and maintain their health. By providing health education and reducing hospital readmissions, CHRs have contributed to lowering mortality rates. The demand for CHRs continues to grow.

IHS Headquarters, Indian Health Service, 5600 Fishers Lane, Rockville, MD 20857 -

THE 10 ESSENTIAL PUBLIC HEALTH SERVICES

To protect and promote the health of all people in all communities

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. To achieve optimal health for all, the Essential Public Health Services actively promote policies, systems, and services that enable good health and seek to remove obstacles and systemic and structural barriers, such as poverty, racism, gender discrimination, and other forms of oppression, that have resulted in health inequities. Everyone should have a fair and just opportunity to achieve good health and well-being.



Created 2020

MANDAN, HIDATSA & ARIKARA NATION
Three Affiliated Tribes * Fort Berthold Indian Reservation
404 Frontage Road New Town, ND 58763
Tribal Business Council

Office of the Chairman
Mark N. Fox

HOUSE BILL 1407
HOUSE HUMAN SERVICES COMMITTEE
JANUARY 27, 2021

TESTIMONY OF CYNTHIA C. MONTEAU
MANDAN, HIDATSA AND ARIKARA NATION (MHA NATION)

Mr. Chairman and members of the Committee, my name is Cynthia Monteau, I am here today on behalf of the Three Affiliated Tribes of the Mandan, Hidatsa and Arikara Nation (MHA Nation). I come before you today as an Opponent of House Bill 1407, a bill that interferes with the MHA Nation's ability to pay healthcare specialists the full amount of our contracts for medical assistance to tribal members.

In 2005, the MHA Nation contracted the federal government's responsibility to provide health care services to tribal members and eligible patients under Public Law 93-638, the Indian Self-Determination and Education Assistance Act of 1975. The MHA Nation is one of two tribes not served by the IHS. The definition on Page 1, Line 14 of the bill includes the MHA Nation as a tribal entity providing health care under Public Law 93-638.

The Centers for Medicare and Medicaid Services (CMS) pays a percentage to states of their total Medicaid expenses, since the states administer Medicaid which is a federal program. The percentage is called the Federal Medicaid Assistance Percentage or FMAP. CMS reimburses North Dakota at 53.39% FMAP.

CMS will reimburse at 100% FMAP, for services administered to Medicaid-eligible American Indians and Alaska Natives at Indian Health Service Clinics (IHS) or tribal facilities (Pub. L. 93-638). CMS's reimbursement at 100% FMAP for services at tribal clinics costs the state nothing.

The 100% FMAP reimbursement only applies to a non-IHS/Tribal provider. In other words, only Pub. L. 93-638 tribes can enter into tribal care coordination agreements. The MHA Nation and Spirit Lake Nation are the only two tribes that fall under this eligibility requirement. There is no role for the state to facilitate the agreements or to keep a percentage of our agreements. CMS sought to permit Pub. L. 93-638 Tribes it contracts with the higher reimbursement amount it would not otherwise receive. If we cannot pass the 100% FMAP along to our contract providers, they are not going to want to take our Medicaid patients.

Page 1, Lines 17-21 of the bill, allows the state to retain any federal funding received in excess of its regular share of 53.39% FMAP. Of that excess, the state shall deposit ninety percent in the tribal health care coordination fund and ten percent in the general fund. Why is the State keeping the Tribes reimbursement when there is zero cost to the State? These are federal funds allocated to the tribal nations for care coordination agreement requests for services and the State is simply a "pass through" for the federal funds to be distributed to the tribes. The state is not a party to the care coordination agreements, the State is not offering any services under the agreements, and Pub. L. 93-638 clinics are reimbursed at 100% of our expenditures - but yet this bill allows the State to retain 10% of these pass-through dollars. What are these funds being used for when the State has absolutely no cost to begin with?

Finally, Line 13 on Page 3 specifically names the Three Affiliated Tribes of the Fort Berthold Reservation. We do not want to be included in this bill as it interferes with our contracts to provide services to tribal members.

It is for these reasons that the MHA Nation cannot support this bill. Unless there is an opt out provision for Public Law 93-638 Tribes or the MHA Nation is excluded, the MHA Nation will continue to stand in opposition of HB1407.

Thank you, Mr. Chairman.

House Human Services Committee

January 27, 2021

Testimony on HB 1407 (Tribal Health Coordinated Care Agreements)

Hello Chairman Weisz and members of the House Human Services Committee. My name is Scott Davis and I am an enrolled member of the Standing Rock Sioux Tribe and a decedent of the Turtle Mountain Band of Chippewa. I am the Executive Director of the ND Indian Affairs Commission.

Our position on HB 1407 is neutral, but we have been and will continue to be committed to making sure the Tribal Nations are working with the State of North Dakota and Non-Native Health Care Providers to improve the health care for Tribal people in ND.

This work was initially started back in 2016 after the 65th Legislative Session. There were meetings set up with Standing Rock Sioux Tribe (SRST) initially since they have lands in North Dakota and South Dakota. There were numerous meetings with Standing Rock and a few with Turtle Mountain Band of Chippewa. These meetings talked about the referral process and how to ensure that the different health systems are communicating about the patients' care.

Prior to the 66th Legislative session, we had meetings with the Tribal leaders on a potential bill to address the savings from the coordinated care agreements. The Tribal leaders agreed to have the bill be written to have a 70/30 split of the savings with 70% going back to the Tribes and 30% to the state. HB 1194 was created with this percentage and through the legislative process the split of the savings was changed to 60% going to the Tribes and 40% to the State. This bill also created a separate fund.

The Tribes of ND have some of the worst health care disparities in the region. We continue to find new ways to improve access to quality services, address major health care disparities and having a quality health care workforce. This effort would be a new tool for each Tribe to address the health care needs that are unique to each community. This project could increase the federal funding coming back to ND and help our current system to improve moving forward.

That concludes my testimony. I will stand for any questions.

2021 HB 1407
House Human Services Committee
Representative Robin Weisz, Chairman
January 27, 2021

Good afternoon Chairman Weisz and Members of the House Human Services Committee. I am Melissa Hauer, General Counsel of the North Dakota Hospital Association. I am here to testify regarding 2021 House Bill 1407 and ask that you give this bill a **Do Pass** recommendation.

We support this bill because it would enhance collaboration between hospitals and North Dakota tribes to improve access to health care, strengthen continuity of care, and address disparities in health outcomes for American Indians. This joint effort not only provides improved access to health care for American Indians, but it also provides the state with the opportunity to benefit from a Centers for Medicare & Medicaid Services (CMS) policy which provides 100 percent federal payments when an American Indian Medicaid beneficiary who is also eligible to receive care through Indian Health Services (IHS) receives care outside an IHS/Tribal facility, so long as the referring and receiving facilities have in place a care coordination agreement.

Currently, Medicaid payments at non-IHS/Tribal facilities for Medicaid-eligible American Indians are subject to states' regular Federal Medicaid Assistance Percentage (FMAP), costing states millions of dollars. North Dakota's current FMAP is 52.4 percent, meaning that for every dollar spent on medical services, the federal government contributes fifty-two cents. The new CMS policy provides 100 percent federal payment if the several requirements are met. One of those requirements is that the IHS/Tribal facility has in place a Care Coordination Agreement with the non-IHS/Tribal facility to which the patient is being referred. At a high level, the care coordination under these agreements requires the IHS/Tribal facility practitioner to request specific services (by electronic or other verifiable means) and provide relevant information about

the patient to the non-IHS/Tribal provider; the non-IHS/Tribal provider must send information about the care it provides to the patient, including results of screening, diagnostic or treatment procedures, back to the IHS/Tribal facility practitioner; the IHS/Tribal facility practitioner must continue to assume responsibility for the patient's care by assessing the information and taking appropriate action, including furnishing or requesting additional services; and the IHS/Tribal facility must incorporate the patient's information in the medical record.

In this way, the care of these patients is better coordinated between the IHS/Tribal facility practitioner and the outside health care provider who sees the patient for a particular treatment or procedure that could not be provided at the IHS/Tribal facility. It is not only better for the patient, but it also allows the state to receive 100 percent federal reimbursement, rather than the current 52 percent for the traditional Medicaid population.

As you might recall from our discussion last session of House Bill no. 1197, care coordination agreements were signed in February 2018 between the two large hospitals in Bismarck and the Great Plains Area Indian Health Services office. A great deal of work has been done since then by the two hospitals, the Standing Rock Sioux Tribe, and IHS to coordinate the care of American Indians in the region who need to be referred outside the IHS facility for specialized health care. These referrals were anticipated to be reported to the North Dakota Department of Human Services via the Medicaid billing process. And the Department would then submit them to the federal government for the enhanced payment of 100%, rather than the current 52 percent FMAP.

The "savings" returned to North Dakota from being able to claim the enhanced 100 percent FMAP was to be deposited in a tribal health care coordination fund in the state treasury. Unfortunately, further care coordination agreements have not been executed between any other tribes or hospitals. And the claims under the current care coordination agreements between the two Bismarck hospitals and Great Plains Area IHS have unfortunately not yet been able to be processed by the Department of Human Services due to the need for reprogramming of the Medicaid management information system (MMIS). It is estimated that this process could be providing millions in state general fund savings annually. The fiscal note on 2019 House Bill no. 1194, which created the law that this bill will amend, stated that, for the 2019-2021 biennium, the total savings were projected to be $7,386,113 and for the 2021-2023 biennium, the total savings were projected to be $8,532,324.

We stand ready to continue facilitating this project. We hope that other hospitals and the Tribes will agree to join in this project in order to better coordinate health care and take advantage of the enhanced FMAP payment. With everyone working together, we hope to be able to realize those additional federal funds. We support sharing the additional federal funding with participating Tribes in order to incentivize participation in the project and to recognize the additional work Tribes will need to do if they join the project.

In summary, we support sharing with participating Tribes of the additional funding that the care coordination will garner. We ask that you give this bill a **Do Pass** recommendation.

I would be happy to try to answer any questions you may have. Thank you.

Respectfully Submitted,

Tim Blasl, President
North Dakota Hospital Association

TESTIMONY OF BRANDON MAUAI
FOR THE STANDING ROCK SIOUX TRIBE
BEFORE THE HOUSE COMMITTEE ON HUMAN SERVICES
CONCERNING HB: 1407; THE TRIBAL HEALTH CARE COORDINATION AGREEMENTS
JANAURY 27, 2021

Chairman Weisz and Members of the Committee:

I am Councilman Brandon Mauai, the representative from the Standing Rock Sioux Tribe and serve as the Vice-Chairman of the Committee on Health, Education, and Welfare. My testimony today will provide some background and explain the Standing Rock Sioux Tribe's stance on HB 1407 pertaining to the care coordination agreements (known from the prior legislative session as HB 1194). Today, the Standing Rock Sioux Tribe is asking for 100% of the "Received Through" FMAP.

Standing Rock has come to the table to meet, time and time again, with you – the law makers for the State of North Dakota. Time and time again, the Standing Rock Sioux Tribe has held firm in asking for 100% of the FMAP. Why? There is much guidance to provide that tribes were to be given a large, if not all, the "received through" FMAP. In fact, the SHO (State Health Official) Letter #16-002, which was issued as guidance by the Centers for Medicare and Medicaid Services in 2016 to the state so that tribes could receive 100% of the FMAP (see attached SHO #16-002).

On June 28, 2018, I provided testimony to the Healthcare Reform and Review Committee stating the Standing Rock Sioux Tribe wanted 100% of the Tribal Health Care Coordination Fund due to the health concerns, disparities, and needs of the Standing Rock Sioux Tribe. Then, once again, I provided testimony on January 15, 2019, this time before this body, stating the Standing Rock Sioux Tribe should still receive 100%. However, HB 1194 was introduced at the rate of 70/30 and although we vehemently disagreed, we did not halt the process of the care coordination agreements.

On February 6, 2019, an amendment was proposed by Chairman Weisz, despite not being present to hear the words of the tribes at the January 15th hearing, to change the rate from 70/30 to 50/50 as, "a compromise looking to get this thing moved forward" (Chairman Weisz's words from the transcript). Let me state that the Standing Rock Sioux Tribe was not aware of this "compromise" when it went forward on February 6, 2019. Additionally, it objected to the amendment and to the bill as it moved forward and as it was signed into law by Governor Burgum at 60/40 on May 1, 2019.

Two years have passed and today our stance has not changed. We are opposed to the 90/10 split. Just as we were with the proposed 50/50 split and then the 2019 rate of 60/40. The Standing Rock Sioux Tribe should be receiving 100% of the "Received Through" FMAP. Although the share of 60/40 continues to be the percentage in the signed Bill, HB 1194, the FMAP rate has changed, and the health disparities on Standing Rock continue to increase every year. In conclusion, the Standing Rock Sioux Tribe, requests the percentage of the "received through" FMAP to the tribes to be 100%.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

SHO #16-002

Re: Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives

February 26, 2016

Dear State Health Official:

The purpose of this letter is to inform state Medicaid agencies and other state health officials about an update in payment policy affecting federal funding for services received by Medicaid-eligible individuals, who are American Indians and Alaska Natives (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes. As described in this letter, IHS/Tribal facilities[1] may enter into care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements would be eligible for the enhanced federal matching authorized under section 1905(b) of the Social Security Act at a rate of 100 percent. Upon execution of a written care coordination agreement, this will be effective immediately for states for the expenditures for services furnished by non-IHS/Tribal providers to AI/AN Medicaid beneficiaries who are patients of an IHS/Tribal facility acting under such agreement, as described below. This update in payment policy is intended to help states, the IHS, and Tribes to improve delivery systems for AI/ANs by increasing access to care, strengthening continuity of care, and improving population health.

Background

The IHS, a federal agency within the Department of Health and Human Services, is responsible for furnishing comprehensive, culturally-appropriate health services to almost 2.2 million AI/ANs who are eligible for services from the IHS, per regulations at 42 CFR Part 136. To achieve this goal, IHS operates its own hospitals and clinics and partners with Tribes as authorized by the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended. The IHS also provides funding for Urban Indian Health Organizations to operate Urban Indian Health Programs (UIHPs) under title V of the Indian Health Care Improvement Act, P.L. 94-437, as amended. The IHS, Tribes, and UIHPs operate health programs in 36 states.[2]

[1] For purposes of this document, Tribal facilities are facilities that are operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act, P.L. 93-638.

[2] As of the date of this SHO, the states are: AL, AK, AZ, CA, CO, CT, FL, ID, IL, IN, IA, KS, LA, ME, MD, MA, MI, MN, MS, MT, NE, NV, NM, NY, NC, ND, OK, OR, RI, SC, SD, TX, UT, WA, WI, and WY. This list is subject to change.

AI/ANs who meet the eligibility requirements for the Medicaid program in the state in which they reside are entitled to Medicaid coverage, whether or not they are eligible for services from IHS. IHS-eligible AI/ANs who are also Medicaid beneficiaries may choose to receive covered services from an IHS facility, a Tribal facility, a UIHP, or from any other provider participating in a state's Medicaid program.

Under section 1905(b) of the Social Security Act, the federal government is required to match state expenditures at the Federal Medical Assistance Percentage (FMAP) rate, which is 100 percent for state expenditures on behalf of AI/AN Medicaid beneficiaries for covered services "received through" an Indian Health Service facility whether operated by the Indian Health Service or by a Tribe or Tribal organization (as defined in section 4 of the Indian Health Care Improvement Act)." If services are not "received through" an IHS/Tribal facility, the federal government will match the state's payment for the services at the state's regular FMAP rate, which in FY 2016 ranges from 50.00 percent to 74.17 percent.

Our long-standing interpretation of this statutory provision as reflected in sub-regulatory guidance,[3] Departmental Appeals Board decisions,[4] and federal court decisions,[5] has been that 100 percent 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" – i.e., within the scope of services that a facility (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center/Rural Health Clinic, nursing facility) can offer under Medicaid law and regulation;
(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.

Last year, the Centers for Medicare & Medicaid Services (CMS) announced it was strongly considering re-interpreting the statutory language to expand the services it considers "received through" an IHS/Tribal facility and eligible for the 100 percent FMAP. Specifically, in October 2015, we posted on the CMS Medicaid.gov website a Request for Comment, in which we sought comments on a proposal to re-interpret the statutory language providing 100 percent FMAP for "services received through an IHS facility" by: (1) Modifying the scope of services eligible for enhanced FMAP; (2) Expanding the meaning of contractual agent to be an enrolled Medicaid provider that provides services that are identified in the state's approved Medicaid plan and are arranged for and overseen by the IHS/Tribal facility; and (3) Increasing the flexibility for billing arrangements so that IHS/Tribal facilities or their contractual agents could bill Medicaid directly

[3] Memorandum of Agreement (MOA) between IHS and HCFA (July 11, 1996); HCFA Memorandum to Associate Regional Administrators (May, 1997).
[4] *North Dakota Dept. of Human Services*, DAB No. 1854 (2002); *South Dakota Dept. of Social Services*, DAB No. 1847 (2002); *Arizona Health Care Cost Containment System*, DAB No. 1779 (2001); *Alaska Department of Health and Social Services*, DAB No. 1919 (2004).
[5] *North Dakota ex. Rel. Olson v. Centers for Medicare & Medicaid Services*, 403 F.3d 537 (8th Cir. 2005); *Alaska Department of Health & Social Services v. Centers for Medicare & Medicaid Services*, 424 F. 3rd 931 (9th Cir. 2005); *Arizona Health Care Cost Containment System v. McClellan*, 508 F.3rd 1243 (9th Cir. 2007).

for services. CMS received 182 comments from 91 commenters including Tribes, Tribal organizations, Urban Indian Health Organizations, states, and other stakeholders. We have reviewed and considered those comments in establishing this new policy interpretation.

Permitting a Wider Scope of Services

In this letter, we are re-interpreting the scope of services considered to be "received through" an IHS/Tribal facility. Under our previous interpretation, in order to be "received through" an IHS/Tribal facility, and therefore, qualify for 100 percent FMAP, the service had to be a "facility service." By that, we meant that it had to be within the scope of services that a Medicaid facility of the same type (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center/Rural Health Clinic, nursing facility) can provide under Medicaid law and regulation. Under our new interpretation, as described more fully below, the scope of services that can be considered to be "received through" an IHS/Tribal facility for purposes of 100 percent FMAP includes any services that the IHS/Tribal facility is authorized to provide according to IHS rules, that are also covered under the approved Medicaid state plan, including long-term services and supports (LTSS). Medicaid coverable benefit categories include all 1905(a), 1915(i), 1915(j), 1915(k), 1945, and 1915(c) services set forth in the state plan, as well as any other authority established in the future as a state plan benefit.

This scope of service change also applies to transportation that is covered as a service under the state Medicaid plan. Under regulations at 42 CFR 440.170(a), a state can elect to cover transportation and other related travel expenses determined necessary to secure medical examinations and treatment for a beneficiary. Related travel expenses include the cost of meals and lodging en route to and from medical care, and while receiving medical care, as well as the cost for an attendant to accompany the beneficiary, if necessary. Covered transportation services can include both emergency medical transportation and non-emergency medical transportation.

Medicaid Beneficiary and IHS/Tribal Facility Participation is Voluntary

This new interpretation does not provide authority for states to require any AI/AN Medicaid beneficiary to receive services through an IHS/Tribal facility. Nothing in this letter affects the entitlement of AI/AN Medicaid beneficiaries to freedom of choice of provider under section 1902(a)(23) of the Social Security Act. State Medicaid agencies may not, directly or indirectly, require AI/ANs who are eligible for Medicaid to receive covered services from IHS/Tribal facilities for the purpose of qualifying the cost of their services for 100 percent FMAP. Similarly, neither state Medicaid agencies nor IHS/Tribal facilities may require an AI/AN Medicaid beneficiary to receive services from a non-IHS/Tribal provider to whom the facility has referred the beneficiary for care. Nor can a state delay the provision of medical assistance by requiring that beneficiaries initiate or continue a patient relationship with the IHS/Tribal facility. Finally, federal Medicaid law does not require either IHS/Tribal facilities or non-IHS/Tribal providers to enter into the written care coordination agreements described in this SHO.

Request for Services In Accordance With a Written Care Coordination Agreement

In this letter, CMS also revises its interpretation to provide that a service may be considered "received through" an IHS/Tribal facility when an IHS/Tribal facility practitioner requests the service, for his or her patient, from a non-IHS/Tribal provider (outside of the IHS/Tribal facility), who is also a Medicaid provider, in accordance with a care coordination agreement meeting the criteria described below. The purpose of this revised policy interpretation is to enable IHS/Tribal 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.

A covered service will be considered to be "received through" an IHS/Tribal facility not only when the service is furnished directly by the facility to a Medicaid-eligible AI/AN patient, but also when the service is furnished by a non-IHS/Tribal provider at the request of an IHS/Tribal facility practitioner on behalf of his or her patient and the patient remains in the Tribal facility practitioner's care in accordance with a written care coordination agreement meeting the requirements described below. Under this policy, both the IHS/Tribal facility and the non-IHS/Tribal provider must be enrolled in the state's Medicaid program as rendering providers. Second, there must be an established relationship between the patient and a qualified practitioner at an IHS/Tribal facility. Third, care must be provided pursuant to a written care coordination agreement between the IHS/Tribal facility and the non-IHS/Tribal provider, under which the IHS/Tribal facility practitioner remains responsible for overseeing his or her patient's care and the IHS/Tribal facility retains control of the patient's medical record.

A non-IHS/Tribal provider from which an IHS/Tribal facility practitioner could request services could include an Urban Indian Health Organization that participates in Medicaid, or any other Medicaid-participating provider. Furthermore, the relationship between the IHS/Tribal facility practitioner and the patient could be based on visits, including the initial visit, through telehealth procedures that meet state and/or IHS standards for such procedures, if the IHS/Tribal facility has that capacity[6].

A self-request by the beneficiary, or a request from a non-IHS/Tribal provider, does not suffice for purposes of 100 percent FMAP; in such circumstances, the non-IHS/Tribal provider could furnish the service and bill the state Medicaid program, but the state expenditure for the service would not qualify for 100 percent FMAP. Similarly, the non-IHS/Tribal provider may refer the facility patient to another non-IHS/Tribal provider; however, if the patient receives a covered service from that other provider without a request from the IHS/Tribal facility practitioner, or the IHS/Tribal facility practitioner does not remain responsible for the patient's care, the state expenditure for the service would not qualify for 100 percent FMAP.

At a minimum, care coordination will involve:

(1) The IHS/Tribal facility practitioner providing a request for specific services (by electronic or other verifiable means) and relevant information about his or her patient to the non-IHS/Tribal provider;

[6] Or as specified in a demonstration project authorized under section 1637 of the Indian Health Care Improvement Act.

(2) The non-IHS/Tribal provider sending information about the care it provides to the patient, including the results of any screening, diagnostic or treatment procedures, to the IHS/Tribal facility practitioner;
(3) The IHS/Tribal facility practitioner continuing to assume responsibility for the patient's care by assessing the information and taking appropriate action, including, when necessary, furnishing or requesting additional services; and
(4) The IHS/Tribal facility incorporating the patient's information in the medical record through the Health Information Exchange or other agreed-upon means.

Written care coordination agreements under this policy could take various forms, including but not limited to a formal contract, a provider agreement, or a memorandum of understanding and, to the extent it is consistent with IHS authority, would not be governed by federal procurement rules. The IHS/Tribal facility may decide the form of the written agreement that is executed with the non-IHS/Tribal provider.

Medicaid Billing and Payments to Non-IHS/Tribal Providers

For services provided to Medicaid-eligible AI/AN beneficiaries that are rendered by a non-IHS/Tribal provider in accordance with a written care coordination arrangement, there are several options regarding how those services may be billed to Medicaid.

The first option is for the non-IHS/Tribal provider to bill the Medicaid agency directly. If the non-IHS/Tribal provider bills the state Medicaid program directly, the provider would be reimbursed at the rate authorized under the Medicaid state plan applicable to the provider type and service rendered. To support the application of the 100 percent FMAP, the state should ensure that claims include fields that document that the item or service was "received through" an IHS/Tribal facility. When a non-IHS provider bills a state directly, the state's payment rate for a covered service furnished by a non-IHS/Tribal provider to an AI/AN Medicaid beneficiary under a written care coordination agreement must be the same as the rate for that service furnished by that provider to a non-AI/AN beneficiary or to an AI/AN beneficiary who self-refers to the provider. Similarly, a state agency cannot establish one rate for services furnished by the facility to AI/AN beneficiaries and another for the same services provided by that facility to non-AI/AN Medicaid beneficiaries.

A second option is for the IHS or Tribal facility to handle all billing. In that case, the IHS/Tribal facility would have to separately identify services provided by non-IHS/Tribal providers under agreement that can be claimed as services of the IHS/Tribal facility ("IHS/Tribal facility services") from those that cannot. Inpatient services that are furnished by non-IHS providers outside of IHS/Tribal facilities could never be claimed as IHS/Tribal facility services. For IHS, other services provided by non-IHS providers outside of an IHS facility generally cannot be claimed as IHS facility services. Tribal facilities generally may have more flexibility than IHS and should consult with their state to determine the circumstances in which other services provided by non-Tribal providers can be claimed as Tribal facility services. The circumstances under which Tribal facilities may claim services as their own are the same as those that apply for other similar facilities in the state (e.g., inpatient or outpatient hospitals, nursing facilities, Federally Qualified Health Centers, etc.). Services that can properly be claimed as IHS/Tribal facility services may be billed directly by the IHS/Tribal facility and are paid at the applicable Medicaid state plan IHS/Tribal facility rate. For all other services provided by non-IHS/Tribal

providers, IHS or the Tribe could bill for these services as an assigned claim by that provider and the payment rate would be the state plan rate applicable to the furnishing provider and the service, not the applicable Medicaid state plan IHS/Tribal facility rate. These services are still eligible for the 100 percent FMAP, provided other requirements have been met.

The billing arrangement should be reflected in the written agreement between the IHS/Tribal facility and the non-IHS/Tribal provider. Payment methodologies for facility services furnished by both the IHS/Tribal facility and rate methodologies paid to non-IHS/Tribal providers must be set forth in an approved state Medicaid plan. Payment rates can reflect the unique access concerns in particular geographic areas, or with respect to certain types of providers. However, rates may not vary based on the applicable FMAP. States should review existing state plans to ensure compliance with the policy articulated in this letter.

Managed Care

The discussion above assumes that the Medicaid-eligible AI/AN has "received [services] through" the IHS/Tribal facility on a fee-for-service basis. In some cases, however, Medicaid-eligible AI/ANs may be enrolled in a risk-based Medicaid managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), in which case the state Medicaid agency is making monthly capitation payments on behalf of the AI/AN enrollee to the MCO, PIHP, or PAHP. The state may claim 100 percent FMAP for the portion of the capitation payment attributable to the cost of services "received through" an IHS/Tribal facility if the following conditions are met:

(1) The service is furnished to an AI/AN Medicaid beneficiary who is enrolled in the managed care plan;
(2) The service meets the same requirements to be considered "received through" an IHS/Tribal facility as would apply in a fee-for-service delivery system and the managed care plan maintains auditable documentation to demonstrate that those requirements are met;
(3) The non-IHS/Tribal provider is a network provider of the enrollee's managed care plan;
(4) The non-IHS/Tribal provider is paid by the managed care plan consistent with the network provider's contractual agreement with the managed care plan; and
(5) The state has complied with section 1932(h)(2)(C)(ii) of the Act consistent with CMS guidance.

States would be permitted to claim the 100 percent FMAP for a portion of the capitation payment for AI/ANs who are enrolled in managed care, even though the state itself has made no direct payment for services "received through" an IHS/Tribal facility. The portion of the managed care payment eligible to be claimed at 100 percent FMAP must be based on the cost of services attributable to IHS/Tribal services or encounters received through an IHS/Tribal provider meeting the requirements outlined in this section.

Compliance and Documentation

To ensure accountability for program expenditures, in states where IHS/Tribal facilities elect to implement the policy described in this letter, the Medicaid agency will need to establish a process for documenting claims for expenditures for items or services "received through" an

IHS/Tribal facility. The documentation must be sufficient to establish that (1) the item or service was furnished to an AI/AN patient of an IHS/Tribal facility practitioner pursuant to a request for services from the practitioner; (2) the requested service was within the scope of a written care coordination agreement under which the IHS/Tribal facility practitioner maintains responsibility for the patient's care; (3) the rate of payment is authorized under the state plan and is consistent with the requirements set forth in this letter; and (4) there is no duplicate billing by both the facility and the provider for the same service to the same beneficiary.

Applicability to Section 1115 Demonstrations

State expenditures for services covered under section 1115 demonstration authority are eligible for 100 percent FMAP as long as all of the elements of being "received through" an IHS or Tribal facility that are described in this SHO are present.

Relationship Between 100 Percent FMAP for Tribal Services and Other Federal Matching Rates

The 100 percent FMAP for services "received through" an IHS/Tribal facility is available for services provided to AI/ANs as described in this SHO instead of the regular FMAP rate described in section 1905(b) of the Act, the newly eligible FMAP rate described in section 1905(y) of the Act, the enhanced FMAP rate for breast and cervical cancer, or the enhanced rate for Community First Choice services.

We intend to issue additional guidance materials after the release of this SHO. CMS is available to work closely with each state to implement the policy established in this state health official letter regarding receiving 100 percent FMAP for services "received through" an IHS/Tribal facility. If you have any questions regarding this information, please contact TribalAffairs@cms.hhs.gov or Kirsten Jensen, Director, Division of Benefits and Coverage, 410-786-8146.

Sincerely,
/s/
Vikki Wachino
Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

American Public Human Services Association

National Governors Association

Council of State Governments

Association of State and Territorial Health Officials

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1407
2/8/2021

Relating to medical assistance tribal health care coordination agreements; to provide for a legislative management report; and to provide a continuing appropriation.

Chairman Weisz opened the committee meeting at 4:53 p.m.

Representatives	Attendance
Representative Robin Weisz	P
Representative Karen M. Rohr	P
Representative Mike Beltz	P
Representative Chuck Damschen	P
Representative Bill Devlin	P
Representative Gretchen Dobervich	P
Representative Clayton Fegley	P
Representative Dwight Kiefert	P
Representative Todd Porter	P
Representative Matthew Ruby	P
Representative Mary Schneider	P
Representative Kathy Skroch	P
Representative Bill Tveit	P
Representative Greg Westlind	P

Discussion Topics:

- Capital construction
- Renovations
- New buildings
- Tribal nations

Rep. Robin Weisz presented proposed **Amendment 21.0870.01001 –** #6950.

Scott Davis, North Dakota Indian Affairs Commission (4:58) answered committee questions.

Rep. Nathan Davis, Turtle Mountain Tribal Council (5:02) answered committee questions.

Chris Jones, Department of Human Services (5:05) answered committee questions.

Rep. Matthew Ruby (5:08) motioned to adopt **Amendment 21.0870.01001**

Rep. Karen Rohr (5:08) second

Rep. Matthew Ruby (5:17) amended his motion to Amendment 21.0870.01001 to change maximum from 30% to 35%.

Rep. Karen Rohr (5:17) second.

Voice Vote – Motion Carried.

Rep. Matthew Ruby (5:18) made motion **Do Pass As Amended Rerefer to Appropriations**

Rep. Kathy Skroch (5:18) second.

Representatives	Vote
Representative Robin Weisz	Y
Representative Karen M. Rohr	Y
Representative Mike Beltz	Y
Representative Chuck Damschen	Y
Representative Bill Devlin	Y
Representative Gretchen Dobervich	Y
Representative Clayton Fegley	Y
Representative Dwight Kiefert	Y
Representative Todd Porter	Y
Representative Matthew Ruby	Y
Representative Mary Schneider	Y
Representative Kathy Skroch	Y
Representative Bill Tveit	Y
Representative Greg Westlind	Y

Motion Carried Do Pass As Amended Rerefer to Appropriations 14-0-0.

Bill Carrier: Rep. Gretchen Dobervich

Chairman Weisz adjourned at 5:20 p.m.

Tamara Krause, Committee Clerk

21.0870.01002
Title.02000

Adopted by the Human Services Committee

February 8, 2021

2/8/21

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1407

Page 1, line 2, after the semicolon insert "to repeal section 50-24.1-40 of the North Dakota Century Code, relating to medical assistance tribal health care coordination agreements;"

Page 1, line 2, remove "a"

Page 1, line 3, replace "report" with "and legislative council reports"

Page 1, line 3, remove "and"

Page 1, line 3, after "appropriation" insert "; and to provide a contingent effective date"

Page 1, line 20, replace "ninety" with "seventy"

Page 1, line 20, replace "ten" with "thirty"

Page 2, line 2, remove the overstrike over the overstruck colon

Page 2, line 3, remove the overstrike over "~~(1)~~ ~~Use~~ "

Page 2, line 3, remove "use"

Page 2, line 6, after "services" insert "; however, no more than thirty-five percent may be used for capital construction"

Page 2, remove the overstrike over lines 14 through 21

Page 2, line 25, remove the overstrike over "~~upon completion of any auditing and verification actions of the~~"

Page 2, line 26, remove the overstrike over "~~department,~~"

Page 2, remove the overstrike over lines 28 through 30

Page 3, remove the overstrike over lines 1 through 7

Page 3, line 13, remove "The Three Affiliated Tribes of the Fort Berthold Reservation, Spirit Lake Tribe,"

Page 3, remove line 14

Page 3, line 15, replace "each" with "Each participating tribe"

Page 3, line 16, replace "tribes'" with "tribe's"

Page 3, after line 16, insert:

"**SECTION 2. REPEAL.** Section 50-24.1-40 of the North Dakota Century Code is repealed.

SECTION 3. DEPARTMENT OF HUMAN SERVICES - REPORT TO LEGISLATIVE COUNCIL. On January 2, 2023, the executive director of the department of human services shall certify to the legislative council whether any care coordination agreements have been facilitated under section 50-24.1-40 by December

31, 2022. If no care coordination agreements have been facilitated, the executive director also shall certify this status to the secretary of state.

QS
2/8/21

SECTION 4. CONTINGENT EFFECTIVE DATE. Section 2 of this Act becomes effective on January 3, 2023, if the executive director of the department of human services certifies to the secretary of state and to the legislative council that by December 31, 2022, no care coordination agreements have been facilitated under section 50-24.1-40."

Renumber accordingly

REPORT OF STANDING COMMITTEE

HB 1407: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1407 was placed on the Sixth order on the calendar.

Page 1, line 2, after the semicolon insert "to repeal section 50-24.1-40 of the North Dakota Century Code, relating to medical assistance tribal health care coordination agreements;"

Page 1, line 2, remove "a"

Page 1, line 3, replace "report" with "and legislative council reports"

Page 1, line 3, remove "and"

Page 1, line 3, after "appropriation" insert "; and to provide a contingent effective date"

Page 1, line 20, replace "ninety" with "seventy"

Page 1, line 20, replace "ten" with "thirty"

Page 2, line 2, remove the overstrike over the overstruck colon

Page 2, line 3, remove the overstrike over "~~(1) Use~~ "

Page 2, line 3, remove "use"

Page 2, line 6, after "services" insert "; however, no more than thirty-five percent may be used for capital construction"

Page 2, remove the overstrike over lines 14 through 21

Page 2, line 25, remove the overstrike over "~~upon completion of any auditing and verification actions of the~~"

Page 2, line 26, remove the overstrike over "~~department,~~"

Page 2, remove the overstrike over lines 28 through 30

Page 3, remove the overstrike over lines 1 through 7

Page 3, line 13, remove "The Three Affiliated Tribes of the Fort Berthold Reservation, Spirit Lake Tribe,"

Page 3, remove line 14

Page 3, line 15, replace "each" with "Each participating tribe"

Page 3, line 16, replace "tribes'" with "tribe's"

Page 3, after line 16, insert:

"**SECTION 2. REPEAL.** Section 50-24.1-40 of the North Dakota Century Code is repealed.

SECTION 3. DEPARTMENT OF HUMAN SERVICES - REPORT TO LEGISLATIVE COUNCIL. On January 2, 2023, the executive director of the department of human services shall certify to the legislative council whether any care coordination agreements have been facilitated under section 50-24.1-40 by

December 31, 2022. If no care coordination agreements have been facilitated, the executive director also shall certify this status to the secretary of state.

SECTION 4. CONTINGENT EFFECTIVE DATE. Section 2 of this Act becomes effective on January 3, 2023, if the executive director of the department of human services certifies to the secretary of state and to the legislative council that by December 31, 2022, no care coordination agreements have been facilitated under section 50-24.1-40."

Renumber accordingly

21.0870.01001
Title.

Prepared by the Legislative Council staff for
House Human Services Committee
February 8, 2021

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1407

Page 1, line 2, after the semicolon insert "to repeal section 50-24.1-40 of the North Dakota Century Code, relating to medical assistance tribal health care coordination agreements;"

Page 1, line 2, remove "a"

Page 1, line 3, replace "report" with "and legislative council reports"

Page 1, line 3, remove "and"

Page 1, line 3, after "appropriation" insert "; and to provide a contingent effective date"

Page 1, line 20, replace "ninety" with "seventy"

Page 1, line 20, replace "ten" with "thirty"

Page 2, line 2, remove the overstrike over the overstruck colon

Page 2, line 3, remove the overstrike over "~~(1)~~ ~~Use~~ "

Page 2, line 3, remove "use"

Page 2, line 6, after "services" insert "; however, no more than thirty percent may be used for capital construction"

Page 2, remove the overstrike over lines 14 through 21

Page 2, line 25, remove the overstrike over "~~upon completion of any auditing and verification actions of the~~"

Page 2, line 26, remove the overstrike over "~~department,~~"

Page 2, remove the overstrike over lines 28 through 30

Page 3, remove the overstrike over lines 1 through 7

Page 3, line 13, remove "The Three Affiliated Tribes of the Fort Berthold Reservation, Spirit Lake Tribe."

Page 3, remove line 14

Page 3, line 15, replace "each" with "Each participating tribe"

Page 3, line 16, replace "tribes'" with "tribe's"

Page 3, after line 16, insert:

"**SECTION 2. REPEAL.** Section 50-24.1-40 of the North Dakota Century Code is repealed.

SECTION 3. DEPARTMENT OF HUMAN SERVICES - REPORT TO LEGISLATIVE COUNCIL. On January 2, 2023, the executive director of the department of human services shall certify to the legislative council whether any care coordination agreements have been facilitated under section 50-24.1-40 by

December 31, 2022. If no care coordination agreements have been facilitated, the executive director also shall certify this status to the secretary of state.

SECTION 4. CONTINGENT EFFECTIVE DATE. Section 2 of this Act becomes effective on January 3, 2023, if the executive director of the department of human services certifies to the secretary of state and to the legislative council that by December 31, 2022, no care coordination agreements have been facilitated under section 50-24.1-40."

Renumber accordingly

2021 HOUSE APPROPRIATIONS

HB 1407

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Brynhild Haugland Room, State Capitol

HB 1407
2/12/2021

Relating to medical assistance tribal health care coordination agreements, relating to medical assistance tribal health care coordination agreements

9:37 Chairman Delzer- Opens the meeting for HB 1407;

Representatives	P/A
Representative Jeff Delzer	P
Representative Keith Kempenich	A
Representative Bert Anderson	P
Representative Larry Bellew	P
Representative Tracy Boe	P
Representative Mike Brandenburg	P
Representative Michael Howe	P
Representative Gary Kreidt	A
Representative Bob Martinson	P
Representative Lisa Meier	P
Representative Alisa Mitskog	P
Representative Corey Mock	P
Representative David Monson	P
Representative Mike Nathe	P
Representative Jon O. Nelson	P
Representative Mark Sanford	P
Representative Mike Schatz	P
Representative Jim Schmidt	P
Representative Randy A. Schobinger	P
Representative Michelle Strinden	P
Representative Don Vigesaa	P

Discussion Topics:

- Tribal health care
- Essential Services

9:37 Representative Weisz- Introduces HB 1407 and testifies in favor.

Additional written testimony: No written testimony

9:53 Chairman Delzer-Closes the meeting for HB 1407

Risa Berube, House Appropriations Committee Clerk

2021 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Brynhild Haugland Room, State Capitol

HB 1407
2/16/2021

Relating to medical assistance tribal health care coordination agreements; to provide for legislative management and legislative council reports; to provide a continuing appropriation; and to provide a contingent effective date.

11:28 Chairman Delzer- Opens the meeting for HB 1407;

Attendance	P/A
Representative Jeff Delzer	P
Representative Keith Kempenich	P
Representative Bert Anderson	P
Representative Larry Bellew	P
Representative Tracy Boe	P
Representative Mike Brandenburg	P
Representative Michael Howe	P
Representative Gary Kreidt	P
Representative Bob Martinson	P
Representative Lisa Meier	P
Representative Alisa Mitskog	P
Representative Corey Mock	P
Representative David Monson	P
Representative Mike Nathe	P
Representative Jon O. Nelson	P
Representative Mark Sanford	P
Representative Mike Schatz	P
Representative Jim Schmidt	P
Representative Randy A. Schobinger	P
Representative Michelle Strinden	P
Representative Don Vigesaa	P

Discussion Topics:

- Tribal care coordinating
- December 31st, 2022 expiration date of tribal coordination agreements
- Methods of Public Health

11:28 Chairman Delzer- Reviews HB1407

11:30 Representative Jon O. Nelson –Makes a motion for a Do Pass

Representative Meier-Second the motion

Further discussion

11:32 Roll Call vote was taken;

Representatives	Vote
Representative Jeff Delzer	N
Representative Keith Kempenich	Y
Representative Bert Anderson	Y
Representative Larry Bellew	N
Representative Tracy Boe	Y
Representative Mike Brandenburg	Y
Representative Michael Howe	Y
Representative Gary Kreidt	Y
Representative Bob Martinson	Y
Representative Lisa Meier	Y
Representative Alisa Mitskog	Y
Representative Corey Mock	Y
Representative David Monson	Y
Representative Mike Nathe	Y
Representative Jon O. Nelson	Y
Representative Mark Sanford	Y
Representative Mike Schatz	N
Representative Jim Schmidt	Y
Representative Randy A. Schobinger	Y
Representative Michelle Strinden	Y
Representative Don Vigesaa	Y

Motion Carries 18-3-0 Representative Dobervich will carry the bill

Additional written testimony: No Written Testimony

11:33 Chairman Delzer- Closes the meeting for HB 1407

Risa Berube,

House Appropriations Committee Clerk

REPORT OF STANDING COMMITTEE

HB 1407, as engrossed: Appropriations Committee (Rep. Delzer, Chairman) recommends **DO PASS** (18 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1407 was placed on the Eleventh order on the calendar.

2021 SENATE HUMAN SERVICES

HB 1407

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

HB 1407
3/8/2021

A BILL for an Act to amend and reenact section 50-24.1-40 of the North Dakota Century Code, relating to medical assistance tribal health care coordination agreements; to repeal section 50-24.1-40 of the North Dakota Century Code, relating to medical assistance tribal health care coordination agreements; to provide for legislative management and legislative council reports; to provide a continuing appropriation; and to provide a contingent effective date.

Madam Vice Chair K. Roers opened the hearing on HB 1407 at 2:57 p.m. Members present: K. Roers, Hogan, Anderson, Clemens, O. Larsen. Absent: Lee

Discussion Topics:

- Capital construction funds
- Tribal/State negotiations
- Auditing requirements
- South Dakota FMAP distribution percentage
- Tribal community services delivery
- DHS possible expenditures
- Administrative costs
- MHA Medicaid reimbursement percentage

[2:58] Representative Scott Louser, District 5. Introduced HB 1407.

[3:01] Representative Nathan Davis, Turtle Mountain Band of Chippewa. Provided oral testimony in favor.

[3:07] Representative Jon Nelson, District 14. Provided oral neutral testimony.

[3:16] Representative Gretchen Dobervich, District 11. Provided oral neutral testimony.

[3:24] Councilman Brandon Mauai, Standing Rock Sioux Tribe. Provided testimony #8018 in favor.

[3:33] Lorraine Davis, Founder and CEO, Native American Development Center and Native Community Development, Inc. dba NATIVE, Inc. Provided testimony #8011 in favor.

[3:45] Scott Davis, Executive Director, ND Indian Affairs Commission. Provided neutral testimony #8023.

[3:56] Representative Nathan Davis, Turtle Mountain Band of Chippewa. Stands to provide clarification on Tribal positions on HB 1407 to the committee.

[4:01] Tim Blasl, President, ND Hospital Association. Provided testimony #8046 in favor.

[4:06] LeeAnn Thiel, Assistant Director, Medical Services Division, DHS. Provided neutral testimony #7854.

[4:12] Erik Elkins, Assistant Director, Medical Services Division, DHS. Provided the committee with clarification on the associated fiscal note.

[4:16] Cynthia Monteau, On behalf of Chairman Mark Fox, MHA (Mandan, Hidatsa, Arikara) Nation. Provided testimony #8054 in opposition.

Additional written testimony: N/A

Madam Vice Chair K. Roers closed the hearing on HB 1407 at 4:35 p.m.

Justin Velez, Committee Clerk

TESTIMONY OF BRANDON MAUAI FOR THE STANDING ROCK SIOUX TRIBE
BEFORE THE SENATE COMMITTEE ON HUMAN SERVICES CONCERNING HB: 1407; THE TRIBAL HEALTH CARE COORDINATION AGREEMENTS
MARCH 8, 2021

Chairwoman Lee and Members of the Committee:

I am Councilman Brandon Mauai, the representative from the Standing Rock Sioux Tribe and serve as the Vice-Chairman of the Committee on Health, Education, and Welfare. My testimony today will provide some background and explain the Standing Rock Sioux Tribe's stance on HB 1407 pertaining tothe care coordination agreements (known from the prior legislative session as HB 1194). Today, the Standing Rock Sioux Tribe is asking for 100% of the "Received Through" FMAP.

Standing Rock has come to the table to meet, time and time again, with you – the law makers for the State of North Dakota. Time and time again, the Standing Rock Sioux Tribe has held firm in asking for 100% of the FMAP. Why? There is much guidance to provide that tribes were to be given a large, if not all, the "received through" FMAP. In fact, the SHO (State Health Official) Letter #16-002, which was issued as guidance by the Centers for Medicare and Medicaid Services in 2016 to the state so that tribes could receive 100% of the FMAP (see attached SHO #16-002).

On June 28, 2018, I provided testimony to the Healthcare Reform and Review Committee stating the Standing Rock Sioux Tribe wanted 100% of the Tribal Health Care Coordination Fund due to the health concerns, disparities, and needs of the Standing Rock Sioux Tribe. Then, once again, I provided testimony on January 15, 2019, this time before this body, stating the Standing Rock Sioux Tribe shouldstill receive 100%. However, HB 1194 was introduced at the rate of 70/30 and although we vehemently disagreed, we did not halt the process of the care coordination agreements.

On February 6, 2019, an amendment was proposed by Chairman Weisz of the Hous Committee of human Services, despite not being present to hear the words of the tribes at the January 15th hearing, to change the rate from 70/30 to 50/50 as, "a compromise looking to get this thing moved forward" (Chairman Weisz's words from the transcript).Let me state that the Standing Rock Sioux Tribe was not aware of this "compromise" when it went forward on February 6, 2019. Additionally, it objected to the amendment and to the bill as it moved forward and as it was signed into law by Governor Burgum at 60/40 on May 1, 2019.

Two years have passed and today our stance has not changed. We are opposed to the 70/30 split. Just as we were with the proposed 50/50 split and then the 2019 rate of 60/40. The Standing Rock Sioux Tribe should be receiving 100% of the "Received Through" FMAP. Although the share of 60/40 continues to be the percentage in the signed Bill, HB 1194, the FMAP rate has changed, and the health disparities on Standing Rock continue to increase every year. In conclusion, the Standing Rock Sioux Tribe, continues to request the percentage of the "received through" FMAP to the tribes to be 100%, but are open to negotiating in a government to government setting.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO #16-002

Re: Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives

February 26, 2016

Dear State Health Official:

The purpose of this letter is to inform state Medicaid agencies and other state health officials about an update in payment policy affecting federal funding for services received by Medicaid-eligible individuals, who are American Indians and Alaska Natives (AI/AN) through facilities of the Indian Health Service (IHS), whether operated by IHS or by Tribes. As described in this letter, IHS/Tribal facilities[1] may enter into care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are AI/AN Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements would be eligible for the enhanced federal matching authorized under section 1905(b) of the Social Security Act at a rate of 100 percent. Upon execution of a written care coordination agreement, this will be effective immediately for states for the expenditures for services furnished by non-IHS/Tribal providers to AI/AN Medicaid beneficiaries who are patients of an IHS/Tribal facility acting under such agreement, as described below. This update in payment policy is intended to help states, the IHS, and Tribes to improve delivery systems for AI/ANs by increasing access to care, strengthening continuity of care, and improving population health.

Background

The IHS, a federal agency within the Department of Health and Human Services, is responsible for furnishing comprehensive, culturally-appropriate health services to almost 2.2 million AI/ANs who are eligible for services from the IHS, per regulations at 42 CFR Part 136. To achieve this goal, IHS operates its own hospitals and clinics and partners with Tribes as authorized by the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended. The IHS also provides funding for Urban Indian Health Organizations to operate Urban Indian Health Programs (UIHPs) under title V of the Indian Health Care Improvement Act, P.L. 94-437, as amended. The IHS, Tribes, and UIHPs operate health programs in 36 states.[2]

---

[1] For purposes of this document, Tribal facilities are facilities that are operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act, P.L. 93-638.

[2] As of the date of this SHO, the states are: AL, AK, AZ, CA, CO, CT, FL, ID, IL, IN, IA, KS, LA, ME, MD, MA, MI, MN, MS, MT, NE, NV, NM, NY, NC, ND, OK, OR, RI, SC, SD, TX, UT, WA, WI, and WY. This list is subject to change.

AI/ANs who meet the eligibility requirements for the Medicaid program in the state in which they reside are entitled to Medicaid coverage, whether or not they are eligible for services from IHS. IHS-eligible AI/ANs who are also Medicaid beneficiaries may choose to receive covered services from an IHS facility, a Tribal facility, a UIHP, or from any other provider participating in a state's Medicaid program.

Under section 1905(b) of the Social Security Act, the federal government is required to match state expenditures at the Federal Medical Assistance Percentage (FMAP) rate, which is 100 percent for state expenditures on behalf of AI/AN Medicaid beneficiaries for covered services "received through" an Indian Health Service facility whether operated by the Indian Health Service or by a Tribe or Tribal organization (as defined in section 4 of the Indian Health Care Improvement Act)." If services are not "received through" an IHS/Tribal facility, the federal government will match the state's payment for the services at the state's regular FMAP rate, which in FY 2016 ranges from 50.00 percent to 74.17 percent.

Our long-standing interpretation of this statutory provision as reflected in sub-regulatory guidance,[3] Departmental Appeals Board decisions,[4] and federal court decisions,[5] has been that 100 percent 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" – i.e., within the scope of services that a facility (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center/Rural Health Clinic, nursing facility) can offer under Medicaid law and regulation;
(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.

Last year, the Centers for Medicare & Medicaid Services (CMS) announced it was strongly considering re-interpreting the statutory language to expand the services it considers "received through" an IHS/Tribal facility and eligible for the 100 percent FMAP. Specifically, in October 2015, we posted on the CMS Medicaid.gov website a Request for Comment, in which we sought comments on a proposal to re-interpret the statutory language providing 100 percent FMAP for "services received through an IHS facility" by: (1) Modifying the scope of services eligible for enhanced FMAP; (2) Expanding the meaning of contractual agent to be an enrolled Medicaid provider that provides services that are identified in the state's approved Medicaid plan and are arranged for and overseen by the IHS/Tribal facility; and (3) Increasing the flexibility for billing arrangements so that IHS/Tribal facilities or their contractual agents could bill Medicaid directly

---

[3] Memorandum of Agreement (MOA) between IHS and HCFA (July 11, 1996); HCFA Memorandum to Associate Regional Administrators (May, 1997).
[4] *North Dakota Dept. of Human Services*, DAB No. 1854 (2002); *South Dakota Dept. of Social Services*, DAB No. 1847 (2002); *Arizona Health Care Cost Containment System*, DAB No. 1779 (2001); *Alaska Department of Health and Social Services,* DAB No. 1919 (2004).
[5] *North Dakota ex. Rel. Olson v. Centers for Medicare & Medicaid Services*, 403 F.3d 537 (8th Cir. 2005); *Alaska Department of Health & Social Services v. Centers for Medicare & Medicaid Services*, 424 F. 3rd 931 (9th Cir. 2005); *Arizona Health Care Cost Containment System v. McClellan*, 508 F.3rd 1243 (9th Cir. 2007).

for services. CMS received 182 comments from 91 commenters including Tribes, Tribal organizations, Urban Indian Health Organizations, states, and other stakeholders. We have reviewed and considered those comments in establishing this new policy interpretation.

Permitting a Wider Scope of Services

In this letter, we are re-interpreting the scope of services considered to be "received through" an IHS/Tribal facility. Under our previous interpretation, in order to be "received through" an IHS/Tribal facility, and therefore, qualify for 100 percent FMAP, the service had to be a "facility service." By that, we meant that it had to be within the scope of services that a Medicaid facility of the same type (e.g., inpatient hospital, outpatient hospital, clinic, Federally Qualified Health Center/Rural Health Clinic, nursing facility) can provide under Medicaid law and regulation. Under our new interpretation, as described more fully below, the scope of services that can be considered to be "received through" an IHS/Tribal facility for purposes of 100 percent FMAP includes any services that the IHS/Tribal facility is authorized to provide according to IHS rules, that are also covered under the approved Medicaid state plan, including long-term services and supports (LTSS). Medicaid coverable benefit categories include all 1905(a), 1915(i), 1915(j), 1915(k), 1945, and 1915(c) services set forth in the state plan, as well as any other authority established in the future as a state plan benefit.

This scope of service change also applies to transportation that is covered as a service under the state Medicaid plan. Under regulations at 42 CFR 440.170(a), a state can elect to cover transportation and other related travel expenses determined necessary to secure medical examinations and treatment for a beneficiary. Related travel expenses include the cost of meals and lodging en route to and from medical care, and while receiving medical care, as well as the cost for an attendant to accompany the beneficiary, if necessary. Covered transportation services can include both emergency medical transportation and non-emergency medical transportation.

Medicaid Beneficiary and IHS/Tribal Facility Participation is Voluntary

This new interpretation does not provide authority for states to require any AI/AN Medicaid beneficiary to receive services through an IHS/Tribal facility. Nothing in this letter affects the entitlement of AI/AN Medicaid beneficiaries to freedom of choice of provider under section 1902(a)(23) of the Social Security Act. State Medicaid agencies may not, directly or indirectly, require AI/ANs who are eligible for Medicaid to receive covered services from IHS/Tribal facilities for the purpose of qualifying the cost of their services for 100 percent FMAP. Similarly, neither state Medicaid agencies nor IHS/Tribal facilities may require an AI/AN Medicaid beneficiary to receive services from a non-IHS/Tribal provider to whom the facility has referred the beneficiary for care. Nor can a state delay the provision of medical assistance by requiring that beneficiaries initiate or continue a patient relationship with the IHS/Tribal facility. Finally, federal Medicaid law does not require either IHS/Tribal facilities or non-IHS/Tribal providers to enter into the written care coordination agreements described in this SHO.

Request for Services In Accordance With a Written Care Coordination Agreement

In this letter, CMS also revises its interpretation to provide that a service may be considered "received through" an IHS/Tribal facility when an IHS/Tribal facility practitioner requests the service, for his or her patient, from a non-IHS/Tribal provider (outside of the IHS/Tribal facility), who is also a Medicaid provider, in accordance with a care coordination agreement meeting the criteria described below. The purpose of this revised policy interpretation is to enable IHS/Tribal 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.

A covered service will be considered to be "received through" an IHS/Tribal facility not only when the service is furnished directly by the facility to a Medicaid-eligible AI/AN patient, but also when the service is furnished by a non-IHS/Tribal provider at the request of an IHS/Tribal facility practitioner on behalf of his or her patient and the patient remains in the Tribal facility practitioner's care in accordance with a written care coordination agreement meeting the requirements described below. Under this policy, both the IHS/Tribal facility and the non-IHS/Tribal provider must be enrolled in the state's Medicaid program as rendering providers. Second, there must be an established relationship between the patient and a qualified practitioner at an IHS/Tribal facility. Third, care must be provided pursuant to a written care coordination agreement between the IHS/Tribal facility and the non-IHS/Tribal provider, under which the IHS/Tribal facility practitioner remains responsible for overseeing his or her patient's care and the IHS/Tribal facility retains control of the patient's medical record.

A non-IHS/Tribal provider from which an IHS/Tribal facility practitioner could request services could include an Urban Indian Health Organization that participates in Medicaid, or any other Medicaid-participating provider. Furthermore, the relationship between the IHS/Tribal facility practitioner and the patient could be based on visits, including the initial visit, through telehealth procedures that meet state and/or IHS standards for such procedures, if the IHS/Tribal facility has that capacity[6].

A self-request by the beneficiary, or a request from a non-IHS/Tribal provider, does not suffice for purposes of 100 percent FMAP; in such circumstances, the non-IHS/Tribal provider could furnish the service and bill the state Medicaid program, but the state expenditure for the service would not qualify for 100 percent FMAP. Similarly, the non-IHS/Tribal provider may refer the facility patient to another non-IHS/Tribal provider; however, if the patient receives a covered service from that other provider without a request from the IHS/Tribal facility practitioner, or the IHS/Tribal facility practitioner does not remain responsible for the patient's care, the state expenditure for the service would not qualify for 100 percent FMAP.

At a minimum, care coordination will involve:

(1) The IHS/Tribal facility practitioner providing a request for specific services (by electronic or other verifiable means) and relevant information about his or her patient to the non-IHS/Tribal provider;

---

[6] Or as specified in a demonstration project authorized under section 1637 of the Indian Health Care Improvement Act.

(2) The non-IHS/Tribal provider sending information about the care it provides to the patient, including the results of any screening, diagnostic or treatment procedures, to the IHS/Tribal facility practitioner;
(3) The IHS/Tribal facility practitioner continuing to assume responsibility for the patient's care by assessing the information and taking appropriate action, including, when necessary, furnishing or requesting additional services; and
(4) The IHS/Tribal facility incorporating the patient's information in the medical record through the Health Information Exchange or other agreed-upon means.

Written care coordination agreements under this policy could take various forms, including but not limited to a formal contract, a provider agreement, or a memorandum of understanding and, to the extent it is consistent with IHS authority, would not be governed by federal procurement rules. The IHS/Tribal facility may decide the form of the written agreement that is executed with the non-IHS/Tribal provider.

Medicaid Billing and Payments to Non-IHS/Tribal Providers

For services provided to Medicaid-eligible AI/AN beneficiaries that are rendered by a non-IHS/Tribal provider in accordance with a written care coordination arrangement, there are several options regarding how those services may be billed to Medicaid.

The first option is for the non-IHS/Tribal provider to bill the Medicaid agency directly. If the non-IHS/Tribal provider bills the state Medicaid program directly, the provider would be reimbursed at the rate authorized under the Medicaid state plan applicable to the provider type and service rendered. To support the application of the 100 percent FMAP, the state should ensure that claims include fields that document that the item or service was "received through" an IHS/Tribal facility. When a non-IHS provider bills a state directly, the state's payment rate for a covered service furnished by a non-IHS/Tribal provider to an AI/AN Medicaid beneficiary under a written care coordination agreement must be the same as the rate for that service furnished by that provider to a non-AI/AN beneficiary or to an AI/AN beneficiary who self-refers to the provider. Similarly, a state agency cannot establish one rate for services furnished by the facility to AI/AN beneficiaries and another for the same services provided by that facility to non-AI/AN Medicaid beneficiaries.

A second option is for the IHS or Tribal facility to handle all billing. In that case, the IHS/Tribal facility would have to separately identify services provided by non-IHS/Tribal providers under agreement that can be claimed as services of the IHS/Tribal facility ("IHS/Tribal facility services") from those that cannot. Inpatient services that are furnished by non-IHS providers outside of IHS/Tribal facilities could never be claimed as IHS/Tribal facility services. For IHS, other services provided by non-IHS providers outside of an IHS facility generally cannot be claimed as IHS facility services. Tribal facilities generally may have more flexibility than IHS and should consult with their state to determine the circumstances in which other services provided by non-Tribal providers can be claimed as Tribal facility services. The circumstances under which Tribal facilities may claim services as their own are the same as those that apply for other similar facilities in the state (e.g., inpatient or outpatient hospitals, nursing facilities, Federally Qualified Health Centers, etc.). Services that can properly be claimed as IHS/Tribal facility services may be billed directly by the IHS/Tribal facility and are paid at the applicable Medicaid state plan IHS/Tribal facility rate. For all other services provided by non-IHS/Tribal

providers, IHS or the Tribe could bill for these services as an assigned claim by that provider and the payment rate would be the state plan rate applicable to the furnishing provider and the service, not the applicable Medicaid state plan IHS/Tribal facility rate. These services are still eligible for the 100 percent FMAP, provided other requirements have been met.

The billing arrangement should be reflected in the written agreement between the IHS/Tribal facility and the non-IHS/Tribal provider. Payment methodologies for facility services furnished by both the IHS/Tribal facility and rate methodologies paid to non-IHS/Tribal providers must be set forth in an approved state Medicaid plan. Payment rates can reflect the unique access concerns in particular geographic areas, or with respect to certain types of providers. However, rates may not vary based on the applicable FMAP. States should review existing state plans to ensure compliance with the policy articulated in this letter.

Managed Care

The discussion above assumes that the Medicaid-eligible AI/AN has "received [services] through" the IHS/Tribal facility on a fee-for-service basis. In some cases, however, Medicaid-eligible AI/ANs may be enrolled in a risk-based Medicaid managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), in which case the state Medicaid agency is making monthly capitation payments on behalf of the AI/AN enrollee to the MCO, PIHP, or PAHP. The state may claim 100 percent FMAP for the portion of the capitation payment attributable to the cost of services "received through" an IHS/Tribal facility if the following conditions are met:

(1) The service is furnished to an AI/AN Medicaid beneficiary who is enrolled in the managed care plan;
(2) The service meets the same requirements to be considered "received through" an IHS/Tribal facility as would apply in a fee-for-service delivery system and the managed care plan maintains auditable documentation to demonstrate that those requirements are met;
(3) The non-IHS/Tribal provider is a network provider of the enrollee's managed care plan;
(4) The non-IHS/Tribal provider is paid by the managed care plan consistent with the network provider's contractual agreement with the managed care plan; and
(5) The state has complied with section 1932(h)(2)(C)(ii) of the Act consistent with CMS guidance.

States would be permitted to claim the 100 percent FMAP for a portion of the capitation payment for AI/ANs who are enrolled in managed care, even though the state itself has made no direct payment for services "received through" an IHS/Tribal facility. The portion of the managed care payment eligible to be claimed at 100 percent FMAP must be based on the cost of services attributable to IHS/Tribal services or encounters received through an IHS/Tribal provider meeting the requirements outlined in this section.

Compliance and Documentation

To ensure accountability for program expenditures, in states where IHS/Tribal facilities elect to implement the policy described in this letter, the Medicaid agency will need to establish a process for documenting claims for expenditures for items or services "received through" an

IHS/Tribal facility. The documentation must be sufficient to establish that (1) the item or service was furnished to an AI/AN patient of an IHS/Tribal facility practitioner pursuant to a request for services from the practitioner; (2) the requested service was within the scope of a written care coordination agreement under which the IHS/Tribal facility practitioner maintains responsibility for the patient's care; (3) the rate of payment is authorized under the state plan and is consistent with the requirements set forth in this letter; and (4) there is no duplicate billing by both the facility and the provider for the same service to the same beneficiary.

Applicability to Section 1115 Demonstrations

State expenditures for services covered under section 1115 demonstration authority are eligible for 100 percent FMAP as long as all of the elements of being "received through" an IHS or Tribal facility that are described in this SHO are present.

Relationship Between 100 Percent FMAP for Tribal Services and Other Federal Matching Rates

The 100 percent FMAP for services "received through" an IHS/Tribal facility is available for services provided to AI/ANs as described in this SHO instead of the regular FMAP rate described in section 1905(b) of the Act, the newly eligible FMAP rate described in section 1905(y) of the Act, the enhanced FMAP rate for breast and cervical cancer, or the enhanced rate for Community First Choice services.

We intend to issue additional guidance materials after the release of this SHO. CMS is available to work closely with each state to implement the policy established in this state health official letter regarding receiving 100 percent FMAP for services "received through" an IHS/Tribal facility. If you have any questions regarding this information, please contact TribalAffairs@cms.hhs.gov or Kirsten Jensen, Director, Division of Benefits and Coverage, 410-786-8146.

Sincerely,
/s/
Vikki Wachino
Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

American Public Human Services Association

National Governors Association

Council of State Governments

Association of State and Territorial Health Officials

Senate Human Services Committee
IN SUPPORT – HB1407 | 03/08/2021 | Lorraine Davis

Native American Development Center & Native Community Development, Inc. dba NATIVE, Inc.
email: lorraine@ndnadc.org | tel: (701) 595-5181, dial 4 | cell: (701) 214-7911

Madam Chairwoman Lee and Members of the Senate Human Services Committee. My name is Lorraine Davis, Founder and Chief Executive Officer of Native American Development Center and Native Community Development, Inc. dba NATIVE, Inc. Native American Development Center is a Native community development financial institution serving North Dakota. Its mission is to provide lending services and financial education to distressed communities in ND, at least 60% must be provided to Native American communities within our state. NATIVE, Inc. is a community development corporation serving North Dakota urban areas. Its mission is to create safe and inclusive communities within urban areas across North Dakota through affordable housing, culture, education and workforce and economic services.

I support HB1407. This is a great opportunity for the state and tribes to work together to improve the lives of tribal members living both on and off the reservations through this new opportunity to participate in medical assistance tribal health care coordination agreements. So often, Native Americans living off the reservations fall through the cracks. With 70% of "new" tribal revenues and 30% of "new" state revenues that are generated from this "new" agreement, after a tribal member has been referred to a private hospital for specialized care, the tribes who opt-in and the state may contribute a very small percentage of new revenue to a statewide community-based organization to assist tribal populations living off reservations with coordinated care and community health representative programs or services. What a great opportunity for the State and Tribes to not only improve healthcare but to improve "culturally responsive" coordinated care services amongst tribal members living across jurisdictions to improve the social determinants of health. Social determinants of health are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes. [1] Social determinants of health are complex, interrelated social structures and economic systems that shape these conditions and include aspects of the social environment (e.g., discrimination, income, education level, marital status), the physical environment (e.g., place of residence, crowding conditions, built environment [i.e., buildings,

[1] Social Determinants of Health: Know What Affects Health. Centers for Disease Control and Prevention retrieved from https://www.cdc.gov/socialdeterminants/index.htm

spaces, transportation systems, and products that are created or modified by people]), and health services (e.g., access to and quality of care, insurance status). CDC works to addressing these factors through policy, practice, research, and partnership activities. [2]

This bill creates the systematic structure to be able to properly address social determinants of health amongst tribal populations in our state. This is so desperately needed when reviewing racial disparities within public health, behavioral health, criminal justice, breakdown of family, poverty, homeless and unemployment in North Dakota. Our work addresses the ten essential services of public health identified by the federal centers for disease control and prevention and the social determinants of health for not only Native Americans but ALL Americans with low to moderate income levels living in urban areas within North Dakota. However, with funding, we can increase our administrative capacity to manage over twenty-five community-based programs that we offer and components of the ten essential services of public health.

24% of the state's Native American population lives in the Bismarck metropolitan area. It is largest urban Indian population in our state and is almost three times the size of Fargo's urban Indian population. [3]

[2] National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Social Determinants of Health retrieved from https://www.cdc.gov/nchhstp/socialdeterminants/index.html

[3] U.S. Census Bureau. 2016 American Community Survey 1-Year Estimates. American Indian and Alaska Native or in combination with one or more other races.

Senate Human Services Committee

January 27, 2021

Testimony on HB 1407 (Tribal Health Coordinated Care Agreements)

Good afternoon Madam Chair Lee and members of the Senate Human Services Committee. My name is Scott Davis and I am an enrolled member of the Standing Rock Sioux Tribe and a decedent of the Turtle Mountain Band of Chippewa. I am the Executive Director of the ND Indian Affairs Commission.

Our position on HB 1407 is neutral, but we have been and will continue to be committed to making sure the Tribal Nations are working with the State of North Dakota and Non-Native Health Care Providers to improve the health care for Tribal people in ND.

This work was initially started back in 2016 after the 65th Legislative Session. There were meetings set up with Standing Rock Sioux Tribe (SRST) initially since they have lands in North Dakota and South Dakota. There were numerous meetings with Standing Rock and a few with Turtle Mountain Band of Chippewa. These meetings talked about the referral process and how to ensure that the different health systems are communicating about the patients' care.

Prior to the 66th Legislative session, we had meetings with the Tribal leaders on a potential bill to address the savings from the coordinated care agreements. The Tribal leaders agreed to have the bill be written to have a 70/30 split of the savings with 70% going back to the Tribes and 30% to the state. HB 1194 was created with this percentage and through the legislative process the split of the savings was changed to 60% going to the Tribes and 40% to the State. This bill also created a separate fund.

Currently, there have been some changes to HB 1407, that we encourage you to consider as I am sure the Tribes may have more ideas on how to improve the Bill.

The Tribes of ND have some of the worst health care disparities in the region. We continue to find new ways to improve access to quality services, address major health care disparities and having a quality health care workforce. This effort would be a new tool for each Tribe to address the health care needs that are unique to each community. This project could increase the federal funding coming back to ND and help our current system to improve moving forward.

That concludes my testimony. I will stand for any questions.

NDHA
North Dakota Hospital Association Est. 1934

2021 HB 1407
Senate Human Services Committee
Senator Judy Lee, Chairman
March 8, 2021

Chairman Lee and Members of the Senate Human Services Committee. I am Tim Blasl, President of the North Dakota Hospital Association. I am here to testify regarding House Bill 1407 and ask that you give this bill a **Do Pass** recommendation.

We support this bill because it would enhance collaboration between hospitals and North Dakota tribes to improve access to health care and strengthen continuity of care. This joint effort not only provides improved access to health care for American Indians, but it also provides the state with the opportunity to benefit from a Centers for Medicare & Medicaid Services (CMS) policy which provides 100 percent federal payments when an American Indian Medicaid beneficiary who is also eligible to receive care through Indian Health Services (IHS) receives care outside an IHS/Tribal facility, so long as the referring and receiving facilities have in place a care coordination agreement.

Currently, Medicaid payments at non-IHS/Tribal facilities for Medicaid-eligible American Indians are subject to states' regular Federal Medicaid Assistance Percentage (FMAP). North Dakota's current FMAP is 52.4 percent, meaning that for every dollar spent on medical services, the federal government contributes fifty-two cents. The new CMS policy provides 100 percent federal payment if requirements are met. One of those requirements is that the IHS/Tribal facility has in place a Care Coordination Agreement with the non-IHS/Tribal facility to which the patient is being referred.

It is estimated that this process could be providing millions in state general fund savings annually. The fiscal note on 2019 House Bill no. 1194, which created the law that this bill will amend, stated that, for the 2019-2021 biennium, the total savings were projected to be $7,386,113 and for the 2021-2023 biennium, the total savings were projected to be $8,532,324.

We support sharing the additional federal funding with participating Tribes in order to incentivize participation in the project and to recognize the additional work Tribes will need to do if they join the project. We ask that you give this bill a **Do Pass** recommendation.

I would be happy to try to answer any questions you may have. Thank you.

Respectfully Submitted,

Tim Blasl, President
North Dakota Hospital Association

Testimony

Engrossed House Bill 1407 – Department of Human Services

Senate Human Services Committee

Senator Judy Lee, Chairman

March 8, 2021

Chairman Lee, members of the Senate Human Services Committee, I am LeeAnn Thiel, Assistant Director of the Medical Services Division, for the Department of Human Services (Department). I am here today to testify on Engrossed House Bill 1407, which makes changes to section 50-24.1-40 of North Dakota Century Code as it relates to Tribal Care Coordination agreements.

As you are aware, last session section 50-24.1-40 was added to the North Dakota Century Code. That section allows for a tribal health care organization to enter into a signed care coordination agreement with a provider enrolled in Medicaid. If an agreement is signed between a provider and a tribal health care organization, the State will be able to claim 100% FMAP funding on covered services received through IHS/Tribal 638 facilities that have care coordination agreements with non-IHS/Tribal providers. These covered services, and their subsequent bills, must be processed through the Department's normal payment system often referred to as the MMIS. MMIS will capture the billing and this information will be used in federal reporting to claim the 100% as opposed to regular FMAP.

Section 1 of the bill notes that any savings captured from the 100% versus regular FMAP will be captured and placed in a tribal health care coordination fund. Subsequently, 70% of that savings will be distributed to the tribal entity and 30% will remain with the State.

The Department is neutral on this part of the bill but offers the following information.

The original bill struck through language that would require the tribes to submit audit reports to the State every two years. This was restored by the House. The Department supports the restoration of this language.

Medicaid routinely audits payments, and this is in alignment with other program integrity activities. We also reached out to South Dakota Medicaid and they confirmed that they as well audit these tribal care coordination payments. There are two types of audit that Medicaid would want to conduct: audit that the care coordination activities are valid and audit that the correct FMAP was used. Tribal health care organizations would be audited, and the Department already has a tribal liaison staff to conduct these audits.

Page 3, lines 11 through 15, of the engrossed bill requires the Department to compile a report on how the dollars in the fund (due to the 30 percent savings) are distributed. However, the Department requests clarity on how the legislature expects these funds to be spent. The bill does describe that funds should be spent on essential services of public health or enhancement of community health representative programs or services. The Department requests clarity in those functions and if the dollars spent should be targeted toward a specific population or sub-population.

This concludes my testimony. I would be happy to answer any questions.

MANDAN, HIDATSA & ARIKARA NATION
Three Affiliated Tribes * Fort Berthold Indian Reservation
404 Frontage Road New Town, ND 58763
Tribal Business Council

Office of the Chairman
Mark N. Fox

HOUSE BILL 1407
SENATE HUMAN SERVICES COMMITTEE
MARCH 8, 2021

TESTIMONY OF MARK N. FOX, CHAIRMAN
MANDAN, HIDATSA AND ARIKARA NATION

Mr. Chairman and members of the Committee, my name is Cynthia Monteau, representing and on behalf of Chairman Mark Fox of the Three Affiliated Tribes of the Mandan, Hidatsa and Arikara Nation (MHA Nation). I come before you today as an Opponent of House Bill 1407.

While we appreciate that the MHA Nation was specifically removed from the bill in the prior version, the bill still does not provide for a Tribe to "opt out," which remains a concern for the MHA Nation. A participating tribe is one that is defined on page 1, lines 16-18 and the MHA Nation satisfies that definition of a participating tribe because we provide health care under the federal Indian Self-Determination and Education Assistance Act (ISDEAA).

To gain MHA Nation's support of this bill we recommend the following language to be inserted on line 19:

2. The department of human services shall facilitate care coordination agreements.

When services are furnished to an AI/AN Medicaid beneficiary by a non-IHS/Tribal provider based on a referral from an IHS/Tribal facility and under the terms of a written care coordination agreement, and the non-IHS/Tribal provider bills the state Medicaid program directly. The provider will be reimbursed at the rate authorized under the Medicaid state plan applicable to the provider type and the service rendered. Of any federal funding in excess of the state's regular share of federal medical assistance funding which results from care coordination agreements, the department shall deposit seventy percent in the tribal health care coordination fund and thirty percent in the general fund.

By inserting this language, it clarifies the process of reimbursement. The distinction is that an IHS/Tribal facility referring a qualified AI/AN Medicaid beneficiary through its own contracting authority with that provider is reimbursed at 100% FMAP and therefore the state is not contributing to that cost but acts simply as a "pass through" of the federal dollars to the tribal facility. Whereas in the case of a Medicaid provider that does not want to submit to the tribe for payment, but instead elects to be directly paid by Medicaid, the department of human services may facilitate those care coordination agreements and reimburse

the provider at the rate authorized under the Medicaid state plan and retain excess of the state's regular share of federal medical assistance funding which results from care coordination agreements. This language change does not interfere with an ISDEAA tribe's contracting authority and aso supports the states recovery of federal funding in excess of the state's regular share of federal medical assistance funding for services to an AI/AN Medicaid beneficiary where the state is contributing 50% of the costs of the care, which is the true purpose of this bill - to address those funds specifically.

Mr. Chairman we urge a Do Not Pass unless this bill is amended accordingly. Thank you.

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

HB 1407
3/9/2021

A BILL for an Act to amend and reenact section 50-24.1-40 of the North Dakota Century Code, relating to medical assistance tribal health care coordination agreements; to repeal section 50-24.1-40 of the North Dakota Century Code, relating to medical assistance tribal health care coordination agreements; to provide for legislative management and legislative council reports; to provide a continuing appropriation; and to provide a contingent effective date.

Madam Chair Lee opened the discussion on HB 1407 at 9:01 a.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- FMAP tribal percentage of funds
- Capital construction funds

[9:02] Representative George Keiser, District 47. Provided the committee with a background of HB 1407 and negotiations between Tribal Nations and the State of North Dakota during the 66th Legislative session.

Additional written testimony: N/A

Madam Chair Lee closed the discussion on HB 1407 at 9:13 a.m.

Justin Velez, Committee Clerk

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

HB 1407
3/16/2021

A BILL for an Act to amend and reenact section 50-24.1-40 of the North Dakota Century Code, relating to medical assistance tribal health care coordination agreements; to repeal section 50-24.1-40 of the North Dakota Century Code, relating to medical assistance tribal health care coordination agreements; to provide for legislative management and legislative council reports; to provide a continuing appropriation; and to provide a contingent effective date.

Madam Chair Lee opened the discussion on HB 1407 at 2:27 p.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Use of funds
- Health inequities
- Administrative costs
- Native Medicaid enrollment
- Tribe/state distribution rate

[2:35] LeeAnn Thiel, Medical Services Division, DHS. Provided clarification to the committee on potential administrative costs to DHS associated with HB 1407.

Additional written testimony: N/A

Madam Chair Lee closed the discussion on HB 1407 at 3:03 p.m..

Justin Velez, Committee Clerk

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

HB 1407
3/17/2021

A BILL for an Act to amend and reenact section 50-24.1-40 of the North Dakota Century Code, relating to medical assistance tribal health care coordination agreements; to repeal section 50-24.1-40 of the North Dakota Century Code, relating to medical assistance tribal health care coordination agreements; to provide for legislative management and legislative council reports; to provide a continuing appropriation; and to provide a contingent effective date.

Madam Chair Lee opened the discussion on HB 1407 at 2:18 p.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Proposed Amendment
- Annual State reporting

[2:19] Senator Judy Lee, District 13. Provided the committee with an overview of proposed amendment 21.0870.02002 (testimony #9806).

Senator K. Roers moves to **ADOPT AMENDMENT** 21.0870.02002
Senator Hogan seconded.

Voice Vote – Motion passed

Senator K. Roers moves **DO PASS, AS AMENDED, REREFER TO APPROPRIATIONS.**
Senator Hogan seconded.

Senators	Vote
Senator Judy Lee	Y
Senator Kristin Roers	Y
Senator Howard C. Anderson, Jr.	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Oley Larsen	N

The motion passed 5-1-0
Senator K. Roers will carry HB 1407.

Additional written testimony: N/A

Madam Chair Lee closed the hearing on HB 1407 at 2:26 p.m.

Justin Velez, Committee Clerk

SL 3/17, 18

21.0870.02002
Title.03000

Prepared by the Legislative Council staff for
Senate Human Services Committee
March 16, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1407

Page 1, line 19, overstrike "Of"

Page 1, line 20, overstrike "any" and insert immediately thereafter "The department shall deposit all"

Page 1, line 21, overstrike ", the department"

Page 1, line 22, overstrike "shall deposit"

Page 1, line 22, remove "seventy"

Page 1, line 22, overstrike "percent"

Page 1, line 22, overstrike "and"

Page 1, line 23, overstrike "forty",

Page 1, line 23, remove "thirty"

Page 1, line 23, overstrike "percent in the general fund"

Page 2, line 9, after the underscored comma insert "through June 30, 2025, no more than seventy-five percent and thereafter,"

Page 3, line 11, remove the overstrike over the overstruck comma

Page 3, line 11, remove the underscored colon

Page 3, line 12, remove "a. The"

Page 3, line 12, overstrike "department shall compile"

Page 3, line 13, remove "data"

Page 3, line 13, overstrike "and provide the legislative"

Page 3, line 14, overstrike "management with a biennial report on the"

Page 3, line 14, remove "state"

Page 3, line 14, overstrike "government use of"

Page 3, overstrike line 15

Page 3, line 16, replace "b. Each" with "each"

Renumber accordingly

REPORT OF STANDING COMMITTEE

HB 1407, as engrossed: Human Services Committee (Sen. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (5 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING). Engrossed HB 1407 was placed on the Sixth order on the calendar.

Page 1, line 19, overstrike "Of"

Page 1, line 20, overstrike "any" and insert immediately thereafter "The department shall deposit all"

Page 1, line 21, overstrike ", the department"

Page 1, line 22, overstrike "shall deposit"

Page 1, line 22, remove "seventy"

Page 1, line 22, overstrike "percent"

Page 1, line 22, overstrike "and"

Page 1, line 23, overstrike "forty",

Page 1, line 23, remove "thirty"

Page 1, line 23, overstrike "percent in the general fund"

Page 2, line 9, after the underscored comma insert "through June 30, 2025, no more than seventy-five percent and thereafter,"

Page 3, line 11, remove the overstrike over the overstruck comma

Page 3, line 11, remove the underscored colon

Page 3, line 12, remove "a. The"

Page 3, line 12, overstrike "department shall compile"

Page 3, line 13, remove "data"

Page 3, line 13, overstrike "and provide the legislative"

Page 3, line 14, overstrike "management with a biennial report on the"

Page 3, line 14, remove "state"

Page 3, line 14, overstrike "government use of"

Page 3, overstrike line 15

Page 3, line 16, replace "b. Each" with "each"

Renumber accordingly

21.0870.02002
Title.

Prepared by the Legislative Council staff for
Senate Human Services Committee
March 16, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1407

Page 1, line 19, overstrike "Of"

Page 1, line 20, overstrike "any" and insert immediately thereafter "The department shall deposit all"

Page 1, line 21, overstrike ", the department"

Page 1, line 22, overstrike "shall deposit"

Page 1, line 22, remove "seventy"

Page 1, line 22, overstrike "percent"

Page 1, line 22, overstrike "and"

Page 1, line 23, overstrike "forty",

Page 1, line 23, remove "thirty"

Page 1, line 23, overstrike "percent in the general fund"

Page 2, line 9, after the underscored comma insert "through June 30, 2025, no more than seventy-five percent and thereafter,"

Page 3, line 11, remove the overstrike over the overstruck comma

Page 3, line 11, remove the underscored colon

Page 3, line 12, remove "a. The"

Page 3, line 12, overstrike "department shall compile"

Page 3, line 13, remove "data"

Page 3, line 13, overstrike "and provide the legislative"

Page 3, line 14, overstrike "management with a biennial report on the"

Page 3, line 14, remove "state"

Page 3, line 14, overstrike "government use of"

Page 3, overstrike line 15

Page 3, line 16, replace "b. Each" with "each"

Renumber accordingly

2021 SENATE APPROPRIATIONS

HB 1407

2021 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1407
3/29/2021
Senate Appropriations Committee

Relating to medical assistance tribal health care coordination agreements.

Senator Holmberg opened the hearing at 9:15 AM.

Senators present: **Holmberg, Krebsbach, Wanzek, Bekkedahl, Erbele, Dever, Oehlke, Poolman, Rust, Davison, Hogue, Sorvaag, Mathern, and Heckaman.**

Discussion Topics:

- Infrastructure building on reservations
- Tribal participation

Senator Kristin Roers, District 27, introduced the bill and testified in favor.

Brad Hawk, ND Indian Affairs Commission – testified in favor.

Tim Blasl, President, ND Hospital Association – testified in favor and submitted #10889.

Senator Mathern moved Do Pass on HB 1407.
Senator Heckaman second.

Senators			***Senators***	
Senator Holmberg	Y		*Senator Hogue*	Y
Senator Krebsbach	Y		*Senator Oehlke*	Y
Senator Wanzek	Y		*Senator Poolman*	Y
Senator Bekkedahl	Y		*Senator Rust*	Y
Senator Davison	Y		*Senator Sorvaag*	Y
Senator Dever	Y		*Senator Heckaman*	Y
Senator Erbele	Y		*Senator Mathern*	Y

Roll Call vote 14-0-0. Motion passed.

Senator Holmberg closed the hearing at 9:55 AM.

Rose Laning, Committee Clerk

REPORT OF STANDING COMMITTEE

HB 1407, as engrossed and amended: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1407, as amended, was placed on the Fourteenth order on the calendar.

2021 HB 1407

Senate Appropriations Committee

Senator Holmberg, Chairman

March 29, 2021

Chairman Holmberg and members of the Senate Appropriations Committee. I am Tim Blasl, President of the North Dakota Hospital Association. I am here to testify regarding House Bill 1407 and ask that you give this bill a **Do Pass** recommendation.

We support this bill because it would enhance collaboration between hospitals and North Dakota tribes to improve access to health care and strengthen continuity of care. This joint effort not only provides improved access to health care for American Indians, but it also provides the state with the opportunity to benefit from a Centers for Medicare & Medicaid Services (CMS) policy which provides 100 percent federal payments when an American Indian Medicaid beneficiary who is also eligible to receive care through Indian Health Services (IHS) receives care outside an IHS/Tribal facility, so long as the referring and receiving facilities have in place a care coordination agreement.

Currently, Medicaid payments at non-IHS/Tribal facilities for Medicaid-eligible American Indians are subject to states' regular Federal Medicaid Assistance Percentage (FMAP). North Dakota's current FMAP is 52.4 percent, meaning that for every dollar spent on medical services, the federal government contributes fifty-two cents. The new CMS policy provides 100 percent federal payment if requirements are met. One of those requirements is that the IHS/Tribal facility has in place a Care Coordination Agreement with the non-IHS/Tribal facility to which the patient is being referred.

We support sharing the additional federal funding with participating Tribes in order to incentivize participation in the project and to recognize the additional work Tribes will need to do if they join the project. We ask that you give this bill a **Do Pass** recommendation.

I would be happy to try to answer any questions you may have. Thank you.

Respectfully Submitted,

Tim Blasl, President
North Dakota Hospital Association

2021 CONFERENCE COMMITTEE

HB 1407

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1407
4/12/2021
Conference Committee

Relating to medical assistance tribal health care coordination agreements; to provide for a legislative management report; and to provide a continuing appropriation.

Chairman Greg Westlind opened the conference committee at 9:29 a.m.

Representatives	Attendance	Senators	Attendance
Chairman Greg Westlind	P	Chairman Howard Anderson	P
Rep. Bill Tveit	P	Sen. Kristin Roers	P
Rep. Gretchen Dobervich	P	Sen. Kathy Hogan	P

Discussion Topics:

- Capital construction
- Tribe report
- State benefit
- One-time coding change

Chairman Greg Westlind adjourned at 9:48 a.m.

Tamara Krause, Committee Clerk

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

HB 1407
4/14/2021
Conference Committee

Relating to medical assistance tribal health care coordination agreements; to provide for a legislative management report; and to provide a continuing appropriation.

Chairman Greg Westlind opened the conference committee at 10:59 a.m.

Representatives	Attendance	Senators	Attendance
Chairman Westlind	P	Chairman Howard Anderson	P
Rep. Bill Tveit	P	Sen. Kristin Roers	P
Rep. Gretchen Dobervich	P	Sen. Kathy Hogan	P

Discussion Topics:

- Capital construction
- Money Distribution date extension
- Care coordination agreements
- Legislative Management department reporting

Rep. Greg Westlind (10:59) presented amendment on Page 1, lines 22-23 replace seventy with eighty, replace thirty with twenty and Page 2, line 9, change no more than seventy-five percent to no more than fifty percent.

Sen. Howard Anderson (11:00) moved to adopt proposed amendment.

Voice Vote – Motion Carried

Sen. Kristin Roers (11:04) moved amendment on Page 3, line 14 remove "and tribal government use of money distributed from the fund."

Rep. Bill Tveit (11:05) second

Voice Vote – Motion Carried

Sen. Kristin Roers (11:05) moved **Senate Recede from Senate Amendments and Amend**

Rep. Gretchen Dobervich (11:05) second

Roll Call Vote – Motion Carried Senate Recede from Senate Amendments and Amend 6-0-0

House Bill Carrier: Rep. Greg Westlind

Senate Bill Carrier: Sen. Kristin Roers

Chairman Greg Westlind adjourned at 11:06 a.m.

Tamara Krause, Committee Clerk

DP 4/19/21
1 of 1

21.0870.02003
Title.04000

Adopted by the Conference Committee

April 14, 2021

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1407

That the Senate recede from its amendments as printed on page 1360 of the House Journal and pages 913 and 914 of the Senate Journal and that Engrossed House Bill No. 1407 be amended as follows:

Page 1, line 22, replace "seventy" with "eighty"

Page 1, line 23, replace "thirty" with "twenty"

Page 2, line 9, after the underscored comma insert "through June 30, 2025, no more than fifty percent and thereafter,"

Page 3, line 11, remove the overstrike over "~~, the~~"

Page 3, line 11, remove the underscored colon

Page 3, line 12, remove "a. The"

Page 3, line 12, remove the overstrike over "~~and summarize the annual reports and audit~~"

Page 3, line 13, remove the overstrike over "~~reports from the participating tribal governments~~"

Page 3, line 14, remove the overstrike over "~~fund~~"

Page 3, line 14, remove "state"

Page 3, line 14, overstrike "government use of"

Page 3, line 15, overstrike "money distributed from the fund"

Page 3, line 16, remove "b."

Renumber accordingly

Date: 4/14/2021
Roll Call Vote #: 1

2021 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1407 as (re) engrossed

House Human Services Committee

Action Taken
- ☐ **HOUSE accede to Senate Amendments**
- ☐ **HOUSE accede to Senate Amendments and further amend**
- ☐ **SENATE recede from Senate amendments**
- ☒ **SENATE recede from Senate amendments and amend as follows**

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Sen. Kristin Roers Seconded by: Rep. Gretchen Dobervich

Representatives	4/12/21	4/14/21	Yes	No		Senators	4/12/21	4/14/21	Yes	No
Chairman Greg Westlind	P	P	Y			Chairman Howard Anderson	P	P	Y	
Rep. Bill Tveit	P	P	Y			Sen. Kristin Roers	P	P	Y	
Rep. Gretchen Dobervich	P	P	Y			Sen. Kathy Hogan	P	P	Y	
Total Rep. Vote			3			Total Senate Vote			3	

Vote Count Yes: 6 No: 0 Absent: 0

House Carrier Rep. Greg Westlind Senate Carrier Sen. Kristin Roers

LC Number 21.0870 . 02003 of amendment

LC Number 21.0870 . 04000 of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

Insert LC: 21.0870.02003
House Carrier: Westlind
Senate Carrier: K. Roers

REPORT OF CONFERENCE COMMITTEE

HB 1407, as engrossed: Your conference committee (Sens. Anderson, K. Roers, Hogan and Reps. Westlind, Tveit, Dobervich) recommends that the **SENATE RECEDE** from the Senate amendments as printed on HJ page 1360, adopt amendments as follows, and place HB 1407 on the Seventh order:

That the Senate recede from its amendments as printed on page 1360 of the House Journal and pages 913 and 914 of the Senate Journal and that Engrossed House Bill No. 1407 be amended as follows:

Page 1, line 22, replace "seventy" with "eighty"

Page 1, line 23, replace "thirty" with "twenty"

Page 2, line 9, after the underscored comma insert "through June 30, 2025, no more than fifty percent and thereafter,"

Page 3, line 11, remove the overstrike over "~~, the~~"

Page 3, line 11, remove the underscored colon

Page 3, line 12, remove "a. The"

Page 3, line 12, remove the overstrike over "~~and summarize the annual reports and audit~~"

Page 3, line 13, remove the overstrike over "~~reports from the participating tribal governments~~"

Page 3, line 14, remove the overstrike over "~~fund~~"

Page 3, line 14, remove "state"

Page 3, line 14, overstrike "government use of"

Page 3, line 15, overstrike "money distributed from the fund"

Page 3, line 16, remove "b."

Renumber accordingly

Engrossed HB 1407 was placed on the Seventh order of business on the calendar.