NATIVE HEALTH

November 17, 2015

Sent via email to TribalAffairs@CMS.hhs.gov

Feedback and comment to the Centers for Medicare & Medicaid Services, CMCS on Medicaid Services "Received Through" an Indian Health Service/Tribal Facility: A Request for Comment

To CMS Tribal Affairs:

Native Health is an urban Indian health program funded by Title V of the Indian Health Care Improvement act. The board of directors, comprised of a majority of AI/AN members writes to strongly support changes to the 100% FMAP policy. Specifically with respect to modifying the third and fourth conditions the following comments are offered.

Modifying the third condition

Urban Indian health programs are an integral part of the IHS health care delivery system I/T/U. Native Health has had a contract in force with the IHS since 1978 to provide outreach, access, and direct care services to the urban Indian population of Phoenix Arizona. In that respect, Native Health is a contractual agent of the Indian Health Service as written in the CMS paper.

The contractual relationship is defined by law with certain requirements, including the provision of care where necessary. It also allows the Secretary, through the IHS, the right to review records, operations, and finances. Additional requirements are in place through regulation by the IHS.

Two items in the CMS paper are problematic when considering the circumstances under which an AI/AN would access care from an urban program.

1. Referral from a IHS facility/638 facility. The proximity of IHS/tribal facility may not allow for a direct referral for each AI/AN patient served for every visit. Urban Indian health providers (UIHP) are mandated, through contractual agreement, to provide services regardless of a referral as part of the I/T/U system of care. Urban programs are primary providers of services, just as outpatient clinics operated by the IHS or a tribe are.

2. Medical records. As patients may be seen by UIHP directly, the medical record is owned, retained, and controlled by the UIHP. The IHS maintains the right to review all records, including patient records as a provision of the law. A copy of the visit may be provided, but that presents some practical concerns. For instance, where would the records be kept in the IHS system? Would there be a central repository system for records belonging to urban programs and, in some cases, contractual providers of tribes? Additionally, would the correspondence from an urban or 638 clinic be considered part of the legally defined IHS medical record?

The need to establish a connection of patient care between IHS/638 programs and UIHP and contractors seems to be a clear requirement of CMS. When considering the regulation, CMS should contemplate an exception for UIHP from that provision considering their foundation under the IHCIA and oversight by the IHS.

Modifying the fourth condition

Native Health supports the concept of contractors billing the state Medicaid program directly and that cost being considered a 100% FMAP encounter. However, billing for a patient visit through the IHS or 638 would be impractical for the UIHP facility and the contractor. CMS should give flexibility for billing directly to the states who have varied billing and payment system capabilities.

Further comments

Acting as a contractual agent with a unique mandate from the IHCIA, urban programs are a primary source for care where there is not a nearby IHS or 638 facility. That provision of care currently is incongruous in states with 1115 waivers that include only IHS/638 facilities. That uneven compensation for the same service provided by an urban clinic puts a strain on the UIHP to meet the health care access and treatment needs of AI/AN.

The proposed policy changes are a good solution to establishing parity within the I/T/U system. Further, consideration should be given to referrals generated by a UIHP to be in the 100% FMAP category as well.

Thank you for the opportunity to provide these comments.

Sincerely,

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Walter Murillo
Chief Executive Officer