Tribal Technical Advisory Group
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Delivered Electronically

March 24, 2011

Dr. Donald Berwick
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-08010

Subject: Determination of Patient Volume in Tribal and Urban Indian Health Programs for Meaningful Use Incentives

Dear Administrator Berwick:

On behalf of the Tribal Technical Advisory Group to the Centers for Medicare and Medicaid ("TTAG")[1], I am writing in regard to the determination of patient volume in Tribal and urban Indian health programs for purposes of "meaningful use" incentives. TTAG advises CMS on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program, and any other health care program funded (in whole or in part) by the Centers for Medicare and Medicaid Services ("CMS").[2]

As the analysis in this letter indicates, any "outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act[3] or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act[4] for the provision of primary health services"[5] is an FQHC as that term is defined in both Titles XVIII (Medicare)[6] and XIX (Medicaid) of the Social Security Act.

1. SUMMARY RECOMMENDATION.

Based on this analysis, TTAG is requesting that CMS undertake a set of actions that would serve to clarify the issue of Tribal health programs being within the definition of an FQHC and thereby indicate that it is appropriate for Tribal health programs to use the "needy individual" count when determining patient volume for electronic health records meaningful use incentive payments.

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[1] Sec. 5006(e) of the American Recovery and Reinvestment Act codifies in statute, at sections 1902(a)(73) and 2107(e)(1)(C) of the Social Security Act, the requirement for the Secretary of Health and Human Services to maintain a Tribal Technical Advisory Group within CMS and the requirement that States seek advice from Tribes on a regular and ongoing basis where one or more Indian health program or urban Indian organization furnishes health care services.
[2] http://www.cmsttag.org/docs/ttag_charter_final.pdf, January 28, 2011.
[3] Pub. L. 93-638, as amended; 25 U.S.C. § 450f *et seq*. (hereafter "ISDEAA").
[4] Pub. L. 94-437, as amended; 25 U.S.C. § 1651 *et seq*. (hereafter "IHCIA").
[5] Social Security Act § 1905(*l*)(2)(B). The quoted language is the definition of FQHC as defined in Title XIX (Medicaid) of the Social Security Act.
[6] Social Security Act § 1861(aa)(4).

2. STATEMENT OF THE ISSUE.

Recent correspondence with various state and federal health departments reveals uncertainty about whether Tribal and urban Indian health programs (T/Us) fall within the definition of federally-qualified health centers ("FQHCs"). Being within the definition of an FQHC carries significant benefits in the context of the electronic health records program ("EHR") Medicaid meaningful use incentive payments established under § 4201 of the American Recovery and Reinvestment Act ("ARRA").[7] An accurate interpretation and application of the definition of FQHC is therefore critical to ensure that T/Us receive the benefits to which they are entitled under these statutes.

3. PRINCIPAL FINDINGS.

Any outpatient health program or facility operated by a Tribe or Tribal organization under the Indian Self-Determination Act[8] or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act[9] for the provision of primary health services is an FQHC as that term is defined in both Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act. Tribal and urban Indian health programs need not fulfill any other statutory or regulatory requirements to be treated as FQHCs for the purpose of calculating patient volume for EHR meaningful use incentives. ARRA does not limit the application of the term "FQHC" to only entities receiving reimbursement from Medicaid or Medicare as an FQHC (*i.e.*, the term "FQHC" applies to all entities meeting the requirements of an FQHC without regard to whether a facility subsequently receives reimbursement from Medicaid or Medicare as an FQHC.) The likely source of confusion about whether T/Us are FQHCs for the purpose of determining patient volume appear to be the way the definition of FQHC appears in a Frequently Asked Question ("FAQ") document on the CMS website and in a similar document on the HRSA website. The discussion of each of these findings follows.

4. ACTION NEEDED.

The following actions, if undertaken by CMS, would serve to clarify the issue of Tribal health programs being within the definition of an FQHC and thereby indicate that it is appropriate for Tribal health programs to use the "needy individual" count when determining patient volume for EHR incentive payments.

- CMS should provide direction to States that all Tribal health programs are included in the definition of FQHC and are entitled to use the "needy individual" count when determining patient volume for EHR incentive payments.

[7] Pub. L. 111-5. Further, the Patient Protection and Affordable Care Act ("ACA"), as amended, Pub. L. 111-148, uses FQHC status to identify a category of providers that may be eligible for essential community provider ("ECP") designation.

[8] Pub. L. 93-638, as amended; 25 U.S.C. § 450f *et seq.* (hereafter "ISDEAA").

[9] Pub. L. 94-437, as amended; 25 U.S.C. § 1651 *et seq.* (hereafter "IHCIA").

- CMS should work with the TTAG, and its Policy Subcommittee, to address other issues associated with implementation of meaningful use incentive payments for Indian health providers, including IHS, Tribal health programs, and urban Indian health programs.

- CMS should reissue the online FQHC definition FAQ with the correct quotation of the law.

- CMS should work with HRSA to ensure that the definition of FQHC on HRSA's website is similarly updated and clarified.

- CMS should work with IHS to obtain a list of tribal FQHCs for EHR incentive payment purposes. Because HRSA uses a separate definition of FQHC that does not apply in the EHR context, CMS should obtain this list from IHS alone.

5. ANALYSIS.

5.1 Why does it matter whether Tribal health programs are FQHCs? Section 4201(a) of the ARRA amended § 1903 of the Social Security Act, 42 U.S.C. § 1396b, to allow certain "Medicaid providers" to qualify for Medicaid EHR meaningful use incentive payments. The full text of 42 U.S.C. § 1396b(t)(2), as amended, defines "Medicaid provider" for the purposes of these incentives:

> In this subsection and subsection (a)(3)(F) [providing for 100% FMAP for incentive payments], the term "Medicaid provider" means—
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> **(A)** an eligible professional (as defined in paragraph (3)(B))—
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> **(i)** who is not hospital-based and has at least 30 percent of the professional's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this subchapter;
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> **(ii)** who is not described in clause (i), who is a pediatrician, who is not hospital-based, and who has at least 20 percent of the professional's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this subchapter; and
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> **(iii)** who practices predominantly in a Federally qualified health center or rural health clinic and has at least 30 percent of the professional's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to needy individuals (as defined in paragraph (3)(F)) . . .

Although the majority of T/U professionals providing services in Tribal and urban Indian health programs would qualify for incentive payments under clause (A)(i) (the "receiving medical assistance

under Medicaid" standard), some may not. T/Us can much more easily demonstrate that they meet the patient volume threshold if they are measured against the standard in clause (A)(iii) (FQHC "needy individual" standard). For instance, in Alaska, the State integrated its children's health insurance assistance ("CHIP") program funds into its Medicaid program. Tribal health programs are now being told that the State will have to identify which individuals are on Medicaid and which are actually funded through CHIP. However, there is no means by which the Tribal health programs can do that since information available to a provider does not distinguish between those on regular Medicaid and those on CHIP. Although the State may not be able to avoid providing that information to non-Tribal, non-FQHC providers, it would ease the State's administrative burden if it need not expand its effort to include the Tribal health programs. Moreover, having to rely on the information from the State will make it that much more administratively burdensome for Tribal health programs to determine which qualifying quarters they want to rely upon to determine whether they meet the meaningful use incentive payment conditions.

Pursuant to 42 U.S.C. § 1396b(t)(3)(F), patients who receive Medicaid or CHIP or are furnished uncompensated care by the provider qualify as "needy individuals."[10] Thus, using the "needy individual" volume standard of FQHC eligibility would forego the need to differentiate between Medicaid and CHIP patients. Because the three categories of needy (Medicaid, CHIP, and uncompensated care) include most of the people served by Tribal and urban Indian health programs, using the broader patient volume count instead of the more limited Medicaid recipient count will improve the likelihood of Tribal health programs being able to participate in meaningful use incentives.

AI/ANs are precisely the type of impoverished and underserved demographic whose providers, like Tribal and urban Indian health programs, are very much in need of the incentive payments to give them capacity to achieve and maintain meaningful use. The U.S. Department of Health and Human Services estimates that twenty-five percent of AI/ANs live at or below poverty level.[11] AI/ANs die at higher rates than other Americans from tuberculosis (500% higher), alcoholism (514% higher), diabetes (177% higher), unintentional injuries (140% higher), homicide (92% higher) and suicide (82% higher).[12] Despite these shocking disparities, the Indian health system is critically underfunded: the IHS National Tribal Budget Formulation Workgroup estimates that the IHS budget requires an extra $21 billion to achieve health parity between AI/ANs and the general American population.[13] These statistics

[10] 42 U.S.C. § 1396b(t)(3)(F) provides

> (F) The term "needy individual" means, with respect to a Medicaid provider, an individual—
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> (i) who is receiving assistance under this subchapter [XIX (Medicaid)];
> (ii) who is receiving assistance under subchapter XXI of this chapter;
> (iii) who is furnished uncompensated care by the provider; or
> (iv) for whom charges are reduced by the provider on a sliding scale basis based on an individual's ability to pay.

[11] U.S. Department of Health and Human Services, Office of Minority Health, "American Indian/Alaska Native Profile," *available at* http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=52 (Jan. 20, 2011).

[12] U.S. Department of Health and Human Services, Indian Health Service, "Disparities Fact Sheet," January 2011, *available at* http://info.ihs.gov/Disparities.asp.

[13] Indian Health Service National Tribal Budget Formulation Workgroup, FY 2012 Tribal Budget Recommendations to the U.S. Department of Health and Human Services, Advancing a New Tribal and Federal Government Partnership: Investing in Indian Health to Achieve a Sustainable Model for National Health Care Reform 2 (Mar. 4, 2010).

demonstrate that the people served by Tribal and urban Indian health programs are, at best, as poor and underserved as those served by FQHCs.

Further, one study estimates that thirty-five percent of AI/ANs who are Medicaid-eligible (and thus needy by definition), for whatever reason, are not enrolled in Medicaid.[14] For instance, the Alaska Medicaid program recently reported that as of December, 2010, there were 11,838 AI/ANs receiving Food Stamps benefits who were ***not enrolled in Medicaid*** despite being eligible for participation. These people are certainly receiving health services in the Tribal health system and are needy, but would not show up in the Medicaid-only categories. Qualifying under the needy individual standard ensures that services to these patients count towards the eligibility threshold.

In order to use the more inclusive "needy individual" standard, an entity need only fall within the definition of FQHC. As mentioned above and outlined below, the definition of FQHC includes any Tribe or Tribal organization operating an outpatient health program or facility operated by a Tribe or Tribal organization under the ISDEAA or by an urban Indian organization receiving funds under title V of the IHCIA for the provision of primary health services.

5.2 The definition of FQHC includes Tribal and urban Indian health programs. The EHR Medicaid incentive provisions are found in ARRA § 4201(a), 42 U.S.C. § 1396b. Although the term "federally qualified health center" is used, it is not defined in the provisions regarding Medicaid meaningful use incentives. In fact, the only place in the entirety of the ARRA that actually defines FQHC is § 13101, which creates support centers for adoption, implementation, and utilization of health information technology ("HIT"). Under the newly-added § 3012(c)(4)(B) of the Public Health Service Act (added through ARRA § 13101), these regional centers must give priority assistance to "Federally qualified health centers (as defined in section 1861(aa)(4) of the Social Security Act, 42 U.S.C. § 1395(aa)(4))", which is the definition of FQHC contained in Title XVIII, the Medicare program.

Whether one relies on the Medicare definition cited above or the definition of FQHC provided for in Title XIX of the Social Security Act, the Medicaid program, T/Us clearly fall within the definition of FQHC for both Medicaid and Medicare purposes, and therefore for the purposes of EHR Medicaid incentive payments. Each of the definitions is discussed below.

5.3 Statutory interpretation of 42 U.S.C. § 1396d(*l*)(2)(B). The statutory definition of "federally-qualified health center" for Medicaid purposes is found in 42 U.S.C. § 1396d(*l*)(2)(B) and reads as follows:

> **(B)** The term "Federally-qualified health center" means an entity which—
>
> **(i)** is receiving a grant under section 254b of this title,
>
> **(ii)(I)** is receiving funding from such a grant under a contract with the recipient of such a grant, and **(II)** meets the requirements to receive a grant under section 254b of this title,

[14] U.S. Department of Health and Human Services, "Meeting American Indian LTC Needs," *available at* http://archive.ahrq.gov/news/ulp/amindltc/ulpailtc4.htm (last visited Feb. 3, 2011).

> **(iii)** based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity, or
>
> **(iv)** was treated by the Secretary, for purposes of part B of subchapter XVIII of this chapter, as a comprehensive Federally funded health center as of January 1, 1990***;***
>
> ***and*** includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) [25 U.S.C.A. § 450f et seq.] or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act [25 U.S.C.A. § 1651 et seq.] for the provision of primary health services.

Emphasis added.

When this section was quoted in recent FAQs that CMS published online, the last semi-colon was replaced with a comma and the last clause was added immediately to the end of clause (iv). This has apparently caused some government officials to interpret this statute as conditioning T/U inclusion as FQHCs upon the T/U fulfilling the requirements of subsections (i) - (iv), or at least subsection (iv). However, this interpretation violates basic principles of statutory construction. First, subsections (i) - (iv) are distinguished from one another through the use of the disjunctive "or" clause between subsections (iii) and (iv). This indicates that each of these subsections describes an individual FQHC-eligible program.[15] Because each of the entities listed in subsections (i) - (iv) are clearly contextually distinct from one another, they must be interpreted as four separate types of potential qualifying entities for FQHC status.[16] The fact that the T/U clause is not even a part of the enumerated list is further evidence that T/Us are intended to be a fifth category by which to qualify as an FQHC, separate from the entities listed in (i) - (iv).

It has also been suggested that subsection (iv) might individually apply to limit FQHC qualification to T/Us treated as a comprehensive Federally funded health center as of January 1, 1990. But, the presence of the semicolon between subsection (iv) and the T/U clause, as opposed to a comma or a lack of punctuation altogether, indicates that there is a conceptual and interpretive distinction between the two clauses.[17] As a result, T/U facilities are independently eligible for FQHC classification

[15] *Reiter v. Sonotone Corp.*, 442 U.S. 330, 339 (1979) ("Canons of construction ordinarily suggest that terms connected by a disjunctive be given separate meanings, unless the context dictates otherwise.").

[16] *Rankin v. City of Philadelphia*, 963 F. Supp. 463, 468 (E.D.P.A. 1997) ("The use of semicolons and the word 'or' in the statutory definition suggests that a person who satisfies any one of the three descriptions is an 'employer' for purposes of the Whistleblower Law, even if that person does not satisfy the other descriptions.").

[17] *See, e.g., Jones v. United States*, 526 U.S. 227, 252 (1999) (interpreting three subsections of a federal carjacking statute divided by semicolons as creating three distinct crimes); *United States v. Rigas*, 605 F.3d 194, 209 (3rd Cir. 2010)

so long as they are operated under the ISDEAA or IHCIA. They need not fulfill any of the requirements found in subsections (i) - (iv).

The statute's very structure supports this interpretation. 42 U.S.C. § 1396d(*l*)(2)(B) begins with an initial paragraph that is lined flush with the left margin, and then includes indented subsections, and then after those subsections includes the T/U clause, which is neither indented nor numbered according with the subsections but rather is also flush with the left margin. Courts agree that when statutes are so arranged, the final paragraph is either a direct continuation of the initial paragraph[18] or at the very least is not tethered to the indented subsection that immediately precedes it unless context so requires.[19] As a result, because the T/U clause is non-indented and non-enumerated, and is contextually divorced from subsection (iv), it must be read as establishing an independent fifth category of FQHC-eligible entities, separate entirely from subsections (i)-(iv).

Medicaid regulations indirectly support the reading outlined above. 42 C.F.R. § 435.904(c)(2), "Establishment of Outstation Locations to Process Applications for Certain Low-Income Eligibility Groups", requires that "[t]he agency must establish outstation locations at *Indian Health clinics operated by a tribe or tribal organization as these clinics are specifically included in the definition of Federally-qualified health centers under section 1905(l)(2)(B) of the Act*." Emphasis added. Although perhaps not dispositive, this reference does suggest that for Medicaid purposes, Tribal health programs are unqualifiedly eligible for FQHC designation: the regulation does not refer to any limiting factors or cite to subsections (i) - (iv).

Finally, the legislative history of T/Us being defined as FQHCs under Medicaid and Medicare supports this conclusion. Tribes and Tribal organizations were added to the Medicaid definition of FQHC in 1990.[20] In 1993, the current clause (iv) was added to (then as a new clause (iii)) to the Medicaid definition of FQHC, and the Tribal clause was expanded to include urban Indian organizations.[21] The 1993 additions made it clear that current subsection (iv) was to be specifically so enumerated as part of the listed subsections (i)-(iv), and was specifically separated from the T/U clause by the use of a semicolon rather than a comma. As a result, the T/U clause must be read as establishing an independent category of FQHC entities.

5.4 Medicare definition of FQHC explicitly includes T/Us. The Medicare definition of FQHC similarly includes a T/U provision. The definition, which is substantively identical for the purposes of the treatment of T/Us but structurally much clearer than its equivalent Medicaid definition, is found in 42 U.S.C. § 1395x(aa)(4) and reads as follows:

> **(4)** The term "Federally qualified health center" means an entity which—

(holding that the use of commas in lieu of semicolons will link clauses together into a single definition rather than separately enumerate and distinguish between each individual clause).

[18] *Dep't. of Soc. Services, Div. of Aging v. Carroll Care Centers, Inc.*, 11 S.W.3d 844, 849 (Mo. App. W.D. 2000).

[19] *See, e.g., City of Philadelphia v. C. A. B.*, F.2d 770, 773-74 (D.C. Cir. 1961); Frillz, Inc. v. Lader, 925 F. Supp. 83, 86-87 (D. Mass. 1996).

[20] Omnibus Budget Reconciliation Act of 1990, PL 101-508 § 4704(d), which provides that the new Tribal provision shall appear "after and below clause (ii)". At the time of this amendment, neither clauses (iii) or (iv) were present in the Medicaid definition.

[21] Omnibus Budget Reconciliation Act of 1993, PL 103-66 § 13631(a).

> **(A)(i)** is receiving a grant under section 330 of the Public Health Service Act, or
>
> **(ii)** (I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 of such Act;
>
> **(B)** based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant;
>
> **(C)** was treated by the Secretary, for purposes of part B of this subchapter, as a comprehensive Federally funded health center as of January 1, 1990; or
>
> **(D)** is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act [25 U.S.C.A. § 450f et seq.] or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act.

The subparagraph (D), which addresses T/Us, was also added in 1993, although its effective date was retroactive to the 1990 Omnibus Budget Reconciliation Act.[22] Subparagraph (D) clearly establishes that T/Us are an independent category of FQHC-eligible providers. The House Report discussed the addition of the T/U provision to the definition of FQHC and noted that

> [u]nder current law these programs and facilities are included in the definition of FQHCs for purposes of the Medicaid program. This amendment conforms the Medicare definition of FQHC with that included under Title XIX of the Social Security Act.[23]

The fact that Congress clearly intended that the Medicare and Medicaid FQHC T/U clauses be read identically is further evidence of the consistent federal goal of allowing any of the listed ISDEAA/IHCIA programs to independently qualify for FQHC status, absent any other limiting factors.

5.5. Need to Reword FAQ. The apparent source of the confusion appears to arise from the CMS citation of the definition in an online FAQ explaining provider eligibility for FQHC status for the purposes of EHR Medicaid incentive payments. The CMS website, which mirrors the citation on the Health Resources Services Administration ("HRSA") webpage,[24] lists entities qualifying for FQHC status under 42 U.S.C. § 1396d*l*)(2)(B) as follows:

[22] *Id*., § 13556.

[23] H.R. REP. NO. 103-111, at 160 (1993).

[24] The citation on the HRSA webpage is found at http://bphc.hrsa.gov/policy/pin0321.htm#legis . It appears in Part II with addresses the legislative background for FQHCs.

> (i) is receiving a grant under section 330 of the Public Health Service Act, or (ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant and (II) meets the requirements to receive a grant under section 330 of the Public Health Service Act, (iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, and is determined by the Secretary to meet the requirements for receiving such a grant including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity; or (iv) was treated by the Secretary, for purposes of Part B of title XVIII, as a comprehensive Federally-funded health center as of January 1, 1990**,** and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services."[25]

Emphasis added.

This citation includes a *comma* (rather than a *semicolon)* between subsection (iv) and the T/U provision, and fails to maintain the actual physical arrangement of the statute. As noted above, the actual statute separates these provisions with a *semicolon*, and neither indents nor enumerates the T/U clause, altering the interpretation entirely.[26]

Unfortunately, restating the statutory definition in this manner does make it appear that the T/U provision is part of clause (iv), which the earlier discussion amply demonstrates is not the case. As a result, it is not surprising that a quick reference to the CMS or HRSA websites could mislead a casual inquirer into thinking that T/Us are bound by the requirements of subsection (iv). However, proper interpretation of the statute as it is actually drafted makes clear that T/Us are eligible for FQHC status for EHR purposes so long as they meet the requirements of the T/U clause alone, and not subsections (i)-(iv). Both websites should be corrected.

5.6. T/U programs are entitled to use the "needy individual" count for the purposes of establishing eligibility for EHR Medicaid incentive payments without meeting other requirements. As noted, the ARRA provisions establishing the EHR Medicaid incentive program did not include any additional requirements for reliance on the "needy individual" count other than the provider be an FQHC. This is significant, as there are several areas in which enjoying the benefits of FQHC status requires compliance with additional regulations, reporting duties, etc. For example, an entity seeking reimbursement from Medicare as an FQHC must enter into an agreement with CMS to meet Medicare

[25] [EHR Incentive Program] How does CMS define FQHC and RHC?, *available at* https://questions.cms.hhs.gov/app/answers/detail/a_id/10127/~/%5Behr-incentive-program%5D-how-does-cms-define-fqhc-and-rhc%3F (last visited Jan. 24, 2011).

[26] *See*, *e.g.*, *United States v. Rigas*, 605 F.3d 194, 209 (3rd Cir. 2010) (holding that the use of commas in lieu of semicolons will link clauses together into a single definition rather than separately enumerate and distinguish between each individual clause).

program requirements.[27] Similarly, FQHCs applying for Section 330 grants under the Public Health Service Act are subject to various restrictions and administrative requirements, such as annual audits.[28]

By comparison, there are other benefits available to FQHCs based solely on an entity's falling within the definition of FQHC. The most notable example is that FQHCs are eligible for the 340B drug-pricing program solely by virtue of falling within the definition of FQHC found in 42 U.S.C. § 1396d(*l*)(2)(B). No additional requirements are imposed, just as ARRA imposed no additional requirements for an FQHC (including a T/U) to use the "needy individual" count.

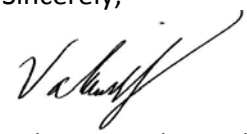
There is nothing unusual about a health care provider qualifying for or participating in programs for some purposes and not others, and thus there is no reason why a T/U could not participate as an FQHC for EHR incentive purposes but not, for example, for Medicare reimbursement purposes. As a result, T/Us need only fall within the definition of FQHC to be eligible for EHR Medicaid incentive payments.

6. CONCLUSION

Statutes governing EHR incentive payments specifically indicate that FQHCs are eligible for participation in these programs. As discussed above, it appears that many state and federal officials are taking guidance as to who qualifies as an FQHC from either CMS's or HRSA's websites, which contain a typo and formatting inconsistencies that unfortunately distort the statutory definition of FQHC. As the statute is written and must be interpreted, though, any outpatient health program or facility operated by a Tribe or Tribal organization under the ISDEAA or by an urban Indian organization receiving funds under title V of the IHCIA for the provision of primary health services is statutorily an FQHC. These providers need not fulfill any other statutory or regulatory requirements, and qualify for EHR simply by virtue of their satisfying this T/U provision.

We appreciate your consideration of this TTAG analysis and recommendations. We urge CMS to take the actions requested, and we are available at any time to provider further clarification on these issues as may be needed.

Sincerely,



Valerie Davidson, Chair

cc: Kitty Marx, Director, Tribal Affairs Group, CMS

[27] 42 C.F.R. §405.2401(b).

[28] 42 U.S.C. § 254b.