November 17, 2015

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

On behalf of the Gerald L. Ignace Indian Health Center, Inc., 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 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).

This is the Gerald L. Ignace Indian Health Center, Inc. response to "The Medicaid Services "Received Through" an Indian Health Service/Tribal Facility: A Request for Comment" white paper released 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.

We are providing 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.

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.

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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." The Gerald L. Ignace Indian Health Center, Inc. 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". Our 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 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 Gerald L. Ignace Indian Health Center, Inc. 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 Gerald L. Ignace Indian Health Center, Inc. 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,

Lyle Ignace, M.D., M.P.H.
Executive Director

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