May 11, 2017

INDIAN HEALTH CARE REFORM PRIORITIES
AND THE AMERICAN HEALTHCARE ACT

Providing for Indian health care is a federal responsibility based on the United States' treaty and trust obligations and the unique, government-to-government relationship between Indian tribes and the federal government expressly affirmed by the Congress.[1] In approaching health care reform, it is critical that Congress act to protect and preserve Indian health care.

I. Ensure Medicaid Reform Upholds Federal Responsibility for Indian Health Care

As Congress approaches Medicaid reform, it should ensure that any reform efforts maintain the federal responsibility for Indian health care, rather than passing this obligation on to the states. In 1976, Congress amended Section 1905(b) of the Social Security Act to provide for a 100% Federal Medical Assistance Percentage (FMAP) for Medicaid. This ensures that the federal government pays 100% of the Medicaid costs for AI/ANs rather than draining state Medicaid funds.

The American Healthcare Act of 2017 preserves 100 percent FMAP for services received through the IHS and tribal healthcare facilities. The Senate should ensure that 100 percent FMAP for services received through an IHS or tribal healthcare facility is preserved.

II. Exempt Medicaid Reimbursements for Services Received Through IHS/Tribal Facilities from Eligibility or Services Limitations Resulting from Caps

Medicaid is an important tool through which the federal government works to fulfill its trust and treaty responsibility to provide for Indian health care. Exempting services received through an IHS or tribal facility from statewide caps or block grants is critically important, but not enough to protect IHS and tribal programs from state limitations on eligibility or services that may result from capping Medicaid funds. The United States funds Medicaid reimbursements to States at 100 percent FMAP, and capping Medicaid services for American Indians and Alaska Natives regardless of need is fundamentally inconsistent with fulfillment of the trust responsibility and Congress' intent in authorizing the Indian health system to access Medicaid resources.

The American Health Care Act (AHCA) as passed by the House of Representatives exempts reimbursements to States for services received through IHS and tribal healthcare facilities from per-capita allotment caps through Section 1903A, and exempts services received through the IHS and tribal healthcare facilities from optional block-granting, as added in new section (i) on pp. 10-17 of the manager's amendment. If the Senate considers similar caps, which Tribes oppose, it must include a similar exemption.

Additionally, if the Senate considers similar caps, it should develop a mechanism to exempt reimbursements for services received through IHS and tribal facilities from any State limitations

[1] 25 U.S.C. §§ 1601 and 1602.

on eligibility or services that may result from Medicaid caps. Such reimbursements would be covered by 100% FMAP and therefore will not affect State budgets.

III. Preserve Medicaid Expansion

Medicaid expansion has provided critical third-party revenues to the Indian health system, greatly expanding the care available to AI/ANs. Medicaid expansion has increased Medicaid revenues at IHS and tribal health programs by approximately 20%.

The AHCA would roll back Medicaid expansion starting in 2020 by ending the enhanced FMAP rates for new enrollees or enrollees that experienced a gap in coverage of over a month. Only States that expanded Medicaid coverage as of March 1, 2017 would be able to continue enhanced FMAP for grandfathered enrollees. The Senate should preserve Medicaid expansion as an option for States.

IV. Exempt AI/AN from Any Mandatory Work Requirements

The American Healthcare Act would allow the States to impose mandatory work requirements as a condition of Medicaid eligibility, and incentivize States that impose such requirements with a 5 percent increase in FMAP to reimburse them for the administrative costs of implementing such a requirement.

Mandatory work requirements will not work in Indian country because the incentive structures are completely different. Unlike other Medicaid beneficiaries, Indians members have access to IHS services, and will simply elect not to enroll in Medicaid and fall back on the underfunded IHS if work requirements are imposed as a condition of Medicaid eligibility. As a result, rather than encouraging job seeking or saving program costs, mandatory work requirements will discourage AI/ANs from enrolling in Medicaid.

Tribes fully support work programs and employment, but we believe such programs should be voluntary so as not to provide a barrier to access to Medicaid for our members. Again, this is consistent with over 40 years of Medicaid policy for Indian Country.

To the extent it considers imposing work requirements, the Senate should exempt American Indians and Alaska Natives from any work requirements to the same extent as other exempt groups, such as the aged and disabled.

V. Support State Flexibility While Preserving Tribal Rights

State flexibility is an important part of the Medicaid program. We support State flexibility, but important existing tribal protections in the Medicaid program must be preserved. These include:

- An AI/AN who is eligible to receive or has received an item or service from an Indian health care provider or through referral under Contract Health Services (CHS) is exempt from Medicaid premiums or cost sharing (such as deductibles and copayments) if the items or services are furnished by an I/T/U or through referral under CHS. SSA § 1916(j)(1)(A); 42 U.S.C. § 1396o(j)(1)(A).

- Payment to I/T/U providers cannot be reduced by the absence of copays or premiums from an AI/AN patient. SSA § 1916(j)(1)(B); 42 U.S.C. § 1396o(j)(1)(B).

- A state is prohibited from classifying trust land and items of cultural, religious or traditional significance as "resources" for purposes of determining Medicaid eligibility for AI/ANs. SSA 1902(ff)(1)-(4); 42 U.S.C. § 1396a(ff)(1)-(4).

- Certain income and resources (including interests in or income from trust land or other resources) are also exempt from Medicaid estate recovery. SSA § 1917(b)(3)(B); 42 U.S.C. § 1396p(b)(3)(B).

- If an AI/AN elects to enroll in an MCO, they are allowed to designate an Indian health care provider as their primary care provider if in-network. SSA § 1932(h)(1); 42 U.S.C. § 1396u-2(h)(1).

- An Indian health care provider must be promptly paid at a rate negotiated between the MCO and provider, or at a rate not less than the amount an MCO would pay to a non-Indian health care provider. SSA § 1932(h)(2)(A)-(C); 42 U.S.C. § 1396u-2(h)(2)(A)-(C).

- If the MCO pays the Indian health care provider less than what the Indian health care provider would be paid under the State plan (the encounter rate), then the State must make up the difference in a wraparound payment to the Indian health care provider. SSA § 1932(h)(2)(C)(ii); 42 U.S.C. § 1396u-2(h)(2)(C)(ii).

The American Healthcare Act of 2017 does not impact these protections, and the Senate should ensure they are preserved.

VI: Preserve Cost-Sharing Protections for AI/ANs

Section 131 of the AHCA repeals the cost-sharing subsidy program, which is at Section 1402 in the Patient Protection and Affordable Care Act (ACA). However Section 1402(d) of the ACA includes important and critical cost sharing protections for AI/ANs that have incomes at or below 300% of the federal poverty level or through referral by IHS Purchased/ Referred Care (PRC) program. These cost-sharing protections make health insurance affordable for AI/AN people. Eliminating them would also have a destabilizing effect on the Indian health system that is responsible for providing health care to most AI/AN people.

To the extent that the Congress considers changes to exiting cost-sharing protections, it should maintain cost sharing protections for AI/ANs. These protections were included for AI/ANs in fulfillment of Congress and the United States federal trust responsibility to provide health care to Indians.

VII. Preserve the Indian Health Care Improvement Act

The Indian Health Care Improvement Act (IHCIA), 25 U.S.C. Chapter 18, is the foundational legislation governing the Indian health care system. In 2000, IHCIA's authorization expired, and in 2010 IHCIA was permanently enacted by cross-reference in Section 10221 of the ACA. Although the ACA was the legislative vehicle through which the IHCIA was passed, the IHCIA predates and is independent from the ACA. As Congress addresses the ACA, it is critical that it leaves intact the IHCIA, exempting it from any repeal.

The American Healthcare Act of 2017 preserves the IHCIA. The Senate should ensure that the IHCIA is preserved as well.

VIII. Safeguard Indian-specific Provisions of the Affordable Care Act

In addition to enacting the IHCIA, the ACA contained several crucial Indian-specific provisions unrelated to the rest of the ACA, and these provisions must be safeguarded as reform moves forward. These provisions include Section 2901, which makes Indian health programs the payer of last resort; Section 2902, which allows the Indian Health Service (IHS) permanent authority to bill Medicare Part B; and Section 9021, which excludes Indian health benefits from taxation.

The American Healthcare Act of 2017 preserves these important provisions. The Senate should ensure that they are preserved as well.