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The Honorable Barack Obama
President of the United States of America
The White House
1600 Pennsylvania Ave., NW
Washington, DC 20500

Dear Mr. President,

I am writing in response to a letter that was recently sent by your Cabinet member, Health and Human Services Secretary Sylvia Burwell, to the Governor of Alaska, Bill Walker, wherein she 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 her comment about CMS updating the aforementioned policy, Native Americans for Community Action, Inc., stands firmly with the National Council of Urban Indian Health (NCUIH) to respectfully request that you have your administration use its authority and work with the IHS to create an avenue to extend 100% FMAP for Urban Indian Health Organizations (UIHOs) that serve as IHS contractors under the Indian Health Care Improvement Act (IHCIA).

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. Urban Indians are the result of the consequences from the Indian relocation and termination policies designed to assimilate Indians in the 1950's and 1960's. 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. 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

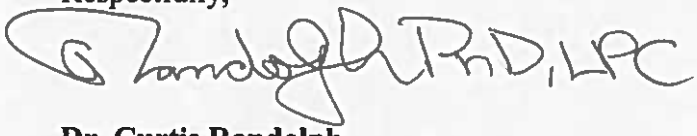
hospitals and clinics under the contract and compact authority of P.L. 93-638 and the (U) stipulating UIHOs that contract with the IHS under the authority of P.L. 94-437, now a permanent law and part of the Affordable Care Act (ACA) that you signed into law. These three health service models, I/T/U, make up the Indian Health Program for the nation.

As you intended, one of the main objectives of the ACA is to address health disparities. A 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.

With the inclusion of Urban Indian Health Organizations in the Indian Healthcare Improvement Act and subsequent developments, Native Americans for Community Action, Inc., requests CMS to use its authority and work together with IHS to extend 100% FMAP for Urban Indian Health Programs, which exist under Title V of the Indian Health Care Improvement Act, PL 94-437, to unify us within the Indian Health Service System of I/T/U (I-Indian Health; T-Tribal; U-Urban). Urban Indian Health programs that provide services and care to individuals eligible for IHS services should receive Medicaid reimbursement parity for fair and equal treatment. This request is made without any adverse impact on current IHS/Tribal reimbursement of services. By taking this action, you would be fulfilling the Affordable Care Act goal of reducing health disparities and meeting the nation's obligation to the health status of all American Indian and Alaskan Native people.

Respectfully,



Dr. Curtis Randolph
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