November 13, 2015

RE: *Extending 100% FMAP for UIHOs*

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

On behalf of the San Diego American Indian Health Center, we, the Urban Indian Health Programs (UIHPs) that contract with the Indian Health Service (IHS), would like 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 is appropriate for the Federal government to 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). This is the San Diego American Indian Health Center's response to "The Medicaid Services Received Through an Indian Health Service/Tribal Facility: A Request for Comment" white paper released October 2015.

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" exists 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 Urban Indian programs. We should not have to be making a request to be added to the process when we have already been recognized as an essential element of the Indian Health Service delivery system through the Indian Healthcare Improvement Act.

UIHPs provide primary care to eligible AI/AN individuals who live in and near our 37 Urban 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.

❑ Administration
2602 First Avenue Suite 105
San Diego, CA 92103
(619) 234-2158
(619) 234-0505 Fax

❑ Behavioral Health
2602 First Avenue Suite 100
San Diego, CA 92103
(619) 234-2158
(619) 234-1979 Fax

❑ Medical/Dental/Fiscal
2630 First Avenue
San Diego, CA 92103
(619) 234-2158
(619) 234-0206 Fax

Our contractual relationship *within* the IHS is ESSENTIAL and UNIQUE and includes:

1. Mandates that 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 of Accreditation.
3. Requirements 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 management personnel are approved and authorized by HIS, and
6. UIHPs are included in the Budget Formulation process, which includes determining top health issues and funding level needs for AI/AN individuals.
7.

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." The San Diego American Indian Health Center greatly appreciates CMS' willingness to be flexible to ensure programs provide services to this very distinct population and this 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. 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.

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. Additional funding accessed by UIHPs includes health care for the homeless, Ryan White AIDS care, and many others. 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.

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".

An example is: Having an AI/AN eligible patient who lives in an Urban Indian Health community travel to an IHS/tribal facility (which is miles/hours away) to establish being "their" patient and get a referral from the IHS/tribal facility to receive care back in their "home" urban community at an Urban Indian Health Program simply will not work.

If the IHS and 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 that they would not view such practices as appropriate. Yet, this is what is being asked of UIHPs in order to qualify for the 100% FMAP. Furthermore, the maintenance of patient records and responsibility would also 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. 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 India 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.

The San Diego American Indian Health Center respectfully submits these comments to resolve our issues and concerns that 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 <u>through</u> IHS. MOU language should also 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.

The San Diego American Indian Health Center urges CMS to re-assess the language to state: **Urban Indian Health Programs that are current 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,

[redacted]

Joe Bulfer, CEO

September 16, 2015

The Honorable Sylvia Burwell, Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

RE: Extending 100% FMAP for UIHOs

Dear Secretary Burwell,

I am writing in response to a letter that you recently sent to the Governor of Alaska, Bill Walker, wherein you informed him that the Centers for Medicare and Medicaid Services (CMS) intends to review and revise its guidance with regard to the 100 percent Federal Medical Assistance Percentage (FMAP) payment for American Indians and Alaska Natives (AI/AN). Currently, the availability of the enhanced matching rate is limited to facilities of the Indian Health Service (IHS) and certain tribally operated hospitals and clinics managed by federally recognized Indian tribes. This arrangement has been beneficial to states and tribes by increasing service networks and helps address the severe health disparities that all too many Indian people experience. In light of your comment about CMS updating the aforementioned policy, the **San Diego American Indian Health Center, Inc.** stands firmly with the National Council of Urban Indian Health (NCUIH) to request that you use your administrative authority to extend 100% FMAP for Urban Indian Health Organizations (UIHOs) that currently serve as IHS contractors.

As you know, Indian Country extends beyond the boundaries of Indian reservations. Both Congress and the Supreme Court have determined that the federal trust obligation doctrine extends to American indigenous people who live outside of the Indian reservation boundaries. Presently, more than 7 out of 10 Americans who self-identify as having American Indian or Alaska Native heritage (71%) live in cities according to the 2010 U.S. Census. Those Indian people who do not receive or who are deemed ineligible for healthcare at an IHS or tribally operated hospital or clinic are not able to have their care reimbursed at the 100% federal payment at UIHOs in spite of the fact that these Medicaid eligible individuals are American Indians.

Congress established a discrete authority to aid urban Indian with their health. Recognized as Subchapter IV in the now permanent Indian Healthcare Improvement Act, many more Indian people find themselves living away from traditional Indian communities, mostly in larger cities. Additionally, contractors under the urban authority reach the larger constituency of Indian people who do not qualify for direct care from IHS facilities. The law defines urban Indian Americans more broadly to address the consequences from the Indian relocation and termination policies

❑ Administration
2602 First Avenue Suite 105
San Diego, CA 92103
(619) 234-2158
(619) 234-0505 Fax

❑ Behavioral Health
2602 First Avenue Suite 100
San Diego, CA 92103
(619) 234-2158
(619) 234-1979 Fax

❑ Medical/Dental/Fiscal
2630 First Avenue
San Diego, CA 92103
(619) 234-2158
(619) 234-0206 Fax

designed to assimilate Indian in the 1950's and 1960's. This includes those non-enrolled/dis-enrolled tribal members, descendants, and members of terminated tribes, state recognized tribes and organized Indian groups. The policy of the termination and assimilation era was repudiated by President Nixon in 1970 as a failure, by then the damage had been done with tens of thousands of Indian people displaced and with little or no help. Few have been successful in regaining their Indian status, thus the need for a more liberal eligibility standards for urban Indians. In light of this outcome, Nixon asked that federal officials find better ways to help urban Indians displaced by termination. Medicaid was seen as one key financing strategy.

The IHS recognizes its federal obligation to address the health of AI/AN people. To clarify its role, the IHS recognizes three health service models of care to reach AI/AN people. These three models are: the (I) for IHS directly managed hospitals and clinics, (T) the tribally operated hospitals and clinics under the contract and compact authority of P.L. 93-638 and the (U) stipulating UIHOs that contract with the IHS under the authority of P.L. 94-437, now a permanent law and part of the Affordable Care Act (ACA). The three health service models make up the Indian Health Program for the nation.

One of the main objectives of the ACA is to address health disparities. One disparity within the Indian Health Program is the method of payment for AI/ANs eligible for Medicaid assistance. The IHS and tribes receive 100% FMAP for eligible AI/ANs while those receiving similar care at an UIHO receive payment at the state's matching percentage. The lack of uniformity in payment provides an unjust and unequal payment for AI/ANs receiving care at an UIHO. The lower payment and state-match requirement received by UIHOs reduce funds to these organizations, thereby decreasing the agency's capabilities to address health disparities that are well documented among AI/AN populations generally. Such an arrangement creates an unfair practice that limits healthcare access for an underserved population and constrains the UIHOs that are contracting to carry out the nation's obligation to assist AI/AN people.

While the UIHOs were excluded from the 100% FMAP for AI/ANs that was granted to the tribes and the IHS, the ACA offers an opportunity to unite the Indian Health Program by extending the 100% FMAP payment and its fee schedule to the UIHOs. Just as CMS has made changes to in the FMAP to enable states to meet the ACA objectives, there is no reason that a similar change in FMAP cannot be made to strengthen the Indian health system.

In summary, the **San Diego American Indian Health Center, Inc.**, urges you to use your administrative authority to unite the Indian Health Program by extending the 100% FMAP and its corresponding fee structure to the UIHOs thus upholding the ACA's intent to reduce health disparities and ensuring a fair and equitable financing system for meeting the nation's obligation to the health status of all AI/AN people.

Respectfully,

[redacted]

Joe Bulfer, CEO
San Diego American Indian Health Center, Inc.

Subject: Fw: Attachment: Letter to Honorable Secretary Burwell RE: 100 Percent FMAP for UIHOs

From: [redacted]

To: [redacted]

Date: Wednesday, September 16, 2015 5:39 PM

On Wednesday, September 16, 2015 5:27 PM, "Burwell, Sylvia M. (HHS/OS)" <Sylvia.Burwell@hhs.gov> wrote:

Thank you very much for your email. I am honored to work with such a dedicated and passionate team at the U.S. Department of Health and Human Services. Our ability to make a difference depends on your input, so I appreciate that you have taken the time to write.

This Department belongs to the American people. Our work touches Americans at every age, from every background, in every part of our country. Every day, scientists and researchers at the National Institutes of Health are working to find cures for some of our world¹s most serious diseases, and experts at the Centers for Disease Control and Prevention are working to prevent them from spreading. The Food and Drug Administration is protecting the safety of the food we eat and the medications our doctors prescribe us. Our parents and grandparents rely on the Centers for Medicare and Medicaid Services, and millions of our children benefit from the work of the Administration for Children and Families. At the same time, the Department¹s work to ensure accessible, affordable, quality health care through the implementation of the Affordable Care Act is making a difference in the lives of our families and communities, and strengthening the economy.

Together, this work forms the foundation of a stronger middle class, a more prosperous economy, and safer, healthier communities. At the Department, we are committed to delivering on our mission with integrity and innovation, and by engaging with a broad range of voices to deliver the kind of impact the American people deserve.

Thank you again for writing. We appreciate hearing from you.

Sincerely,

Sylvia M. Burwell
Secretary

Stay connected with the Secretary online.

****

Follow @SecBurwell on Twitter. Sign up for the Secretary's Blog. Check out HHS photos. Like HHS on Facebook. Watch HHS Videos.