



NPAIHB POLICY UPDATE INDIAN HEALTH LEGISLATION IN 109TH CONGRESS

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Legislative Update on Indian Health Legislation in the 109th Congress

Indian Health Care Improvement Act (S. 1057)

The Senate Committee on Indian Affairs earlier in this legislative session favorably reported out on S. 1057, a bill to reauthorize the Indian Health Care Improvement Act (IHCIA). The bill, introduced on May 17, 2005 by Senators John McCain (AZ) and Byron Dorgan (ND), is the key Federal law that authorizes appropriations for Indian Health Service (IHS) programs. It establishes the basic programmatic structure for delivery of health services to Indian people and authorizes the construction and maintenance of health care and sanitation facilities in Indian Country. Since its initial enactment in, the IHCIA has been periodically reauthorized and amended, most notably in 1988 and 1992. The IHCIA provisions expired in FY 2000 however Congress extended them for one year through FY 2001; since then, no further extension of the IHCIA has occurred.

On December 20, 2005, Senator Charles Grassley (IA) placed a hold on S. 1057 requesting that Majority Leader Bill Frist (TN) inform him—as Chair of the Finance Committee—before entering in any unanimous consent agreement related to S. 1057. Senator McCain had hoped to bring S. 1057 under a unanimous consent agreement in order avoid other committee referrals and possible objections. Senator Grassley has indicated his objection with the IHCIA legislation that exempts AI/ANs from co-payments, premiums, and other deductibles in the Medicaid and SCHIP programs. He also objects to the estate recovery exemptions in determining Medicaid eligibility. The basis of Senator Grassley's objection is treating one "group" differently than others in Medicaid. Clearly the senator's objections relate to racial groups versus the political distinction of Tribes. It is evident that many, including the Senate leader, continue do not understand the nature of the Federal trust relationship. The senator has requested additional information and justification from the Indian Affairs committee so that he better understands the reasons for the provisions. It is anticipated that this process could take as long as two to three months to resolve given other priorities of the Finance Committee.

It is expected that Representative Don Young (AK) will be introducing a companion bill in the House sometime shortly. Representative Young has been awaiting the Senate mark up bill in order to align as many of the House provisions to the Senate version. Last year, Representative Young introduced H.R. 2440, which was developed by the National Steering Committee for the reauthorization of the IHCIA, and used by Sen. Campbell to adopt the Senate version of the bill (S. 556) in the 108th Congress.

On October 27, 2005, the SCIA held its mark up on S. 1057 with the bill being reported favorably out of committee. Committee members did offer technical amendments to the bill. Senator McCain offered an amendment in the form of a substitute to address some of the known concerns of the Administration. Senator Dorgan offered a three part amendment that included increasing the number of psychology scholarship programs from three to nine, creating a tele-health demonstration for mental health, and making teen suicide a research priority for IHS. An amendment offered by Senator Coburn (OK) was defeated which would have limited the Dental Health Aide program. Chairman McCain did offer a compromise that would limit the program to Alaska and require the completion of a study on the

effectiveness of the program with committee members agreeing to the compromise. Finally, Senator Crapo (ID) amendment to create an Office of Men's Health within IHS was approved.

On July 14, 2005, the Senate Committees on Indian Affairs (SCIA) and Health, Education, Labor, and Pensions conducted a joint hearing on S. 1057. The witness list included Dr. Charles Grim, IHS Director, testifying on behalf of the Administration and tribal representatives that included Rachael Joseph, IHCIA National Steering Committee, Don Kashavaroff, Tribal Self-Governance Advisory Committee, Richard Brannan, Chairman, Arapahoe Tribe, and Ralph Forquera, Seattle Indian Health Board. The most significant issues discussed during the hearing were the Dental Health Aide Program, the requirement for a GAO study on the condition of health facilities, and the need for expanded behavioral health services in Indian Country.

Medicaid Indian Health Act of 2005 (S. 2074 and H.R. 4447)

Two bills have been recently introduced in an effort to bring certain protections to American Indian and Alaska Native (AI/AN) people participating in the Medicaid program. The proposed bills address issues that are currently underway in budget reconciliation and/or in proposals being considered by the Medicaid Commission. Senator Jeff Bingaman (NM-D) and Representative Frank Pallone (NJ) have both introduced similar bills titled, "Medicaid Indian Health Act of 2005," that will amend Medicaid program by providing the following:

1. Apply 100% of the federal medical assistance percentage (FMAP) to services furnished to an Indian by an urban Indian health program;
2. Prohibit the imposition of premiums, deductibles, co-payments, and other cost-sharing on Indians in the Medicaid program;
3. Prohibit estate recovery against AI/AN in the Medicaid program;
4. Require consultation with Indian tribes prior to approval of "Section 115" waivers;
5. Provide for the treatment of medical expenses paid by or on behalf of an Indian by an Indian health program as medical care costs for purposes of determining medically needy eligibility; and
6. Give states the option to exempt Indians from reductions in eligibility or benefits.

Both the Senate (S. 2074) and House (H.R. 4447) bills require Medicaid managed care organizations contracting with the Indian Health Service (IHS) or a Tribal program that is not a federally-qualified health center or a rural health clinic to provide payment at the highest level and amount that it would make for the services if they were furnished by a provider that is not an IHS facility or program.

Medicaid for American Indians and States Act of 2005 (S. 1572)

S.1572, introduced by Senators Bingaman (NM) and Johnson (SD) would amend Title XIX of the Social Security Act to clarify the application of the 100 percent Federal Medical Assistance Percentage (FMAP) under the Medicaid program for services provided by IHS and Tribal health programs directly or through referral, contract, or other arrangement. The legislation specifies that such services must be provided under a state plan and received at or by written medical referral from an IHS facility (whether operated by the IHS or by an Indian tribe or tribal organization) and shall apply to items and services furnished on or after January 1, 1997, and to previously disallowed payments.

This bill will attempt to bring consistency to the interpretation of "medical services received through an IHS facility." The IHCIA provides 100 percent FMAP for applicable Medicaid services received "through an Indian Health Service facility." This definition has created some issues for state Medicaid

programs when applying the full FMAP rate for services provided to AI/ANs that are referred by an IHS or Tribal facility to a non-IHS facility. The states of North Dakota and South Dakota have recently had favorable court decisions overturned on this issue. The Centers for Medicare & Medicaid Services (CMS) has determined that the 100 percent FMAP is not allowable for referred services outside of an IHS facility. The two states prevailed in an earlier lawsuit at the District court level however a Federal appeals court has now reversed the lower court's decision and affirmed that those states must repay CMS for the excess payments.

While the court sided in favor of CMS, the decision states that there is a lack of clarity in the statute pertaining to how referred patients are covered through the Federal match. CMS disallowed \$4 million in payments that South Dakota's Department of Social Services had billed Medicaid through the 100 percent FMAP for Indian patients seen in non-IHS facilities through referrals. At issue is a lack of specificity regarding how far "received through" should extend. The Federal court decision even states "the statutory language is susceptible to multiple interpretations."

The legislation will clarify the statute and make it completely clear that any services provided under a state Medicaid plan which are referred by an IHS facility, whether operated by the IHS or a Tribe, are covered by the 100 percent FMAP amount. The bill also provides for previous disallowed claims to be reviewed by HHS and if they meet standards set forth in the bill to be paid by CMS.

American Indian Elderly and Disabled Access to Health Care Act of 2005 (S. 1239)

S. 1239, introduced by Sen. McCain, will amend the IHCA to authorize the IHS, Tribal and urban health programs to utilize funding they receive to operate health programs to pay the monthly part D premium for eligible Medicare Part D (Voluntary Prescription Drug Benefit Program) beneficiaries. Currently, these funds can be used for paying Medicare Parts A and B premiums but not Part D, and this legislation will enable eligible Indian beneficiaries to enroll and participate in the Part D program when it begins in January 2006. The legislation will increase the ability of the elderly and disabled American Indians and Alaska Natives to access the prescription drug benefits available under Medicare Part D and assist the IHS health programs achieve potentially significant cost savings.

Albuquerque Indian Health Center Act of 2005 (S. 972)

S. 972, a bill introduced by Sen. Bingaman, will designate the Albuquerque Indian Health Center as a critical access facility and directs the Secretary of Health and Human Services to provide funds made available under the Act to carry out its operations. Senator Bingaman indicates that this legislation is needed to address a crisis in the delivery of health care at the Albuquerque Indian Health Center, which provides critical primary, urgent, and oral health care services to more than 30,000 urban Indians living in the Albuquerque area. About 50 percent of the base appropriation to the Albuquerque Service Unit goes to Tribes who are delivering their own health care services. However, the demand at AIHC has not decreased due to the constant underfunding of IHS, and AIHC now receives \$5 million less than it did just a few years ago. As a result, AIHC is running a severe deficit and IHS has directed AIHC to begin the process of a reduction in force, that will result in a significant downsizing of clinical personnel and the closure of the urgent care unit which sees an estimated 120 patients a day. This bill would designate AIHC as a "critical access facility" for the region with additional funding of \$8 million to address its shortfall and allow AIHC to be restored as a comprehensive ambulatory care center for urban Indians in the region.