National Indian Health Board

May 22, 2009

HEALTH CARE REFORM AND INDIAN COUNTRY:

Recommendations for Meaningful Participation of the Indian Health System in a Health Care Reform Environment

Introduction

The legislative effort to improve access to health care for many millions of uninsured or underinsured Americans will, without question, impact the Indian health system through which health care is now delivered to some 1.9 million American Indians/Alaska Natives (AI/ANs). The Indian health system is unique. It was created and designed by the Federal government to carry out the Federal trust responsibility for Indian health. In addition, Federal policy dictates that the Federal government interact with Indian tribes on a government-to-government basis.

Federal policymakers – Congress and the Administration – have a solemn obligation

(i) to assure that health care reform legislation fully supports and protects the Federal Indian health delivery system;

(ii) to assure that Indian people and Indian health programs have full opportunities to participate in and benefit from reform programs, and

(iii) to acknowledge and respect the status of Indian tribes as sovereign governments.

Thus, the legislation must necessarily include provisions specific to the Indian health system, Indian beneficiaries, and Indian tribes.

The existing system consists of services provided by the Indian Health Service (IHS -- an agency of the Department of Health and Human Services); by programs operated by Indian tribes and tribal organizations through Indian Self-Determination and Education Assistance (ISDEAA) agreements; and by urban Indian organizations that receive grant funding from IHS. [Collectively, these three components are referred to as the "Indian health system" or "I/T/U".]

Most beneficiaries served by the Indian health system live in remote, sparsely-populated reservation areas and Alaska Native Villages; in fact, the Indian health system was designed in large part to reach these beneficiaries in their communities which have little, if any, other health infrastructure presence. Even in more populated areas, the Indian health system provides the most meaningful access to health care due to challenges of low income and cultural differences that make other health services essentially inaccessible. This is what makes the system unique – and requires it to have a comprehensive focus. The IHS delivery system strives to be an

integrated, community-based system that emphasizes prevention and public health, delivers and purchases health care services, and provides the infrastructure for health improvements by building health facilities and sanitation systems, as well as guaranteeing long term improvement through training, recruitment and retention of health personnel. This system is the health care home for the AI/AN people it serves. The tribal leaders who direct it, and, increasingly, its workforce, are its users, as are their grandparents and their grandchildren, and it will be the health care home for their grandchildren's grandchildren. The incentives in the Indian health system are not financial; its mission is the improvement of the health status of Indian people.

But despite its attempt to be an integrated public health-based system, resource inadequacies impede the Indian health system's ability to fully achieve its mission. As a consequence, the level of services available differ from location to location. The Government Accountability Office described these service disparities in its aptly titled 2005 report "*Health Care Services are Not Always Available to Native Americans*".[1] Similarly, a 2008 Congressional Budget Office report observed that due to "staff shortages, limited facilities, and a capped budget, the IHS rarely provides benefits comparable with complete insurance coverage for the eligible population".[2]

All of these circumstances make it incumbent on Congress and the Administration to evaluate the impact of new health policies on the Indian health system, and to take affirmative steps to assure those policies are helpful, not harmful.

Indian-specific Recommendations for Health Care Reform

Many tribal leaders and tribal health advocates, including the workgroup formed by the National Indian Health Board, have examined the components of health care reform proposals currently under consideration. Described below are eight categories of basic Indian-specific provisions that must be a part of reform efforts. Please note, however, that the health care reform dialogue – including the issues described here – continues throughout Indian Country. Congress can expect to receive additional recommendations flowing from the on-going dialogue from tribes and Indian organizations.

---

[1] U.S. Government Accountability Office, Report to the Committee on Indian Affairs, U.S. Senate, *Health Care Services are Not Always Available to Native Americans*, GAO-05-789 (Aug. 2005).

[2] Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals,* at 127 (Dec. 2008).

1. Substantive Tribal Involvement in Development of Reform Policies

1.1 ***Include Tribal representation on key commissions, boards and other groups created by health reform legislation, and direct the Secretary of HHS to consult with Tribes on health reform policies and regulations.*** Only by engaging knowledgeable Tribal leaders before policy approaches are evaluated, refined and implemented can health reform promise to improve the Indian health system and the health status of AI/ANs.

1.2 ***Consult with tribes and tribal organizations (as defined in the ISDEAA) across the country to be sure health reform policies and regulations are developed in a way that will create positive changes in the diverse Indian communities.*** Across the United States Indian cultures, tribal resources and tribal health system structures differ greatly. Health reform must work in all of these situations. Only by directly consulting with Tribes as policies and regulations are being developed can HHS develop policies and regulations that will work in all Indian communities.

1.3 ***Confer with representatives of urban Indian organizations to determine the impact of reform proposals on the Indian people served by those programs.***

1.4 ***To the extent any new entity or agency is created by health care reform legislation, it, too, must be required to engage in consultation with tribes and tribal organizations and to confer with urban Indian organizations regarding the impact of its policies on the Indian health system.***

2. Recognition of Indian Tribes as Sovereign Governments

2.1 Indian tribes perform several roles in a health care context: They are governments, employers, health care providers), patient advocates, and beneficiaries of the U.S. trust responsibility for health. All of these roles must be respected, together with the recognition that Indian tribes are political entities, not merely a racial group.

2.2 To the extent reform legislation includes an employer mandate, Indian tribes should be exempt from any requirement that an employer provide health insurance coverage to its employees or suffer a financial penalty. As sovereign governments, tribes as employers must be permitted to determine for themselves the extent to which they can/will provide health insurance coverage to their employees, and must not be subject to any penalty or tax for declining to do so.

- The exemption of Indian tribes from any penalty or tax must also apply with regard to any tribal employees who opts out of a tribally-sponsored group health plan and buy insurance on their own outside of the workplace.

2.3 Indian tribes, as sovereign governments, and the tribal organizations that serve them by providing health services, should have the express authority to pay the costs of providing health insurance coverage to their members and beneficiaries and the value of such coverage should not be considered to be taxable income to the AI/AN.

2.4 Indian tribes must retain the authority to decide whether to serve non-Indians at their health facilities. Tribes recognize that the demand for health services will greatly increase in a reformed health care environment and that they are likely to be asked to open their doors to serve non-Indian patients and receive payment for such services. The I/T/Us must be able to either open their doors or continue to serve only IHS beneficiaries. This is a challenging decision that requires consideration of capacity and resources and whether adding users will improve the breadth of services that can be offered or would diminish an already limited capacity. To support tribes who are willing to expand accessibility to health care by serving non-Indians, the legislation must –

- Extend the Federal Tort Claims Act coverage now provided to ISDEAA contractors to include coverage for services to non-Indians. (This is consistent with the FTCA coverage extended to community health centers which receive funding from HRSA under Sec. 330 of the Public Health Service Act.)
- Revise as necessary Sec. 813 of the Indian Health Care Improvement Act to facilitate a tribal decision to serve non-Indians.

2.5 Indian Tribes should be given the option to purchase health insurance for their governmental employees through the Federal Employees Health Benefit Plan. As employers, some Indian tribes have been unable to find affordable health insurance. Indian tribes should have the option to purchase coverage for their governmental employees through the FEHBP, an option that would benefit both tribes – by making an

affordable option available – and the FEHBP – by increasing the volume of insured and thereby promoting greater competition among participating insurers.

- This option should also be extended to tribes and tribal organizations for their employees who perform services under the Indian Self-Determination and Education Assistance Act and the Tribally Controlled Schools Act, as well as to the employees of health programs operated by urban Indian organizations.

2.6 Health care reform should require collaboration across all HHS agencies (e.g. HRSA, SAMHSA, Administration on Aging, CMS) and programs with Tribes to coordinate health care resources in order to ensure health related funding is more effectively available to tribes.

3. Individual Mandate/Personal Responsibility Coverage Requirement

3.1 Because of the Federal trust responsibility to provide health care to Indian people, AI/ANs must be exempted from any penalty for failing to obtain or purchase health insurance if an individual mandate is included in the legislation.

- Whether an individual mandate applies may depend on whether an individual is considered to have creditable coverage or is considered uninsured. A recent Congressional Budget Office report concludes that AI/ANs served by the IHS system are uninsured.[3]

3.2 Despite this, the fact that an AI/AN is eligible for health care from the Indian health system (whether or not such eligibility is considered creditable coverage) should not be a barrier to an AI/AN's eligibility for any publicly-funded health program such as Medicaid, or any publicly-subsidized health insurance option.

3.3 To the extent tribal governments provide insurance for AI/ANs (employees and members) who would be eligible for premium subsidies, the subsidies should be made available to the tribal government to offset the cost of acquiring coverage that should be available without cost.

- This support should also be extended to tribal organizations carry out programs under the Indian Self-Determination and Education Assistance Act and the Tribally Controlled Schools Act, as well as urban Indian organizations.

?

[3] Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals* (Dec. 2008), at 127.

4. Individual AI/AN Participation in Publicly Sponsored Health Insurance/ Public Health Insurance Option

4.1 Any new publicly-sponsored health insurance plan established to provide coverage for low/moderate income individuals must assure that AI/ANs who meet the income requirements are eligible to enroll, and that eligibility for services from the Indian health system is not a barrier to participation.

- AI/ANs eligible for care through the Indian health system have been encouraged to also enroll in Medicaid if they meet the eligibility criteria. The same opportunity must be made available for any Federally supported or subsidized health insurance coverage.

- AI/ANs must not be subject to any restriction on selection of a provider. AI/ANs must be permitted to elect to obtain care from their IHS, tribal, or urban Indian organization program without any financial or other penalty. *See* recent amendment to Sec. 1932(h)(1) of the Social Security Act to permit an Indian enrolled in Medicaid to select an Indian health care provider as a primary care provider. Pub. L. 111-5, Sec. 5006(d) (Feb. 17, 2009).

4.2 In recognition of the Federal government's trust responsibility to provide health care to Indian people, to the extent that any cost-sharing (premium, co-pay, etc.) would apply to a publicly-subsidized plan, an AI/AN served by the Indian health system should be expressly exempt from all such cost-sharing.

- Such a policy is consistent with the recent amendments to Title XIX (Medicaid) of the Social Security Act which prohibit the assessment of any cost-sharing against an AI/AN enrolled in Medicaid who is served by the IHS, or by a health program operated by a tribe, tribal organization or urban Indian organization. *See* Pub.L. 111-5, §5006(a) (Feb. 17, 2009).

4.3 In recognition of the Federal government's trust responsibility to provide health care to Indian people, a special (open) enrollment period should apply for AI/ANs served by the Indian health system.

4.4 In recognition of the Federal trust responsibility to Indian people, individual Indian income from Federally-protected sources must be excluded from the calculation of an individual AI/AN's income for purposes of determining eligibility for participation in a publicly-subsidized plan. *See, e.g.,* 25 USC §§1407, 1408; 43 USC §1626.

4.5 In order to enhance AI/AN access to a public insurance plan, the legislation should expressly allow outreach and enrollment activities to take place at I/T/U sites.

4.6 To the extent premiums and cost-sharing apply to AI/ANs, I/T/Us should be expressly permitted to make such payments on behalf of their Indian beneficiaries, and administrative barriers to doing so must be removed.

5. Indian Health System Provider Participation in Networks Established for Publicly-Sponsored Health Insurance Plan

5.1 If the legislation requires either the Secretary or outside entities to establish provider networks to serve individuals covered by a public insurance plan, it should contain assurances of participation by Indian health system (I/T/U) providers including –

- assurance that the network includes sufficient Indian health care providers to assure access for Indians;
- a requirement that I/T/U providers be paid (whether or not enrolled in the network) at a rate negotiated with the I/T/U, or if no rate is negotiated, at the rate paid to a non-Indian network provider; and
- a requirement for prompt payment to an I/T/U provider.

5.2 Express language is needed to assure that I/T/U providers are not arbitrarily excluded from participation as has occurred with some Medicaid managed care entities. When an I/T/U provider serves an individual enrolled in a public plan, the provider must be able to claim reimbursements and be assured of receiving payments.

- Congress recently enacted protections for Indian health providers vis a vis Medicaid managed care entities which can be used as a model for similar protections for public plan network creation. *See* amendment to Sec. 1932 of the Social Security Act as enacted in Sec. 5006(d) of Pub.L. 111-5 (Feb. 17, 2009).

5.3 The legislation should also include a requirement that the Secretary establish special terms for participation by I/T/Us that takes into account the unique circumstances of those providers in order to facilitate their participation.

- This recommendation builds on lessons learned during implementation of the Medicare Part D drug program where it was necessary for CMS to require special additions to pharmacy contracts in order to assure participation opportunities for I/T/U pharmacies.

6. Expansion of Eligibility for Medicaid and CHIP

6.1 ***If Medicaid and CHIP are expanded to raise the maximum income ceiling or establish new eligibility categories, the legislation must require States to perform outreach and enrollment activities on/near Indian reservations and in Indian communities.*** The AI/AN population suffers from disproportionately high poverty rates and thus has a high proportion of Medicaid and CHIP eligibility. In order for this segment of the U.S. population to have full opportunity to participate in these programs, a significant outreach effort is required.

6.2 ***All expansions of Medicaid and CHIP (including any waiver or demonstration programs) must expressly exempt AI/ANs from any form of cost-sharing pursuant to the recent amendment to Title XIX made by Sec. 5006(a) of Pub.L. 111-5 (Feb. 17, 2009).***

6.3 ***Indian tribes support the proposal of the Finance Committee to require interstate coordination for child Medicaid beneficiaries to ensure that a child's home-state Medicaid program will cover the child's health care costs when he/she is out of state.*** Such a requirement would beneficially impact Indian children enrolled in Medicaid who leave their home states for such purposes as attending Bureau of Indian Affairs boarding schools.

- This proposal should be expanded to require an adult Indian's home-state Medicaid program to cover the health care costs of such a patient who travels out of state in order to receive culturally competent care at an Indian health facility, including care related to behavioral health needs, including substance abuse treatment.

6.4 ***Indian health providers must be permitted to enroll eligible AI/AN beneficiaries on site and to participate as Express Lane or other Medicaid enrollment simplification network entities.***

7. Safeguards and Enhancements Needed for the Indian Health System

7.1 Tribal leaders strongly endorse Chairman Baucus's proposal to augment funding for the Indian health system, and concur with his observation that "IHS desperately needs addition funding. It is impossible to keep America's promise to provide care to Native Americans and Alaska Natives with the current level of IHS funding."[4] Health care reform legislation should supply the Indian health system with sufficient resources to meet the Federal obligation to raise "the health status of Indians [] to the highest possible level"[5], and to guarantee to AI/ANs the quality and quantity of health care envisioned for all Americans in the reform effort.

7.2 The Indian Health Service budget must be protected from offsets and must be enhanced to assure that Indian programs can attract and retain vital health care personnel.

- As millions more individuals enter the ranks of the insured, the demand for health care professionals and administrators will increase well beyond our Nation's current health care workforce capabilities.
- Indian health programs must be provided with the resources needed to enable them to compete for health care professionals, to recruit personnel to fill existing vacancies, and to retain existing staff.
- Funding for scholarship and loan programs to encourage Indian people to enter the health professions and serve in Indian health programs must be enhanced.
- Mechanisms for assignment of National Health Service Corps personnel should be revised to enable Indian health programs to access these personnel on the basis of their Indian service population.

7.3 Health reform legislation must include funding to develop, and support implementation by all providers within the I/T/U of, a system for monitoring and measuring the needs of the Indian health system to assure that budgetary resources support the level of need throughout the system and improve the quality and effectiveness of care..

- Funding should also be provided for developing and implementing throughout the I/T/U patient identification smart card technology.

7.4 The proposed coordinated national strategy to address health care workforce shortages must include as a key focus area the Indian health delivery system.

- Unlimited access to the National Health Service Corp should be made available to the I/T/U.
- Resources for training, recruiting and retaining health providers should be made available to the I/T/U directly.

---

[4] Baucus, Senator Max, *Call to Action: Health Reform 2009 (Nov. 12, 2008), at 28.*
[5] 25 USC §1601(b).

- Funding for training and supporting alternative provider types who have proven records of providing quality care, such as community health representatives, community health aides, behavioral health aides, and dental health aide therapists should be expanded.

7.5 ***Pursuant to the Federal trust responsibility for Indian health, the Medicare law should be amended to provide 100% payment to Indian health programs for covered Medicare services.*** At present, the system for making Medicare reimbursements to IHS and tribally-operated facilities provides payment at only 80%, as Medicare presumes a 20% patient co-pay, and expects patients to satisfy deductibles before qualifying for benefits. But in recognition of the trust responsibility for Indian health, the IHS does not charge patient co-pays; thus, the IHS budget subsidizes the remaining 20%, as well as applicable deductibles. According to 2008 data, reimbursing Indian facilities for Medicare services at 100% would annually infuse over $40 million more into the Indian health system, funds that would be used to reduce health status disparities.

7.6 ***Health information technology improvements must reach all Indian health providers.*** The remote location of many I/T/U facilities and complex relationships with IHS lead to wide disparities in health technology capabilities. Explicit policies are needed to assure that all Indian health providers receive a fair share of resources for improving health information technology and that Indian health providers are not penalized for lack of information technology.

7.7 ***Include coordination of benefits policies which assure that, consistent with existing Federal regulations, the I/T/U program is the payor of last resort.***

- To assure such policies are properly implemented, require the involvement of the CMS Tribal Technical Advisory Group in development of regulations, and provide funding to support the TTAG's work. (NOTE: Federal law formally recognizes the TTAG and directs the Secretary to maintain this panel within CMS. *See* Pub.L. 111-5, §5006(e) (Feb. 17, 2009)).

7.8 ***Enact incentives to facilitate opportunities for IHS and tribes to develop cost-effective cooperative arrangements for sharing of facilities and staff with local non-Indian communities.***

7.9 ***Enact provisions that permit and encourage integration of behavioral health (mental health and substance use disorders) services with other health services.***

7.10 ***Assure that prevention services are eligible for payment by all publicly-supported health programs (Medicare, Medicaid, CHIP and any new public health insurance option), and that I/T/U providers are eligible to collect such payments.***

- To the extent an Indian health program integrates traditional health care practices into its prevention programs, it should be permitted to do so with no adverse impact on its ability to collect reimbursements for covered prevention services.

7.11 ***Extend the new Indian-specific provisions of ARRA and CHIPRA to all health programs in which the federal government participates financially.***

8. Long-Term Care Programs in Indian Country

8.1 ***Funding should be made available through CMS and IHS (or other new health service capacity building programs that may be created under health reform legislation) to assist tribes and tribal organizations to develop the full range of long-term care services needed to meet their community needs, with an emphasis on culturally appropriate home and community based services, including care management services that will delay or prevent the need for nursing home care.***

8.2 ***State Medicaid programs should be required to enter into agreements with IHS and tribal health programs under which reimbursement would be made for the range of long term care services tribal programs are able to offer, and assure covered services include care management and home health care.***

8.3 ***Indian tribes must be expressly included as entities eligible for long-term care grant programs, including: the Community Choice Act Demonstration Project; Real Choice Systems Change Grant Initiative; Aging and Disability Resource Centers (ADRC); Informal Caregivers; prevention and Health Promotion; and Green House Model.***

8.4 ***Include provisions which require States, all agencies of the Department of Health and Human Services, and the Department of Veterans Affairs to demonstrate how they will assure that AI/ANs have meaningful access to Federally-supported long-term care programs and services.***

Inquiries regarding this document may be directed to:
Jennifer Cooper, Legislative Director
National Indian Health Board
926 Pennsylvania Ave., S.E.
Washington, D.C. 20003
(202)507-4070
jcooper@nihb.org