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**SENT VIA TELEFAX: (202) 228-0554**

The Honorable Max Baucus  
United States Senate  
Finance Committee  
Senate Dirksen Building 219  
Washington, D.C. 20510

Dear Mr. Chairman:

The Northwest Portland Area Indian Health Board (NPAIHB) is a tribal organization, organized under the Indian Self-Determination and Education Assistance Act (P.L. 93-638), to represent the health care interests of forty-three federally recognized Indian Tribes in the states of Idaho, Oregon, and Washington. Affiliated Tribes of Northwest Indians (ATNI) was established in 1953, and represents 53 federally-recognized Tribes in Idaho, Oregon, Washington, southeast Alaska, northern California, and western Montana.

We are transmitting to the Finance Committee our recommendations on how to include and improve the Indian health system in the current health reform proposals that are being discussed by the Administration and Congress. Our recommendations have been organized into a matrix to follow the Finance Committee's three policy option papers issued on April 29<sup>th</sup>, May 14<sup>th</sup>, and May 20<sup>th</sup>, 2009. The matrix is organized by each paper's section/policy proposal and followed by our recommendations for how to address the issues for the Indian health system. Our intent is to make it as easy as possible for the Finance Committee and drafters of the legislation to correlate our recommendation back to the Committee's proposals.

Our recommendations were developed at our "*Northwest Roundtable on Health Care Reform Policy Options for the Indian Health System*," held on June 2-3, 2009 in Portland, Oregon. During our health reform roundtable, Tribal leaders and health directors stressed three overarching policy areas for the Congress and the Administration to be mindful of as they craft legislation to move toward national health reform:

1. ***There is a Special Legal Obligations Involving American Indians***: It is the policy of the nation, in fulfillment of its legal obligation to Indian Tribes, to meet the national goal of providing the highest possible health status to American Indians and Alaska Natives (AI/AN) and to provide existing health services with all resources necessary to affect that policy. Indian Tribes are not simply another interest group. They are recognized in law as sovereign entities that have the power to govern their internal affairs. It is unacceptable either legally or pragmatically to distribute funds or program authority to state governments and private insurance companies or HMOs for distribution to Tribes and Indian people. Because of this, Tribes must be consulted with in the development of any health reform legislation and included on any commissions, boards and other groups created by health reform legislation.

1. **Containing Costs and Improving Quality:** Tribal governments, like the Administration and Congress, support containing costs and improving health quality outcomes. The Indian health system has proven to be a leader at doing more with less, and improving quality outcomes for AI/ANs served by its system. In order to continue to build on this, all Indian health providers must be able to participate in prevention initiatives. Health information technology improvements must reach all Indian health providers and include systems used by Tribal government and not just those selected by federal agencies and providers participating in the Exchange. The Indian health system should be exempt from provider disincentives used to contain health costs.
2. **Expanding Coverage:** Indian health programs need special considerations as essential providers in Indian communities. Health coverage mandates for individuals or employers need to take into consideration the special relationship between Tribes and the federal government. Permit Tribes the option to purchase employee health insurance through the federal employee's health benefits program. Protect the right of AI/ANs to use Indian health providers. Extend Federal Tort Claim Act (FTCA) to permit Tribal health programs to provide health care access to non-Indian patients. Ensure research and benefit designs take into account the unique needs and culture of AI/AN people.

In addition to our recommendations included here, we are attaching a list of Indian Health Care Improvement Act provisions that the National Indian Health Board, National Congress of American Indians, and National Council of Urban Indian Health provided the Committee on May 31, 2009. We are conveying our support for these recommendations to be included in the health reform legislation.

Please note, that our Tribes, like the rest of Indian Country have only recently started the dialogue on national health reform. While our recommendations represent a consensus of Northwest Tribes, that each Tribe may submit their own recommendations on specific issues as this process moves forward.

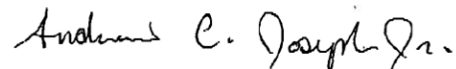
If you should have questions concerning our recommendations, please contact Jim Roberts, NPAIHB Policy Analyst at (503) 416-3276 or by email at [jroberts@npaihb.org](mailto:jroberts@npaihb.org).

Thank you in advance for your consideration!

Sincerely,



Brian Cladoosby,  
ATNI Chairman  
Chairman, Swinomish Tribe



Andrew Joseph, Jr.  
NPAIHB Chairman  
Colville Tribal Council Member

cc: Richard Litsey, Sr. Advisor for Indian Affairs, Finance Committee  
Brenda Shore, Sr. Health Policy Advisor, Indian Affairs Committee  
Rhonda Harjo, Deputy Chief Counsel for the Minority, Indian Affairs Committee  
NW Congressional Delegation

# **NPAIHB and ATNI Recommendations on Health Care Reform Policy Options for the Indian Health System<sup>1</sup>**

*Submitted to the Finance Committee  
June 4, 2009*

**The Portland Area Indian Health Board (NPAIHB) believes that the May 31, 2009 joint letter (National Indian Health Board, National Congress of American Indians and National Council of Urban Indian Health) contained a serious error that needs to be corrected. On page 3, under “Subsidies”, the letter says, “IHS is not creditable coverage”. If this policy is adopted, many American Indians and Alaska Natives (AI/AN) will NEVER be able to achieve the important promise of “portability”.**

- Although IHS is not insurance it is health coverage.
- Provisions under Medicare Part D (42 CFR 423.56(b)(9)), which granted Indian health provider coverage as creditable coverage have worked well. New health insurance programs, especially those coordinated through “The Exchange” must explicitly recognize the Indian health system as creditable coverage. To underscore this important point, many AI/AN elders did not enroll in Medicare Part B when first eligible because they received care through Indian health services. For those who subsequently moved away from tribal communities and needed to rely on non-Indian providers, they found they could only enroll in Part B with a very significant and unaffordable financial penalty. Most Indian health programs are not prepared to provide extensive counseling to patients who receive health care under treaty rights about why they need to purchase health insurance.
- NPAIHB is also concerned about the unintended incentives created by not deeming Indian health creditable coverage. If AI/AN found themselves “locked into” the Indian health system, because if it is not recognized as creditable coverage, would it force AI/AN to remain in the Indian health system because they could not afford to leave? This would further burden already inadequately funded providers.
- While Indian health providers are proud of the public health, community based delivery model they have built over the years, they still must coordinate public and private insurance coverage for patients and thus are very familiar with the complexities of the broken health care system that Congress hopes to fix. As such, NPAIHB strongly encourages Congress to explicitly include the Indian health system as creditable coverage so individual AI/ANs are able to purchase insurance, without penalty when they are unable to access Indian health services. Only knowledgeable Indian health providers, who work everyday coordinating coverage for AI/AN can adequately advise policy makers on how the details of health reform can help or hurt tribal communities.
- AI/AN using Indian health system must be deemed to have creditable coverage and any penalty assessed for failure to enroll in a health insurance plan must be waived. Creditable coverage must not disqualify AI/AN for any health insurance or subsidy for which they would otherwise qualify.
- Portability for AI/AN requires that the Indian health system coverage be deemed creditable coverage.

## **Tribal Specific Recommendations:**

1. **Include Tribal representation on key commissions, boards and other groups created by health reform legislation. Direct the Secretary of HHS to consult with Tribes on a government to government basis 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.

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<sup>1</sup> The Northwest Portland Area Indian Health Board and Affiliated Tribes of Northwest Indians convened a regional meeting, “Northwest Roundtable on Health Care Reform Policy Options for the Indian Health System,” on June 2-3, 2009 in Portland, Oregon. This paper transmits the recommendations of Tribal leaders and health directors, urban Indian program directors, and other Indian health advocates that participated in the meeting.

2. **Consult with Tribes on a government to government basis across the country to be sure health reform policies and regulations are developed in a way that will create positive changes in the diverse Indian communities.** Across the United States Indian cultures, tribal resources and tribal health system structures differ greatly. Health reform must work in all of these situations. Only by directly consulting with Tribes as policies and regulations are being developed can HHS develop policies and regulations that will work in all Indian communities.
3. **Confer with representatives of urban Indian organizations to determine the impact of reform proposals on the Indian people served by those programs.**
4. **Indian tribes perform several roles in a health care context: They are governments, employers, health care providers (through Indian Self-Determination agreements), patient advocates, and beneficiaries of the U.S. trust responsibility for health. All of these roles must be respected, together with the recognition that Indian people are unique and distinct political group, not merely a minority classification.**
5. **Indian tribes must retain the authority to decide whether or not to serve non-Indians at their health facilities.** Tribes recognize that the demand for health services will greatly increase in a reformed health care environment and that they are likely to be asked to open their doors to serve non-Indian patients and receive payment for such services. The I/T/Us must be able to either open their doors or continue to serve only IHS beneficiaries. 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 wish to serve non-Indians, the legislation must –
  - a. 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 currently.)
  - b. Revise as necessary Sec. 813 of the Indian Health Care Improvement Act to facilitate a tribal decision to serve non-Indians.
6. **Health care reform should require Tribal collaboration across all HHS agencies (e.g. HRSA, SAMSA, Administration on Aging, CMS) and other federal health programs, such as but not limited to, the Veterans Administration to coordinate health care resources in order to ensure health related funding is more effectively available to tribes.**
7. **The Indian Health Service budget must be protected from offsets and must be enhanced to assure that Indian programs can attract and retain health care personnel needed to fulfill the Federal government's trust obligation to "permit the health status of Indians to be raised to the highest possible level".**
  - a. Chairman Baucus has noted that "[i]n fiscal year 2008, total funding for IHS was \$4.3 billion, about 48 percent of estimated need."
8. **Health reform should provide opportunities and incentives to facilitate opportunities for IHS and tribes to develop cost-effective cooperative arrangements for sharing of facilities and staff with local non-Indian communities.**
9. **While health care reform holds great promise for ensuring coverage for all Americans, in Indian Country it will create a short term financial burden on the already seriously under funded Indian health system.** Tribes need to be involved in policy analysis and rule making, but there are no new resources. At the tribal level staff will need training and the resources to build the local systems that are needed to effectively educate, enroll and coordinate patient participation in a reformed system. When new funding is available for implementing health reform in Indian Country, provisions must be made to ensure that it is available to all Tribes equally.
10. **If the Indian Health Service (IHS) is provided additional resources to fund health services consistent with what would be provided in a publicly-funded health plan or other programs addressed under health reform, the IHS shall distribute funds equitably to tribal and urban health programs under the terms and conditions of Indian Self-Determination and Education Assistance Act (ISDEAA) and the Indian Health Care Improvement Act (IHICA) on the same allocation basis IHS makes funds available to directly operated service units.**

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Section	Policy Issue	Recommendations
<b>I: Insurance Market Reforms</b>	<b>Page 2</b>	
	Non-Group and Micro-Group Market Reforms	
	Small Group Market Reforms	
	Health Insurance Exchange	<ol style="list-style-type: none"> <li>1. In order to AI/AN access to a public insurance plan, the legislation shall expressly authorize and fund outreach and enrollment activities to take place at I/T/U sites.</li> <li>2. In recognition of the Federal government's trust responsibility to provide health care to Indian people, a special (open) enrollment period should apply for AI/ANs eligible for Indian health programs and electing to participate in insurance coverage</li> <li>3. Any new publicly-sponsored health insurance plan established to provide coverage for low/moderate income individuals must assure that AI/ANs who meet the income requirements are eligible to enroll, and that eligibility for services from the Indian health system is not a barrier to participation.               <ol style="list-style-type: none"> <li>a. AI/ANs eligible for care through the Indian health system have been encouraged to also enroll in Medicaid if they meet the eligibility criteria. The same opportunity must be made available for any federally supported or subsidized health insurance coverage.</li> </ol> </li> <li>4. AI/AN using Indian health system must be deemed to have creditable coverage and any penalty assessed for failure to enroll in a health insurance plan must be waived. Creditable coverage must not disqualify AI/AN for any health insurance or subsidy for which they would otherwise qualify.</li> <li>5. Include coordination of benefits policies which assure that, consistent with existing Federal regulations, the I/T/U program is the payor of last resort.               <ol style="list-style-type: none"> <li>a. 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)).</li> </ol> </li> </ol>
	Transition	
	Role of State Insurance Commissioners	
<b>II: Making Coverage Affordable</b>	<b>Page 8</b>	
	Benefit Options	<ol style="list-style-type: none"> <li>1. In recognition of the Federal government's trust responsibility to provide health care to Indian people, for any cost-sharing (premium, co-pay, etc.) that would apply to a publicly-subsidized plan, an AI/AN served by the Indian health system</li> </ol>

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		<p>should be expressly exempt from all such cost-sharing.</p> <ol style="list-style-type: none"> <li>a. Such a policy is consistent with the recent amendments to Title XIX (Medicaid) of the Social Security Act which prohibit the assessment of any cost-sharing against an AI/AN enrolled in Medicaid who is served by the IHS, or by a health program operated by a tribe, tribal organization or urban Indian organization.</li> </ol> <p>2. For Indian communities, consider options for that will build on the holistic and public health model of health. In particular, enact provisions that permit and encourage integration of behavioral health services (mental health and substance use disorder) with other health services, especially primary care.</p>
	Low-Income Tax Credits	
	Small Business Tax Credits	
<b>III: Public Health Insurance Option</b>	<b>Page 13</b>	
<p>Approach 1: Medicare-Like Plan Approach 2: Third Party Administrator Approach 3: State-Run Public Option</p>		<ol style="list-style-type: none"> <li>1. NPAIHB supports Approach 1 for several key reasons: <ol style="list-style-type: none"> <li>a. Indian tribes' relationship is directly with the federal government. Approach 1 preserves that relationship.</li> <li>b. Most ITU providers are currently able to bill and receive reimbursement for Medicare services. If a new private contractor administers the public health insurance, Indian health providers will be required to expend significant new resources in contracting, and establishing new relationships at the regional or state level. Approach 1 will save significant administrative resources as well as minimize disruptions in reimbursement collections.</li> </ol> </li> <li>2. If Approach 2 or 3 is adopted: <ol style="list-style-type: none"> <li>a. AI/ANs must not be subject to any restriction on selection of a provider. AI/ANs must be permitted to elect 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.</li> </ol> </li> <li>3. If the legislation requires either the Secretary or outside entities to establish provider networks to serve individuals covered by a public insurance plan, it should contain assurances of participation by Indian health system (I/T/U) providers including: <ol style="list-style-type: none"> <li>a. Assurance that the network provides access to all Indian health care providers t;</li> <li>b. 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; and</li> <li>c. A requirement for prompt payment to an I/T/U provider.</li> </ol> </li> <li>4. Such express language is needed to assure that these providers are not arbitrarily excluded from participation as has occurred with some Medicaid managed care entities. When an I/T/U provider serves an individual enrolled in a public plan, the</li> </ol>

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		<p>provider must be able to claim reimbursements and be assured of receiving payments.</p> <ol style="list-style-type: none"> <li>a. Congress recently enacted protections for Indian health providers <i>vis-a-vis</i> Medicaid managed care entities which can be used as a model for similar protections for public plan network creation.</li> </ol> <p>5. The legislation should also include a requirement that the Secretary establish special terms for participation by I/T/Us that takes into account the unique circumstances of those providers in order to facilitate their participation.</p> <ol style="list-style-type: none"> <li>a. This recommendation builds on lessons learned during implementation of the Medicare Part D drug program where it was necessary for CMS to require special additions to pharmacy contracts in order to assure participation opportunities for I/T/U pharmacies. For example, FTCA coverage meets the requirements of malpractice insurances when entering into agreements with provider networks, but some insurance plans will not accept this and require additional malpractice insurance.</li> </ol> <p>6. Explicitly permit Indian plans to qualify as options available through the Exchange and allow them to limit enrollment to the beneficiaries determined by tribes</p>
<b>IV: Role of Public Programs</b>	<b>Page 14</b>	
<ul style="list-style-type: none"> <li>• Eligibility Standards and Methodologies</li> <li>• Medicaid Program Payments</li> <li>• Options for Medicaid Coverage               <ul style="list-style-type: none"> <li>Approach 1: Increased Coverage through the Current Medicaid Structure</li> <li>Approach 2: Increased Coverage through the Exchange</li> <li>Approach 3: Increased Coverage through Both the Current Medicaid Structure and the Health Insurance Exchange</li> </ul> </li> </ul>	Medicaid Coverage	<ol style="list-style-type: none"> <li>1. 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.           <ol style="list-style-type: none"> <li>a. 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).</li> <li>b. 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.</li> <li>c. 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.</li> <li>d. Tribal governments should be authorized as portals for accepting Medicaid applications.</li> </ol> </li> </ol>
	Children's Health Insurance Program (CHIP)	
	Quality of Care in Medicaid and CHIP	<ol style="list-style-type: none"> <li>1. Membership in the MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION (MACPAC) should include at least one representative of the CMS Tribal Technical Advisory Group pursuant to requirements that CMS consult with the TTAG at .</li> </ol>
<ul style="list-style-type: none"> <li>• Enrollment and Retention Simplification</li> <li>• Family Planning Services and Supplies</li> <li>• Treatment of Selected Optional Benefits</li> </ul>	Other Improvements to Medicaid	<ol style="list-style-type: none"> <li>1. NPAIHB supports establishing a distinct national/federal tribal Medicaid option for administration, eligibility, payment, and delivery of Medicaid eligible services. This would assure a Medicaid "uniform benefit package" for AI/AN across the country to address the significant health disparities that exist in Indian Country. This concept has been discussed many times</li> </ol>

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<ul style="list-style-type: none"> <li>• Interstate Coordination Requirements for Child Medicaid Beneficiaries</li> <li>• Mandatory Coverage for Prescription Drugs</li> <li>• Change the Status of Some Excludable Drugs</li> <li>• Changes to Medicaid Payment for Prescription Drugs</li> <li>• Transparency in Medicaid and CHIP Section 1115 Waivers</li> <li>• Changes to the FMAP Formula</li> <li>• Automatic Countercyclical Stabilizer</li> </ul>		<p>over the years and could comprise a key component of health reform for Indian people. A national approach could help ensure that LTC reaches tribal communities and that an integrated approach to a benefit package could specifically address the unique cultural needs of AI/AN residing in tribal communities.</p> <ol style="list-style-type: none"> <li>2. Indian health providers must be permitted, but not required to enroll eligible AI/AN beneficiaries on site and to participate as Express Lane or other Medicaid enrollment simplification network entities.</li> <li>3. 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.               <ol style="list-style-type: none"> <li>a. 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, including substance abuse treatment.</li> </ol> </li> <li>4. All expansions of Medicaid and CHIP (including any waiver or demonstration programs) must expressly exempt AI/ANs 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).</li> </ol>
	Medicaid Disproportionate Share (DSH) Hospital Payments	
<ul style="list-style-type: none"> <li>• Waiver Authority for Dual Eligible Demonstrations</li> <li>• Cost-Effectiveness Test</li> <li>• Office of Coordination for Dually Eligible Beneficiaries</li> </ul>	Dual Eligibles	
<ul style="list-style-type: none"> <li>• Reduce or Phase-Out the Medicare Disability Waiting Period</li> <li>• Temporary Medicare Buy-In</li> </ul>	Medicare Coverage	<ol style="list-style-type: none"> <li>1. Pursuant to the Federal trust responsibility for Indian health, 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. But in recognition of the trust responsibility for Indian health, the IHS does not charge patient co-pays; thus, the IHS budget subsidizes the remaining 20%, as well as applicable deductibles. According to 2008 data, reimbursing Indian facilities for Medicare services at 100% would annually infuse over \$40 million more into the Indian health system, funds that would be used to reduce health status disparities.</li> <li>2. Medicare changes should correct an omission in MMA that will permit CHS or other Tribal payments to count toward Part D</li> </ol>

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		<p>TROOP.</p> <ol style="list-style-type: none"> <li>3. In order to continue to permit billing for Medicare part B services:</li> <li>4. <input type="checkbox"/> Remove from Section 1880 of the Social Security Act the sunset date (December 31, 2009) applicable to</li> <li>5. IHS and tribal program authority to receive payment for certain Medicare covered items and services.</li> <li>6. All AI/AN who do not have Part B should be granted equitable relief in order to enroll in Medicare Part B and be exempt from financial penalties. Over the years some AI/AN elders did not enroll in Part B because they trusted that services would always be available for them through the Indian health system. Others were told in some meetings by federal officials that they didn't need to pay for Part B.</li> </ol>
<b>V: Shared Responsibility</b>	<b>Page 39</b>	
	Personal Responsibility Coverage Requirement	<ol style="list-style-type: none"> <li>1. Indian tribes, as sovereign governments, should have the express authority to pay the costs of providing health insurance coverage to their members and the value of such coverage should not be considered to be taxable income to the tribal member.</li> <li>2. Because of the Federal trust responsibility to provide health care to Indian people, AI/ANs must be exempted from any penalty for failing to obtain or purchase health insurance if an individual mandate is included in the legislation. (creditable coverage)</li> <li>3. Despite this, the fact that an AI/AN is eligible for health care from the Indian health system should not be a barrier to an AI/AN's eligibility for any publicly-funded health program such as Medicaid, or any publicly-subsidized health insurance option.</li> <li>4. To the extent premiums and cost-sharing apply to AI/ANs, I/T/Us should be expressly permitted to make such payments on behalf of their Indian beneficiaries, and administrative barriers to doing so must be removed.</li> <li>5. In recognition of the Federal trust responsibility to Indian people, 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 participation in a publicly-subsidized plan.</li> </ol>
	Employer Requirement	<ol style="list-style-type: none"> <li>1. To the extent reform legislation includes an employer mandate, Indian tribes 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 as employers 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.             <ol style="list-style-type: none"> <li>a. The exemption of Indian tribes from any penalty or tax must also apply with regard to any tribal employees who opts out of a tribally-sponsored group health plan and buy insurance on their own outside of the workplace.</li> </ol> </li> </ol>

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		<p>2. Indian Tribes should be given the option to purchase health insurance for their governmental employees through the Federal Employees Health Benefit Plan. As employers, some Indian tribes have been unable to find affordable health insurance. Indian tribes should have the option to purchase coverage for their governmental employees through the FEHBP, an option that would benefit both tribes – by making an affordable option available – and the FEHBP – by increasing the volume of insured.</p> <ul style="list-style-type: none"> <li>a. This option should be extended to tribes and tribal organizations for their employees who perform agreements issued under the Indian Self-Determination and Education Assistance Act and the Tribally Controlled Schools Act.</li> <li>b. Some tribes have extreme difficulty finding affordable employee coverage in the commercial market – some, but not all, are small employers. FEHBP would assure affordable coverage for these tribes.</li> </ul>
<b>VI: Prevention and Wellness</b>	<b>Page 43</b>	<p>1. Assure that prevention services are eligible for payment by all publicly-supported health programs (Medicare, Medicaid, CHIP and any new public health insurance option), and that I/T/U providers are eligible to collect such payments.</p> <ul style="list-style-type: none"> <li>a. To the extent an Indian health program integrates traditional health care and promising practices into its prevention programs, it should be permitted to do so with no adverse impact on its ability to collect reimbursements for covered prevention services. Preventive services that are considered to be effective in Indian Country should be included as covered preventive benefits</li> </ul>
<ul style="list-style-type: none"> <li>• Personalized Prevention Plan and Routine Wellness Visit</li> <li>• Incentives to Utilize Preventive Services and Engage in Healthy Behaviors Coverage of Evidence-Based Preventive Services</li> </ul>	Promotion of Prevention and Wellness in Medicare	<p>1. In light of the significant health disparities for AI/AN, include tribal representation on groups that determine services so unique cultural considerations can be addressed.</p>
<ul style="list-style-type: none"> <li>• Access to Preventive Services for Eligible Adults</li> <li>• Incentives to Utilize Preventive Services and Encourage Healthy Behaviors</li> </ul>	Promotion of Prevention and Wellness in Medicaid	<p>1. In light of the significant health disparities for AI/AN, include tribal representation on groups that determine services so unique cultural considerations ca be addressed.</p>
<ul style="list-style-type: none"> <li>• “RightChoices” Grants</li> <li>• Prevention and Wellness Innovation Grants</li> </ul>	Options to Prevent Chronic Disease and Encourage Healthy Lifestyles	<p>1. Include tribes as entities eligible for Right Choices Grants.</p>
	Employer Wellness Credits	
<b>SECTION VII: Long Term Care Services and Supports</b>	<b>Page 49</b>	
	Medicaid Home and Community Based Services (HCBS) Waivers and the Medicaid	<p>1. State Medicaid agencies have varying relationships with Indian tribes. For a variety of reasons, AI/AN have difficulty accessing LTC services. To assist with this access problem, authorize tribes to secure LTC waivers either directly with CMS or require</p>

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	HCBS State Plan Option	States to submit LTC waivers on behalf of a tribe or tribal organization.
	Eligibility for HCBS Services	
	Increase Access to Medicaid HCBS	<ol style="list-style-type: none"> <li>1. Include provisions which require States, all agencies of the Department of Health and Human Services, and the Department of Veterans Affairs to demonstrate how they will assure that AI/ANs have meaningful access to Federally-supported long-term care programs and services.</li> <li>2. A demonstration project should be funded through CMS, Administration on Aging and IHS 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. This project should specifically address identifying and removing impediments to building LTC services in tribal communities as well as establishing effective methods to link/integrate LTC with ITU medical, dental and behavioral health services.</li> <li>3. Include research on using cost based reimbursement for tribal LTC services</li> <li>4. State Medicaid programs should be required to enter into agreements with IHS and tribal health programs under which reimbursement would be made for the full range of long term care services tribal programs are able to offer, and assure covered services include care management and home health care.</li> </ol>
	Increase Federal Match for Medicaid HCBS	
	Medicaid Spousal Impoverishment Rules	
	Medicaid Resources / Asset Test	
	Long Term Care Grants Program	<ol style="list-style-type: none"> <li>1. Indian tribes must be expressly included as entities eligible for long-term care grant programs, including, but not limited to: the Community Choice Act Demonstration Project; Real Choice Systems Change Grant Initiative; Aging and Disability Resource Centers (ADRC); Informal Caregivers; prevention and Health Promotion; and Green House Model.</li> </ol>
	Functional Assessment Tool for Post-Acute LTC	
	Money Follows the Person Rebalancing Demonstration	<ol style="list-style-type: none"> <li>1. Authorize tribes to directly access federal funding under this program.</li> </ol>
<b>SECTION VIII: Options to Address Health Disparities</b>	<b>Page 56</b>	<ol style="list-style-type: none"> <li>1. Establish an Indian Health Reform Task Force to conduct comprehensive research and a decision making process to redesign the Indian health system within the context of health reform goals. The Indian health system has evolved over time and by and large has been successful at recognizing and responding to the challenges of serving diverse and very poor populations with health status that is unacceptable by any</li> </ol>

**Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans  
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Section	Policy Issue	Recommendations
		<p>measure. Significant inroads have been hampered primarily by a serious lack of funding. Indian health has adopted a community based, public health model to provide services. Health reform activities are using a competitive, insurance based model, which will not work in many Tribal communities. To research the options and develop the most promising changes for the Indian health system will take time and money. It is important to preserve the strengths while ushering in new system changes that are specifically designed to improve the health of AI/AN in a culturally relevant way.</p> <p>The Task Force will:</p> <ol style="list-style-type: none"> <li>a. Review and analyze gaps in the levels of health care services provided across the Indian health system that are a result of the varying levels of IHS funding, facilities infrastructure, staffing packages, and third-party collections;</li> <li>b. Gather evidence on utilization, third party collection data;</li> <li>c. Identify conditions that have lead to the poor health of AI/AN across the country;</li> <li>d. Identify models of Indian health care delivery that are successful;</li> <li>e. Identify and recommend actions for revising statutes and regulations that impede or restrict access to funding or services needed to systematically improve the health of AI/AN across the country.</li> <li>f. Submit a report back to the Secretary within 12 months of convening.</li> <li>g. The Secretary, acting through the IHS Director shall appoint members of the Commission and must include a majority membership of tribal representatives.</li> <li>h. The Task Force shall submit its recommendations to the HHS Secretary one year after enactment of the health reform bill.</li> </ol>
	Required Collection of Data	<ol style="list-style-type: none"> <li>1. Health reform legislation must include funding to develop, and support implementation by all I/T/Us, a system for monitoring ,measuring and evaluating the needs of the Indian health system to assure that budgetary resources support the level of need throughout the system and improve the quality and effectiveness of care.</li> </ol>
	Data Collection Methods	
	Standardized Categories for Data	
	Public Reporting, Transparency, and Education	<ol style="list-style-type: none"> <li>1. Beginning one year after enactment of the health reform bill, the Secretary shall submit a report to Congress regarding enrollment and health status of AI/ANs receiving items or services under Medicaid, Medicare, CHIPRA, or other health benefit programs funded under the health reform bill in order to evaluate health care outcomes. Each report shall include the following: <ol style="list-style-type: none"> <li>a. Total number of AI/ANs enrolled in, or receiving items or services, under such programs.</li> <li>b. The number of Indians described above that also received benefits under programs funded by the</li> </ol> </li> </ol>

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Section	Policy Issue	Recommendations
		<p>Indian Health Service.</p> <p>c. General information regarding the health status of the Indians described above disaggregated with respect to specific diseases or conditions and presented in a manner that is consistent with protections for privacy of individually identifiable health information under section 264(c) of the Health Insurance Portability and Accountability Act. of 1996.</p> <p>d. Provide a specific appropriation to fund this report.</p>
	Language Access	
	Elimination of Five-year Waiting Period for Non-Pregnant Adults	
	Reduction in Infant Mortality and Improved Maternal Well-Being	NPAIHB wants to thank Senate Finance for specifically including tribes as entities eligible to apply.

**Transforming the Health Care Delivery System:  
Proposals to Improve Patient Care and Reduce Health Care Costs  
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Section	Policy Issue	Recommendations
<b>Section I: Payment Reform - Options to Improve the Quality and Integrity of Medicare Payment Systems</b>	<i>Page 2</i>	
<ul style="list-style-type: none"> <li>Physician Quality Reporting Initiative (PQRI) Improvements and Requirement</li> <li>Quality Reporting</li> </ul>	Linking Payment to Quality Outcomes	1. Extend the option for bonus payments to physicians and clinics that receive FQHC "look alike" status.
<ul style="list-style-type: none"> <li>Primary Care and General Surgery Bonus</li> <li>Payment for Transitional Care Activities</li> </ul>	Primary Care	
<b>Section II: Long-Term Payment Reforms – Options to Foster Care Coordination and Provider Collaboration</b>	<i>Page 11</i>	
	Chronic Care Management	
<ul style="list-style-type: none"> <li>Sustainable Growth Rate (SGR)</li> <li>Medicare Shared Savings Program (i.e. Accountable Care Organizations)</li> <li>Extension and Expansion of the Medicare Health Care Quality Demonstration Program</li> </ul>	Moving From Fee-for-Service to Payment for Accountable Care	

**Transforming the Health Care Delivery System:  
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Section	Policy Issue	Recommendations
<b>Section III: Health Care Infrastructure Investments – Tools to Support Delivery System Reform</b>	<i>Page 19</i>	<ol style="list-style-type: none"> <li>1. Establish a loan guarantee fund and loan repayment program at the Treasury of the United States to be known as the Health Care Facilities Loan Fund to provide to Indian Tribes and tribal organizations direct loans, or guarantees for loans, for construction of health care facilities (including but not limited to inpatient facilities, outpatient facilities, associated staff quarters and specialized care facilities—such as behavioral health and elder care facilities).</li> </ol>
<ul style="list-style-type: none"> <li>• Encouraging Health Information Technology Use and Adoption in Support of Delivery System Reform Goals</li> <li>• Improving Quality Measurement</li> </ul>	Health IT	<ol style="list-style-type: none"> <li>1. Health information technology 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 a fair share of resources for improving health information technology and that Indian health providers are not penalized for lack of information technology.</li> <li>2. Health reform legislation must include funding to develop, and support implementation by all providers within the I/T/U of, a system for monitoring ,measuring and evaluating the needs of the Indian health system to assure that budgetary resources support the level of need throughout the system and improve the quality and effectiveness of care.</li> </ol>
	Comparative Effectiveness Research	<ol style="list-style-type: none"> <li>1. Ensure that Tribes and Tribal organizations as defined by the ISDEAA are included in the national framework to set national priorities and eligible to conduct such research.</li> </ol>
<ul style="list-style-type: none"> <li>• Physician Payment Sunshine</li> <li>• Physician-Owned Hospitals</li> <li>• Nursing Home Transparency</li> </ul>	Transparency	
<ul style="list-style-type: none"> <li>• Redistribution of Unused GME Slots to Increase Access to Primary Care and Generalist Physicians</li> <li>• Promoting Greater Flexibility for Residency Training Programs</li> <li>• TANF Health Professions Competitive Grants</li> <li>• Proposal on Development of a National Workforce Strategy</li> </ul>	Workforce	<ol style="list-style-type: none"> <li>1. The proposed coordinated national strategy to address health care workforce shortages must be included as a key focus area in the Indian health delivery system:               <ol style="list-style-type: none"> <li>a. Expand training and funding for mid-level providers and allied providers who have proven records of providing quality care, such as, but not limited to, community health representatives, community health aides, behavioral health aides, and dental health aide therapists.</li> <li>b. Resources for training, recruiting and retaining health providers should be made available to the I/T/U directly.</li> <li>c. Indian health programs must be provided with the resources needed to enable them to compete for health care professionals, to recruit personnel to fill existing vacancies, and to retain existing staff.</li> <li>d. Funding for scholarship and loan programs to encourage Indian people to enter the health professions and serve in Indian health programs must be enhanced.</li> </ol> </li> <li>2. Unlimited access to the National Health Service Corp should be made available to the I/T/U.               <ol style="list-style-type: none"> <li>a. Mechanisms for assignment of National Health Service Corps personnel should be revised to enable tribally operated programs to access these personnel on the same basis as the Indian Health Service.</li> </ol> </li> </ol>

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Section	Policy Issue	Recommendations
		3. Unlimited access to Nursing education loan repayment program be made available to the ITU.
<b>Section IV: Medicare Advantage – Options to Promote Quality, Efficiency and Care Management</b>	<i>Page 37</i>	
<b>Section V: Public Program Integrity - Options to Combat Fraud, Waste and Abuse</b>	<i>Page 42</i>	
	Provider Screening	
	Data Base Creation and Data Matching	
	Provider Compliance and Penalties	
	Program Integrity Funding and Reporting Requirements	

**Financing Comprehensive Health Care Reform:  
Proposed Health System Savings and Revenue Options  
Finance Committee Paper - May 20, 2009**

Section	Policy Issue	Recommendations
<b>SECTION I: Health System Savings</b>	<i>Page 4</i>	
<ul style="list-style-type: none"> <li>o Improving Payment Accuracy through Adjusting Annual Market Basket Updates</li> <li>o Updating Payment Rates for Home Health Services</li> <li>o Updating Payment Rates for Inpatient Services</li> <li>o Adjusting Reimbursement for High-Growth, Over-Valued Physician Services</li> <li>o More Appropriate Payment for Durable Medical Equipment</li> <li>o Increase the Medicaid Brand-Name and Generic Drug Rebate Amounts</li> <li>o Extend to and Collect Rebates on Behalf of Managed Care Organizations</li> <li>o Application of Rebates to New Formulations of Existing Drugs</li> </ul>	Ensuring Appropriate Payment	1. Authorize the extension of the Medicare Modernization Act of 2003 (MMA) (Section 506) “Medicare like rates” to all Medicare participating providers. This would save I/T CHS significant money without costing the federal government anything. Expand from current hospital policy to all Medicare providers.
	Capturing Productivity Gains	
	Reducing Geographic Variation in Spending	

**Financing Comprehensive Health Care Reform:  
Proposed Health System Savings and Revenue Options  
Finance Committee Paper - May 20, 2009**

Section	Policy Issue	Recommendations
<ul style="list-style-type: none"> <li>○ Making Beneficiary Contributions More Predictable</li> <li>○ Means Testing Part D Premiums</li> </ul>	Modifying Beneficiary Contributions	
<b>SECTION II: Options to Modify the Exclusion for Employer-Provided Health Coverage</b>	<b>Page 16</b>	<ol style="list-style-type: none"> <li>1. AI/AN are entitled to receive health care as a federal trust responsibility. As such, AI/AN (as defined in the Legal citations) must be exempt from any personal income tax on health benefits, services, premiums or cost sharing paid or provided on their behalf.</li> <li>2. (See attached explanation and proposed language)</li> </ol>
<b>SECTION III: Other Health Care Related Revenue Raisers</b>	<b>Page 18</b>	
	Modify or Repeal the Itemized Deduction for Medical Expenses	
	Repeal of Modify the Special Deduction and Special Unearned Premium Rule for Blue Cross and Blue Shield or Other Qualifying Organizations	
	Modify Health Savings Accounts	
	Modify or Repeal the Exclusion for Employer-Provided Reimbursement of Medical Expenses Under Flexible Spending Arrangements and Health Reimbursement Arrangements	
	Limit the Qualified Medical Expense Definition	
	Modify FICA Tax Exemption	
	Extend Medicare Payroll Tax to all State and Local Government Employees	
	Modify the Requirements for Tax-Exempt Hospitals	
<b>SECTION IV: Lifestyle Related Revenue Raisers</b>	<b>Page 33</b>	
	Impose a Uniform Alcohol Excise Tax	
	Enact a Sugar-Sweetened Beverage Excise Tax	
<b>SECTION V: Administration's Revenue Raising Proposals</b>	<b>Page 35</b>	