

TRIBAL NATIONS HEALTH BRIEFING: 2017 PRESIDENTIAL TRANSITION

American Indian & Alaska Native Leader Handbook



National Indian
Health Board



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Introduction:

With every new Administration and Congress entering Washington, DC, Indian Country must invest in comprehensive and vigorous education efforts to ensure policy makers have the requisite knowledge about Tribal health needs, Indian health care delivery, Tribal governance and infrastructure, federal duties to Tribes, and most importantly, Tribal health priorities. Over the last several decades Tribes have made major improvements in the government-to-government relationship and the acknowledgement of the federal trust responsibility for health. In the coming weeks, months, and years it is critical that we build upon these successes to continue providing outreach for Indian health priorities.

The Indian Health Care Improvement Act and Healthcare Reform

Among the most significant achievements of the last several years was permanent authorization of the Indian Health Care Improvement Act (IHCIA) which was included as part of the Patient Protection and Affordable Care Act (ACA), though it is unrelated to the underlying healthcare reform legislation. Tribes fought for almost two decades to see the law passed. Previous iterations of IHCIA had been enacted, but authorization had expired by 2000. Provisions included in the ACA were a result of years of negotiations, meetings and strategy sessions led by the National Indian Health Board (NIHB). Tribes worked collaboratively to develop a final product that included permanent reforms that were not only impactful, but had bipartisan support.

The IHCIA provides a wealth of resources and opportunities for Tribal health care institutions, families, providers, and patients. Now, with the permanent reauthorization of the IHCIA in the ACA, the Indian Health Service (IHS)/ Tribal / Urban (I/T/U) health system has begun a new chapter in the delivery of quality health care to American Indians and Alaska Natives (AI/ANs). Other critical provisions for the Indian health delivery system that are outside of the IHCIA but still in the ACA include making IHS the payer of last resort; tax exemption for Tribal health benefits; and the ability for I/T/U providers to bill Medicare Part B. Similarly, Medicaid expansion from the ACA has substantially increased third-party revenue to the Indian health care delivery system, making it a vital component in filling the disparity gap created by inadequate IHS funding.

Congress is considering legislation that may repeal the ACA either partially or in its entirety. NIHB is working to ensure that the progress made by the permanent enactment of the IHCIA is retained, with that, we need the help and engagement of Indian Country. NIHB is organizing a coalition to support the continued inclusion of IHCIA and Indian-specific priorities in healthcare reform and to ensure that AI/ANs can continue to benefit from the Medicaid program.

The following transition document represents Tribal priorities developed from extensive consultation and collaboration with Tribes and Tribal organizations. Included are additional resources, talking points, and other information that will be helpful to you as you reach out to and engage with Congress and the Administration on these and other critical issues facing Indian health today. We encourage you to help advocate for Tribal health priorities by:

- Participating in Tribal advisory committee meetings
- Writing letters to Congress and the new Administration
- Visiting Washington, DC to take part in Congressional and Administration visits
- Providing NIHB with stories, information, and data on how the ACA or IHCIA has benefited your Tribal community

At the end of this briefing book, you will find handouts on key Indian health issues that you can share with Congressional and Administration staff. You can find materials and other information on the ACA and IHCIA here:

http://nihb.org/legislative/ihcia_and_aca.php.

If you have any questions please contact NIHB staff:

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Who is the National Indian Health Board?

Our Mission: One voice affirming and empowering American Indian and Alaska Native Peoples to protect and improve health and reduce health disparities.

Who Are We?

We are a national Tribal organization founded by the Tribes in 1972 to serve as the unified, national Native/Tribal voice for American Indian and Alaska Native health in the policy-making arena. The National Health Board (NIHB) is a 501(c)3 not for profit, charitable organization.

Our Members are the regional Tribal organizations, either Area Indian Health Boards, or Regional Tribal organizations that include health in their scope, located within each of the 12 geographic service areas of the Indian Health Service (IHS).

Our Board of Directors is comprised of distinguished and highly respected Tribal leaders in American Indian and Alaska Native health. They are elected by the Tribes in each region to be the voice of those Tribes at the national level. Because the NIHB serves all federally-recognized Tribes, it is important that the work of the NIHB reflect the unity and diversity of Tribal values and opinions in an accurate, fair, and culturally-sensitive manner. This objective is accomplished through the work of the NIHB Board of Directors representing the Tribes in their region.

Raising Awareness and elevating the visibility of Indian health care issues to national policymakers and funders is at the heart of NIHB's work. It has been a struggle shared by Tribal governments, the federal government and private agencies. For 45 years, NIHB has continuously played a central role in focusing national attention on Indian health care needs, developing Tribal health policy recommendations, and advocating for Tribal priorities. These efforts continue to gain results and momentum.

Since 1972, the NIHB has advised the U.S. Congress, IHS, other federal agencies and private foundations about health disparities and service issues experienced in Indian Country. The future of health care for American Indians and Alaska Natives is intertwined with policy decisions at the federal level and changes in mainstream health care management. The NIHB provides Tribal governments with timely information to assist them with effective health care policy decisions.

NIHB provides health care advocacy services, facilitates Tribal budget formulation, provides culturally informed Tribal consultation support and preparation, testifies before Congress and provides timely information and other services to all Tribal Governments. NIHB offers two premiere national health conferences annually, a National Tribal Public Health Summit and a National Tribal Health Conference focused on Law, Policy and the Business of Medicine. Whether Tribes operate their own health care delivery systems through contracting and compacting or receive health care directly from the IHS, NIHB is their advocate.

NIHB also conducts research; provides policy analysis; develops policy recommendations; and provides training, technical assistance, and project management. These services are provided to Tribes, Area Health Boards, Tribal organizations, federal agencies, and private foundations. The NIHB continually presents the Tribal perspective in its quest to build support for, and advance, Indian health care issues.

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AN OVERVIEW OF THE INDIAN HEALTH SYSTEM

INTRODUCTION

The Indian Health Service (IHS), an operating division of the U.S. Department of Health and Human Services (HHS),¹ delivers culturally competent health services for American Indians and Alaska Natives (AI/ANs). IHS is one of four core federal health delivery systems.² IHS provides services in a variety of ways: directly, through agency-operated programs; through Tribally-contracted and operated health programs; and indirectly, through services purchased from private providers. IHS also provides limited funding for urban Indian health programs that serve AI/ANs living outside of reservations or other Tribally operated lands. This varied system of delivery is commonly referred to by its initials: I/T/U (IHS, Tribal, and urban). Tribes may choose to receive services directly from IHS, through contracting or compacting agreements, or they may combine these options based on their needs and preferences.

Indian health services were permanently reauthorized in 2010 through the Indian Health Care Improvement Act (IHCIA), which was enacted as part of the Patient Protection and Affordable Care Act (P.L. 110-148) (ACA). In the IHCIA, Congress declared: “[I]t 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.”³ Despite challenges in the I/T/U system, it is a critically important component of care for AI/ANs and many others living in remote, rural communities. For those populations, IHS represents health care access in its entirety, both in terms of monetary resources but also facility access. Without IHS, and the Tribal clinics and hospitals it funds, there would be no care for hundreds of miles in some cases. The IHCIA is entirely independent from the broader health reform authorized by the ACA and it must be preserved.

THE VALUE OF THE INDIAN HEALTH SYSTEM

AI/ANs experience worse health outcomes compared with the rest of the U.S. population. High rates of poverty, accompanied by high unemployment rates, barriers to accessing higher education, poor housing, lack of transportation and geographic isolation all contribute to poor health outcomes. AI/ANs continue to experience historical trauma from damaging federal policies, including those of forced removal, boarding schools, and taking of Tribal lands, and continuing threats to culture, language, and access to traditional foods. Historic and persistent under-funding of the Indian healthcare system has resulted in problems with access to care, and has limited the ability of the Indian healthcare system to provide the full range of medications and services that could help prevent or reduce the complications of chronic diseases.

IHS exists to serve the health care needs of AI/ANs and to address those disparities. Since the creation of the agency in 1955, the life expectancy of AI/ANs has increased from 60 years to 73.7 years.⁴ Today the Indian healthcare system includes 46 Indian hospitals (1/3 of which are Tribally operated) and nearly 630 Indian health centers, clinics, and health stations (80 percent of which are Tribally operated). When specialized services are not available at these sites, health services are purchased from public and private providers through the IHS-funded purchased/referred care (PRC) program. Additionally, 34 urban Indian programs offer services ranging from community health to comprehensive primary care.

Community Care, Public Health & Innovation

¹ Congressional appropriations for IHS flow through the Interior, Environment and Related Agencies Appropriations bill.

² Other federal health systems include: Veterans Health Administration; Defense Health Agency; and Bureau of Prisons Health Services Division.

³ 25 U.S.C. § 1602.

⁴ It is important to note that the life expectancy of AI/ANs is still 4.2 years less than the national average, and in some states it is a full 20 years less than the white population.

The I/T/U system utilizes a community-based public health model with many approaches that are not found in typical American medical delivery systems. For example, Indian health programs include public health nursing, community outreach workers, prevention services, dental health aide therapists, and even support community water and sanitation services. Indian health programs have pioneered new types of providers, such as community health aides and dental health therapists, as well as new approaches to delivering services in remote rural areas, including telehealth. Tribal governments manage a wide range of services, such as substance abuse treatment, the United States Department of Agriculture (USDA)'s Special Supplemental Nutrition Program for Women, Infants and Children (WIC), senior centers and elder nutrition sites, rabies vaccinations for dogs, and injury prevention programs, to name just a few. Tribal programs tend to be more grounded in the cultural practices and norms of the community members they serve. For instance, many programs routinely include language services and are located within the Tribal communities they serve .

FUNDING AND STRUCTURE OF IHS

Direct Service Tribes (DST) are those Tribes that either in whole or in part, receive primary health care directly from the Indian Health Service. Self-Governance Tribes (SGT) are those Tribes that negotiate with IHS and assume funding and control over programs, services, functions or activities or portions thereof, that IHS would otherwise provide. DSTs choose to rely on IHS for their delivery of health care, citing a number of reasons for doing so, including: lack of resources and infrastructure, rural locations, and belief that the United States upholds its treaty obligations by providing direct services. However, IHS is only funded at approximately half of actual need, which creates challenges to the system overall. The funding that IHS receives is shared between DSTs and SGTs, with DSTs receiving roughly 40 percent of funding.

SGTs have achieved great improvements in health outcomes, and more and more Tribes choose to operate their own health programs. Self-governance represents efficiency, accountability and best practices in managing and operating Tribal programs and administering federal funds at the local level. In fact, many of the programs founded by SGTs are some of the most innovative and modern health systems in the country. By investing their own revenues, pooling resources together and creating systems that are culturally appropriate and efficient, many SGTs are able to provide a continuum of care unparalleled in mainstream America. About 56 percent of the IHS budget is operated directly by the Tribes through self-governance contracts and compacts. However, it is important to note, that it is still the sovereign decision of each individual Tribe to choose to enter into self-governance compacts.

THE INDIAN HEALTH CARE IMPROVEMENT ACT AND OTHER ACA INDIAN PROVISIONS

The IHCA was permanently reauthorized in 2010 in section 10221 of the ACA, even though it is entirely unrelated to the ACA or the underlying healthcare reform the ACA represents. The IHCA provides critical new resources and opportunities for Tribal health care institutions, families, providers and patients and is the foundation of the modern Indian health care system. IHCA updates and modernizes health delivery services, such as cancer screenings, home and community based services 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 examples of IHCA authorities making a major difference in the delivery of Tribal health programs include the ability for medical professionals working at an I/T/U program to be licensed in any state; the ability for Tribes to participate in the Federal Employees Health Benefit program; and authority for long-term care services. It is critical that IHCA be preserved. Revoking this law would remove many important cost-saving and modernizing laws that have helped bring IHS into the 21st Century.

In addition, there are other Indian-specific provisions enacted as part of the ACA that are similarly unrelated to the broader health reform programs enacted by the ACA. These independent, Indian specific stand-alone provisions play an important role in modernizing the Indian health care system and ensuring that federal resources are

maximized to lead to the best possible health outcomes. For example, Section 2901 of the ACA made IHS the payor of last resort, and Section 2902 granted IHS and Tribal health programs permanent authority to collect reimbursements for all Medicare Part B services. Section 9021 of the ACA added Section 139D to the tax code to make the value of health benefits provided by a Tribe to its members not includable as taxable income. None of these provisions have anything to do with the health reforms enacted by the ACA as a whole, but all are critically important reforms to the Indian health system. These important protections for the Indian health system must be preserved in future legislation. Finally, the ACA recognized the Indian health system as a critical component of health care reform and included many Indian-specific provisions to help the IHS and Tribes leverage health reform to improve federal and Tribal health services and outcomes, like premium subsidies, cost sharing exemptions, and monthly enrollment for Indians. These provisions have helped to increase revenues for I/T/U programs to begin to address the historic underfunding of these programs. As health reform continues to evolve, the importance of these programs to the federal health care system must not be forgotten.

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Preservation of the Indian Health Care Improvement Act

Request: Preserve the Indian Health Care Improvement Act (IHCIA) and other provisions directly benefiting Indian health system in any healthcare reform legislation.

Issue: The Indian Health Care Improvement Act (IHCIA) was enacted in 2010 as part of the Patient Protection and Affordable Care Act (ACA), though it is unrelated to the underlying healthcare reform legislation. It was tacked onto the end of the law at Section 10221. It serves as the backbone legislation for the Indian Health Service (IHS)/Tribal/ and Urban Indian health system which provides healthcare services for American Indians and Alaska Natives (AI/ANs) in fulfillment of the federal government's trust responsibility for health that is derived from statutes, treaties, and Executive Orders. Tribes worked collaboratively with Congress to develop a final product that included impactful and bipartisan reforms. Tribes fought for over a decade to see this legislation move, and when ACA was moving through Congress in 2010, it was thought that this would be a good vehicle to get it enacted, not because it was related to healthcare reform. The specific IHCIA authorizations and provisions represented an entirely discrete legislative effort that just so happened to culminate in the same public law.

Talking Points:

- The IHCIA provides a wealth of new resources and opportunities for Tribal health care institutions, families, providers and patients. With the permanent reauthorization of the IHCIA, the Indian health care system has begun a new chapter in the delivery of quality health care to American Indians and Alaska Natives.
- IHCIA updates and modernizes health delivery services, such as cancer screenings, home and community based services and long-term care for the elderly and disabled.
- IHCIA provides many essential cost-saving provisions for IHS and Tribes, such as the authority for I/T/U health providers to be licensed in any state and practice at an I/T/U facility.
- IHCIA allows I/T/U providers to be eligible for participation in any federal healthcare program and for reimbursement from 3rd party payers which is critical to bring in additional much needed resources into the I/T/U system.
- Additionally, it provides many essential cost-saving provisions for IHS and Tribes, such as the authority for I/T/U health providers to be licensed in any state and practice at an I/T/U facility and the ability for Tribes to access the Federal Employee Health Benefits (FEHB) system.

In addition, there are Indian-specific provisions in the ACA other than the IHCIA that provide important protections and funding opportunities for the I/T/U system.

- **Section 2901** which 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.
- **Section 2902** which granted I/T/U providers permanent authority to collect reimbursements for all Medicare Part B services.
- **Section 9021** ensures that any health benefits provided by a Tribe to its members are not included as taxable income.

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Medicaid Reform

Request: Preserve 100 percent federal reimbursement rate for Medicaid services provided to American Indians and Alaska Natives that are received through the Indian health system.

Issue: In 1976, Congress enacted Title IV of the IHCA which amended the Social Security Act (SSA) to require Medicare and Medicaid reimbursement for services provided in IHS and Tribally operated health care facilities. The Medicaid program is vital in augmenting the chronically underfunded Indian health system. The Medicaid program is a key component in the United States' fulfillment of its trust responsibility to provide for the health care needs of American Indians and Alaska Natives (AI/ANs).

Talking Points:

- The Medicaid program is vital in fulfilling the federal trust and legal responsibility toward AI/ANs. In 1976, Congress enacted Title IC of the IHCA which amended the Social Security Act to require Medicare and Medicaid reimbursement for services provided in IHS & Tribal health care facilities.
- This was 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 health care program which has for too long been insufficient to provide quality health care to the American Indian."
- With discretionary appropriations consistently falling far short of need, Medicaid provides the Indian health system with much needed funding to provide basic healthcare services to AI/ANs. Expanded eligibility under the Medicaid program 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.
- Congress should ensure that increased Medicaid eligibility is continued for AI/ANs in any type of Medicaid reform to ensure that the I/T/U system does not experience significant funding shortfalls.
- **100% FMAP:** For over 40 years, the federal government has reimbursed States for 100 percent of the cost of providing Medicaid services to AI/ANs.
 - This ensures that IHS access to state Medicaid services does not burden the states with what is a federal responsibility.
 - The reimbursement by the federal government to states 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 that the federal government's trust responsibility is not shifted to the States.

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Tribal Consultation

Request: Preserve and Reaffirm Executive Order 13175

Issue: On November 6, 2000, President Clinton issued Executive Order 13175 that set forth clear definitions and frameworks for consultation, policymaking and accountability in order to support the following aims: (1) strengthen the government-to-government relationship between the United States and Indian Tribes (2) establish meaningful consultation with Tribal officials in the development of federal policies and (3) limit the number of unfunded mandates imposed on Indian Tribes. Executive Order 13175 applies broadly, to any federal agency; this includes “any executive department, military department, government corporation, government controlled corporation, or other establishment in the executive branch of the federal government.” Today, seventeen agencies have created or updated Tribal consultation policies. Many of these consultation policies also created Tribal advisory committees to assist the department in the development of policies and regulations that have an impact on Tribes.

Talking Points:

- Tribal advisory committees provide opportunities for Tribal representatives to set priority issues and recommendations to federal officials and are an essential component of Tribal consultation. They play an important role in guiding the direction and development of federal policies and regulations by providing education on how policies will impact their communities.
 - Membership of Tribal Advisory Committees must be Tribally driven and at the discretion of Tribes and Tribal organizations and include representation from every IHS Area and representation from both Direct Service Tribes and those Tribes that receive services by compacting and contracting with the Indian Health Service. Tribal committees should also include representation from large Native health organizations.
 - Tribal Advisory Committees must also permit the presence and assistance of Technical advisors to provide Tribal representatives with technical expertise on priority issues.
- Consultation Must be Meaningful
- Tribes must have timely written notice before moving forward with new policies that have Tribal implications. Tribal implications refers to regulations, legislative comments or proposed legislation, and other policy statements or actions that have substantial direct effect on one or more Tribes, on the relationship between the Federal Government and Tribes, or on the distribution of power and responsibilities between the Federal Government and Tribes.
- Consultation must take place prior to the rulemaking process.

Tribal Consultation Policies

- Each agency or department should continue to develop or update Tribal consultation to reflect the needs of Indian country. Each agency or department must consult with Tribes in the development or update of any Tribal consultation policy.
- The Federal Government must require states that receive federal funding to conduct meaningful consultation to ensure that Tribes have access to the necessary services in fulfillment of the Federal Government’s trust responsibility.

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Expansion of Tribal Self Governance Throughout the U.S.

Department of Health and Human Services

Request: Utilize current legal and administrative authority to expand self-governance within HHS through demonstration projects, and work with Congress to support the permanent expansion of Self-Governance

Issue: In 2000, P.L. 106-260, included a provision directing the U.S. Department of Health and Human Services to conduct a study to determine the feasibility of a demonstration project extending Tribal Self-Governance to HHS agencies other than the IHS. The HHS Study, submitted to Congress in 2003, determined that a demonstration project was feasible. In the 108th Congress, Senator Ben Nighthorse Campbell introduced S. 1696 - Department of Health and Human Services Tribal Self-Governance Amendments Act- that would have allowed these demonstration projects. A second study was completed in 2011 by the U.S. Department of Health and Human Services Self-Governance Tribal Federal Workgroup that noted additional legislation would be needed.

Talking Points:

Additional Background:

- Self-Governance represents efficiency, accountability and best practices in managing and operating Tribal programs and administering Federal funds at the local level.
- Expanding Self-Governance translates to greater flexibility for Tribes to provide critical social services within agencies such as the Administration on Aging, the Administration on Children and Families, the Substance Abuse and Mental Health Administration, and the Health Resources and Services Administration.
- It is imperative that HHS work closely with Tribes to strengthen current Self-Governance programs and advance initiatives that will streamline and improve HHS program delivery in Indian Country.
- Self-Governance is a proven solution that has improved health outcomes for AI/ANs.
- Allowing Tribes to enter into self-governance compacts with HHS, would mean that federal dollars are used more efficiently because resources in Tribal communities, which are often small, could be more easily pooled and would allow Tribes to organize wrap around services to better serve those who have the greatest need.
- Self-governance Tribes extend services to more eligible Indians leveraging other opportunities more efficiently than the federal government.
- Self-governance also leads to better outcomes because program Administrators are in close contact with the people they serve making the programs more responsive and effective

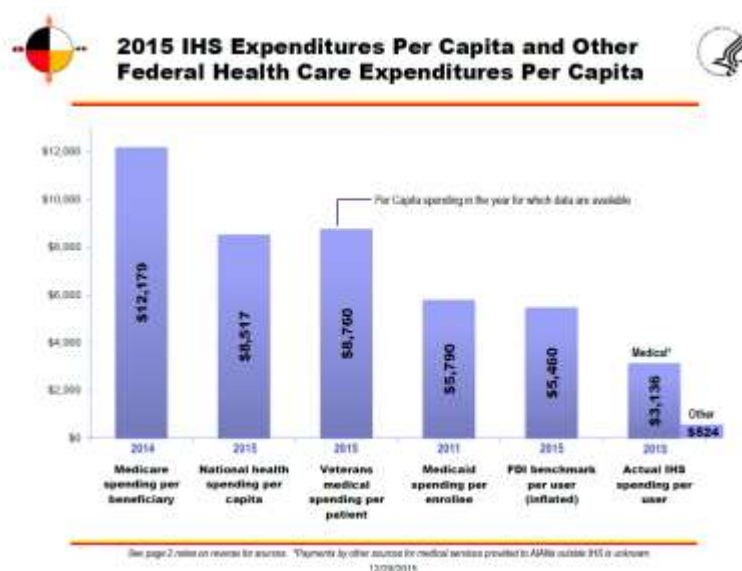
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Full Funding for IHS

Request: Support full-funding for the Indian Health Service in any budgets submitted to Congress and aggressively petition Congress for the enactment of this budget.

Issue: Year after year, the federal government has failed American Indians and Alaska Natives by drastically underfunding the Indian Health Service (IHS) far below the demonstrated need. For example, in 2015, IHS spending for medical care per user was only \$3,136, while the national average spending per user was \$8,517 - an astonishing 63% difference. This correlates directly with the unacceptable higher rates of premature deaths and chronic illnesses suffered throughout Indian communities. While the average life expectancy is 4.2 years less for all AI/ANs than it is for other Americans, the disparity is much greater in certain Tribal communities.



Unless sufficient funding is made available for Tribal health programs, health disparities will never be eliminated as called for in Healthy People 2020. It will take a more meaningful investment targeted toward primary and preventative health, including public health services, in order for Tribes to begin reversing the trend of rising premature death rates and early onset of chronic illnesses.

During the last several years, bipartisan collaboration between Congress and the Administration has resulted in a noticeable overall increase for the total IHS budget of 53% since FY 2008, sadly however, this has only resulted in a slight increase in the IHS services portion of the budget. In reality, much of the increases in funding over the past eight years have supported population growth, rising medical inflation, staffing funding for specific new/expanded facilities, and the rightful funding of legal obligations such as Contract Support Costs (CSC). A more significant funding increase, including necessary investments in adequate facilities, modernized infrastructure, and a qualified workforce, is needed so that quality healthcare services can be delivered in a safe manner within all AI/AN communities. Only then will we expect to see a noticeable correlating improvement in health outcomes for our people.

Tribes call on the next Administration to take decisive steps to accelerate health gains in American Indian and Alaska Native communities, while preserving the investments and health improvements achieved over these past several years. To do this, the department must propose a budget for IHS that is **bold, effective, and which contains important policy reforms** to ensure that AI/ANs experience the highest standard of care possible. Funding IHS \$7.1 billion in FY 2018 will instill trust in Indian leadership that the recent gains we have made are real, and that we are truly working together to build a more equitable and quality-driven Indian health system.

Talking Points:

IHS Funding is fulfillment of the federal trust responsibility

- The United States assumed this responsibility through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace. The Snyder Act of 1921 (25 USC 13) legislatively affirmed this trust responsibility.
- For American Indians and Alaska Natives, the federal budget is not just a fiscal document, but also a moral and ethical commitment. The budget request for Indian health care services reflects the extent to which the United States honors its promises of justice, health, and prosperity to Indian people.

Health Funding for Indian Country has been hurt by sequestration and government shutdown

- In FY 2013, sequestration cuts devastated Tribal communities throughout the United States. In a health care delivery system that has been chronically underfunded for decades, this was pure disaster for clinics across Indian Country.
- IHS should be permanently, fully exempt from sequestration in FY 2017 and beyond as the treaties that govern IHS funding are promises made.

The Next Administration should work with Tribes to think of creative solutions to increase the IHS budget

- Tribes are aware of the constraints placed on the IHS budget through the annual discretionary appropriations process.
- The Administration should work with Congress to find creative solutions to supplement the discretionary appropriation for IHS such as utilizing authorities at other programs in the Department of Health and Human Services or through Medicaid reform.
- Tribal treaties are not discretionary, and the Administration should explore ways to get additional resources to IHS not dependent on annual appropriations

The cornerstone of any future budget should be transparency and accountability

- The Indian Health Service should provide a detailed breakdown of how spending is allocated at the national and area level to Congress and Tribes each year.
- For many years, revenues at the Indian Health Service have not been provided to Tribes and Congress making it unclear where shortfalls lie and how funding flows to the local level.
- IHS, in partnership with Tribes, should update the level of need funded for the agency and dedicate specific technical staff to keep this figure current.

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End to Sequestration for IHS

Request: The Administration should work with Congress to ensure that IHS is not subject to sequestration that occurs as a result of the Budget Control Act of 2011 (P.L. 112-25) or any future laws passed by Congress.

BACKGROUND: The Budget Control Act of 2011, (P.L. 112-25) requires that federal spending remain under a certain cap. If that does not happen through the annual budget process, then automatic cuts, known as “sequestration” occur. But Congress designed the law so that the federal programs that serve the most vulnerable populations were exempt from the full sequester. When across-the-board sequestration occurred in 2013, all other federal programs that serve the health of our nation’s populations with the highest need, such as Social Security, Medicare, Medicaid, the Children’s Health Insurance Program, and the Veterans Administration, were exempt from full effect of the funding reductions. But, not the Indian Health Service (IHS) or other programs serving Indian Country. This loss of over \$219 million out of the IHS budget translated into a reduction of primary health care and disease prevention services for American Indians and Alaska Natives which means loss of life in both short term and long term. The budget crisis in the United States is not due to the nation’s obligation to Indian Tribes.

Talking Points:

Tribes have prepaid for their health care

- The federal promise to provide Indian health services was made long ago. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation’s obligations to the Tribes which were granted to AI/ANs through treaties as an exchange for Tribal land a peace.
- Sequestration cuts are a violation of the trust responsibility and represent another broken promise the federal government made to Indian Country.
- Even 2% is too much!

Better stability in funding = better care

- The Indian Health Service is funded far below actual need, so any disruption in funding greatly hampers the ability of IHS, Tribes and Urban health systems to deliver necessary services due to lack of funds.
- Exempting IHS from Sequestration would mean that AI/ANs are receiving better care with more access to critical services. Loss health care means surgeries are delayed, prevention not given, which results in increased sickness and even death

Parity between the Indian Health System and other Federal Health Providers

- During the 2013 Sequestration cuts, the Veterans Health Administration (VHA) was practically exempt from sequestration. IHS, like the VHA, provides direct medical care to fulfill legal promises made by the federal government. Other federally-funded health programs such as Medicare and Medicaid were also exempt from the full sequester.
- As a direct health provider to some of the nation’s most in-need populations IHS should be exempt

Better recruitment and Retention of Medical Professionals

- According to the IHS, there are over 1,550 vacancies for health professionals across the system. As a rural health provider, recruitment and retention of medical staff is a chronic challenge.
- When sequestration occurred in 2013, many providers left IHS and Tribal providers, causing long-term vacancies across the IHS and Tribal health system.

2013 Sequestration Cuts		
Program	Population Served	Sequestration
Social Security	Retirees, Survivors and Individuals with Disabilities	Exempt
Medicare	Citizens/Residents 65 Years or Older, Individuals with Disabilities or End-Stage Renal Disease	Exempt ¹
Medicaid and Children's Health Insurance Program	Low-Income Families with Dependent Children, Pregnant Women, Individuals with Disabilities	Exempt
Veterans Health Administration	Veterans	Exempt
Indian Health Service – Special Diabetes Program for Indians	American Indians and Alaska Natives with Diabetes	2.0
Indian Health Service – Services and Facilities	American Indians & Alaska Natives	5.1
Note: ¹ Medicare is subject to a 2% reduction cut. The reductions in Medicare spending would come from payments to various health care providers, but beneficiaries would not be directly impacted. Beneficiaries may feel the effects if the payment cuts lead physicians and hospitals to stop treating Medicare beneficiaries.		

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Special Diabetes Program for Indians

REQUEST: Renew the Special Diabetes Program for Indians at least at \$200 million for 5 years and/or support long-term reauthorization of SDPI by September 30, 2017.

ISSUE: The Special Diabetes Program for Indians (SDPI) will expire on September 30, 2017, unless Congress takes action. This program is usually renewed as part of the “Medicare Extenders” legislation. In 2015, the annual legislation which typically contained Medicare Extenders was permanently reauthorized. SDPI should be included in legislation between now and September 30, 2017.

SDPI is changing the diabetes landscape in Indian Country. Today, the program supports 330 diabetes treatment and prevention programs in 35 states. Community-driven, culturally appreciate programs have led to significant advances in diabetes education, treatment and prevention. Failure to renew this program will mean worse health outcomes for American Indians and Alaska Natives and all the successes built by this program will be gone.

Talking Points:

SDPI is Saving Lives and Dollars

- In 2000-2011, the incidence rate of End-Stage Renal Disease (ESRD) in AI/AN people with diabetes declined by 43% – a greater decline than any other racial or ethnic group.
- ESRD is the largest driver of Medicare costs. Medicare costs per year for one patient on hemodialysis exceeded \$87,000 in 2013. This reduction in new cases of ESRD translates into significant cost savings for Medicare, the Indian Health Service, and other third party payers.
- The average blood sugar level, as measured by the hemoglobin A1C test, decreased from 9.0% in 1996 to 8.1% in 2014. Every percentage drop in A1C results can reduce risk of eye, kidney, and nerve complications by 40%.

Bipartisan Support

- In the fall of 2016, 75 Senators and 356 Members of the House signed a letter in support of SDPI.

Community Transformation

- More than 80% of SDPI grant programs now use recommended public health strategies to provide diabetes prevention activities for AI/AN children and youth. This represents a 73% increase in primary prevention and a 56% increase in weight management activities targeting children and youth.
- Communities with SDPI-funded programs have seen a 57% increase in nutrition services, a 72% increase in community walking and running programs, and a 65% increase in adult weight management programs.

SDPI Improves Economic Conditions

- The SDPI’s significant economic impact on Tribal communities throughout Indian Country has resulted in job creation opportunities that has brought skilled diabetes experts into Tribal communities and has helped to improve the economic infrastructure of Indian Country.
- In many areas, health jobs are limited, so SDPI is enabling these communities to increase employment and contributes to overall economic growth.

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Advance Appropriations for IHS

Request: Support Advance Appropriations for the Indian Health Service in the President's Budget

Issue: An advance appropriation is funding that becomes available one year or more after the year of the appropriations act in which it is contained. This could greatly improve the delivery of care for IHS direct service Tribes as well as compacting Tribes. Since FY 1998, there has been only one year (FY 2006) when the Interior, Environment, and Related Agencies budget, which contains the funding for IHS, has been enacted by the beginning of the fiscal year. The lateness in enacting a final budget during that time ranges from 5 days (FY 2002) to 197 days (FY 2011). These delays make it very difficult for Tribal health providers and IHS to adequately address the health needs of American Indians and Alaska Natives. Advance appropriations will allow IHS and Tribal health professionals time to plan and tackle many other administrative hurdles, thereby enriching access to care.

Talking Points:

Better stability in funding = better care

- The Indian Health Service is funded far below need, so any disruption in funding greatly hampers the ability of IHS, Tribes and Urban health systems to deliver necessary services due to lack of funds. Adopting advance appropriations for IHS would result in the ability of health administrators to continue treating patients without wondering if –or when– they will have the necessary funding.

Better recruitment and retention ability

- IHS and Tribal health professionals will know in advance how many positions they can hire or retain since staff often resign when funding is in doubt.

Parity between the Indian Health System and other Federal Health Providers

- In FY 2010, the Veterans Health Administration (VHA) achieved advance appropriations. IHS, also provides direct medical care to fulfill legal promises made by the federal government. The promises to American Indians and Alaska Natives were made in Treaties and executive orders, and have been repeatedly reaffirmed in Supreme Court cases and legislation. Altogether, these create a trust responsibility that runs from the federal government to the Tribes.
- Other federally-funded health programs such as Medicare and Medicaid are “mandatory” funding, meaning that these programs are automatically funded without annual appropriations, and without the uncertainty seen in other areas of the budget.

Significantly Improved program efficiency

- Funding disruptions create significant administrative costs for health programs. Advance appropriations would result in decreased costs to health programs by allowing long-term contracts with outside vendors and suppliers.
- Better ability to plan programmatic activity over several years, thereby leading to better health outcomes.

IHS Budget is stable over time, and could easily be predicted in advance

- With the exception of population growth and inflation, IHS budget has remained consistent.
- Top Priorities of Purchased/referred care; Mental Health; Alcohol and Substance Abuse; Construction are consistent from year to year.

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Increasing Federal Funding for Indian Health Beyond the IHS

Request: Ensure that health programs throughout the federal government have set-asides for Tribes and Tribal organizations.

Issue: Tribes and Tribal organizations receive a disproportionately low number of Department of Health and Human Services (HHS) grant awards. One significant obstacle for Tribes to receive adequate funds for these programs is the fact that block grant funds typically flow directly to states who then must pass funding on to Tribes. Sadly, these funds often do not make it to the Tribal level.

According to a report issued by the Congressional Research Service (CRS) in June 2013, there are 22 funded block grants. HHS administers 10 of these programs, but where states must “pass through” funds Tribes are often left out, despite eligibility. For example, Tribes are eligible to receive the Preventative Health and Health Services Block Grant, Administered by the Centers for Disease Control and Prevention (CDC). It funds all 50 states, eight U.S. territories, but only two Indian Tribes. Without having a state intermediary, Tribes would not only receive more adequate funding but could more easily tailor program needs to their people.

Talking Points:

Competitive Grants are no Substitute for the Federal Trust Responsibility

- As discussed previously, the federal government’s trust responsibility for health has long be the policy of the United States. However, forcing Tribes to compete with other state and local governments and other private institutions results in patchwork funding that is inconsistent and unpredictable, which does allow for lasting change that is needed to reduce health disparities.
- Creating “set-asides” for Indian Country on federal grants would ensure that specific funding goes to Tribal communities each year, as has been the intention indicated by Congress.

Tribes with the highest need often do not have resources to submit competitive grant applications

- Despite having some of the worst health disparities in the country, many Tribes are under-resourced to search for and apply for federal grants, whereas states and local governments often employ hundreds of staff to seek funding opportunities.
- Without full-time grant staff, applications are often not funded and do not go to the areas with significant needs.

Tribes are not always part of the typical distribution system for federal assistance, and that mean loss of lives

- When Tribes are left out of the funding distribution, it creates pockets of the United States where necessary health services are not available.

For example, during the 2009 H1N1 flu epidemic, Tribal communities had significant problems accessing needed vaccines. As a result, the AI/AN death rate for H1N1 was four times higher than in the general population.

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Building and Strengthening the Native Health Workforce

Request: Work with Tribes to improve the medical workforce at IHS and Tribal health facilities by increasing pipelines of AI/ANs going into medicine; providing better incentives for medical and administrative staff to work in Indian Country; and expanding scholarship and loan repayment programs.

Issue: The Indian Health Service and Tribal health providers continue to struggle to find qualified medical professionals to work in facilities serving Indian Country. Currently, at federal IHS sites, estimated vacancy rates are as follows: Physicians 34%; pharmacist 16%; nurse 24%; dentist 26%; physician's assistant 32% and advanced practice nurse 35%. Current vacancy rates make it nearly impossible to run a quality health care program. With competition for primary care physicians and other practitioners is at an all-time high, the situation is unlikely to improve in the near future. What we do know, is that the IHS has been unable to meet the workforce needs with the current strategy and IHS must improve its ability to address workforce challenges if the care needs of AI/ANs are going to be met.

The current IHS workforce development relies primarily on recruiting non-Indians through the loan repayment program, but those dollars are limited. A much more viable solution is to recruit native youth to enter into medical school. They are much more likely to return to and serve in native communities than non-native counterparts. Additionally, the care provided by Indian medical professionals results in more culturally informed care for all AI/ANs. However, the trend in AI/ANs going to medical school is alarming. In 1977, there were 124 AI/AN applicants to medical school, but by 2011 that number had shrunk to 101 – an almost 20% decrease. Perhaps more alarming is that only 20 out of 18,705 medical school graduates were AI/AN in 2015 – about 0.1%.

Talking Points:

AI/ANs should receive additional mentoring and outreach to apply for Medical school

- Recruiting AI/ANs to enter Medical school must be a key part of any strategy to improve staffing at IHS.
- The Administration should work with Congress and the Administration should work to develop programs targeted at native youth who are interested in becoming Medical professionals
- Congress should increase appropriations for all native students who want to be part of the IHS Scholarship program – this would be an additional \$3.3 million.

Better Incentives must be Provided for Medical professionals who want to work at IHS and Tribal sites

- The new Administration should support proposals to provide medical professionals with more equitable pay and benefits in order to incentivize working for the IHS.
- IHS student loan repayment should be tax exempt so that the agency can provide more opportunities for this program.

The IHS should support allowing medical professionals to take advance of the loan repayment program on a half-time basis for double the amount of time or to accept half the loan repayment award. It would make IHS a more attractive employer for some professionals.

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Native Veteran Health Care

Request: Ensure and improve access to culturally competent quality health care for Native Veterans.

Issue: American Indians and Alaska Natives (AI/ANs) serve in the U.S. military at higher rates compared to any other ethnic group, and have a higher concentration of female service members. AI/AN Veterans are more likely to lack health insurance, and have a disability, service-connected or otherwise, than Veterans of other races. Many AI/AN Veterans experience various challenges in receiving VA health care benefits in remote environments. AI/AN Veterans experience health disparities and barriers to access quality health care service due to factors such as distance, poverty, mental health symptoms, historical mistrust, and a limited number of culturally competent providers.

Talking Points:

Maintain and Strengthen the Implementation of the Reimbursement Agreements between the U.S. Department of Veterans Affairs, the Indian Health Service, and Tribal Health Programs.

- The VA-IHS/THP agreements honor the government-to-government relationship and the unique status of Tribes providing health care to Veterans on behalf of the federal government.
- The agreements promote access to culturally competent quality health care services for AI/AN Veterans near home, including services provided in rural and medically underserved communities.
- Section 405(c) of the Indian Health Care Improvement Act (IHCIA), as amended and enacted by the Affordable Care Act (ACA), requires the VA to reimburse IHS, an Indian Tribe, or a Tribal organization for services provided to beneficiaries eligible for services from either the VA or IHS.
- IHS and the VA should provide technical assistance to Tribes in negotiation and implementation of the reimbursement agreements
- These reimbursement agreements bring in valuable third-party resources to the Indian health care delivery system. In FY 2015, VA reimbursed over \$16.1 million for direct care services provided by IHS and Tribal Health Programs covering 5,000 eligible veterans

Creation of a VA Tribal Advisory Health Care Committee to properly ensure that the VA fulfills its trust responsibility to AI/AN Veterans in a culturally competent manner.

- The VA has a special responsibility to engage in Tribal consultation and support the government-to-government relationships with federally recognized Tribes. Tribal advisory committees are key in promoting strong relationships with Tribal governments to build on to the government-to-government responsibility. As representatives of sovereign governments, Tribal leaders are the most knowledgeable about how to provide quality care to their AI/AN Veteran communities.

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Increase Funding for Public Health Programs and Infrastructure in Indian Country through Direct Funding of Tribes

Request: Create an American Indian and Alaska Native public health block grant administered through the Centers for Disease Control and Prevention (CDC) and create flagship funding for Tribal health departments for key public health issues in Indian Country at the CDC.

Issue: To uphold its trust responsibility to the Tribes, the federal government created the Indian Health Service (IHS) and tasked the agency with providing health services to American Indians and Alaska Natives. Yet, IHS services are largely limited to direct patient care, leaving little, if any, funding available disease prevention, education, research for disease, injury prevention, and promotion of healthy lifestyles. This means that Indian Country continues to lag far behind other communities in basic resources and services.

As independent, sovereign nations, Tribal governments do not operate within the state regulatory structure, and often must compete with their own state governments for resources. Tribes are regularly left out of statewide public health plans and federal funding decisions for public health programs. Without a local tax base and little (if any) outside funding, Tribal communities are often the most in need of public health dollars. Tribes were ignored during the formulation of the US public health system, and it is now time to redress this wrong.

Talking Points:

Tribal Communities were not part of the creation of the U.S. Public Health System and must work to catch up to states and localities

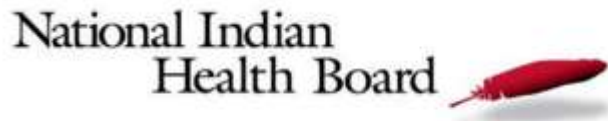
- Tribes are often left out of state public health planning, and often have to compete with their own states for federal dollars.

The Federal Trust Responsibility means that agencies should prioritize funding to Indian Country

- Competitive grants do not fulfill the federal trust responsibility to Indian Country. Healthcare and public health services has already been promised to Tribes- exchanging compensation and benefits for Tribal land and peace.
- Tribes have no local tax base as states and cities do. Meaning, federal cuts impact Indian Country even more because a larger share (e.g. almost 100%) of services revenue comes from the federal government.
- Many federal grants have little dissemination into Indian Country because Tribes have difficulty meeting the service population requirements, match requirements, or are under resourced to even apply for the grants.

Without base funding, Tribes cobble together public health funding from a variety of federal, state, local, and private funding sources

- This leads to rampant unpredictability and inconsistency among Tribal public health initiatives.
- Tribal public health systems remain chronically underfunded, and unable to provide comprehensive services to their members, which results in increase risks from preventable and contagious diseases.



Briefing Papers for Congressional and Administration Meetings

Constitutional Foundation for Indian-Specific Health Care Legislation

Congress has the constitutional authority and responsibility to legislate with regard to the unique circumstances of Indian Tribes and peoples. Congress can and should act to preserve the government-to-government relationship between Tribes and the United States and promote Tribal sovereignty.

The U.S. Constitution recognizes three sovereigns: the Federal government, States, and Indian Tribes. As sovereigns, Tribes predate the United States, and retain rights of self-government.⁵ When the United States was established, the Constitution's Indian Commerce Clause granted Congress the authority to pass legislation specific to Indian Affairs.⁶ The Supreme Court has upheld Indian-specific legislation, determining that it is political in nature, rather than based on an unconstitutional racial classification.⁷ Health care reform legislation that reflects the unique federal responsibility to provide health care for American Indians and Alaska Natives is subject to rational basis review and does not violate the equal protection clause so long as it is "tied rationally to the fulfillment of Congress' unique obligation toward the Indians."⁸

Congress has the constitutional authority and responsibility to provide for Indian health care. Tribes signed treaties and negotiated other agreements with the United States in which they ceded vast amounts of territory in exchange for certain solemn promises. These promises include protecting Tribal self-government and providing for the health and well-being of Indian peoples.⁹ Indian treaties are the supreme law of the land, and in carrying out these treaty obligations, the United States has "moral obligations of the highest responsibility and trust."¹⁰

Congress has passed numerous Indian-specific laws to provide for Indian health care, including establishing the Indian health care system and passing the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1601 *et seq.* In the IHCIA, for instance, Congress found that "Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people." *Id.* § 1601(1). In the Indian Self-determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 450 *et seq.*, Congress enabled Tribes to contract to run their own health care programs while also preserving Tribes' right to choose that services continue to be provided directly by the Indian Health Service. Congress has also legislated to provide Indians with access to general health programs, such as Medicaid, while creating Indian-specific protections within those programs that reflect this unique political relationship.

Congress has full constitutional authority to legislate with regard to Indian health care, and should continue to promote Tribal sovereignty and uphold the government-to-government relationship between the United States and Tribes in fulfillment of its trust and legal responsibilities in any health care reform proposal including current efforts to repeal and replace the Affordable Care Act.

⁵ *Worcester v. State of Ga.*, 31 U.S. 515, 559 (1832).

⁶ U.S. CONST., art. I, § 8, cl. 3; *see also Morton v. Mancari*, 417 U.S. 535, 552–55 (1974).

⁷ *Morton*, 417 U.S. at 555; *see also Moe v. Confederated Salish & Kootenai Tribes of Flathead Reservation*, 425 U.S. 463, 479–80 (1976); *Washington v. Washington State Commercial Passenger Fishing Vessel Ass'n*, 443 U.S. 658, 673 n.20 (1979); *United States v. Antelope*, 430 U.S. 641, 645–47 (1977); *Am. Fed'n of Gov't Employees, AFL-CIO v. United States*, 330 F.3d 513, 520-21 (D.C. Cir. 2003).

⁸ *Morton*, 417 U.S. at 555.

⁹ *See United States v. Winans*, 198 U.S. 371, 380–81 (1905).

¹⁰ *Seminole Nation v. United States*, 316 U.S. 286, 296-97 (1942); *see also* U.S. CONST., art. VI, cl. 2; *Worcester*, 31 U.S. at 539.

American Indian/Alaska Native Specific Provisions Patient Protection and Affordable Care Act

As Congress develops a path forward on healthcare reform, we recommend that these specific provisions are preserved so the Indian health system can continue to operate in a health system that is representative of the 21st century and honors the United States federal trust responsibility to provide healthcare to AI/ANs.

The Indian Health Care Improvement Act (IHCIA) amendments enacted in Section 10221 of the Affordable Care Act (ACA), as well as several other beneficial Tribal provisions enacted as part of the ACA, are separate and distinct from the ACA and must be preserved to ensure that the Indian health delivery system remains viable. Repealing the IHCIA amendments and the other Tribal related provisions enacted as part of the ACA would have devastating impacts on both the health of American Indian and Alaska Natives (AI/ANs) and the Indian health system that serves them.

The IHCIA has been reauthorized and amended a number of times since 1976, with extensive substantive amendments enacted in 1992 to strengthen its programmatic provisions. Although the IHCIA was permanently reauthorized as part of the ACA in 2010, the IHCIA far predates the ACA and should be treated separately. The IHCIA is clearly and easily severable from the ACA because it solely relates to the Federal trust responsibility to provide health care to Indian Tribes and their members. It is critical that the things that Tribal health programs fought for so long, be kept intact in order to provide health care services to AN/AI people. The IHCIA amendments and related Tribal provisions were developed over a period of ten years in a separate legislative process from the ACA. In order to escape a legislative log jam, the Indian-specific provisions were put into the Senate's health care reform bill that became the ACA because it was a moving legislative vehicle. They were not part of or related to the overall Act or other integral pieces of the general health reform legislation. In addition to the IHCIA amendments, other key Tribal provisions enacted as part of the ACA but unrelated to it include:

Section 2901(b) Payor of Last Resort. This very beneficial provision requires that when an IHS eligible Indian beneficiary is covered by another health program (any Federal, state, local health program, or private insurance) it is required to pay. Maintaining the payer of last resort provides authority for Indian health programs to seek primary reimbursement from other sources and saves scarce Indian health care resources that can be utilized to provide additional health care services.

Section 2901(c) Facilitating Enrollment of Indians under the Express Lane Option. This provision defines Indian health programs as Express Lane Agencies and allows them to conduct simplified eligibility determinations and facilitate enrollment in Medicaid and CHIP for Indians seeking services from Indian providers.

Section 2902 Elimination of Sunset for Reimbursement for all Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics – This provision was originally included in the IHCIA and attached as an amendment in the Medicare Modernization Act (MMA). This addressed an issue with creditable services definitions that left Indian hospitals unable to bill for all Medicare part B services. The MMA amendment was limited to five years and was made permanent in the ACA. Approximately 10% of AI/ANs who use IHS services are enrolled in Medicare, with approximately 30% of this population requiring Part B coverage due to such issues as end-stage renal disease or disability. Medicare Part B coverage is an essential resource that ensures that Indian providers save money on costly Part B services.

Title IX, Section 9021 Exclusion of Health Benefits Provided by Indian Tribal Governments as Taxable Income - The provision clarifies that the value of "health services" or "health benefits" received by AI/ANs—whether provided or purchased by the IHS, Tribes, or Tribal organizations—are excluded from gross income because it supplements the programs and services provided by the federal government. Tribes often supplement inadequate health care funding by paying for health care services for their Tribal members, or by purchasing insurance coverage for them (e.g. Medicare Part B, Part D, or private insurance). Section 9021 was enacted in order to resolve a

longstanding dispute Tribes had with the IRS over whether the provision of health care services, including the purchase of insurance for Tribal members, should be included as gross income for that Tribal member. Before Section 9021 was enacted, however, IRS field auditors had taken the position that the value of such coverage should be included in taxable income for Tribal members.

These provisions are entirely unrelated to the ACA as a whole, but like the IHCA were enacted as part of the ACA because it was a moving legislative vehicle. Repealing the IHCA along with these other Tribal provisions would have disastrous consequences for the Indian health system. The Indian health system would lose critical third party revenue, legal authorities, and life-saving programs.

Maintaining Federal Funding for Medicaid Provided Through the Indian Health System

Preserve 100 percent federal reimbursement rate for Medicaid services provided to American Indians and Alaska Natives that are received through the Indian health system.

As Congress approaches Medicaid reform, it should ensure that any reform proposal honors the federal responsibility for Indian health care, rather than passing that obligation on to the states through per capita allocations, block grants or other mechanisms that may be under consideration. The United States has a unique trust responsibility to provide Tribal health care, founded in treaties and other historical relations with Tribes, and reflected in numerous statutes. In recognition of that federal obligation, Congress amended the Social Security Act over 40 years ago in 1976 to authorize Medicare and Medicaid reimbursement for services provided in IHS and Tribally operated health care facilities.¹¹ The House Report explained that “These Medicaid payments are viewed as a much-needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian. . . .”

At the same time, Congress acted to ensure that States would be reimbursed at a 100 percent federal medical assistance percentage (FMAP) for Medicaid services to American Indians and Alaska Natives that are received through the Indian health system. The House Committee observed that since the United States already had an obligation to pay for health services to Indians as IHS beneficiaries, it was appropriate for the U.S. to pay the full cost of their care as Medicaid beneficiaries. The Committee noted that because the 100% FMAP provision was limited to services provided through the Indian health system, it was being provided for IHS eligible Indians and Alaska Natives for whom the United States has an obligation and who are already eligible for “full Federal funding of their services.”¹² This key provision ensures that the responsibility to pay for Medicaid services to American Indians and Alaska Natives remains with the federal government, and is not shifted onto the States. The Committee recognized that many States with large native populations also have large amounts of public land, and thus a limited tax base for providing health services, making it doubly unfair to shift the federal health obligation to them.

Medicaid reimbursements are critically important in filling the gap created by chronic underfunding of IHS, and are a critical source of funding for Tribes seeking to take over IHS hospital systems through self-governance agreements. In 2014 for example, the per capita spending for IHS patient services was \$3,107 as compared to \$8,097 per person nationally.¹³ Medicaid funds represent 13% of total IHS funding, and provides coverage for 34% of non-elderly AI/ANs and over half of AI/AN children.

As important as Medicaid is to the Indian health system, Medicaid reimbursements received through the Indian health system only represent a fraction of one percent of total Medicaid funding. For instance, IHS Medicaid spending in 2015 represented only 0.15 percent of total Medicaid spending. As a result, preserving full federal funding for Medicaid services received through the Indian health system will not adversely affect the overall effort to cap and control federal Medicaid spending.

It is critical that Congress maintain full federal funding of Medicaid services provided in IHS and Tribal healthcare facilities. Tribal healthcare delivery systems need Medicaid funding to be financially viable, as many of their patients

¹¹ 42 U.S.C. § 1395qq and § 1396j

¹² H.R. REP. No. 94-1026, pt. III, at 21 (1976), as reprinted in 1976 U.S.C.C.A.N. 2782, 2796.

¹³ The National Tribal Budget Formulation Workgroup’s Recommendations on the Indian Health Service Fiscal Year 2017 Budget, May 2015.

are low income and have no other form of coverage. Tribal healthcare delivery systems are the only systems that can ensure coordinated, quality of care for the beneficiaries they serve, and the only providers with the incentive to ensure that care is not fragmented. Tribal healthcare providers reinvest in their communities, and Tribal healthcare delivery systems are essential to local Tribal communities and economies. Ensuring full federal funding for Medicaid services received through the Indian health system is also essential to Tribal self-governance. Self-governance Tribes have achieved some remarkable health care improvements and efficiencies, but without the ability to bill Medicaid, those systems are not financially viable.

As Congress moves forward with Medicaid reform, it is essential that the federal trust responsibility for Indian health care be honored, and 100% FMAP for services received through the Indian health system is preserved. Many of the health care proposals being discussed are designed to stop or reduce federal spending on the Medicaid program, yet still recognize that certain limited and unique federal funding streams will have to be maintained. The 100 percent FMAP provision for the Indian health system should be preserved as well. This policy position has been previously supported by the National Governor's Association during past Medicaid reform efforts¹⁴ and is consistent with the United States trust and legal responsibilities to Tribes.

¹⁴ National Governors Association, Resolution HHS-18, "Indian Health Services," March 1, 2006.

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"¹⁵ and reaffirms a system for 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, IHCIA has provided significant progress in the I/T/U system. IHCIA 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 IHCIA include:

- **Sections 825, 2, and 3** {25 U.S.C. §§ 1601, 1602, and 1680o} permanently reauthorizes the IHCIA 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 IHCIA, I/T/Us can operate their

¹⁵ 25 U.S.C. § 1602.

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 IHCIA, 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 IHCA.
 - 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.

You can find materials and other information on the ACA and IHCA here:

http://nihb.org/legislative/ihca_and_aca.php.

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