



# NPAIHB POLICY BRIEF

## INDIAN HEALTH LEGISLATION IN 109<sup>TH</sup> CONGRESS

PREPARED BY: NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Issue No. 19, October 17, 2006

### **Update on Indian Health Legislation in the 109<sup>th</sup> Congress**

#### Indian Health Care Improvement Act (S. 1057)

The three Senate committees with jurisdiction over S. 1057, a bill to reauthorize the Indian Health Care Improvement Act, have favorably reported the bill out of committee. Those committees include the Senate Committee on Indian Affairs (SCIA), Finance Committee, and the Health, Education, Labor, and Pensions Committee. The Senate budget committee, to a limited extent, also weighed in on budget points of order concerns raised by its members however those issues were resolved favorably, paving the way for the bill to be brought to the floor of the Senate for passage.

The SCIA and HELP committees held a joint hearing on the bill on July 14, 2005; with the SCIA passing the bill out of committee on October 7, 2005. On July 12<sup>th</sup>, the Finance Committee approved the provisions under its jurisdiction by amending the bill and passing a separate piece of legislation (S. 3524), a bill to amend Titles XVIII, XIX, and XXI of the Social Security Act to improve health care provided to Indians under the Medicare, Medicaid, and State Children's Health Insurance Programs. The provisions of this bill will correct some of the negative consequences resulting from passage of the Deficit Reduction Act. The Finance Committee bill exempt Indian people participating in the Medicaid program from cost sharing and allow states to accept Tribal enrollment documents as proof of citizenship in order to be enrolled in the Medicaid program.

On September 15, 2006, the bill was “hot-lined” for passage with amendments from the Finance and HELP Committees. Hot-lining is a legislative procedure in which a bill is circulated to all Senate members with a 72 hour window to raise objections; if no Senator objects, the bill passes by unanimous consent. There were four holds placed on the bill after the hot-line call went out. The IHICIA National Steering Committee was working to clear the final hold by the Republican Steering Committee, when an unofficial Department of Justice (DOJ) white paper was provided to key Senators objecting to fundamental Indian health policy principles. The DOJ white paper questions the Federal government’s responsibility to provide health services under the federal trust relationship. (See Policy Brief No. 18: *Reauthorization of IHICIA Update*, October 9, 2006)

The DOJ white paper surfaced on September 29<sup>th</sup>, the final day of Congress meeting prior to recessing for the November elections. Because Tribes received the DOJ document so late there was no one to respond to before the Senate recessed. The DOJ is not printed on letterhead, is not dated, nor signed by anyone—and does not include any information as to what office or person issued it. Leaving Tribal leadership in complete limbo as to who to respond?

While the DOJ white paper has not killed the bill, but it did serve to derail passage of the IHICIA. The DOJ subterfuge occurred during the late hours on the final day before Congress recessed for the November elections; and quite possibly leaving the bill to linger and die in a lame duck session when Congress reconvenes in November.

Tribal leaders have requested meetings with senior officials at the White House and DOJ to address and resolve the issues outlined in the white paper. Pending the outcome of these meetings and resolution of the issues presented in the DOJ white paper will determine the status of S. 1057 in the remaining days of the 109<sup>th</sup> Congress.

#### Indian Health Care Improvement Act (H.R. 5312)

The House companion bill to reauthorize the Indian Health Care Improvement Act (H.R. 5312) was introduced by Representative Don Young (AK) on May 9, 2006. The bill has 28 co-sponsors that include only one Northwest representative from the State of Washington (Rep. Jay Inslee). H.R. 5312 mirrors its Senate version in that it includes the work that was done by the Finance Committee (S. 3524). The committees that have jurisdiction over H.R. 5312 include the House Resources, Ways and Means, and Energy and Commerce. The Committee on Resources favorably reported H.R. 5312 out of committee on September 14, 2006. The House Committee on Ways and Means was granted an extension to further consider the bill through November 17, 2006. Before Congress recessed for the November elections, Indian health advocates sent a barrage of letters to Ways and Means members to encourage them to take up and approve the bill during this 109<sup>th</sup> session. Prior to this, it was questionable if Ways and Means was going to take up the bill during the final days of this legislative session.

#### Medicare, Medicaid, SCHIP Indian Health Improvement Act of 2006 (S. 3524)

The Finance Committee passed S. 3524, the Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2006 on June 8, 2006. S. 3524 is an original bill encompassing provisions of S. 1057, that fall into the Finance Committee's jurisdiction—i.e., issues related to Medicare, Medicaid, and SCHIP. The Finance Committee's work amends titles XVIII (Medicare), XIX (Medicaid), and XXI (SCHIP) of the Social Security Act to extend the eligibility of the Indian Health Service (IHS) for payments under such programs to Indian Tribes, Tribal Organizations, and Urban Indian Organizations.

The bill amends SSA title XI to eliminate the National Commission on Children and require the HHS Secretary to encourage states to take steps to provide for enrollment in Medicaid and SCHIP programs on or near Indian reservations. The bill also directs CMS to take steps necessary to facilitate cooperation with, and agreements between, states and the IHS and other Indian health programs for the provision of health care items and services to Indians under the Medicare, Medicaid, and SCHIP programs. S. 3524 will allow the use of documents issued by a federally-recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe as a document evidencing U.S. citizenship or nationality for Medicaid eligibility purposes. The bill further amends the Title XIX to prohibit premiums or cost sharing for Indians furnished items of services directly by Indian health programs or through referral under the contract health service and exempts Indian people from Medicaid and SCHIP estate recovery rules.

S. 3524 amends SSA Title XI to require non-discrimination in qualifications for services provided by an Indian health program under a federal health care program and prohibits federal payments to entities or individuals excluded from participation in federal health care programs or whose state licenses are under suspension or have been revoked. It further requires the Secretary to maintain the CMS Tribal Technical Advisory Group and adds a representative for Urban Indian Organizations and the IHS.

The bill amends Title XIX to require the Medicaid plan, for any state in which the IHS operates or funds health care programs, or in which one or more Indian health programs provide health care for which

Medicaid is available, to provide for a process under which the state seeks advice on a regular, ongoing basis from designees of such programs on matters (including plan amendments, waiver requests, and proposals for demonstration projects) likely to have a direct effect on them. S. 3524 grants the HHS Secretary authority to waive the exclusion of certain individuals and entities from participation in affected Indian health programs and deems safe harbors for any transfers of anything of value, meeting certain criteria, between or among Indian health programs made to provide necessary health care items and services to patients related to: (1) diagnostic specimens or test data; (2) inventory or supplies; (3) staff; or (4) a waiver of all or part of premiums or cost sharing.

Finally, the bill sets forth rules applicable under Medicaid and SCHIP to managed care entities with respect to Indian enrollees, Indian health care providers, and Indian managed care entities. Requires a non-Indian Medicaid managed care entity to allow an Indian enrollee to choose an Indian health care provider as the Indian's primary care provider and prescribes requirements for payment by a managed care entity of participating and non-participating Indian health care providers.

The Finance Committee intention is that the provision of S. 3524 will be incorporated into S. 1057 when it is considered by the full Senate. The bill passed unanimously out of the Finance Committee on July 12, 2006.

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

Two bills have been recently been 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.

S. 2074 was referred to the Finance Committee on November 18, 2005 with no further action taken to date. H.R. 4447 was referred to the House Energy and Commerce Committee's subcommittee on Health on December 16, 2006 with no further action taken to date.

### 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 IHCA 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.

S. 1572 was referred to the Senate Finance Committee on July 29, 2005 with no further action taken to date.

### 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.

S. 1239 was referred to the SCIA on June 14, 2005 and reported favorably without any amendments on July 29, 2005. A bill report has not been filed as of to date.

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.

S. 972 was referred to the SCIA on April 28, 2005 with no further action taken to date.

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](http://www.npaihb.org) or contact Jim Roberts, Policy Analyst, at (503) 228-4185 or by email [jroberts@npaihb.org](mailto:jroberts@npaihb.org).