# Indian Health Care Improvement Act Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)

**Elayne J. Heisler**
Analyst in Health Services

**Roger Walke**
Specialist in American Indian Policy

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# Summary

On March 23, 2010, President Obama signed into law a comprehensive health care reform bill, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148). The new law will, among other things, reauthorize the Indian Health Care Improvement Act (IHCIA). In addition, it makes several changes related to American Indians and Alaska Natives enrolled in and receiving services from the Medicare, Medicaid, and Children's Health Insurance Program (CHIP)—also called Social Security Act (SSA) health benefit programs.

IHCIA authorizes many programs and services provided by the Indian Health Service (IHS), it sets out the national policy for health services administered to Indians, and it states the federal goal to ensure the highest possible health status for Indians, including urban Indians. In addition, it authorizes direct collections from Medicare, Medicaid, and other third-party insurers. This report, one of a series of CRS products on PPACA, summarizes some of the key changes made in the reauthorization of IHCIA. In addition, the report summarizes the provisions related to American Indians and Alaska Natives enrolled in and receiving services from SSA health benefit programs.

PPACA will extend the authorizations of appropriations for IHCIA programs indefinitely. It will also permit tribal organizations (TOs) and urban Indian organizations (UIOs) to apply for contract and grant programs for which they were not previously eligible. The law also expands the mental health services authorized under IHCIA to create comprehensive behavioral health and treatment programs. In addition, it requires IHS to establish new programs related to youth suicide prevention and requires demonstration projects to construct modular and mobile health facilities in order to expand health services available through IHS, Indian Tribes (ITs), and TOs.

With regard to SSA health benefit programs, PPACA permits specified Indian entities to determine Medicaid and CHIP eligibility and extends the period during which IHS, IT, and TO services are reimbursed for all Medicare Part B services, indefinitely, beginning January 1, 2010. Under current law, authority for these facilities to receive Medicare Part B reimbursements for certain specified services expired on January 1, 2010.

PPACA also makes several organizational changes to IHS. IHS is required to establish an Office of Direct Service Tribes to serve tribes that receive their health care and other services directly from IHS as opposed to receiving services through IHS-funded facilities or programs operated by ITs or TOs. In addition, the bill requires a plan to establish a new area office to serve tribes in Nevada and a new IHS Director of HIV/AIDS Prevention and Treatment.

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# Introduction

On March 23, 2010, President Obama signed into law a comprehensive health care reform bill, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), as passed by the Senate on December 24, 2009, and the House on March 21, 2010. The new law will, among other things, reauthorize the Indian Health Care Improvement Act (IHCIA). On March 25, 2010, the Senate modified and passed the accompanying reconciliation bill (H.R. 4872, the Health Care and Education Reconciliation Act of 2010), which had been passed by the House on March 21, 2010. The reconciliation bill changes several controversial elements in H.R. 3590—none of these changes modifies IHCIA—and otherwise amends the underlying legislation so that its budgetary impact meets the reconciliation instructions in last year's budget resolution.[1] The House reapproved the reconciliation measure, with Senate modifications, on March 25, 2010. It was cleared for the White House the same day, and signed into law by the President on March 30.

This report, one of a series of CRS products on PPACA, summarizes some of the key changes made in the reauthorization of IHCIA. In addition, the report summarizes the provisions related to American Indians and Alaska Natives enrolled in and receiving services from Medicare, Medicaid, and the Children's Health Insurance Program (CHIP)—also called SSA health benefit programs.[2]

The report begins with an overview of the Indian Health Service (IHS) and IHCIA. It then discusses each of the eight titles in IHCIA and how PPACA amends each of these titles. Finally, the report discusses how PPACA amends other acts related to Indian health. For each title discussed, the report first gives a brief description of the context, and then describes the changes made by PPACA.

# Overview of Indian Health Care

The Indian Health Service (IHS), an agency in the Department of Health and Human Services (HHS), provides health care for approximately 1.8 million eligible American Indians/Alaska Natives through a system of programs and facilities located on or near Indian reservations, and through contractors in certain urban areas.[3] IHS is organized into 12 Areas administered by an Area Office; Areas, in turn, are further subdivided into service units. IHS may provide services directly, or Indian tribes (ITs) or tribal organizations (TOs) may operate IHS facilities and programs themselves through self-determination contracts and self-governance compacts negotiated with IHS.[4] Although most IHS facilities are located on or near reservations, IHS also

[1] Under the FY2010 budget resolution (S.Con.Res. 13), a health reform reconciliation bill must reduce the federal deficit by $1 billion over the period FY2009 through FY2014, as determined by the Congressional Budget Office.

[2] Other provisions in PPACA may also affect Indian health. For example, Indian tribes may be eligible for new grant or contract programs that augment the health care workforce or improve public health, they may participate in reforms made to the private insurance market, and they may benefit from Medicare and Medicaid reforms. More information about PPACA changes can be found at CRS's website under "Issue in Focus-Health Reform" at http://www.crs.gov/Pages/subissue.aspx?cliid=3746&parentid=13.

[3] Additional information about IHS can be found in CRS Report RL33022, *Indian Health Service: Health Care Delivery, Status, Funding, and Legislative Issues*, by Roger Walke.

[4] Authorized by P.L. 93-638, the Indian Self-Determination and Education Assistance Act of January 4, 1975, 88 Stat. 2203, as amended; 25 U.S.C. 450 et seq.

funds urban Indian health projects (UIHPs), through grants or contracts to urban Indian organizations (UIOs).

The IHS provides an array of medical services, including inpatient, ambulatory, emergency, dental, public health nursing, and preventive health care.[5] The IHS does not have a defined medical benefit package that excludes or includes specific conditions or types of health care. Besides providing general clinical health services, the IHS also focuses on special Indian health problems such as maternal and child health, diabetes, and hepatitis B. In addition, IHS provides mental health and alcohol and substance abuse services, because American Indians and Alaska Natives are more likely to die from alcoholism-related diseases or accidents.[6]

In addition to health services, the IHS funds projects related to health care facilities and sanitation. Specifically, the IHS will fund the construction, equipping, and maintenance of hospitals, health centers, clinics, and other health care delivery facilities, both those operated by the IHS and those operated by tribes. In order to improve the health of, and reduce the incidence of disease among, American Indians and Alaska Natives, the IHS will also fund the construction of water supply and sewage facilities and solid waste disposal systems, and it has provided technical assistance for the operation and maintenance of such facilities. The IHS has attributed decreases in gastrointestinal disease among American Indians and Alaska Natives to improved sanitation facilities.[7]

# Indian Health Care Improvement Act

The Indian Health Care Improvement Act authorizes many specific IHS activities,[8] it sets out the national policy for health services administered to Indians, and it states the federal goal for the health condition of the IHS service population, which is to "assure the highest possible health status for Indians and urban Indians."[9] IHCIA also authorizes direct collections from Medicare, Medicaid, and other third-party insurers for American Indians and Alaska Natives receiving services at facilities operated by the IHS, an IT, or a TO. IHCIA also gives IHS authority to grant funding to urban Indian organizations to provide health care services to urban Indians, and establishes substance abuse treatment programs, Indian health professions recruitment programs, and many other programs. Prior to PPACA, IHCIA was last fully reauthorized by the Indian Health Amendments of 1992,[10] which extended authorizations of its appropriations through FY2000. In 2000, all IHCIA appropriations authorizations were extended through FY2001.[11] Congress has continued to appropriate funds for IHCIA programs since 2001.[12] IHCIA

[5] See 42 CFR 136.11, "Services available."

[6] See Table 3 in CRS Report RL33022, *Indian Health Service: Health Care Delivery, Status, Funding, and Legislative Issues*, by Roger Walke, pp. 3, 9-10.

[7] U.S. Department of Health and Human Services, Indian Health Service, *Justification of Estimates for Appropriations Committees, Fiscal Year 2007*, pp. IHF-9-IHF-10.

[8] In addition to IHCIA, the Snyder Act of 1921 (P.L. 67-85, act of November 2, 1921, 42 Stat. 208, as amended; 25 U.S.C. 13) also authorizes Indian health programs.

[9] IHCIA, § 3(a); 25 U.S.C. 1602(a).

[10] P.L. 102-573, act of October 29, 1992, 106 Stat. 4526.

[11] Omnibus Indian Advancement Act, P.L. 106-568, § 815, act of December 27, 2000, 114 Stat. 2868, 2918.

[12] For a discussion of the relationship between appropriations and authorizations, see CRS Report RS20371, *Overview of the Authorization-Appropriations Process*, by Bill Heniff Jr.

reauthorization had been under consideration in Congress since 1999.[13] In the current Congress, IHCIA reauthorization bills were introduced in the House (H.R. 2708) and the Senate (S. 1790), and were included in the House health reform bill, H.R. 3962, and in the Senate bill, H.R. 3590 (PPACA).

## IHCIA Reauthorization in PPACA

Title X, "Strengthening Quality, Affordable Health Care for All Americans," of PPACA in Subtitle B, "Provisions Relating to Title II," Part III, amends and enacts S. 1790, the "Indian Health Care Improvement Reauthorization and Extension Act of 2009," as reported by the Senate Committee on Indian Affairs on December 16, 2009. In addition, Title II, "Role of Public Programs," Subtitle K, "Protections for American Indians and Alaska Natives," contains provisions related to American Indians and Alaska Natives in SSA health benefit programs and in the private health insurance exchange established by PPACA.[14] PPACA reauthorizes IHCIA permanently and indefinitely; it appropriates such sums as may be necessary for FY2010 and each fiscal year thereafter, to remain available until expended.

## Definitions

PPACA defines a number of new Indian-related terms. Two of the new terms most frequently used are Indian Health Program and Tribal Health Program. "Indian Health Program" (IHP) is defined as (1) any health program administered by the IHS, (2) any Tribal Health Program, or (3) any Indian tribe or tribal organization to which the Secretary provides funding under the Buy Indian Act. "Tribal Health Program" (THP) is defined as any IT or TO operating any health program, service, function, activity, or facility funded, in whole or part, by the IHS through, or provided for in, a contract or compact with the IHS under the Indian Self-Determination and Education Assistance Act (ISDEAA). In addition, the bill maintains a number of IHCIA-defined terms.

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[13] IHCIA reauthorization bills were introduced in the 106th (H.R. 3397 and S. 2526), 107th (S. 212 and H.R. 1662), 108th (S. 556 and H.R. 2440), 109th (H.R. 5312, S. 1057, S. 3524, and S. 4122), and 110th (H.R. 1328, S. 1200, and S. 2532) Congresses.

[14] More information about the private health insurance provisions in PPACA can be found in CRS Report R40942, *Private Health Insurance Provisions in Senate-Passed H.R. 3590, the Patient Protection and Affordable Care Act* , by Hinda Chaikind et al.; and CRS Report R41126, *Private Health Insurance: Changes Made by H.R. 4872, the Health Care and Education Reconciliation Act of 2010*, by Hinda Chaikind et al.. In addition, PPACA contains other changes that may affect American Indians and Alaska Natives, but these are not discussed in this report. For Medicare-related changes, see CRS Report R40970, *Medicare Program Changes in Senate-Passed H.R. 3590*, coordinated by Patricia A. Davis; and CRS Report R41124, *Medicare: Changes Made by the Reconciliation Act of 2010 to the Patient Protection and Affordable Care Act (P.L. 111-148)*, coordinated by Patricia A. DavisFor information on Medicaid and Children's Health Insurance Program-related provisions, see CRS Report R41125, *Medicaid and CHIP: Changes Made by the Reconciliation Act of 2010 to the Patient Protection and Affordable Care Act (PPACA, H.R. 3590, P.L. 111-148)*, coordinated by Evelyne P. Baumrucker and Cliff Binder. For public health, workforce, and quality-related changes, see CRS Report R40943, *Public Health, Workforce, Quality, and Related Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)*, coordinated by C. Stephen Redhead and Erin D. Williams.

# Selected Major Changes

**Purposes and Findings:** PPACA adds two findings: (1) that it is a major national goal of the United States to provide resources, processes, and structure that will enable ITs and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate health disparities between Indians and the general population; and (2) that it is a national goal to ensure that the United States and ITs work in a government-to-government relationship to ensure quality health care for all tribal members.

**Appropriations:** PPACA consolidates appropriations authorizations into a single provision, authorizes such sums as may be necessary, and extends authorizations of appropriations indefinitely. It repeals separate authorizations of appropriations in specified IHCIA sections.

**Expanded Access to UIOs and TOs:** PPACA permits TOs and UIOs to apply for grant and contract programs for which these entities were previously not eligible.

**Behavioral Health Programs:** PPACA expands mental health services to create a comprehensive behavioral health and treatment program. It includes programs related to youth suicide prevention and increases IT and TO access to grants sponsored by the Substance Abuse and Mental Health Services Administration (SAMSHA).

**Payor of Last Resort:** PPACA states that IHS is the payor of last resort for all services provided. Under current regulations,[15] IHS is the payor of last resort only for contract health services (CHS)—services that IHS, ITs, or TOs may purchase, through contracts, from private providers in instances where the IHP cannot provide the needed care.

**Indians in SSA Programs:** PPACA extends Medicare payments to hospitals operated by IHS, ITs, or TOs, and permits Indian entities to determine Medicaid and CHIP eligibility in order to facilitate American Indian and Alaska Native enrollment in Medicaid and CHIP.

**Office of Direct Service Tribes:** PPACA requires that IHS establish an Office of Direct Service Tribes, to serve tribes that receive their health care and other services directly from IHS rather than through facilities or programs operated by ITs or TOs.

**Nevada Area Office**: PPACA requires the establishment of a new area office to serve tribes in Nevada.

**Demonstration Projects:** PPACA includes two facilities demonstration projects that will award funds for IHS, ITs, or TOs to construct modular and mobile health facilities.

[15] See 42 C.F.R.136.61.

# Title I: Indian Health, Human Resources, and Development

IHCIA Title I includes provisions related to increasing the number of American Indians and Alaska Natives entering the health professions in order to increase the supply of health professionals available to facilities and programs operated by IHS, ITs, and TOs. The IHS has high vacancy rates in many of its health professions—over 20% for physicians, dentists, and nurses, for instance, as of December 2008.[16] IHCIA authorizes a number of workforce programs, including, for example, scholarship and loan repayment programs, to encourage health professionals to work at facilities operated by the IHS or ITs; funding for continuing education for IHS employees; funding for advanced training and for recruitment and retention for individuals working at facilities operated by the IHS, an IT, a TO, or a UIO; training for nursing; and programs to encourage American Indians and Alaska Natives to enter medicine. In addition, Title I authorizes two innovative health professions programs: the community health representative (CHR) program, which permits the training of American Indians and Alaska Natives to serve as paraprofessionals who provide health care, health promotion, and disease prevention services at IHS facilities; and the community health aide program (CHAP), which provides training for Alaska Natives to serve as health aides or community health practitioners.

PPACA maintains a number of health professions programs authorized in current law. It expands the CHAP program to areas outside of Alaska, but excludes CHAP's dental health aide therapist program in Alaska from states outside of Alaska unless an IT or a TO, in a state authorizing such a program, elects to include it. PPACA also includes additional requirements for the Secretary to facilitate the implementation of the CHAP dental health aide program by ITs and TOs and prohibits the Secretary from filling IHS program vacancies for certified dentists with dental health aide therapists.

# Title II: Health Services

IHCIA Title II authorizes a number of specific health programs and activities, including mental health programs, prevention activities, diabetes and tuberculosis programs, Indian women's health, Indian school health education programs, epidemiological centers, and a fund for the elimination of backlogs and deficiencies among Indian health programs (called the Indian Health Care Improvement Fund (IHCIF)), and other programs. The title also includes provisions relating to contract health services (CHS) delivery areas in several states.[17] CHS refers to services that IHS, ITs, or TOs may purchase, through contracts, from private providers in instances where the Indian health facility cannot provide the needed care. CHS services are limited to American Indians and Alaska Natives living in defined geographic areas called CHS delivery areas.

[16] U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, *Indian Health Service: Fiscal Year 2010 Justification of Estimates for Appropriations Committees* (Rockville, MD: HHS/PHS/IHS, 2009), pp. CJ-147 to CJ-148; http://www.ihs.gov/NonMedicalPrograms/BudgetFormulation/documents/IHS_CJ_2010_Final_Submission.pdf.

[17] These states are Arizona, California, North Dakota, and South Dakota.

PPACA reauthorizes the IHCIF as well as the Catastrophic Health Emergency Fund (which provides extra funding to facilities with extraordinary medical costs because of disasters and catastrophic illnesses). It expands the range of health promotion and disease prevention activities required to be provided, and includes new authorizations for hospice care, assisted living, long-term care, and home- and community-based services for disabled elderly persons. Title II also expands the Indians into Psychology Program, the Indian youth grant program, epidemiology centers, prevention and control of communicable and infectious diseases, requirements for prompt IHS payments to CHS providers, and timely notification to providers that CHS patients are exempt from payment for CHS services.

PPACA also requires the Secretary to maintain any existing or future model diabetes projects, and requires recurring funding for THPs' model diabetes projects.

# Title III: Facilities

IHCIA Title III covers health care and sanitation facilities. IHS funds the construction, equipping, and maintenance of hospitals, health centers, clinics, and other health care delivery facilities for facilities operated by IHS and tribes. IHS also funds the construction of sanitation facilities, including water-supply and sewage facilities and solid waste disposal systems, and provides technical assistance for the operation and maintenance of such facilities. IHCIA currently requires the Secretary to ensure that pay rates on such facility construction or renovation projects, if funded under IHCIA Title III, must not fall below the prevailing local wage rates, as determined in accordance with the Davis-Bacon Act.[18]

PPACA requires the development of a priority system for construction of Indian health care facilities, with a methodology to be reported to Congress, and with priority lists for the 10 highest-priority facilities in five categories of facilities (inpatient, outpatient, specialized facilities, staff quarters, and facility-related hostels). The priority system also permits new facilities to be nominated at least every three years, but protects the priority of facilities at the top of the current lists for construction. The bill also requires consultation with ITs and TOs to develop innovative approaches to solving unmet health-care facility needs, and includes an "area distribution fund" as an option for such innovation. Under the concept of an area distribution fund, each IHS area would receive at least some health facilities construction funding, which was not the case prior to IHCIA reauthorization.

PPACA also creates a facilities needs assessment workgroup and a facilities appropriations advisory board in IHS. It maintains authorization for construction of sanitation and water-supply facilities, requires reports to Congress on the priority system for such facilities, authorizes the Secretary to accept major renovations or modernizations of Indian health facilities carried out by ITs, and requires grants to ITs and TOs for construction or upgrading of small ambulatory care facilities.

[18] Act of March 3, 1931, chap. 411, 71st Cong., 46 Stat. 1494, as amended; 40 U.S.C., Chap. 31, Subchap. IV. The Davis-Bacon Act requires that employers pay prevailing wage rates, as determined by the Secretary of Labor, on federal construction projects. For more information, see CRS Report R40663, *The Davis-Bacon Act and Changes in Prevailing Wage Rates, 2000 to 2008*, by Gerald Mayer.

PPACA also includes a new provision that authorizes the Secretary to accept funding from any other source for facilities construction. It explicitly authorizes other federal agencies to transfer funds, equipment, or supplies to the Secretary for facilities construction and related activities, makes sanitation as well as health care facilities eligible, requires the Secretary to establish health and sanitation facility construction standards by regulation, and specifies that the Secretary's receipt of funds from other sources would not affect priorities established under Section 301 of IHCIA Title III. In addition, PPACA authorizes a new demonstration grant program for modular component health care facilities in Indian communities, and a new demonstration program for mobile health stations for providing specialty health care services.

# Title IV: Access to Health Services

IHCIA Title IV contains sections related to billing, and enrollment in, the Medicare and Medicaid programs operated by the Centers for Medicare and Medicaid Services (CMS);[19] a section authorizing appropriations; and a section authorizing emergency CHS services. The title's authorization for IHS health care facilities to receive reimbursements from the Medicare and Medicaid program was a major component of the original IHCIA passed in 1976. Prior to PPACA, IHCIA did not mention funds received under the Children's Health Insurance (CHIP) program because the program was enacted after IHCIA was last reauthorized.[20]

Title IV contains provisions related to billing and receiving reimbursements from the Medicare and Medicaid programs. Specifically, IHCIA (1) authorizes a demonstration project that permits ITs or TOs operating under ISDEAA contracts or compacts to directly bill CMS for Medicare and Medicaid payments; (2) requires direct billing reimbursements be placed into a "special fund" that must be used first to achieve compliance with Medicare and Medicaid requirements and then, if excess funds exist, to improve health services available to the population the facility serves; (3) specifies the auditing and other requirements related to direct billing; and (4) requires that the federal government pay 100% of the cost of all Medicaid services billed.[21] In addition, IHCIA requires that reimbursements from Medicare or Medicaid may not be considered when determining annual Indian health appropriations, requires the Secretary to submit a report accounting for Medicare and Medicaid funds reimbursed to IHS, and requires the Secretary to make grants to ITs or TOs to facilitate enrollment in Medicare and Medicaid.

PPACA adds CHIP to IHCIA reimbursement requirements. For example, reimbursements received from CHIP are included in the requirement that reimbursements from SSA health benefit programs not be taken into account when determining IHS appropriations. PPACA also expands the rights of ITs and TOs to directly bill SSA health benefit programs and excludes such direct billing reimbursements from the special fund. In addition, PPACA includes grants for outreach and enrollment into SSA health benefit programs and maintains and expands current authorization to recover reimbursements from third-party entities and to credit such reimbursements to the facility that provided the services. In addition, PPACA authorizes ITs, TOs, and UIOs to use SSA

[19] CMS programs are also referred to herein as SSA health benefits programs.

[20] See CRS Report R40130, *The Children's Health Insurance Program Reauthorization Act of 2009*, by Evelyne P. Baumrucker et al.

[21] In general, Medicaid is a shared federal and state program in which the state government pays a share of Medicaid expenses based on a formula where the federal share is inversely proportional to the state's per capita income (i.e., states with lower per capita income receive a greater percentage of Medicaid payments from the federal government).

health benefit funds and ISDEAA funds to purchase health care coverage and permits ITs, TOs, and UIOs to purchase health insurance coverage for their employees. PPACA requires that federal health care programs accept an entity operated by the IHS, an IT, a TO, or a UIO as a provider eligible to receive payments, on the same basis as other qualified providers, if it meets the applicable licensure requirements for its provider type, regardless of whether the facility obtains the applicable license. PPACA also applies this licensing requirement to providers working at Indian entities, and prohibits providers and entities that are excluded from receiving reimbursements from other federal programs from receiving reimbursements from Indian entities.

PPACA also expands IHS's relationship with the Department of Veterans Affairs (VA) and the Department of Defense (DOD) by authorizing increased coordination to treat Indian veterans. In addition, PPACA requires the Secretary to conduct a study to determine the feasibility of treating the Navajo Nation as a state for Medicaid purposes, for Indians living within the Navajo Nation's boundaries.[22]

# Title V: Health Services for Urban Indians

IHCIA Title V directs the HHS Secretary to make contracts with or grants to UIOs for health projects to serve urban Indians, and sets requirements for the contracts and grants. Such grants or contracts are under the authority of the Snyder Act,[23] not the ISDEAA. The purpose of Title V programs is to make health services more accessible and available to urban Indians. Urban Indian Health Projects (UIHPs) may serve a wider range of eligible persons than the general IHS health care programs, including not only members of federally recognized tribes but also members of terminated[24] or state-recognized tribes, as well as their children and grandchildren.

Currently there are 34 UIHPs operating at 41 locations, with different programs offering different services, such as ambulatory health care, health promotion and education, immunizations, case management, child abuse prevention and treatment, and behavioral health services.[25] Besides IHS grants and contracts, UIHPs receive funding from state and private sources, patient fees,[26] Medicaid, Medicare, and other non-IHS federal programs.[27]

PPACA enables UIOs to expand their urban Indian health programs by striking current language that authorizes a UIO to establish a UIHP only in the urban center where it is located. In addition, PPACA provides UIOs access to goods and services purchased through federal prime vendors, by

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[22] The Navajo reservation is located in parts of Arizona, Utah, and New Mexico.

[23] The Snyder Act of 1921 (P.L. 67-85, act of November 2, 1921, 42 Stat. 208, as amended; 25 U.S.C. 13) provides general authorization for Indian health programs. The Snyder Act is a permanent, indefinite authorization for federal Indian programs, including for "conservation of health." For more information on the Snyder Act, see CRS Report RL33022, *Indian Health Service: Health Care Delivery, Status, Funding, and Legislative Issues*, by Roger Walke.

[24] "Terminated" tribes are tribes whose federal recognition was withdrawn by statute.

[25] U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, *Indian Health Service: Fiscal Year 2010 Justification of Estimates for Appropriations Committees* (Rockville, MD: HHS/PHS/IHS, 2009), p. CJ-133; http://www.ihs.gov/NonMedicalPrograms/BudgetFormulation/documents/IHS_CJ_2010_Final_Submission.pdf.

[26] IHS is forbidden to bill or charge Indians (see 25 U.S.C. 1681 and 25 USC 458aaa-14), but IHCIA, Title V does not prohibit UIHPs from charging their patients.

[27] IHS, Office of Urban Indian Health Programs, *Urban Indian Health Program Statistics, FY2005* (Rockville, MD: October 16, 2007), p. 4.

deeming UIOs with Title V contracts or grants to be federal executive agencies under the section of the Federal Property and Administrative Services Act of 1974[28] concerning federal sources of supply. It also authorizes the Secretary to donate excess or surplus property to such UIOs and to permit the UIOs to use HHS facilities. PPACA also expands to UIOs the authorization for a number of programs currently only at IHS, IT, or TO facilities. For example, PPACA authorizes UIOs to employ Community Health Representatives (CHRs) trained under the CHR program authorized under current IHCIA Title I, and authorizes the Secretary to establish programs for UIOs that are identical to IHS programs for prevention of communicable diseases, for behavioral health prevention and treatment, and for youth multi-drug abuse prevention and treatment. PPACA also authorizes grants to UIOs for the development and implementation of health information technology, telemedicine, and related infrastructure.

# Title VI: Organizational Improvements

IHCIA Title VI establishes IHS's organizational position. Under Title VI, IHS is part of the Public Health Service (PHS) within HHS, and is administered by a Director who reports to the HHS Assistant Secretary for Health. IHCIA Title VI also requires the Secretary to establish an automated management information system for IHS and IHPs, with a patient privacy component, and requires that patients have access to their own IHS records.

PPACA maintains the placement of IHS in PHS, but directs the head of IHS to report directly to the HHS Secretary. It also maintains requirements regarding the automated management information system. PPACA also adds two new requirements: the Secretary must establish an IHS Office of Direct Service Tribes (for tribes served directly by IHS instead of under ISDEAA), and the Secretary must submit to Congress a plan to create a new Nevada Area Office (Nevada is currently within the Phoenix Area Office).

# Title VII: Behavioral Health Programs

IHCIA Title VII authorizes alcohol and substance abuse programs, including grant and contract programs to provide comprehensive alcohol and substance abuse prevention and treatment services. It requires coordination with the Department of the Interior to assess the need for such services and to provide community education in alcohol and substance abuse; requires services to specified groups including women and youth; and authorizes training and community education programs, demonstration projects to establish substance abuse counseling education curricula at tribally operated community colleges, and grants for preventing, treating, and diagnosing fetal alcohol syndrome (FAS) and fetal alcohol effects. In addition, Title VII includes authorization for substance abuse treatment projects in specified locations in New Mexico, Arizona, and Alaska.

PPACA replaces current IHCIA Title VII with new language that authorizes programs to create a "comprehensive behavioral health prevention and treatment program" providing a "continuum of behavioral health care." For example, PPACA includes programs related to behavioral health prevention and treatment; provisions related to training and licensure requirements for the behavioral health workforce serving at facilities operated by IHS, ITs, or TOs; specific programs

[28] Sec. 201(a), P.L. 81-152, act of June 30, 1949, 63 Stat. 377, 383, as amended; 40 U.S.C. 501.

to treat Indian women and youth; and programs to treat and prevent child sexual abuse and fetal alcohol disorder. Many of these programs are similar to those authorized in current IHCIA Title VII. PPACA also includes a new program to award grants to ITs and TOs to carry out demonstration projects using telehealth technology to provide youth suicide prevention and treatment services and authorizes appropriations of $1.5 million for each of FY2010-FY2013 for the new program. In addition, PPACA includes authorization for programs to prevent and treat domestic and sexual violence, and includes a number of requirements for the Secretary to facilitate ITs' and TOs' applying for, and inclusion in, grants from SAMHSA. It also requires the Secretary to carry out activities to increase the use of pre-doctoral psychology and psychiatry interns in order to increase access to mental health services, and authorizes the Secretary to establish a demonstration program through SAMSHA to test a culturally appropriate life skills curriculum to prevent suicide in American Indian and Alaska Native adolescents. PPACA also authorizes an appropriation of $1 million for each of FY2010-FY2014 for the Secretary to establish a grant program to award grants to ITs, TOs, or other entities to establish life skills curriculums to prevent suicide in schools located in high suicide areas that serve Indian children.

# Title VIII: Miscellaneous

IHCIA Title VIII includes a number of separate provisions covering reports, regulations, an IHCIA implementation plan, abortion, eligibility for IHS services, service unit funding reductions, and a variety of other topics.

PPACA not only applies the current IHCIA limitation on the use of federal funds for performing abortion to IHS, but it also applies any such limitations contained in other federal laws to IHS appropriations. It also makes IHP and UIO medical quality assurance records confidential, and adds several new required reports. PPACA requires a new report on disease and injury prevention, and two new GAO reports: (1) on the coordination of Indian health care services provided through IHS, Medicare, Medicaid, or CHIP, or with tribal, state, or local funds; and (2) on the CHS program, including CHS payments to providers (since CHS providers still experience late payments).

PPACA also requires that IHS budget requests reflect inflation and changes in the IHS service population, and requires the establishment of a prescription drug monitoring program at IHP and UIO facilities. PPACA also permits a tribe operating an IHS health program through an ISDEAA self-governance compact to charge Indians for services; adds language stating that the United States has no liability for injury or death resulting from traditional health care practices; and establishes an IHS Director of HIV/AIDS Prevention and Treatment.

# Other Provisions

PPACA also includes the reauthorization of the Native Hawaiian Health Care Act of 1988.[29] It extends the act's authorizations of appropriations through FY2019, permits a specified school in Hawaii to offer educational programs to Native Hawaiians first, and amends a definition in the act.

[29] P.L. 100-579, act of October 31, 1988, 102 Stat. 2916, as amended; 42 U.S.C., Chap 122 (§11701 et seq.).

# SSA Health Benefit Improvements for Indians

PPACA amends the SSA to define a number of Indian terms as they are defined in IHCIA Section 4. These terms include IHS, IT, TOs, UIOs, IHPs, and THPs. These definitions apply for Medicare, Medicaid, and CHIP and general provisions included in SSA Title XI.

PPACA includes amendments to the SSA, although these amendments are not included in the "Indian Health Care Improvement" part of the bill. Rather, amendments to the SSA are included in Title II, Subtitle K, "Protections for American Indians and Alaska Natives." In addition, PPACA does the following: (1) it designates facilities operated by IHS, an IT, a TO, or a UIO as the payor of last resort notwithstanding federal or state law to the contrary;[30] (2) it includes IHS, ITs, and TOs as entities that are permitted to determine Medicaid and CHIP eligibility; (3) it prohibits cost sharing for Indians whose incomes are at or below 300% of the federal poverty level and who are enrolled in a qualified health benefit plan in the individual market through the exchange (as established by PPACA);[31] and (4) it extends the period for which IHS, IT, and TO services are reimbursed by Medicare Part B for all services, indefinitely, beginning January 1, 2010. Under current law, authority for these facilities to receive Medicare Part B reimbursements for certain specified services expired on January 1, 2010.

## Author Contact Information

Elayne J. Heisler
Analyst in Health Services
eheisler@crs.loc.gov, 7-4453

Roger Walke
Specialist in American Indian Policy
rwalke@crs.loc.gov, 7-8641

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[30] Prior to PPACA, IHS is the payor of last resort only for CHS (See 42 C.F.R.136.61). In general, Medicaid is considered the payor of last resort.

[31] For more information about private health insurance reform in PPACA, see CRS Report R40942, *Private Health Insurance Provisions in Senate-Passed H.R. 3590, the Patient Protection and Affordable Care Act* , by Hinda Chaikind et al.; and CRS Report R41126, *Private Health Insurance: Changes Made by H.R. 4872, the Health Care and Education Reconciliation Act of 2010*, by Hinda Chaikind et al.