



NPAIHB POLICY BRIEF

Indian Health and Economic Stimulus

PREPARED BY: NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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The American Recovery Investment Act of 2009 Indian Health Specific Provisions (Revises Policy Brief No. 1)

Despite broad Republican opposition, Congress gave final approval to the economic stimulus package that is intended to prime the U.S. economy. President Obama is expected to sign the \$787.2 billion American Recovery and Reinvestment Act of 2009 (stimulus bill) early this week. The House approved the plan by a comfortable margin 246-183, while the Senate voted 60-38 to waive a point of order that also served to approve the stimulus package by a majority vote.

Indian Health Funding – Economic Stimulus	Senate Approved	House Approved	Final Approved
Facilities Construction, Maintenance, and Equipment – House Approved Total	<u>\$545 million</u>	<u>\$550 million</u>	<u>\$500 million</u>
<i>Health Services – Total</i>	<u>\$135 million</u>	<u>\$0</u>	<u>\$85 million</u>
Contract Health Services	\$ 50 million	\$0	
Health Information Technology	\$ 55 million	\$0	\$85 million
Clinical Health Information	\$ 30 million	\$0	
<i>Health Facilities – Total</i>	<u>\$410 million</u>	<u>\$550 million*</u>	<u>\$415 million</u>
Maintenance & Improvement Program	\$155 million	*	\$100 million
Sanitation & Facilities Program	\$100 million	*	\$68 million
Medical Equipment	\$ 20 million	*	\$ 20 million
Facilities Construction	\$135 million	*	\$227million

The economic stimulus package includes \$500 million for Indian health service related information technology and health facilities construction. The final approved amount is \$45 million less the Senate and \$50 million less than the House approved bills. The agreed upon conference bill provides \$85 million (same amount as recommended by the Senate) for health information technology activities that can be used for both telehealth services development and related infrastructure requirements that are typically funded through "Indian Health Facilities" account. The House recommendation did not include funding for information related activities. The conference bill gives broad authority for the Indian Health Services (IHS) to use health information technology funds at the "discretion" of the IHS Director.

Unfortunately for Northwest Tribes, the final approved bill did not include the Senate's recommended \$50 million for the Contract Health Service (CHS) program. The House did not provide any funding for the CHS program, and was most likely the reason the funding fell out of the final conference agreement.

The stimulus bill also provides \$415 million for "Indian Health Facilities," for facilities construction projects, deferred maintenance and improvement projects, the backlog of sanitation projects, and the purchase of medical equipment. The final approved amount is \$5 million more than the Senate's recommendation and \$135 million less than the House recommended amount. The bill provides for \$100 million for the Maintenance and Improvement program, \$68 million for the Sanitation Program, and \$20 million for medical equipment.

Perhaps the greatest blow for Indian Country is that that almost one-half of the funding provided to stimulate health related economies will be provided for two health facilities located in two states. The stimulus bill language directs that \$227 million be used "for the completion of up to two facilities from the current priority list for which work has already been initiated." The agreement did not specify those projects but they are most likely the Phoenix Indian Medical Center and the Barrow or Nome hospitals. This means that the economic impact affecting health programs throughout Indian Country will be marginal at best and will not reach as many Indian communities. Congress could have had a greater economic impact by investing the construction funds in IHS construction programs such as the Small Ambulatory Program, the Joint Venture Construction Program, and in dental facilities construction that would have reached across more Indian communities.

The bill report language further directs the IHS to use the funding provided for health care facilities construction to complete on-going high priority facilities construction projects. The agreement includes language proposed by the Senate that exempts the funds provided in this bill for the purchase of medical equipment from spending caps carried in the annual appropriation bill in order to provide the maximum flexibility to the Service in meeting the highest priority needs of the tribes.

Congress provided additional funds in the tribal set-aside from the Clean Water State Revolving Funds up to 1.5 percent of the total amount appropriated. This amount is consistent with the amount allowed by law for the States to manage their capitalization grants. Bill report language has been included to allow the Environmental Protection Agency to transfer up to four percent of the tribal set-aside amount in each Revolving Loan Fund to the IHS for administration and management of projects in Indian country.

Medicaid, SCHIP, and Manage Care Provisions

The stimulus bill includes very important provisions that will exempt American Indian and Alaska Natives (AI/AN) from premiums and provide cost-sharing protections in the Medicaid and State Child Health Insurance Programs (SCHIP). The provisions provide protection from estate recovery in the Medicaid and SCHIP programs. The bill also contains consultation requirements for Medicaid and SCHIP programs

by requiring the Centers for Medicare & Medicaid Services (CMS) to maintain the CMS Tribal Technical Advisory Group (TTAG) and add an Urban Indian health organization representative. These exemptions reverse key decisions made by HHS personnel during the Bush Administration and become effective July 1, 2009.

In 1976, Congress amended the Social Security Act to authorize Medicare and Medicaid payments to Indian health programs. When Congress provided this authority, its intent was clear: to enable AI/ANs *full access* to Medicare and Medicaid benefits in health programs operated by the IHS and Tribes, to enhance the quality of care provided, and to improve the substandard conditions of Indian health facilities. The CMS decisions during the Bush Administration attacked long-standing federal Indian policy that granted AI/AN access to important federal programs, claiming that treating AI/AN people differently was a violation of the Civil Rights Act. CMS has routinely advised states that it does not have the authority to approve Medicaid waivers that treat AI/AN people differently in state Medicaid programs because it would be a violation of the equal protection clause in the Civil Rights Act. Tribal advocates have long advised CMS that the United States' federal trust responsibility, and laws enacted pursuant thereto, provides ample authority for CMS take pro-active efforts.

These important provisions underscore the United States responsibility to provide health care to AI/AN people and allow them to be treated differently by exempting Indian people from cost sharing practices and Medicaid and SCHIP estate recovery based on the legal and political status of Indian people—and not one that is based on race as CMS has implied.

The stimulus bill also includes a provision that provides for special rules for AI/AN enrolled in managed care plans and reimbursements to IHS and Tribal health providers serving individuals enrolled in managed care plans.

Medicaid FMAP

The economic recovery bill provides a temporary increase in the share of the Medicaid program paid by the federal government (known as the Federal Medical Assistance Percentage – FMAP). The provision will take effect immediately and provide states with approximately \$87 billion in assistance over nine calendar quarters. This provision and will have a direct and positive effect for Indian health programs, much more than the health faculties funding. Unfortunately, Congress did not understand the correlation of providing the Medicaid program with assistance as the IHS Contract Health Service program. The CHS program is very much like the Medicaid program in which it provides services to similar beneficiary groups and purchases health care from the private sector. The CHS program will also see the same rate of growth as the Medicaid program and AI/AN people are negatively impacted by the economic crisis. Many will look to the CHS program for health care.

There are three components to the FMAP policy. First, each state will be “held harmless” from any drop in its FMAP rate that would otherwise occur under the regular FMAP formula as a result of an increase

in its per capita income in years prior to the recession. Second, states will receive a “base” 6.2- percentage-point FMAP increase. Finally, those states that are experiencing large increases in their unemployment rates — as most states are — will receive an additional FMAP increase, that would proportionally reduce the states’ share of Medicaid costs by 5.5 percent, 8.5 percent, or 11.5 percent, depending on the size of the increase in unemployment.

NPaiHB Policy Brief is a publication of the Northwest Portland Area Indian Health Board, 527 S.W. Hall, Suite 300, Portland, OR 97140. For more information visit www.npaihb.org or contact Jim Roberts, Policy Analyst, at (503) 228-4185 or by email jroberts@npaihb.org.