NPAIHB and ATNI Recommendations on Health Care Reform Policy Options for the Indian Health System[1]

Submitted to the Finance Committee
June 4, 2009

The Portland Area Indian Health Board (NPAIHB) believes that the May 31, 2009 joint letter (National Indian Health Board, National Congress of American Indians and National Council of Urban Indian Health) contained a serious error that needs to be corrected. On page 3, under "Subsidies", the letter says, "IHS is not creditable coverage". If this policy is adopted, many American Indians and Alaska Natives (AI/AN) will NEVER be able to achieve the important promise of "portability".

- Although IHS is not insurance it is health coverage.
- Provisions under Medicare Part D (42 CFR 423.56(b)(9)), which granted Indian health provider coverage as creditable coverage have worked well. New health insurance programs, especially those coordinated through "The Exchange" must explicitly recognize the Indian health system as creditable coverage. To underscore this important point, many AI/AN elders did not enroll in Medicare Part B when first eligible because they received care through Indian health services. For those who subsequently moved away from tribal communities and needed to rely on non-Indian providers, they found they could only enroll in Part B with a very significant and unaffordable financial penalty. Most Indian health programs are not prepared to provide extensive counseling to patients who receive health care under treaty rights about why they need to purchase health insurance.
- NPAIHB is also concerned about the unintended incentives created by not deeming Indian health creditable coverage. If AI/AN found themselves "locked into" the Indian health system, because if it is not recognized as creditable coverage, would it force AI/AN to remain in the Indian health system because they could not afford to leave? This would further burden already inadequately funded providers.
- While Indian health providers are proud of the public health, community based delivery model they have built over the years, they still must coordinate public and private insurance coverage for patients and thus are very familiar with the complexities of the broken health care system that Congress hopes to fix. As such, NPAIHB strongly encourages Congress to explicitly include the Indian health system as creditable coverage so individual AI/ANs are able to purchase insurance, without penalty when they are unable to access Indian health services. Only knowledgeable Indian health providers, who work everyday coordinating coverage for AI/AN can adequately advise policy makers on how the details of health reform can help or hurt tribal communities.
- AI/AN using Indian health system must be deemed to have creditable coverage and any penalty assessed for failure to enroll in a health insurance plan must be waived. Creditable coverage must not disqualify AI/AN for any health insurance or subsidy for which they would otherwise qualify.
- Portability for AI/AN requires that the Indian health system coverage be deemed creditable coverage.

<u>**Tribal Specific Recommendations:**</u>

1. **Include Tribal representation on key commissions, boards and other groups created by health reform legislation. Direct the Secretary of HHS to consult with Tribes on a government to government basis 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] The Northwest Portland Area Indian Health Board and Affiliated Tribes of Northwest Indians convened a regional meeting, "Northwest Roundtable on Health Care Reform Policy Options for the Indian Health System," on June 2-3, 2009 in Portland, Oregon. This paper transmits the recommendations of Tribal leaders and health directors, urban Indian program directors, and other Indian health advocates that participated in the meeting.

2. **Consult with Tribes on a government to government basis across the county 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.

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

4. **Indian tribes perform several roles in a health care context: They are governments, employers, health care providers (through Indian Self-Determination agreements), 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 people are unique and distinct political group, not merely a minority classification.**

5. **Indian tribes must retain the authority to decide whether or not 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 wish to serve non-Indians, the legislation must –
    a. 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 currently.)
    b. Revise as necessary Sec. 813 of the Indian Health Care Improvement Act to facilitate a tribal decision to serve non-Indians.

6. **Health care reform should require Tribal collaboration across all HHS agencies (e.g. HRSA, SAMSA, Administration on Aging, CMS) and other federal health programs, such as but not limited to, the Veterans Administration to coordinate health care resources in order to ensure health related funding is more effectively available to tribes.**

7. **The Indian Health Service budget must be protected from offsets and must be enhanced to assure that Indian programs can attract and retain health care personnel needed to fulfill the Federal government's trust obligation to "permit the health status of Indians to be raised to the highest possible level"**.
    a. Chairman Baucus has noted that "[i]n fiscal year 2008, total funding for IHS was $4.3 billion, about 48 percent of estimated need."

8. **Health reform should provide opportunities and 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.**

9. **While health care reform holds great promise for ensuring coverage for all Americans, in Indian Country it will create a short term financial burden on the already seriously under funded Indian health system**. Tribes need to be involved in policy analysis and rule making, but there are no new resources. At the tribal level staff will need training and the resources to build the local systems that are needed to effectively educate, enroll and coordinate patient participation in a reformed system. When new funding is available for implementing health reform in Indian Country, provisions must be made to ensure that it is available to all Tribes equally.

10. **If the Indian Health Service (IHS) is provided additional resources to fund health services consistent with what would be provided in a publicly-funded health plan or other programs addressed under health reform, the IHS shall distribute funds equitably to tribal and urban health programs under the terms and conditions of Indian Self-Determination and Education Assistance Act (ISDEAA) and the Indian Health Care Improvement Act (IHICA) on the same allocation basis IHS makes funds available to directly operated service units.**

Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans Finance Committee Paper - May 14, 2009		
Section	**Policy Issue**	**Recommendations**
I: Insurance Market Reforms	***Page 2***	
	Non-Group and Micro-Group Market Reforms	
	Small Group Market Reforms	
	Health Insurance Exchange	1. In order to AI/AN access to a public insurance plan, the legislation shall expressly authorize and fund outreach and enrollment activities to take place at I/T/U sites. 2. 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 eligible for Indian health programs and electing to participate in insurance coverage 3. 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. a. 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. 4. AI/AN using Indian health system must be deemed to have creditable coverage and any penalty assessed for failure to enroll in a health insurance plan must be waived. Creditable coverage must not disqualify AI/AN for any health insurance or subsidy for which they would otherwise qualify. 5. Include coordination of benefits policies which assure that, consistent with existing Federal regulations, the I/T/U program is the payor of last resort. a. 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)).
	Transition	
	Role of State Insurance Commissioners	
II: Making Coverage Affordable	***Page 8***	
	Benefit Options	1. In recognition of the Federal government's trust responsibility to provide health care to Indian people, for any cost-sharing (premium, co-pay, etc.) that would apply to a publicly-subsidized plan, an AI/AN served by the Indian health system

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		should be expressly exempt from all such cost-sharing. a. 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. 2. For Indian communities, consider options for that will build on the holistic and public health model of health. In particular, enact provisions that permit and encourage integration of behavioral health services (mental health and substance use disorder) with other health services, especially primary care.
	Low-Income Tax Credits	
	Small Business Tax Credits	
III: Public Health Insurance Option	***Page 13***	
Approach 1: Medicare-Like Plan Approach 2: Third Party Administrator Approach 3: State-Run Public Option		1. NPAIHB supports Approach 1 for several key reasons: a. Indian tribes' relationship is directly with the federal government. Approach 1 preserves that relationship. b. Most ITU providers are currently able to bill and receive reimbursement for Medicare services. If a new private contractor administers the public health insurance, Indian health providers will be required to expend significant new resources in contracting, and establishing new relationships at the regional or state level. Approach 1 will save significant administrative resources as well as minimize disruptions in reimbursement collections. 2. If Approach 2 or 3 is adopted: a. 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. 3. 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: a. Assurance that the network provides access to all Indian health care providers t; b. 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 c. A requirement for prompt payment to an I/T/U provider. 4. Such express language is needed to assure that these 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

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		provider must be able to claim reimbursements and be assured of receiving payments. a. 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. 5. 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. a. 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. For example, FTCA coverage meets the requirements of malpractice insurances when entering into agreements with provider networks, but some insurance plans will not accept this and require additional malpractice insurance. 6. Explicitly permit Indian plans to qualify as options available through the Exchange and allow them to limit enrollment to the beneficiaries determined by tribes
IV: Role of Public Programs	***Page 14***	
• Eligibility Standards and Methodologies • Medicaid Program Payments • Options for Medicaid Coverage Approach 1: Increased Coverage through the Current Medicaid Structure Approach 2: Increased Coverage through the Exchange Approach 3: Increased Coverage through Both the Current Medicaid Structure and the Health Insurance Exchange	Medicaid Coverage	1. Aggressive mechanisms are needed to increase enrollment of eligible Indians in Medicaid and CHIP. The AI/AN population suffers from disproportionately high poverty rates and thus has a high proportion of Medicaid and CHIP eligibility, but Indians are under-enrolled in these programs. a. States should be authorized to rely on a finding of eligibility for Medicaid and CHIP made by an I/T/U to the same extent as they would rely on such a finding by an Express Lane agency (as defined in Sec. 203 of CHIPRA). b. Indian health providers should be permitted to apply fast-track enrollment methods and to participate as Express Lane or other Medicaid enrollment simplification network entities. c. States must be required to demonstrate they have employed effective outreach and enrollment activities on/near Indian reservations and in off-reservation Indian communities, with penalties attaching for failure to do so. d. Tribal governments should be authorized as portals for accepting Medicaid applications.
	Children's Health Insurance Program (CHIP)	
	Quality of Care in Medicaid and CHIP	1. Membership in the MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION (MACPAC) should include at least one representative of the CMS Tribal Technical Advisory Group pursuant to requirements that CMS consult with the TTAG at .
• Enrollment and Retention Simplification • Family Planning Services and Supplies • Treatment of Selected Optional Benefits	Other Improvements to Medicaid	1. NPAIHB supports establishing a distinct national/federal tribal Medicaid option for administration, eligibility, payment, and delivery of Medicaid eligible services. This would assure a Medicaid "uniform benefit package" for AI/AN across the country to address the significant health disparities that exist in Indian Country. This concept has been discussed many times

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• Interstate Coordination Requirements for Child Medicaid Beneficiaries • Mandatory Coverage for Prescription Drugs • Change the Status of Some Excludable Drugs • Changes to Medicaid Payment for Prescription Drugs • Transparency in Medicaid and CHIP Section 1115 Waivers • Changes to the FMAP Formula • Automatic Countercyclical Stabilizer		over the years and could comprise a key component of health reform for Indian people. A national approach could help ensure that LTC reaches tribal communities and that an integrated approach to a benefit package could specifically address the unique cultural needs of AI/AN residing in tribal communities. 2. Indian health providers must be permitted, but not required to enroll eligible AI/AN beneficiaries on site and to participate as Express Lane or other Medicaid enrollment simplification network entities. 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. a. This proposal should be expanded to require an adult Indian's home-state Medicaid program to cover the health care costs of such an 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. 4. 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).
	Medicaid Disproportionate Share (DSH) Hospital Payments	
• Waiver Authority for Dual Eligible Demonstrations • Cost-Effectiveness Test • Office of Coordination for Dually Eligible Beneficiaries	Dual Eligibles	
• Reduce or Phase-Out the Medicare Disability Waiting Period • Temporary Medicare Buy-In	Medicare Coverage	1. 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. 2. Medicare changes should correct an omission in MMA that will permit CHS or other Tribal payments to count toward Part D

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		TROOP. 3. In order to continue to permit billing for Medicare part B services: 4. . Remove from Section 1880 of the Social Security Act the sunset date (December 31, 2009) applicable to 5. IHS and tribal program authority to receive payment for certain Medicare covered items and services. 6. All AI/AN who do not have Part B should be granted equitable relief in order to enroll in Medicare Part B and be exempt from financial penalties. Over the years some AI/AN elders did not enroll in Part B because they trusted that services would always be available for them through the Indian health system. Others were told in some meetings by federal officials that they didn't need to pay for Part B.
V: Shared Responsibility	***Page 39***	
	Personal Responsibility Coverage Requirement	1. Indian tribes, as sovereign governments, should have the express authority to pay the costs of providing health insurance coverage to their members and the value of such coverage should not be considered to be taxable income to the tribal member. 2. 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. (creditable coverage) 3. Despite this, the fact that an AI/AN is eligible for health care from the Indian health system 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. 4. 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. 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.
	Employer Requirement	1. 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. a. 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.

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		2. 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. a. This option should be extended to tribes and tribal organizations for their employees who perform agreements issued under the Indian Self-Determination and Education Assistance Act and the Tribally Controlled Schools Act. b. Some tribes have extreme difficulty finding affordable employee coverage in the commercial market – some, but not all, are small employers. FEHBP would assure affordable coverage for these tribes.
VI: Prevention and Wellness	***Page 43***	1. 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. a. To the extent an Indian health program integrates traditional health care and promising 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. Preventive services that are considered to be effective in Indian Country should be included as covered preventive benefits
• Personalized Prevention Plan and Routine Wellness Visit • Incentives to Utilize Preventive Services and Engage in Healthy Behaviors Coverage of Evidence-Based Preventive Services	Promotion of Prevention and Wellness in Medicare	1. In light of the significant health disparities for AI/AN, include tribal representation on groups that determine services so unique cultural considerations can be addressed.
• Access to Preventive Services for Eligible Adults • Incentives to Utilize Preventive Services and Encourage Healthy Behaviors	Promotion of Prevention and Wellness in Medicaid	1. In light of the significant health disparities for AI/AN, include tribal representation on groups that determine services so unique cultural considerations ca be addressed.
• "RightChoices" Grants • Prevention and Wellness Innovation Grants	Options to Prevent Chronic Disease and Encourage Healthy Lifestyles	1. Include tribes as entities eligible for Right Choices Grants.
	Employer Wellness Credits	
SECTION VII: Long Term Care Services and Supports	***Page 49***	
	Medicaid Home and Community Based Services (HCBS) Waivers and the Medicaid	1. State Medicaid agencies have varying relationships with Indian tribes. For a variety of reasons, AI/AN have difficulty accessing LTC services. To assist with this access problem, authorize tribes to secure LTC waivers either directly with CMS or require

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	HCBS State Plan Option	States to submit LTC waivers on behalf of a tribe or tribal organization.
	Eligibility for HCBS Services	
	Increase Access to Medicaid HCBS	1. 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. 2. A demonstration project should be funded through CMS, Administration on Aging and IHS 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. This project should specifically address identifying and removing impediments to building LTC services in tribal communities as well as establishing effective methods to link/integrate LTC with ITU medical, dental and behavioral health services. 3. Include research on using cost based reimbursement for tribal LTC services 4. State Medicaid programs should be required to enter into agreements with IHS and tribal health programs under which reimbursement would be made for the full range of long term care services tribal programs are able to offer, and assure covered services include care management and home health care.
	Increase Federal Match for Medicaid HCBS	
	Medicaid Spousal Impoverishment Rules	
	Medicaid Resources / Asset Test	
	Long Term Care Grants Program	1. Indian tribes must be expressly included as entities eligible for long-term care grant programs, including, but not limited to: 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.
	Functional Assessment Tool for Post-Acute LTC	
	Money Follows the Person Rebalancing Demonstration	1. Authorize tribes to directly access federal funding under this program.
SECTION VIII: Options to Address Health Disparities	***Page 56***	1. Establish an Indian Health Reform Task Force to conduct comprehensive research and a decision making process to redesign the Indian health system within the context of health reform goals. The Indian health system has evolved over time and by and large has been successful at recognizing and responding to the challenges of serving diverse and very poor populations with health status that is unacceptable by any

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		measure. Significant inroads have been hampered primarily by a serious lack of funding. Indian health has adopted a community based, public health model to provide services. Health reform activities are using a competitive, insurance based model, which will not work in many Tribal communities. To research the options and develop the most promising changes for the Indian health system will take time and money. It is important to preserve the strengths while ushering in new system changes that are specifically designed to improve the health of AI/AN in a culturally relevant way. The Task Force will: a. Review and analyze gaps in the levels of health care services provided across the Indian health system that are a result of the varying levels of IHS funding, facilities infrastructure, staffing packages, and third-party collections: b. Gather evidence on utilization, third party collection data; c. Identify conditions that have lead to the poor health of AI/AN across the country; d. Identify models of Indian health care delivery that are successful; e. Identify and recommend actions for revising statutes and regulations that impede or restrict access to funding or services needed to systematically improve the health of AI/AN across the country. f. Submit a report back to the Secretary within 12 months of convening. g. The Secretary, acting through the IHS Director shall appoint members of the Commission and must include a majority membership of tribal representatives. h. The Task Force shall submit its recommendations to the HHS Secretary one year after enactment of the health reform bill.
	Required Collection of Data	1. Health reform legislation must include funding to develop, and support implementation by all I/T/Us, a system for monitoring ,measuring and evaluating 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.
	Data Collection Methods	
	Standardized Categories for Data	
	Public Reporting, Transparency, and Education	1. Beginning one year after enactment of the health reform bill, the Secretary shall submit a report to Congress regarding enrollment and health status of AI/ANs receiving items or services under Medicaid, Medicare, CHIPRA, or other health benefit programs funded under the health reform bill in order to evaluate health care outcomes. Each report shall include the following: a. Total number of AI/ANs enrolled in, or receiving items or services, under such programs. b. The number of Indians described above that also received benefits under programs funded by the

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		Indian Health Service. c. General information regarding the health status of the Indians described above disaggregated with respect to specific diseases or conditions and presented in a manner that is consistent with protections for privacy of individually identifiable health information under section 264(c) of the Health Insurance Portability and Accountability Act. of 1996. d. Provide a specific appropriation to fund this report.
	Language Access	
	Elimination of Five-year Waiting Period for Non-Pregnant Adults	
	Reduction in Infant Mortality and Improved Maternal Well-Being	NPAIHB wants to thank Senate Finance for specifically including tribes as entities eligible to apply.

Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs Finance Committee Paper - April 29, 2009		
Section	**Policy Issue**	**Recommendations**
Section I: Payment Reform - Options to Improve the Quality and Integrity of Medicare Payment Systems	***Page 2***	
• Physician Quality Reporting Initiative (PQRI) Improvements and Requirement • Quality Reporting	Linking Payment to Quality Outcomes	1. Extend the option for bonus payments to physicians and clinics that receive FQHC "look alike" status.
• Primary Care and General Surgery Bonus • Payment for Transitional Care Activities	Primary Care	
Section II: Long-Term Payment Reforms – Options to Foster Care Coordination and Provider Collaboration	***Page 11***	
	Chronic Care Management	
• Sustainable Growth Rate (SGR) • Medicare Shared Savings Program (i.e. Accountable Care Organizations) • Extension and Expansion of the Medicare Health Care Quality Demonstration Program	Moving From Fee-for-Service to Payment for Accountable Care	

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Section III: Health Care Infrastructure Investments – Tools to Support Delivery System Reform	***Page 19***	1. Establish a loan guarantee fund and loan repayment program at the Treasury of the United States to be known as the Health Care Facilities Loan Fund to provide to Indian Tribes and tribal organizations direct loans, or guarantees for loans, for construction of health care facilities (including but not limited to inpatient facilities, outpatient facilities, associated staff quarters and specialized care facilities—such as behavioral health and elder care facilities).
• Encouraging Health Information Technology Use and Adoption in Support of Delivery System Reform Goals • Improving Quality Measurement	Health IT	1. 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. 2. Health reform legislation must include funding to develop, and support implementation by all providers within the I/T/U of, a system for monitoring ,measuring and evaluating 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.
	Comparative Effectiveness Research	1. Ensure that Tribes and Tribal organizations as defined by the ISDEAA are included in the national framework to set national priorities and eligible to conduct such research.
• Physician Payment Sunshine • Physician-Owned Hospitals Nursing Home Transparency	Transparency	
• Redistribution of Unused GME Slots to Increase Access to Primary Care and Generalist Physicians • Promoting Greater Flexibility for Residency Training Programs • TANF Health Professions Competitive Grants • Proposal on Development of a National Workforce Strategy	Workforce	1. The proposed coordinated national strategy to address health care workforce shortages must be included as a key focus area in the Indian health delivery system: a. Expand training and funding for mid-level providers and allied providers who have proven records of providing quality care, such as, but not limited to, community health representatives, community health aides, behavioral health aides, and dental health aide therapists. b. Resources for training, recruiting and retaining health providers should be made available to the I/T/U directly. c. 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. d. Funding for scholarship and loan programs to encourage Indian people to enter the health professions and serve in Indian health programs must be enhanced. 2. Unlimited access to the National Health Service Corp should be made available to the I/T/U. a. Mechanisms for assignment of National Health Service Corps personnel should be revised to enable tribally operated programs to access these personnel on the same basis as the Indian Health Service.

Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs Finance Committee Paper - April 29, 2009		
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		3. Unlimited access to Nursing education loan repayment program be made available to the ITU.
Section IV: Medicare Advantage – Options to Promote Quality, Efficiency and Care Management	***Page 37***	
Section V: Public Program Integrity - Options to Combat Fraud, Waste and Abuse	***Page 42***	
	Provider Screening	
	Data Base Creation and Data Matching	
	Provider Compliance and Penalties	
	Program Integrity Funding and Reporting Requirements	

Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options Finance Committee Paper - May 20, 2009		
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SECTION I: Health System Savings	***Page 4***	
o Improving Payment Accuracy through Adjusting Annual Market BasketUpdates o Updating Payment Rates for Home Health Services o Updating Payment Rates for Inpatient Services o Adjusting Reimbursement for High-Growth, Over-Valued Physician Services o More Appropriate Payment for Durable Medical Equipment o Increase the Medicaid Brand-Name and Generic Drug Rebate Amounts o Extend to and Collect Rebates on Behalf of Managed Care Organizations o Application of Rebates to New Formulations of Existing Drugs	Ensuring Appropriate Payment	1. Authorize the extension of the Medicare Modernization Act of 2003 (MMA) (Section 506) "Medicare like rates" to all Medicare paticipating providers. This would save I/T CHS significant money without costing the federal government anything. Expand from current hospital policy to all Medicare providers.
	Capturing Productivity Gains	
	Reducing Geographic Variation in Spending	

Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options Finance Committee Paper - May 20, 2009		
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o Making Beneficiary Contributions More Predictable o Means Testing Part D Premiums	Modifying Beneficiary Contributions	
SECTION II: Options to Modify the Exclusion for Employer-Provided Health Coverage	***Page 16***	1. AI/AN are entitled to receive health care as a federal trust responsibility. As such, AI/AN (as defined in the Legal citations) must be exempt from any personal income tax on health benefits, services, premiums or cost sharing paid or provided on their behalf. 2. (See attached explanation and proposed language)
SECTION III: Other Health Care Related Revenue Raisers	***Page 18***	
	Modify or Repeal the Itemized Deduction for Medical Expenses	
	Repeal of Modify the Special Deduction and Special Unearned Premium Rule for Blue Cross and Blue Shield or Other Qualifying Organizations	
	Modify Health Savings Accounts	
	Modify or Repeal the Exclusion for Employer-Provided Reimbursement of Medical Expenses Under Flexible Spending Arrangements and Health Reimbursement Arrangements	
	Limit the Qualified Medical Expense Definition	
	Modify FICA Tax Exemption	
	Extend Medicare Payroll Tax to all State and Local Government Employees	
	Modify the Requirements for Tax-Exempt Hospitals	
SECTION IV: Lifestyle Related Revenue Raisers	***Page 33***	
	Impose a Uniform Alcohol Excise Tax	
	Enact a Sugar-Sweetened Beverage Excise Tax	
SECTION V: Administration's Revenue Raising Proposals	***Page 35***	

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

1. **Sec. 123 – HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS**. This demonstration program is intended to address the chronic shortages of health care professionals in the Indian health system.
2. **Sec. 205 – SHARED SERVICES FOR LONG-TERM CARE**. This would authorize IHS and ISDEAA tribes/tribal organizations to operate long-term care programs, and to share staff and facilities.
3. **Sec. 213 – AUTHORITY FOR PROVISION OF OTHER SERVICE**. This provision would expressly authorize IHS and tribes to offer hospice, assisted living, long-term care and home- and community-based care.
4. **Sec. 207 – MAMMOGRAPHY AND OTHER CANCER SCREENING.** This provision updates current law standards for cancer screenings.
5. **Sec. 209 – EPIDEMIOLOGY CENTERS**. This revision to current law would give epi centers access to IHS health data which they need to do their jobs. NOTE: revise text to combine Sec. (e) of S. 1200 and H.R. 1328 (110th Congress bills).
6. **Sec. 222 – LICENSING**. This provision would enable tribal health programs to employ health care professionals licensed in other states just as the IHS is currently able to do. This authority is needed to aid in recruitment and retention of needed professionals.
7. **Sec. 403 – THIRD PARTY COLLECTIONS**. This revised provision would strengthen IHS and tribal program authority to collect reimbursements from 3rd party insurers, and would make the Federal Medical Care Recovery Act applicable to tribal programs.
8. **Sec. 405 – PURCHASING HEALTH CARE COVERAGE**. This would authorize tribes and tribal organizations to use appropriated funds and Medicare/Medicaid revenue to purchase health benefits coverage for beneficiaries.
9. **Sec. 407 – PAYOR OF LAST RESORT**. This provision would codify in law the existing IHS regulation which makes IHS payor of last resort, meaning that all other available sources (e.g., Medicare, Medicaid, private insurance, other) pay for care before IHS appropriated funds are used.
   - 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)).
10. **Sec. 509 – FACILITIES PROGRAM FOR URBAN INDIAN ORGANIZATIONS.** Authorize funding for acquisition and construction of facilities for urban Indian organizations, and authorize feasibility study for creation of a loan fund for construction of urban Indian organization facilities.
11. **Sec. 514 – CONFERRING WITH URBAN INDIAN ORGANIZATIONS.** – Authorize the IHS to confer with urban Indian organizations.
12. **Sec. 517 – COMMUNITY HEALTH REPRESENTATIVES.** Authorize grants/contracts to urban Indian organizations to operate Community Health Representatives programs authorized by Sec. 109 of current IHCIA.
13. **Sec. 601 – ELEVATION OF IHS DIRECTOR TO ASSISTANT SECRETARY FOR INDIAN HEALTH**. This provision would revise current law to elevate the position of IHS Director to an Assistant Secretary of HHS.
14. **Sec. 814 – CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS**. This provision would facilitate quality assurance program reviews for IHS, tribal and urban Indian organization programs. [NOTE: The National Tribal Steering Committee recommends minor revisions to the S. 1200 text.]
15. **New Title VII on BEHAVIORAL HEALTH**. This new title broadens the existing law's title VII which focuses only on substance abuse programs. [NOTE: The National Tribal Steering Committee recommends revisions to recognize systems of care treatment for youth and families.]
16. **Bill title II, Sec. 201 – EXPANSION OF MEDICARE, MEDICAID AND CHIP FOR ALL COVERED SERVICES FURNISHED BY INDIAN HEALTH PROGRAMS AND URBAN INDIAN PROGRAMS**. This provision would amend the

Social Security Act to facilitate access to payments from Medicare, Medicaid and CHIP by IHS, tribal and urban Indian organization programs.

17. **Bill title II, Sec. 209 – ANNUAL REPORT ON INDIANS SERVED BY SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.** This provision would require HHS to collect on an on-going basis much needed data on Indian enrollment in Medicare, Medicaid and CHIP. Congress and tribal health advocates need such data to design policies to assure proper access to these programs. HHS does not now have a mechanism in place to collect this information.

Other recommendations not contained in 110th Congress IHCIA reauthorization bills:

1. **TAX EXEMPTION FOR IHS SCHOLARSHIPS AND LOANS.** [Sec. 124 from S. 211, 107th Cong.]. Make health profession scholarships and loans from IHS non-taxable to recipients.
2. **ACCESS TO FEDERAL FACILITIES AND FEDERAL SOURCES OF SUPPLY FOR URBAN INDIAN ORGANIZATIONS.** [Sec. 517 from S. 212, 107th Cong.) Authorize the Secretary to permit urban Indian Organizations to access FSS, and to acquire excess and surplus Federal property.
3. **ADDITIONAL PROGRAM AUTHORITY FOR URBAN INDIAN ORGANIZATIONS.** Authorize urban Indian organizations to operate the following types of programs authorized by IHCIA current law: mental health training (per Sec. 209); school health education (per Sec. 215); prevention of tuberculosis (per Sec. 218); and behavioral programs in proposed new IHCIA Title VII (see above): Sec. 701 (behavioral health prevention and treatment services); and Sec. 707(g) (multi-drug abuse program).

APPENDIX A

PROPOSAL TO CLARIFY THE EXCLUSION OF HEALTH BENEFITS PROVIDED BY INDIAN TRIBES FROM INCOME

Current Law

Internal Revenue Code ("Code") Section 61 provides that, except as otherwise provided, gross income includes all income from whatever source derived. The U.S. Supreme Court has ruled that Code Section 61 generally includes in-kind benefits and payments to third parties satisfying the obligations of the taxpayer.[3] Treasury Regulation Section 1.61-1(a) states that "gross income" means all income from whatever source derived unless excluded by law.

The Internal Revenue Service ("IRS") and federal courts have consistently held that payments made under legislatively provided social benefit programs for the promotion of general welfare are not includable in the recipient's gross income.[4] Revenue Ruling 76-131, 1976-1 C.B. 16 explicitly lists health as a need that promotes the general welfare. Consistent with this position, in Revenue Ruling 70-341, 1971-2 C.B. 31, the IRS ruled that government provided health care benefits for the elderly, commonly known as Medicare benefits, were nontaxable to recipients. However, in recent non-binding guidance, the IRS has required individuals participating in state-sponsored health-related assistance programs to satisfy a financial means test.[5]

Reasons for Change

A statutory exclusion is needed to clarify that health benefits and health care coverage provided by Indian tribes to their members are not subject to income taxation. The Federal government has a longstanding policy of providing tax-free medical care to Indians. To effect this policy, federal statutes have been enacted stating that a major "goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level"[6] and providing specific authorization for the Indian Health Service, a federal agency that administers funds provided by Congress for the promotion of Indian health care services.[7] However, the federal funds appropriated for Indian Health Service programs have been consistently inadequate to meet even basic health care needs,[8] and Indian tribal governments have been encouraged to use gaming revenues to provide for the health care needs of their members, including through universal coverage programs.[9]

Consistent with the Federal government's policy of providing health care services to Indians, the proposal would clarify that health care benefits provided to Indians are not subject to income taxation. It would also encourage Indian tribes to provide such benefits to their members on a non-discriminatory basis.

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[3] See Old Colony Trust Co. v. Commissioner, 279 U.S. 429 (1929).
[4] See, e.g., Rev. Rul. 57-102, 1957-1 C.B. 26 (payments to the blind); Private Letter Ruling 200845025 (November 7, 2008) (ruling that payments made by an Indian tribe to elderly tribal members who were displaced by a flood were general welfare payments); Bailey v. Commissioner, 88 T.C. 1293 (1987) (considering whether grants to restore a building façade were excludable from income as general welfare payments).
[5] See e.g., Chief Counsel Advice 200648027 (July 25, 2006).
[6] 25 U.S.C. §1601(b).
[7] 25 U.S.C. §13.
[8] See Overview of Federal Tax Provisions Relating to Native American Tribes and Their Members (JCX-61-08) (stating that "the average funding of an IHS site was found to be 40 percent less than an equivalent average health insurance plan").
[9] See NIGC Bulletin No. 05-1 (Subject: Use of Net Gaming Revenue) (January 18, 2005) (available at http://www.nigc.gov under the "Reading Room" tab and "Bulletins" sub-tab).

Description of Proposal
The proposal clarifies that the value of "health services," "health benefits" or "health coverage" received by Indians, whether provided or purchased by the Indian Health Service, either directly or indirectly through grants to or a contract or compact with an Indian tribe or tribal organization, or grants to or other programs of third parties funded by the Indian Health Service; or by an Indian tribe or tribal organization to an Indian either directly, through purchased services, or through accident or health insurance (or through an arrangement having the effect of accident or health insurance) is excluded from gross income. It also provides for the exclusion from gross income any other benefit or service provided by an Indian tribe that supplements the programs and services provided by the federal government to Indian tribes, or other general welfare benefits or services provided by Indian tribes to their members.

The terms "accident or health insurance" and "personal injuries and sickness" have the same meaning as such terms do in Code Section 104 and, as such, are intended to include preventative health care services.

The term "Indian tribe" is defined in the proposal as any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or regional or village corporation, as defined in, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.) which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.
The term "tribal organization" follows the definition in the Indian Self-Determination and Education Assistance Act and means the recognized governing body of any Indian tribe (or consortium of Indian tribes) or any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization (see 25 U.S.C. 450(*l*)).

The term "Indians" or "Indian" is based on the definition of the term "Indians" or "Indian" under the Indian Health Care Improvement Act (25 U.S.C. 1603(c)). The proposal states that "Indians" or "Indian" means any person who (A) is a member of an Indian tribe, as defined in subsection (b)(2) of this section, (B) (i) irrespective of whether the individual lives on or near a reservation, is a member of tribe, band, or other organized group terminated since 1940 and those recognized now or in the future by the State in which they reside, (ii) is a descendant, in the first or second degree, of any such member, (C) is an Eskimo, Aleut or other Alaska Native, or (D) is considered by the Secretary of the Interior to be an Indian for any purpose.

No inference is intended as to the tax treatment of governmental benefits (including, but not limited to health care benefits not covered under this proposal) provided by Indian tribes to Indians before, on, or after the date of enactment of this section.

Health Benefit Exclusion Language (Internal Revenue Code Section 61)
(a) Gross income does not include

(1) health services or benefits provided or purchased by the Indian Health Service, either directly or indirectly, through a grant to or a contract or compact with an Indian tribe or tribal organization, or grants to or other programs of third parties funded by the Indian Health Service;
(2) health services, health benefits or other amounts for health care services, including preventive care and treatment of personal injuries or sickness and other health conditions, provided by an Indian tribe or tribal organization to an Indian either directly, through purchased services, or through accident or

health insurance (or through an arrangement having the effect of accident or health insurance);

(3) the value of health coverage provided or premiums paid by an Indian tribe or tribal organization to or on behalf of an Indian under an accident or health plan (or through an arrangement having the effect of accident or health insurance); or

(4) any other benefit or service provided by an Indian tribe that supplements the programs and services provided by the federal government to Indian tribes or Indians, or other general welfare benefits or services provided by Indian tribes.

(b) Definitions.

(1) The terms "accident or health insurance" and "personal injuries and sickness" shall have the same use and meaning as 26 U.S.C. 104.

(2) The term "Indian tribe" means any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or regional or village corporation, as defined in, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.) which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(3) The term "Indians" or "Indian" means any person who

(A) is a member of an Indian tribe, as defined in subsection (b)(2) of this section,

(B) (i) irrespective of whether the individual lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, (ii) is a descendant, in the first or second degree, of any such member,

(C) is an Eskimo or Aleut or other Alaska Native,

(D) is otherwise eligible for services provided or funded by the Indian Health Service under applicable law, or

(E) is considered by the Secretary of the Interior to be an Indian for any purpose.

(4) The term “tribal organization” means the recognized governing body of any Indian tribe (or consortium of Indian tribes) or any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization (see 25 U.S.C. 450b(*l*)).

(c) No inference is intended as to the tax treatment of governmental benefits (including, but not limited to health care benefits not covered under this section) provided by Indian tribes to Indians before, on, or after the date of enactment of this section.