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RESPONSE TO A REQUEST FOR COMMENT FROM CMS ON MEDICAID SERVICES "RECEIVED THROUGH" AN INDIAN HEALTH SERVICE/TRIBAL FACILITY

Thank you for this opportunity to offer our comments on the policy re-interpretation CMS is considering, which may potentially expand circumstances where 100% federal funding would be provided to Medicaid-eligible American Indian people for services *"received through"* an Indian Health Service or Tribal (I/T) facility. Our positon is that the role of the I/T must be preserved and enhanced. The trust relationship must be retained and strengthened by the I/T program maintaining oversight and control of services when the FMAP applied is 100% Federal.

The premise for this position is that health care from the United States Government is an absolute entitlement for Federally recognized tribes based on treaties and law, summarized as follows:

1. Treaties – Specific treaties bind the United States Government to provide health care to tribes. This is an obligation that remains enforceable in Court, inasmuch as the United States Constitution, Article VI., states, "*The Constitution . . . and all treaties made . . . under the authority of the United States, shall be the Supreme laws of the land.*"

2. Acts of Congress – The Snyder Act of 1921 and Transfer Act of 1955 provide authority for continuation of services and appropriation of funds to provide health services to Indian people for as long as the Federal-Indian trust relationship continues. The Snyder Act also established the Indian Health Service as an entity separate from the Bureau of Indian Affairs. The Indian Health Care Improvement Act of 1976 *(25 U.S. Code, Chapter 18)* states that Congress finds . . . *"Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people . . . . Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians — (1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy; 5) to require that all actions under this chapter shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and . . .;(6) to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members.*"

3. Federal Court Decisions – White vs. Califano, 437 F. Supp. 543 (DPF 1977), aff'd:581 F2d 697 (1978) summarizes Federal policy regarding Indian Health Service as follows: *"Health care for Indian people is not a racial issue, nor is it a financial issue; it is a legal and historical obligation*

> *based on treaty, law and trust responsibility which the federal government forcibly assumed over Indian nations".*

Although the Federal Government has consistently acknowledged its obligations and responsibilities as stated above, sufficient levels of appropriations have never materialized, resulting in health resource inequities, major health service delivery problems throughout Indian Country, and health disparities.

The Indian Health Care Improvement Act (IHCIA) is a legal cornerstone for health care services to Indian people. It was through this Act that the Indian Health Service received authority to bill Medicaid, Medicare, and private health insurance and to apply these revenues to address deficiencies and become accredited. Accreditation "levels the playing field" by requiring I/T programs to maintain the same standards as other health care facilities so that quality can be deemed equivalent.

There are other important policy implications of the Indian Health Care Improvement Act (IHCIA). It is significant that it received permanent reauthorization as a part of the Affordable Care Act of 2010. Gradually through the years, IHS has become increasingly dependent on third party reimbursements for its basic operations. It appears Federal policy changed so that, rather than appropriating sufficient funding to IHS directly, Treaty responsibility is potentially fulfilled through reimbursement from other Federally-funded programs (e.g., CMS). As American citizens, Indian people can use their CMS benefits and private health insurance anywhere. The IHCIA, now permanently reauthorized through the ACA, in effect compels I/T programs to compete with other healthcare providers for third party reimbursements. Financial survival and success of I/T programs really depends on these collections. A perhaps unintended outcome of the IHCIA is the shift from direct appropriations to the Indian Health Service to funding I/T programs through third party reimbursements. Obviously, however, in order for the American Indian people in South Dakota to benefit from what was intended by Congress as an installment towards better fulfillment of its Treaty obligations, the State Legislature would need to decide to participate. This is the context for the Sisseton-Wahpeton Oyate's position.

The Sisseton-Wahpeton Oyate agrees with the State of South Dakota that health care to Tribes is a Federal responsibility and that, therefore, the FMAP should be 100% Federal for services provided through Indian Health Service / Tribal (I/T) Programs. However, we believe that it is imperative that the policy maintain the purposeful and meaningful relationship between the I/T and its patients while maximizing access to services not usually available within the bricks and mortar of I/T facilities. We do not want this potentially beneficial policy change to undermine the very survival of the Indian Health Service. It is crucial that the meaning of *"arranged and overseen"* by the I/T facility be thoughtfully and clearly delineated. It is essential to enhance the infrastructure of the I/T with resources to gear up and provide coordination of care. It cannot be cursory; it must be real. We must not allow the needs of private providers to get paid – because currently, due to lack of adequate appropriations to the Indian Health Service Purchased and Referred Care Program, they

STRUGGLE for payment – nor a state's desire to be unburdened from the responsibility of providing the Medicaid match for American Indian people, to let the I/T be by-passed, diminished, gradually vestigial, and eventually expendable. A great fear of American Indian people since the Indian Health Care Improvement Act and its billing authorities was first conceptualized is that eventually the Indian Health Service will be no more.

Choice of the American Indian Medicaid patient who is also a State citizen must also continue. The I/T program should be the default primary provider for an American Indian person enrolling in the Medicaid program. However, if the person actively chooses a private provider as her primary care provider, that should be that individual's choice. The State's matching requirement should then be applied. Similar to the special provisions in the Affordable Care Act for American Indian enrollment in health insurance plans through the marketplace, American Indian people should be allowed fluidity in switch back to IHS outside of open season.

Extending services *"arranged and overseen"* by the I/T to the comprehensive spectrum of acute, surgery, and specialty care could result in dramatic improvement to access for users of I/T programs. Providing these comprehensive services through care coordination agreements outside the very limited scopes of most I/T brick and mortar facilities will be essential to achieving this goal. As we know, the constraints of the Purchased and Referred Care (PRC) budgets for our I/T facilities are so limited that oftentimes only Priority I, life or limb threatening, services will be paid for. Medicaid expansion could enable the I/T to stretch its precious PRC budgets so that more patients can be referred out, perhaps even for Priority II and other levels of care, including preventive services such as cancer detecting colonoscopies. Improved access would mean that patients could receive surgery and physical therapy, instead of pain medications that are addictive and harmful to the kidneys. Access to these types of services is critical to achieving health equity.

If a portion of the enhanced revenue that I/Ts might collect through Medicaid expansion is committed to development of infrastructure, the possibilities for care coordination agreements and arrangements will be innovative and varied. As you know, under the authority of the Indian Self-Determination and Educational Assistance Act Tribes are able to contract any programs that the Secretary of the Department of Health and Human Services provides to Indian people. Accordingly, care coordination for American Indian people living off-Reservation could potentially be contractible. Tribal entities may have more flexibility than the Indian Health Service to provide care coordination for our members and lineal descendants. Similarly, South Dakota Urban Health already operates under a contract with the Indian Health Service and could assume a role as agent for care coordination *"arranged and overseen"* by the I/T.

Another consideration is how the contractual mechanisms that the Indian Health Service has with Tribes can be strengthened and clarified so Tribes are full partners in the comprehensive services arena, alongside Federally-managed and private health care facilities. In South Dakota, Reservation health services are typically "combination type". This means that IHS operates part of the services and the Tribe operates other parts. For example, on our Reservation the IHS runs the

clinic, while the Tribe has contracted ancillary services such as Community Health Representative CHR), Community Health Education, and chemical dependency treatment. We recommend that the definition of *"arranged and overseen"* clearly encompass authority for Tribal health programs that operate side-by-side with IHS programs to also be reimbursed through Medicaid for the portion of services we provide. We recommend that the reinterpreted policy clearly state that 100% FMAP applies also to the programs Tribes operate side-by-side and ancillary to IHS-operated programs. Also, we recommend that CMS authorize that there be a mechanism whereby IHS can bill and then reimburse Tribes for their portion of physician directed services covered in the State Plan. An example would be targeted case-management, transportation and preventive education services provided by a CHR or other community health worker to pregnant women through home visiting and/or centering venues. In the late 1980's for a time the Community Health Representative Program was receiving State Medicaid reimbursements through the IHS for transportation services. However after several months the IHS solicitor advised that the practice be discontinued, citing lack of authority and possibly fraud. This is an example of why this must be clarified in the policy.

Similarly, there is no mechanism whereby Tribal programs or entities can bill or participate in reimbursement for evidence-based approaches typically funded by grants such as Healthy Start. Fitness trainers, lifestyle coaches, and nutritionists the Tribes employ for diabetes self-management and prevention services *(funded through the Special Diabetes Program for Indians grant*) are one example. Currently the Tribally-contracted programs are not integrated into the Health Home model, although on our side of the operation we have the substance abuse treatment and tobacco cessation services. Nor can the Tribal program receive any portion of a payment from the Medicaid Program for services rendered for Health Home clientele. Our alcohol/substance abuse program, Dakotah Pride Center, has contracted a portion of the Purchased and Referred Care program of the Sisseton Indian Health Service for specialty care services not available at our Tribal facility. When the client is a pregnant woman eligible for Medicaid, Dakotah Pride Center arranges for that payor to be used instead of the PRC funds, as we are required to. However, it is not clear whether the State must provide the 48% FMAP. It is also not clear to what extent Medicaid expansion will provide better access to treatment, both at Dakotah Pride Center and at its referral facilities. Nor is it clear whether Dakotah Pride Center might be reimbursed for care-coordination for this high risk and vulnerable population -- pregnant and addicted women. Care coordination-augmented 638 contracts, *"arranged and overseen"* through the Indian Health Service have great potential to improve services.

In conclusion, SWO's position is that seven generations from now the I/T Program must be intact, undiminished, having had enhanced care-coordination added to its scope, thereby retaining its role as the provider of health care services in fulfillment of the Federal Government-to-Government relationship and obligation to provide quality health care for the American Indian people.

Crystal Owen

Crystal Owen, Tribal Secretary