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Dear Tribal Affairs Staff at the Centers for Medicare & Medicaid Services,

On behalf of the SOUTH DAKOTA URBAN INDIAN HEALTH, INC., I want to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the proposed White Paper language. Since the Federal government bears a special trust obligation toward American Indian/Alaskan Native (AI/AN) populations, it seems only appropriate that the Federal government assume the full 100% Federal Medical Assistance Percentage (FMAP) cost for care to Medicaid eligible AI/AN in keeping with the nation's obligation to "ensure all resources necessary" as proclaimed in the Declaration of Indian health policy as stated in the Indian Health Care Improvement Act (IHCIA). I have participated on several national CMS conference calls and offered comments on many of them, as well as attending our recent IHS Conferring Meeting held at IHS on November 12, 2015 to specifically discuss issues and concerns relating to the White Paper as it related to 100% FMAP for Urban Indian Health programs. It is imperative that CMS have a full understanding and knowledge of how urban Indians access and receive their care through Urban Indian Health programs.

This is the South Dakota Urban Indian Health, Inc. response to "The Medicaid Services "Received Through" an Indian Health Service/Tribal Facility: A Request for Comment" white paper, October 2015 section *2. Modifying the third condition.* Referring to the statement: Urban Indian Health Programs could participate as contractual agents.

The IHS UIHPs are currently an essential and integral component of the 3-section *within* Indian Health Service "system" – I - Indian Health Service; T - Tribes and U - Urban Indian Health Programs. UIHPs have a primary purpose of providing access to quality care in serving members of federally recognized tribes as is the priority of the Indian Health Service and tribal clinics. This fundamental relationship *within* the IHS "system" is already through a contractual agreement that is vital and unique to provide care for eligible AI/AN individuals. We believe there needs to be a mutually agreed upon understanding about who we are, what we do and how we do it.

Urban Indian Health programs provide primary care to eligible AI/AN individuals who live in and near our 37 Urban Indian Health programs in 21 states. We are currently responsible for the care of the AI/AN patient and hold and maintain all required medical records/forms. Many UIHP locations are miles/hours from an IHS or tribal facility.

Our contractual relationship *within* IHS is far reaching and unique and includes:

1. Mandates Title V retain patient records until a set time after the contract ends.
2. Annual on-site IHS reviews that cover 23 chapter elements (including having the right to review patient records) and is based on quality standards from AAAHC Accreditation.
3. Requirement to maintain and report to IHS quality of care indicators for the AI/AN patients through federal reports, such as GPRA/GPRAMA.
4. An IHS Area Office Project Coordinator is assigned to every UIHP to over-see the program and UIHP provides IHS written monthly or quarterly reports.
5. Key UIHP personnel, i.e. Exec Dir. /CEO, CFO are approved and authorized by IHS.
6. UIHPs are included in the Budget Formulation process, which includes determining top health issues and funding level needs for AI/AN individuals.

As noted on the October 29, 2015 CMS conference call the changes are to "expand the reach for service through contractual agents". The expanded reach has already included the UIHPs for many years, some as early as 1976. Another statement made on the October 29, 2015 CMS conference call was to "provide much flexibility -in how programs provide services and bill Medicaid." South Dakota Urban Indian Health greatly appreciates the willingness to be flexible to ensure programs provide services to our AI/AN population. Our letter is intended to clarify how UIHPs can meet that flexibility.

UIHPs that contract directly with the Indian Health Service do not fall into the category of specialty and consultative services that augment existing IHS and tribally managed health care. My Urban Indian Health clinics provide direct primary health care. The services that fall under this classification are extensions of the scope of care directly offered at an IHS site or at a tribally operated clinic. It is not feasible for any of the parties involved, the patient, IHS/Tribal or Urban Indian Health programs to have to receive a referral in order to provide primary health care to AI/AN patients who live within my service catchment area.

The UIHPs provide primary care services similar to those offered by the IHS and tribes. The majority of the UIHPs are Federally Qualified Health Centers with CMS and a few receive both IHS funding and Section 330 Community Health Center grants. Several of the UIHPs also have other Health Resources and Services Administration (HRSA) and Department of Health and Human Services (HHS) funding. Those that are Medicaid providers operate electronic medical records both commercial and government managed. Some have also acquired Patient Centered Medical Home Accreditation, and many have national accreditation from JCAHO, AAAHC, NCQA, CARF, etc. I provide this profile to illustrate that to include UIHPs in the same category as a private cardiologist offering specialty care or a physical therapist working with an arthritic patient is not comparable to the scope of work or care that is currently provided through our Urban Indian Health Programs. Specifically, South Dakota Urban Indian Health, Inc. is a Federally Qualified Health Center, AAAHC Accredited and AAAHC Patient Center Medical Home Accredited, State of South Dakota Accredited Alcohol Program and a State Medicaid Managed Care and Medicaid Health Home provider.

Therefore, the white paper requirements listed under section 3, *Modifying the fourth condition,* would be wholly inconsistent with our agencies and our clinical service and legal requirements; but most importantly would not be to the best medical benefit for our AI/AN patients. On the October 29, 2015 CMS conference call, CMS asked participants to let them know "what will work and what will not work". As asked by CMS, what are patient scenarios -- here are three real-life patient examples:

1. American Indian male patient, age 43. Chronic alcoholic, pancreatitis, slipped disk, homeless, no insurance, cannot afford premiums for ACA, unemployed due to his back problems at the current time. No transportation and no way to get help with his alcoholism at IHS in Wagner, as they do not do treatment there. Patient would be eligible for Medicaid Expansion if state authorized. Patient seeks care at SD Urban Indian Health for substance abuse and medical care. Patient is enrolled member of Oglala Sioux Tribe from Pine Ridge Reservation – 360 miles from Sioux Falls and travel time is over 5 hours one way.

2. American Indian male patient, age 48. Chronic alcoholic but in remission for one year. Diabetic, amputee, no insurance, cannot afford premiums for ACA, unemployed due to his amputation being less than a year old and needing PT. Was not re-approved for disability for his amputation and thus had to stop going to PT with his prosthesis, as they require a form of payment before they will allow services to continue. Is on the list for "limbs for life" which we assisted him with. Got very depressed when dropped from his PT and ended up inpatient at Behavioral Health due to suicidal ideation and wanting to drink alcohol. Patient would be eligible for State Medicaid Expansion if state authorized. Patient is enrolled member of Rosebud Sioux Tribe, from Rosebud Reservation 260 miles from Sioux Falls and travel time is almost 4 hours one way.

3. American Indian female patient, age 58. Uncontrolled Type II Diabetic. Patient is an unemployed with a family size of 3, with an income of $7,936.00 yearly. Patient has gone between uninsured and having Medicaid several times throughout her time as our patient since 2008. She receives medical care and transportation services. Patient is enrolled member of Standing Rock Sioux Tribe from Ft. Yates (South Dakota/North Dakota) – 360 miles from Sioux Falls and travel time is 6 hours one way.

There are real people, with real health issues who do not live near their home reservation and would face an undue hardship in getting to see a doctor at IHS/Tribe to get a referral to come back to their "home" community (Sioux Falls) to receive care that we provide for them. Besides the hours this would take, none of these patients have transportation – therefore, it would be another burden placed upon them to even make the trip. The proposed "contractual referral" process would not help improve "access", or improve "health outcomes" or better serve the AI/AN population.

If IHS/tribes were asked to perform a subservient role by relinquishing patient care management responsibilities to another entity and having to turn over medical records to an organization that does not have a direct relationship with a patient, they would not view such practices as appropriate. Yet, this is what is being asked of UIHPs in order to

qualify for 100% FMAP. Furthermore, the maintenance of patient records and responsibility would be an undue burden and administrative challenge for IHS and tribes.

As a defined IHS service delivery model, one created to fulfill the requirement that the nation bears in meeting its health care obligation to AI/AN as outlined in IHCIA, it is necessary to consider the UIHPs as a meaningful and vital component *within* in the Indian health care "system". The UIHPs are not IHS subcontractors, but a distinct delivery service model purposefully created to assure that all AI/AN have access to and receive appropriate and timely health care, regardless of where they live. Urban Indian Health Programs are defined as Indian Health Care Providers in the Model Qualified Health Plan (QHP) for Indian Health Care Providers that specifically includes Urban Indian Health Programs that received funding from the IHS pursuant to Title V of the IHCIA (Pub. L. 94-437).

We have support in the form of resolutions from the American Indian Health Commission of Washington State, the Affiliated Tribes of Northwest Indians, and the National Congress of American Indians as well as a letter of bipartisan support from Members of Congress. This is a unified effort to recognize that IHS, Tribal 638, and UIHP (I/T/U) health care delivery models together make up the entire IHS system of health care delivery by federal status and actual practice.

South Dakota Urban Indian Health, Inc. respectfully submits that comments to resolve our issues and concerns could be addressed through a new Memorandum of Understanding (MOU) between IHS and HHS (CMS) that reflects and modifies language to include UIHPs as integral healthcare providers through IHS and include UIHPs as eligible to receive payment/reimbursement under the all-inclusive rate.

Therefore, the inclusion of the UIHPs in the 100% FMAP is an essential demonstration of the nation's congressionally mandated requirement that "all resources necessary" are made available to address Indian health care needs. South Dakota Urban Indian Health, Inc. urges CMS to re-assess the language to state: **Urban Indian Health Programs that are current Title V contractors with the Indian Health Service to serve Indian people as defined in the IHCIA should be recognized for this shared obligation to meet the goals of the Indian Health Service along with the IHS and tribes and therefore, should be entitled to the 100% FMAP payment consistent with our standing *within* the Indian Health system.**

Respectfully,

Donna LC Keeler

Donna LC Keeler
Executive Director
South Dakota Urban Indian Health, Inc.

cc: South Dakota Urban Indian Health Board of Directors
Rudy Soto, National Council of Urban Indian Health, Policy Analyst
U.S. Senator John Thune
U.S. Senator Mike Rounds
U.S. Congresswoman Kristi Noem