HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

EXECUTIVE SUMMARY

Tribal leaders concur with Chairman Baucus's proposal to augment funding for the Indian health system, and concur with his observation that "IHS desperately needs additional funding. It is impossible to keep America's promise to provide care to Native Americans and Alaska Natives with the current level of IHS funding."[1]

Indian Country strongly supports health care reform and seeks to ensure that the Indian health care delivery system is strengthened and improved so that Indian people and Indian health programs benefit from reformed systems.

Some key features of our recommendations include:

- Increasing the number of Indian people enrolled in Medicaid, CHIP and other publicly-funded insurance programs, including using fast track methodologies for Medicaid enrollment.
- Exempt Indian tribes from any employer mandate penalties and individual Indians from individual mandate penalties.
- Innovative ideas for addressing health care workforce shortages in the Indian health system such as pipeline incentive and utilizing alternative provider types.
- Expanding options for delivery of long term care services in Indian Country.
- Support targeted research and best practice benchmarking appropriate to American Indians and Alaska Natives.

Inquiries for this document may be directed to:

Jennifer Cooper, Legislative Director
National Indian Health Board
926 Pennsylvania Ave, SE, Washington, DC 20003
(202) 507-4070
Jcooper@nihb.org

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[1] Baucus, Senator Max, *Call to Action: Health Reform 2009* (Nov. 12, 2008), at 28.

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

INTRODUCTION

Foundation of Federal Obligation to Provide Health Care to Native Americans. When Indian tribes ceded certain lands – lands which now constitute the United States –agreements were made with the United States government. Among them was the establishment of a "trust" responsibility for the safety and well-being of Indian peoples in perpetuity. In addition, a number of the treaties specifically outlined the provision of education, nutrition, and health care. Since the creation of the Indian reservation system, and the subsequent federal policy of trying to move Indians to specific urban communities, the United States government has implemented that trust and treaty health care obligation through different forms of what is now the Indian Health Service.

Current Indian Heath Care Delivery Structure. The current system consists of services provided by: the Indian Health Service (IHS) (an agency of the Department of Health and Human Services); programs operated by Indian tribes and tribal organizations (through contractual agreements with IHS); and urban organizations that receive IHS grants and contracts (collectively the "Indian health system" or "I/T/U"). The I/T/U system serves approximately 1.9 million Native people and medical and dental care is delivered through more than 600 health care facilities.

Most beneficiaries served by the Indian health system live on very remote, sparsely-populated reservations and Alaska Native Villages. The Indian health system was designed in large part to reach these beneficiaries, who often have no other options. Even in more populated urban areas, where the Federal government moved Indian people during the 1950s and 60s, the Indian health system provides the most meaningful access as it is the only culturally competent provider and the only provider with a direct Federal-tribal relationship. The incentives in the Indian health system are not financial; its mission is the improvement of the health status of Indian people.

Inadequacies of Current System. Historical inadequate funding is the most substantial impediment to the current Indian health system's effectiveness. A 2008 CBO report on IHS stated that due to "staff shortages, limited facilities, and a capped budget, the IHS rarely provides benefits comparable with complete insurance coverage for the eligible population."[2] IHS expenditures per capita are roughly one-third the amount spent per capita for the general public and one-half the amount spent on federal prisoners.

RECOMMENDATIONS

Set out below are recommended systemic changes that, in concert with increased appropriations, will dramatically improve health care delivery for American Indians and Alaska Natives (AI/ANs).

Personal Responsibility Coverage Requirement (Individual Mandate)

Indian tribes do not object to the requirement that all Americans acquire a minimum level of health insurance, but would object to imposition of a penalty on an Indian individual who fails to obtain such insurance. The United States has a trust responsibility to provide health care to Indian people without cost, so assessment of any penalty for failing to acquire health insurance would violate this Federal responsibility.

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[2] Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals,* at 127 (Dec. 2008).

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

Subsidies

1. IHS is not creditable coverage. Indian people should not be barred from qualifying for subsidies due to their eligibility for care from the Indian health delivery system. The Indian health system should not count as creditable coverage for two reasons: (i) it is not a health insurance program; and (ii) the Indian health system is unable to provide a consistent, comprehensive package of health benefits to its beneficiaries.

2. Insurance subsidies. To the extent tribal governments provide health insurance for their employees or members who would be eligible for premium subsidies, the subsidies should be made available to the tribal government to offset the cost of acquiring coverage that should be available to Indian people without cost.
   - This same support should also be extended to tribal organizations carrying out programs under the Indian Self-Determination and Education Assistance Act and the Tribally Controlled Schools Act, as well as urban Indian organizations.

3. Apply Federal law protections. The protections afforded to Indians regarding their participation in Medicaid should apply to their participation in any health insurance plan:
   - Indians should be exempted from all cost-sharing (including premiums, co-pays and deductibles), consistent with the recent amendment to the Social Security Act which exempts Indians from cost-sharing under Medicaid.
     - If the law nonetheless requires that Indians pay premiums, Indian health delivery system (I/T/Us) must have the authority to pay the premiums on behalf of their beneficiaries and administrative barriers to doing so must be removed.
   - Individual Indian income from Federally-protected sources must be excluded from the calculation of an individual AI/AN's income for purposes of determining eligibility for a subsidy. See, e.g., 25 USC §§1407, 1408; 43 USC §1626.
   - AI/ANs must not be subject to any restriction on selection of a provider. They must be permitted to obtain care from their IHS, tribal, or urban Indian organization program without any financial or other penalty. See recent amendment to Sec. 1932(h)(1) of the Social Security Act to permit an Indian enrolled in Medicaid to select an Indian health care provider as a primary care provider. Pub. L. 111-5, Sec. 5006(d) (Feb. 17, 2009).
   - A special enrollment period should apply to Indian beneficiaries in order to maximize opportunities for enrollment.

4. Allow integration of traditional health practices. Assure that prevention and wellness programs are covered services in all public programs (Medicare, Medicaid and CHIP). To the extent an Indian health program integrates traditional health care practices into its prevention/wellness programs, it should be permitted to do so with no adverse impact on its ability to receive federal support for prevention and wellness programs.

5. Outreach in Indian communities. Expressly designate Indian health delivery system as a location for outreach and enrollment activities for public programs.

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

Employer Mandate

Indian tribes, as employers, should be exempt from any requirement that an employer provide health insurance coverage to its employees or suffer a financial penalty. As sovereign governments, tribes must be permitted to determine for themselves the extent to which they can/will provide health insurance coverage to their employees, and must not be subject to any penalty or tax for declining to do so.

Medicaid and CHIP Expansion

1. Medicaid income eligibility. Medicaid eligibility should be expanded to 150% of the Federal poverty level, and should be expanded to make childless adults eligible.

2. Cost-sharing exemption. All expansions of Medicaid and CHIP (including any waiver or demonstration programs) must expressly exempt AI/ANs served by the I/T/U system from any form of cost-sharing pursuant to the recent amendment to Title XIX made by Sec. 5006(a) of Pub.L. 111-5 (Feb. 17, 2009).

3. Out of state Medicaid applicability. Indian tribes support the proposal of the Finance Committee to require interstate coordination for child Medicaid beneficiaries to ensure that a child's home-state Medicaid program will cover the child's health care costs when he/she is out of state. Such a requirement would beneficially impact Indian children enrolled in Medicaid who leave their home states for such purposes as attending Bureau of Indian Affairs boarding schools.
   - This proposal should be expanded to require an adult Indian's home-state Medicaid program to cover the health care costs of such a patient who travels out of state in order to receive culturally competent care at an Indian health facility, including care related to behavioral health needs and substance abuse treatment.

4. Outreach and enrollment. Aggressive mechanisms are needed to increase enrollment of eligible Indians in Medicaid and CHIP. The AI/AN population suffers from disproportionately high poverty rates and thus has a high proportion of Medicaid and CHIP eligibility, but Indians are under-enrolled in these programs.
   - States should be authorized to rely on a finding of eligibility for Medicaid and CHIP made by an I/T/U to the same extent as they would rely on such a finding by an Express Lane agency (as defined in Sec. 203 of CHIPRA).
   - Indian health providers should be permitted to apply fast-track enrollment methods and to participate as Express Lane or other Medicaid enrollment simplification network entities.
   - States must be required to demonstrate they have employed effective outreach and enrollment activities on/ near Indian reservations and in off-reservation Indian communities, with penalties attaching for failure to do so.
   - Tribal governments should be authorized as portals for accepting Medicaid applications.

Health Insurance Exchange

1. All insurance plans admitted to a health insurance exchange (including any public option) should be subject to the protections for Indian beneficiaries and Indian health system providers recently applied to Medicaid managed care programs by Sec. 5006 of Pub.L. 111-5 (Feb. 19, 2009). These include:
   - Assurance that an Indian enrolled in a plan in the exchange is permitted to obtain care from his/her Indian health program without any financial or other penalty.

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

- A requirement that provider networks includes sufficient Indian health care providers to assure access for Indians.
- A requirement that I/T/U providers be paid (whether or not enrolled in the network) at a rate negotiated with the I/T/U, or if no rate is negotiated, at the rate paid to a non-Indian network provider.
- A requirement for prompt payment to an I/T/U provider.

2. The legislation should include a requirement that the Secretary establish terms for I/T/U participation in provider networks that take into account their unique treatment under Federal laws that apply to the Indian health delivery system such as the Federal Tort Claims Act.
   - This recommendation builds on lessons learned during implementation of the Medicare Part D drug program where it was necessary for CMS to require specific terms for pharmacy contracts in order to assure participation opportunities for I/T/U pharmacies.

3. Outreach and enrollment. Aggressive mechanisms are needed to assure that Indians eligible for insurance subsidies can quickly obtain subsidy determinations. The AI/AN population suffers from disproportionately high poverty rates and thus has a high proportion of people who will be eligible for a subsidy. Experience demonstrates that Indians are under-enrolled in Medicaid and CHIP; thus it is expected that aggressive outreach and enrollment efforts will be needed to encourage Indian people to avail themselves of premium subsidies for which they are eligible.
   - Insurance plans for which subsidies are available should be authorized to rely on a finding of subsidy eligibility made by an I/T/U to the same extent as means-tested programs rely on eligibility findings by Express Lane agencies (as defined in Sec. 203 of CHIPRA).
   - Indian health providers should be permitted to apply expedited mechanisms (similar to fast track processes in Medicaid) to subsidy determination
   - Authorize Tribal governments to serve as portals for accepting insurance subsidy applications.

Other Safeguards Needed for Indian Health System

1. Health care workforce. Indian health programs already have difficulty recruiting and retaining needed health care professionals, and competition for health care workforce personnel will intensify as millions of individuals enter the ranks of the insured. The Indian Health Service budget must be enhanced to assure that Indian programs can attract and retain health care personnel.
   - Expand funding to train and support alternative provider types who have proven records of providing quality care, such as community health representatives, community health aides, behavioral health aides, and dental health aide therapists.
   - Include the Indian health delivery system as a key focus area in the coordinated national strategy to address health care workforce shortages.

2. Medicare amendments.
   - The Medicare law should be amended to provide 100% payment to Indian health programs for covered Medicare services. At present, the system for making Medicare reimbursements to IHS and tribally-operated facilities provides payment at only 80%, as Medicare presumes a 20% patient co-pay, and expects patients to satisfy deductibles before qualifying for benefits. Because of the trust responsibility for Indian health, the IHS does not charge patient co-pays; thus, the IHS budget subsidizes Medicare by paying the remaining 20%, as well as applicable deductibles. According to 2008 data, reimbursing Indian facilities for Medicare services at 100% would infuse over $40 million more into the Indian health system annually, funds that would be used to reduce health status disparities.

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

- Remove from Section 1880 of the Social Security Act the sunset date (December 31, 2009) applicable to IHS and tribal program authority to receive payment for certain Medicare covered items and services.

3. Research. Reform legislation must support targeted research and best practice benchmarking appropriate to AI/ANs. Best practices in prevention and treatment must be grounded in evidence-informed study on the actual population involved.
   - Any Federally-funded population survey or collection of data to establish best practices, or benchmarking must ensure that AI/ANs are over-sampled to be able to generate statistically reliable estimates.

4. Health information technology. HIT improvements must reach all Indian health providers. The remote location of many I/T/U facilities and complex relationships with IHS lead to wide disparities in health technology capabilities. Explicit policies are needed to assure that all Indian health providers receive an equitable distribution of resources for improving health information technology and that Indian health providers are not penalized for lack of information technology.
   - Supply funding to develop and implement a system for monitoring and measuring the needs of the Indian health system to assure that budgetary resources are sufficient to support the level of need throughout the system.
   - The Secretary of HHS should be required to conduct a feasibility study to determine how the Indian health system can efficiently integrate smart card technology through which a patient's medical history can be stored on a portable microchip pocket card.

5. Payor of Last Resort. Include coordination of benefits policies which assure that, consistent with existing Federal regulations, the I/T/U program is the payor of last resort.
   - To assure such policies are properly implemented, require the involvement of the CMS Tribal Technical Advisory Group in development of regulations, and provide funding to support the TTAG's work. (NOTE: Federal law formally recognizes the TTAG and directs the Secretary to maintain this panel within CMS. See Pub.L. 111-5, §5006(e) (Feb. 17, 2009)).

6. Facilities. The quality and capacity of facilities throughout the Indian health system differ widely as the IHS construction budget has never kept up with the level of need. Thus, tribes need the authority to explore innovative ideas for addressing facility needs and the flexibility to utilize existing facilities fully and efficiently. Proposals follow:
   - Facilitate tribal authority to decide whether to serve non-Indians at their health facilities. The demand for health services will greatly increase in a reformed health care environment and tribes are likely to be asked to open their doors to serve non-Indian patients and receive payment for such services. This is a challenging decision that requires consideration of capacity and resources and whether adding users will improve the breadth of services that can be offered or would diminish an already limited capacity. To support tribes who are willing to expand accessibility to health care by serving non-Indians, the legislation must –
     - Extend the Federal Tort Claims Act coverage now provided to ISDEAA contractors to include coverage for services to non-Indians. (This is consistent with the FTCA coverage extended to community health centers which receive funding from HRSA under Sec. 330 of the Public Health Service Act.)
     - Revise as necessary Sec. 813 of the Indian Health Care Improvement Act to facilitate a tribal decision to serve non-Indians.

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

Long-Term Care Services and Support in Indian Country

Federal support. Grant funding and federal support should be made available to assist tribes and tribal organizations to develop the full range of long-term care services needed to meet their community needs, with an emphasis on culturally appropriate home and community based services, including care management services that will delay or prevent the need for nursing home care. Specifically, Indian tribes must be expressly included as entities eligible for long-term care grant programs, including: the Community Choice Act Demonstration Project, Real Choice Systems Change Grant Initiative, Aging and Disability Resource Centers (ADRC), Informal Caregivers and Green House Model.

Other Matters

1. Tribal involvement. Include Tribal representation on key commissions, boards and other groups created by health reform legislation, and direct the Secretary of HHS to consult with Tribes on health reform policies and regulations. Only by engaging knowledgeable Tribal leaders before policy approaches are evaluated, refined and implemented can health reform promise to improve the Indian health system and the health status of AI/ANs.
   - Tribal organizations (as defined in the ISDEAA) which operate health programs should be included in the consultation, as they are created by tribal governments expressly to perform health care delivery.
   - Consultation should occur throughout Indian Country, as Indian cultures, tribal resources and health system structures differ greatly.
   - The views of Federally-funded programs serving Indian people in urban communities should also be sought.

2. Exclusion of health benefits as income. Indian tribes, as sovereign governments, and the tribal organizations that serve them by providing health services, should have the express authority to pay the costs of providing health insurance coverage to their members and beneficiaries and the value of such coverage should not be considered to be taxable income to the AI/AN.