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November 17, 2015

RE: Urban Indian Health Program inclusion in 100% FMAP; Response to CMS White Paper (October 2015)

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

On behalf of the Sacramento Native American Health Center, Inc. (SNAHC), we are submitting comment on the White Paper FMAP language, released October 2015. Referring the statement in *section 2. Modifying the third condition*: Urban Indian Health Programs could participate as contractual agents, it is SNAHC's position that UIHPs should be able to participate as contractual agents through our existing Title V contracts with the Indian Health Service.

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.

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. Key UIHP personnel, i.e. Exec Dir. /CEO, CFO are approved and authorized by IHS.
5. UIHPs are included in the Budget Formulation process, which includes determining top health issues and funding level needs for AI/AN individuals.

Clearly, 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.
In California, there are currently 10 UIHPs that provide primary care to eligible AI/AN individuals (Nationally, there are 37 programs in 21 states). The majority of the UIHPs in California are Federally Qualified Health Centers with CMS and 3 of our Urban programs receive both IHS funding and Section 330 Community Health Center grants. UIHPs in California operate electronic medical records and have national accreditation from AAAHC, NCQA, CARF, etc. UIHPs are health homes for our AI/AN patients, responsible for their care, including maintaining all required medical records/forms. Therefore, the white paper requirements listed under both section 2, *Modifying the third condition* and 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.

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.

SNAHC 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 through 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. SNAHC 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,

Britta Guerrero
Chief Executive Officer