



For More Information, Contact:

Stacy A. Bohlen, Executive Director: sbohlen@nihb.org

Caitrin Shuy, Director of Congressional Relations: cshuy@nihb.org

Devin Delrow, Director of Federal Relations: ddelrow@nihb.org

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IMPACTS OF HEALTHCARE REFORM AND INDIAN COUNTRY

When the Patient Protection and Affordable Care Act (ACA) was passed in 2010, numerous provisions were added to the law which help improve the Indian health delivery system that are unrelated to overall healthcare reform. Repealing these specific provisions of the ACA would have devastating impacts on the health of American Indians and Alaska Natives (AI/ANs) and would end critical cost-saving and life-saving modernizations that have been the result of the enactment of the ACA.

The following paper highlights several Indian specific provisions in the ACA and the impact these provisions have in Indian Country. A full listing of all provisions in the ACA can be found at http://nihb.org/legislative/ihcia_and_aca.php.

Indian Health Care Improvement Act:

First enacted in 1976, the Indian Health Care Improvement Act (IHCIA) is the legislative embodiment of the federal trust and treaty responsibilities to American Indian and Alaska Native people for healthcare. IHCIA was permanently enacted in 2010 as part of the ACA (Section 10221) in an effort to pass this long-stalled legislation, despite being unrelated to the overall ACA. Provisions included in the IHCIA were a result of years of negotiations, meetings and strategy sessions between Tribes and Congress resulting in legislation that was not only impactful, but bipartisan. It serves as the backbone legislation for the Indian Health Service (IHS)/Tribal/ and Urban Indian (collectively known as the I/T/U) health system which provides healthcare services for AI/ANs in fulfillment of the federal government's trust responsibility for health that is derived from statutes, treaties, and executive orders.

IHCIA states that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians -- to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy"¹ and reaffirms a system for

¹ 25 U.S.C. § 1602.



the federal government to do so. The law provides the foundational authority for the Indian Health Service to be reimbursed by Medicare, Medicaid and third party insurers, to make grants to Indian Tribes and Tribal organizations, and to run programs designed to address specific, critical health concerns for AI/ANs such as substance abuse, diabetes and suicide.

Six years later, IHCA has provided significant progress in the I/T/U system. IHCA updates and modernizes health delivery services, such as cancer screenings, home and community based services, hospice care, and long-term care for the elderly and disabled. It establishes a continuum of care through integrated behavioral health programs (both prevention and treatment) to address alcohol/substance abuse problems and the social service and mental health needs of Indian people. Some specific impacts of the IHCA include:

- **Sections 825, 2, and 3** {25 U.S.C. §§ 1601, 1602, and 1680o} permanently reauthorizes the IHCA and states that a major national goal is to provide the resources, processes, and structure to eradicate health disparities between American Indians and Alaska Natives and the general population.
 - This section is critical in setting forth all federal Indian health policy by declaring that it will be a priority of the federal government to provide healthcare resources to AI/ANs and legislatively affirms the trust responsibility for health. By permanently enacting IHCA, I/T/Us can operate their health programs without fear of expiring legislation allowing them to provide a consistent continuum of care for patients, thereby improving health outcomes.
- **Section 124** {25 U.S.C. § 1616q} extends the exemption from Federal agency licensing fees available to the Public Health Service Commission Corps to employees of Tribal health programs and urban Indian organizations.
 - This provision provides parity for Tribal health providers with other federal providers and allows cost savings which are then able to be reinvested into health programs to provide additional services to AI/ANs.
- **Section 202** {25 U.S.C. § 1621a} revises regulation terms of the CHEF threshold to the 2000 level of \$19,000 with increases for subsequent years.
 - The Catastrophic Health Emergency Fund (CHEF) is part of the Purchased and Referred Care (PRC) program and is designed to help meet the medical costs of disasters and catastrophic illnesses of CHEF eligible persons. It is an essential piece of the PRC program that is used to fund critical referral services for AI/AN patients and lowering the threshold to \$19,000 ensures that more services can be provided under CHEF. Traditionally, it has been funded at \$51.5 million annually.

- **Section 206** {25 U.S.C. § 1621e} allows Tribes and Tribal Organizations who operate their own programs the right to recover costs from third parties (such as an insurance company, HMO, employee health plan) who do not reimburse for services provided.
 - The Indian health system is already severely underfunded, section 206 permits Indian healthcare providers the ability to bring in supplemental revenue from third parties by giving them the authority to be reimbursed from third parties for the services provided. This permits facilities to generate significant funds that can be used to support the specific facility services expansion and PRC. There have been cases where insurers would not reimburse I/T/U facilities for the services provided, but upon notification of section 206, compliance occurred. To take away this authority from I/T/U providers would be devastating. Third-party revenue brought in an estimated 1.2 billion in reimbursements in FY 2017.

- **Section 207** {25 U.S.C. § 1621f} clarifies that IHS may not offset or limit any amount obligated to any service unit, Tribe, Tribal organization or urban Indian organization because of receipt of third party reimbursements.
 - This provision is critically important to ensure that the federal government lives up to the federal trust responsibility to provide appropriations for healthcare to AI/ANs. Since FY 2011, the IHS discretionary budget has increased 18%, despite increased revenues due to Medicaid Expansion and access to the health insurance marketplace. By not allowing funding to be offset by reimbursements, all Tribes are treated equally under the law regardless of socioeconomic status or availability of additional revenue.

- **Section 213** {25 U.S.C. § 1621i} continues the authority for funds to be used for travel costs of patients receiving healthcare services provided either directly by IHS, under PRC, or through a contract or compact.
 - Because Indian reservations are often located in remote and rural areas, having funds available for travel is a critical need to ensure that patients are receiving access to the best treatment. This provides life-saving resources for patients who are in critical health emergency situations.

- **Section 221** {25 U.S.C. § 1621t} exempts a licensed health care professional who is employed by a Tribally operated health program from state licensing requirements if the professional is licensed in any state, as is the case with IHS healthcare professionals.
 - As rural, not-for-profit healthcare providers, Tribal healthcare providers often struggle to find qualified medical personnel to work at their health facilities. Because Tribal providers are taking over the role of the federal government in providing healthcare to AI/ANs, it is critical that they are given the same opportunities to recruit and retain health staff as federal sites. This provision has made recruitment for Tribal health providers to be national in scope and allowed expedient hiring of licensed professionals.

- **Section 222** {25 U.S.C. § 1621u} says that a patient who receives authorized PRC services will not be held liable for any charges or costs associated with those authorized services. Following receipt of proper notice or an accepted claim, the PRC provider shall have no further recourse against the patient who received the health care.
 - Many Tribes have experienced difficulty and resistance with PRC health providers who are requesting payment from Tribal patients. Under this authority a patient is not liable for services that have been authorized by PRC and carried out by an I/T/U program. Providers are prohibited from collecting any payments for these services from a patient. This authority is essential for protection of AI/AN patient rights.

- **Section 309** {25 U.S.C. § 1638a} allows Tribes and Tribal organizations that operate a health facility and federally owned quarters associated with a facility under the Indian Self-Determination and Education Assistance Act to set rental rates and collect rents from occupants of the quarters.
 - Several Tribes have utilized this authority to manage living quarters for federal staff working in their community. Managing the facilities through the Tribe allows additional revenue to be generated to potentially reinvest in the facilities. Under this provision Tribes can make quarters more attractive to recruits, reinvest rental income into the properties or expanded properties and provide technical jobs in the community.

- **Section 311** {25 U.S.C. § 1638e} allows for the transfer of funds, equipment or other supplies from any source, including federal or state agencies, to HHS for use in construction or operation of Indian healthcare facilities.
 - This provides authority for other agencies to transfer funds to IHS for health and sanitation facility construction and operation. Due to the remoteness of Tribal communities and lack of infrastructure, the need for improvements and maintenance of water supply, sewer systems and solid waste facilities remain substantial.

- **Section 401** {25 U.S.C. § 1641} updates current law regarding collection of reimbursements from Medicare, Medicaid, and CHIP by Indian health facilities, and revises procedures, which allow a Tribally-operated program to purchase health benefits coverage for IHS beneficiaries.
 - This provision is intended to help fulfill the federal trust responsibility and bring additional revenue into the Indian health system. The House Report stated: “These Medicaid payments are viewed as a much needed supplement to a healthcare program which has for too long been insufficient to provide quality healthcare to the American Indian.” The Medicaid program is a crucial component in filling the disparity gap created by inadequate IHS funding. Without it, many IHS and Tribal

facilities would have to shutter necessary programs and lay off critical staff. In FY 2016, IHS and Tribally operated facilities received \$808 million in Medicaid funding for services provided to the Medicaid eligible individuals they serve. This represents 13 percent of the total funds received by IHS facilities in 2016. Medicaid today covers 34 percent of non-elderly AI/ANs and more than half of AI/AN children.

- **Section 402** {25 U.S.C. § 1642} authorizes Tribes and Tribal organizations to purchase health benefits coverage for IHS beneficiaries.
 - Sponsorship occurs when a Tribe pays health insurance premiums on behalf of IHS beneficiaries. When Tribal members enroll in coverage they can improve their access to care through increased options for health care. In turn, revenue collected by Tribal and IHS providers goes back into the facility to meet conditions of participation and provide additional funds to hire staff and purchase services and new equipment. In addition, with greater alternate resources, Purchased/Referred Care (PRC) funds go farther as more patients have coverage.
- **Section 404** {25 U.S.C. § 1644} authorizes IHS to issue grants or contracts to Tribes, Tribal organizations and urban Indian organizations to conduct outreach and education to enroll eligible Indians in Social Security Act health benefits programs including through electronic methods or telecommunication networks.
 - Medicaid and Medicare are an essential component to fulfilling the federal government's fiduciary trust responsibility to provide health care to AI/AN. It helps supplement the underfunded Indian health system by bringing in an additional \$808 million in third party revenue but only about 34% of non-elderly AI/ANs are enrolled. More outreach and education on the benefits of Medicaid and Medicare are needed to get more eligible AI/AN enrolled and additional revenue into the Indian health system.
- **Section 405** {25 U.S.C. § 1645} authorizes IHS to enter into arrangements with the U.S. Department of Veterans Affairs (VA) and U.S. Department of Defense to share medical facilities and services. These arrangements could include IHS, Tribal, and Tribal organization hospitals and clinics.
 - The VA and IHS signed a Memorandum of Understanding (MOU) on October 1, 2010 with the purpose to establish coordination, collaboration, and resource-sharing between VA and IHS. By the end of 2015, VA had disbursed a total of \$33 million to IHS and Tribal Health Programs (THPs) to support the care of eligible veterans. This supplemental income is crucial to the Indian health system to ensure that services are provided to AI/AN veterans who serve in the US military at a proportionately higher rate than any other population in the United States.

- **Section 407** {25 U.S.C. § 1647} establishes procedures to facilitate the provision of health services to eligible Indian veterans by the IHS and VA.
 - This provision establishes procedures to facilitate the provision of health services to eligible Indian veterans would to prevent delayed access to health care services, especially to AI/AN veterans living in remote and rural areas. It promotes access to culturally competent quality healthcare in rural and medically underserved healthcare areas consisting of disproportionately high number of American Indian and Alaska Native (AI/AN) veterans. It prevents redundancies in federal healthcare services.

- **Section 408** {25 U.S.C. §1647a} deems a health program operated by the IHS, an Indian Tribe, Tribal organization or urban Indian organization to be licensed under state or local law if it meets all requirements for such a license regardless of whether it obtains such a license.
 - This authority requires healthcare programs that receive federal funding to accept I/T/U providers. This is essential to ensure that AI/AN providers have access to essential healthcare services.

- **Section 409** {25 U.S.C. § 1647b} grants Tribes and Tribal organizations the ability to purchase coverage for its employees from the access to the Federal Employees Health Benefits Program.
 - This provision saves money for Tribal employers which they then reinvest back into the health system. The Office of Personnel Management recently reported that 19,540 Tribal employees from over 90 Tribes are participating in the program.

- **Section 514** {25 U.S.C. § 1660d} requires IHS to confer with urban Indian organizations in carrying out certain provisions of this Act.
 - Consultation with Tribes and Urban Indian organizations is essential to protecting the government-to-government relationship between Tribes and the United States. While the federal government, as the trustee for Indian Tribes, has a duty to consult with their beneficiaries, AI/ANs and Tribes, much of that consultation occurs only with Tribal entities. However, approximately 70% of AI/AN live in urban areas, with 25% residing in counties served by Urban Indian health programs. Urban organizations must be conferred with when health policies are implemented that affect such a large percentage of the AI/AN population.

- **Section 601** {25 U.S.C. § 1661} amends current law to enhance the duties, responsibilities, and authorities of the IHS Director, including the responsibility to facilitate advocacy and promote consultation on matters relating to Indian health within HHS.
 - This establishes the IHS Director as an official appointed by the President with the advice and consent of the Senate for a four-year term. This provision states that the

IHS Director reports directly to the Secretary of the U.S. Department of Health and Human Services on all policy and budget matters related to Indian health, interacts with assistant secretaries and agency heads on Indian health, and coordinates department activities on Indian health. This section also maintains Indian preference for IHS employment which ensures culturally competent care is delivered. This provision has elevated Indian health issues within the Administration as a top priority leading to better understanding of Indian health challenges across all HHS agencies.

- **Section 809** {25 U.S.C. § 1679} updates the current law provision for services to California Indians.
 - Due to the unique history of California Indian Tribes who lost their reservation lands in 1958 after Congress enacted PL 280 which gave states jurisdiction over reservation lands and Indians. This provision clarifies that California Indians are still eligible for IHS services. This is essential to provide PRC services in California due to the absence of IHS hospitals. According to the most recent census, there are approximately 590,445 Indians in California.
- **Section 812** {25 U.S.C. § 1680b} facilitates access to National Health Service Corps (NHSC) personnel by Indian health programs.
 - There are 471 NHSC clinicians, 60 of which identify as AI/AN, working at Tribal sites across the country. These clinicians are part of more than 10,000 primary care clinicians currently providing care in the NHSC. Of those, 144 provided mental and behavioral health services in Tribal sites as a Licensed Professional Counselor, Health Service Psychologist, Marriage and Family Therapist, Licensed Clinical Social Worker, Allopathic Psychiatrist, Osteopathic Psychiatrist, and Nurse Practitioner. There are 36 active NHSC-approved sites and 23 NHSC clinicians in the Great Plains states.

Affordable Care Act:

In addition to the IHClA, the ACA contains several important provisions for Indian Country within the overall ACA. These provisions are also unrelated to the overall healthcare reform legislation, but remain critically important to health delivery for AI/ANs and the viability of the Indian health system.

- **Section 2901** {25 U.S.C. § 1623} states that any I/T/U should remain the payer of last resort the payer of last resort for services provided by such notwithstanding any federal, state, or local law to the contrary.
 - It has been the longstanding policy of the federal government that the I/T/U providers are the payers of last resort. Prior to the enactment of the ACA, I/T/U

providers had payer of last resort status under 42 CFR § 136.61. However, having I/T/U providers be payers of last resort in statute, gives I/T/U providers the legal authority to seek reimbursement from other sources and saves the I/T/U much needed third party revenue they can use to provide additional services.

- **Section 2902** {25 U.S.C. 1395qq} grants I/T/U providers permanent authority to collect reimbursements for all Medicare Part B services.
 - Approximately 10% of AI/ANs who use IHS services are enrolled in Medicare. Of that population, nearly 30% of Medicare enrollees have coverage due to end-stage renal disease or disability. Part B coverage is an essential resource that ensures AI/ANs receive essential life-saving services. Access to Medicare Part B ensures that I/T/Us save money on costly Part B services, allowing them to use the money saved to provide additional services.

- **Section 9021** {26 U.S.C. 139D} ensures that any health benefits provided by a Tribe to its members are not included as taxable income.
 - Tribes often supplement inadequate PRC funding by both directly authorizing and paying for health care services for their members, or by purchasing insurance coverage for them, such as Medicare Part D plans. Section 9021 was enacted to resolve a longstanding dispute Tribes had with the IRS over whether the provision of healthcare services, including the purchase of insurance for Tribal members by a Tribe, should be included as gross income for that Tribal member. Before Section 9021 was enacted, IRS field auditors had taken the position that the value of such coverage should be included in Tribal members' taxable income. This provision has been instrumental in clarifying the value of healthcare provided by a Tribe to its members is not taxable income, and ensures that Tribes, like the United States and the states can provide health coverage for their members without such services being considered income by the IRS. It incentivizes Tribal governments to purchase healthcare for members, thereby improving access to services for all.

- **Section 2951** {42 U.S.C. § 711} provides funding to states, Tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s). Sets aside 3% of funding for I/T/Us.
 - Currently, 25 Tribal grantees are receiving funds under this program which enables their communities to have operate programs to improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness. Without these funds available, these programs would likely not be available putting Native children and families at risk.

- **Section 3314** {42 U.S.C. 1395w-101} amends the Social Security Act to allow IHS, Indian Tribe or Tribal organization, and urban Indian program spending to count toward the Medicare Part D out of pocket threshold or coverage gap.
 - This provision allows I/T/Us to improve HIV treatment by ensuring access to life-extending medications that are otherwise cost-prohibitive. It is important because it helps to assure an accurate accounting of actual monies spent towards prescription HIV medications, but also assists any beneficiary to avoid undue additional medication expenses by helping them to avoid the Medicare Part D coverage gap. Without this authority, access to HIV treatments would be greatly diminished in Indian Country as the IHS does not have funding to directly treat and prevent HIV for eligible AI/ANs.

- **Section 4302** { 42 U.S.C. 300kk} adds section 3101 which makes data analyses of federally conducted or supported healthcare or publicly health programs or activity available to IHS and epidemiology centers funded under the IHICIA.
 - This provision has enabled Tribes, Tribal organizations and epidemiology centers to collect, access and analyze data to make informed decisions on the health of their population. If this provision were not part of law it could impede the ability to select and invest in appropriate interventions that lead to the prevention of disease, lives saved and the avoidance of unnecessary and costly spending on healthcare.

Medicaid Reform:

In 1976, Congress enacted Title IC of the IHICIA which amended the Social Security Act to require Medicare and Medicaid reimbursement for services provided in IHS and Tribally operated healthcare facilities. The Affordable Care Act expanded eligibility under the Medicaid program and has allowed the I/T/U system to realize important financial gains that have allowed expanded access to care and helped alleviate pressure off of discretionary appropriations.

- Medicaid serves as a key source of revenue for I/T/U providers. According to the IHS Congressional Budget Justification, from FY 2011 to FY 2016 Medicaid reimbursements at IHS went up by 21.15% or \$171 million.
- This funding helps fill a critical gap for the Indian health system and translates into patients receiving needed surgeries, preventative care, and oral healthcare which saves lives and taxpayer dollars.
- In many locations, Medicaid Expansion has meant that patients no longer need to wait for “life or limb” situations to receive referrals to get care.

100% FMAP

Also in 1976, Congress amended Section 1905(b) of the Social Security Act to apply a 100 percent federal medical assistance percentage (FMAP) paid for by the federal government for services

provided to American Indians and Alaska Natives (AI/ANs) that were received through an IHS or Tribally-operated facility. Though this was enacted outside of the ACA, it is still important for discussions on Medicaid reform.

- 100% FMAP ensures that IHS access to state Medicaid services does not burden the states with what is a federal trust responsibility.
- The reimbursement to states from the federal government for Medicaid payments to IHS and Tribally operated facilities is critical in filling the gap created by inadequate IHS funding.

Any plan to change the manner in which state Medicaid costs are reimbursed by the federal government must include a carve out for services provided to AI/ANs so the federal government's trust responsibility is not shifted to the states.