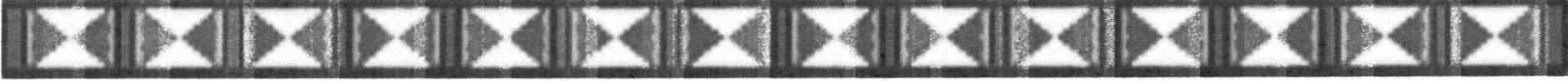


INDIAN HEALTH CARE IMPROVEMENT ACT REAUTHORIZATION LEGISLATION

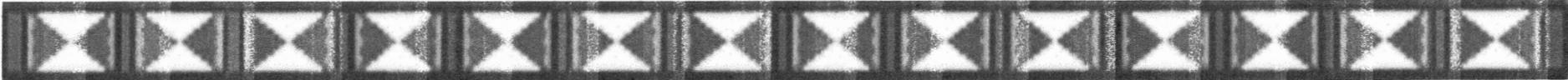
**Congressional Staff Briefing
September, 2007**



House Report 94-1026

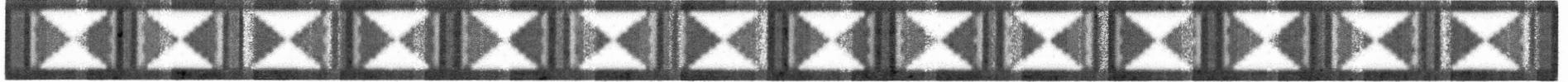
April 9, 1976

- “The most basic human right must be the right to enjoy decent health. Certainly, any effort to fulfill Federal responsibilities to the Indian people must begin with the provision of health services. In fact, health services must be the cornerstone upon which rest all other Federal programs for the benefit of Indians.”



Federal responsibility to provide health care based on treaties

- The Federal government entered into close to 400 treaties with Indian Tribes between 1778 and 1871.
- Indian Tribes exchanged over 500 million acres of land to the U.S. Government.
- Many of the treaties contain provisions which explicitly include promises to provide health care.



Treaty with the Winnebago, September 15, 1832

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Federal trust responsibility to provide health care to Indians

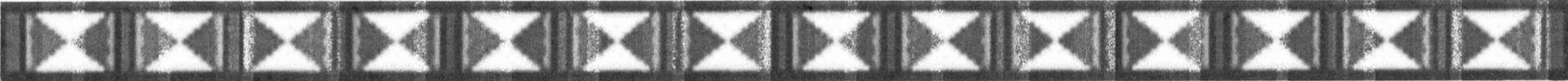
- In Worcester v. Georgia, Chief Justice John Marshall, described Indian Nations as “domestic dependent nations.”
- Justice Marshall described the relationship between Tribes and the U.S. government as a “trust” relationship to that of ward to his guardian.
- This special relationship is based on the U.S. Constitution, and reconfirmed in treaties and federal statutes.



Legislation Assigning Federal Responsibility for Health Care

Snyder Act of 1921

- First time Congress formulated broad Indian health policy: “direct, supervise and expend such moneys as Congress may from time to time appropriate for the benefit, care and assistance of the Indians...for relief of distress and conservation of health.”



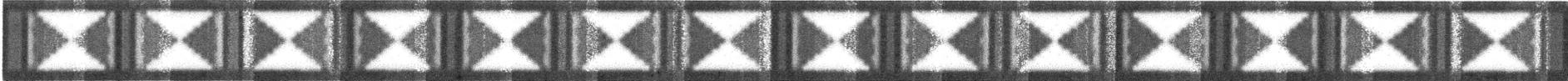
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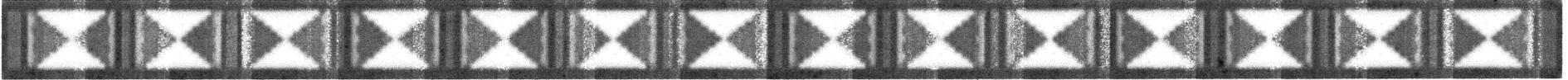
Indian Health Care Improvement Act of 1976 – beyond Snyder

- The IHClA, along with the Snyder Act, serves as the statutory basis for the Federal government’s responsibility to provide health care.
- The IHClA clearly acknowledged the legal and moral responsibility for providing the “highest possible health status to Indians...with all the resources necessary to effect that policy.”



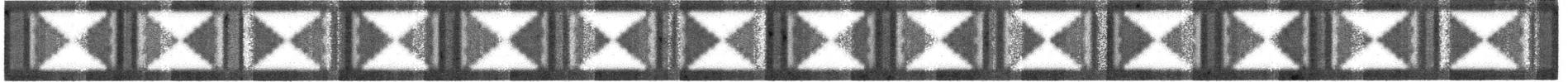
Health Disparities in 1976 vs. 2006

- In 1976, the incidence of tuberculosis for AI/ANs was 7.3 times higher than U.S. general population.
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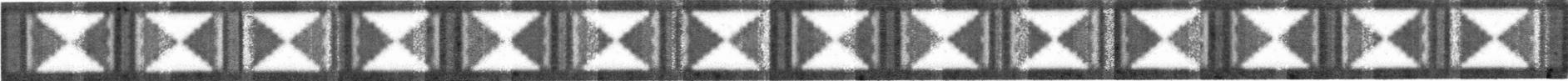
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- Since the bill was first enacted, American health care has evolved.
- Indians who live in the most remote, rural, and poorest parts of this Country deserve to have a health care delivery that is available to the general U.S. population.



IHCIA reauthorization effort, 1998-present

- 1998 -- IHS initiated tribal consultation with tribal leaders, health program experts, and IHS officials
- National Tribal Steering Committee (NSC) comprised of tribal leaders selected by tribes to lead reauthorization effort
- NSC delivered comprehensive reauthorization proposal to Congress in October, 1999
- Bills introduced in every Congress since 1999



Guiding principles of NSC --

- No regression from current law authorities
- Improve Indian health care delivery system and facilities to --
 - reflect 21st Century best practices
 - address health care needs in Indian Country
 - Reduce health status disparities



109th Congress Action (2005-06)

S. 1057 – IHCIA reauthorization bill

- Reported by Indian Affairs Committee, Oct. 2005
- Offered for “hotline” with changes to resolve objections raised by HHS, DOJ and other Senators
- Unanimous consent consideration failed, Sept. 2006

S. 3524 – Indian-Specific Social Security Act Amendments

- Unanimously reported by Finance Committee, July 2006
- Bi-partisan amendments to Medicare, Medicaid, SCHIP
- Merged with S. 1057 hotline bill

H.R. 5312 – IHCIA reauthorization and SSA Amendments

- Reported by Resources Committee, June 2006
- No action by Energy & Commerce Committee



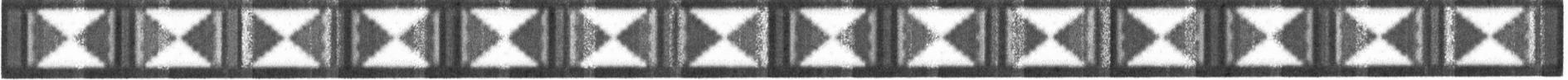
110th Congress (2007-08)

S. 1200: Sen. Dorgan + 18 co-sponsors

- Similar to 109th Congress bill
- Includes SSA provisions from S. 3524 (2006)
- Reported by Indian Affairs Committee 5/10/07
- Finance Committee unanimously reported out on 9/12/07

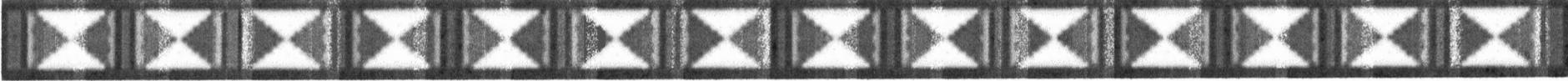
H.R. 1328 -Reps. Pallone, Rahall, Young

- 46 co-sponsors
- Reported by Natural Resources Committee 4/25/07
- Energy & Commerce hearing 6/7/07



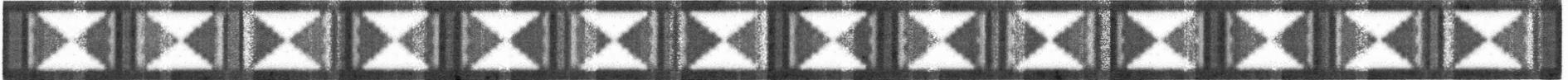
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- Comprehensive revision of existing IHCIA law using current law format of 8 topical Titles
- Retains many provisions, concepts of current law
- Amendments to SSA regarding Indian health program participation in Medicare, Medicaid, SCHIP
 - Written, approved by Finance Committee in 2006



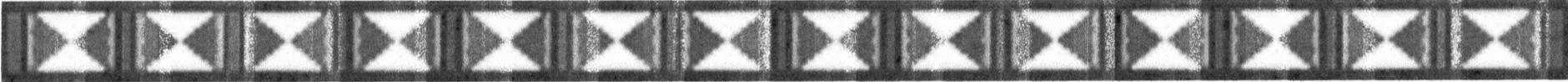
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- V Urban Indian Health
- VI IHS Organizational Improvements
- VII Behavioral Health
- VIII Miscellaneous



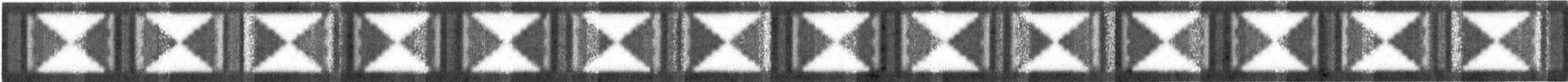
IHCIA Title I -- Human Resources

- Recruitment, retention of health professionals for IHS, tribal and urban Indian programs
- Encourage, assist Indian people to enter health professions to serve in Indian programs
- Community Health Aide Program (CHAP)
 - continue program in Alaska
 - authority to establish CHAP for Lower 48 Tribes
 - dental health technician issue resolved by ADA and Alaska Native Tribal Health Consortium



Title II -- Health Services

- Indian Health Care Improvement Fund
 - eliminate health status deficiencies
- Catastrophic Health Emergency Fund
 - meet extraordinary medical costs
- Diabetes prevention, treatment
- Epidemiology Centers
 - Track disease incidence; develop prevention priorities
- Health promotion, disease prevention programs
- Mammography and other cancer screenings
- Modern methods of health care delivery
 - long-term care, hospice, home/community-based care



Title III -- Facilities

- Authority for construction of health care facilities and sanitation facilities
- Sec. 301 unresolved issue: whether to create new authority for Area Distribution Fund
 - Alternative method for distributing health care facility construction funding
 - Favored by some tribes, opposed by others
 - Issue will be resolved by Congress
- Fundamental problem: inadequate funding for health care facilities construction
 - Enormous unmet need for new facilities
 - FY03 appropriation: \$81.6 million
 - FY08 budget request: \$12.7 million



Title IV-- Access to Health Services

- Implements authority for IHS/tribal programs to collect Medicare and Medicaid reimbursements
- Grants for M + M outreach activities to increase enrollment of eligible Indians
- Authority to collect reimbursements from other third party payors
- Sharing arrangements with other Federal agencies, e.g., DoD, DVA
- IHS payor of last resort



Title V -- Urban Indian Programs

- Grants to urban Indian organizations for health services to Indians in urban areas
- Over 30 urban centers in operation
- Permanent status for Tulsa + OK City urban programs
- Grants for Diabetes prevention services and for community health representatives



Title VI -- IHS Organization

- Created Indian Health Service (1976)
- Bills would elevate IHS Director to Assistant Secretary for Indian Health
 - Tribes have urged elevation for years
- IHS automated information systems
 - financial management, cost accounting, billing
 - patient care
 - training



Title VII -- Behavioral Health

- Comprehensive approach for behavioral health assessment, treatment, prevention
- Comprehensive mental health programs
- Addresses behavioral health needs of all age groups
- Innovative programs with focus on Indian youth
- Child sexual abuse prevention, treatment
- Address fetal alcohol disorders
- New provision to address domestic and sexual violence
 - Prevention and treatment programs
 - Work with DOJ to improve prosecutions



Title VIII -- Miscellaneous

- Reports to Congress on Indian health
- Negotiated Rulemaking for development of some regulations
- Health services for non-beneficiaries -- retains current law
- Continues moratorium on implementation of expanded IHS eligibility regulations until funds provided to cover additional costs



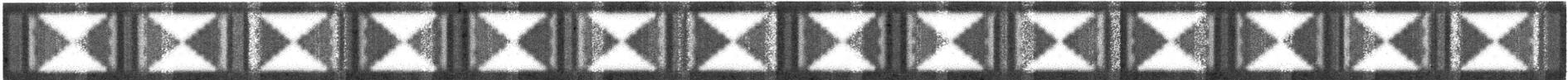
Social Security Act Amendments

- Authority for Indian health programs to receive payment for all M+M and SCHIP services
 - retains current law limitation on payment for some Medicare Part B service through 2009, only
- Increased outreach for M+M and SCHIP enrollment
- Tribal enrollment documents as proof of US citizenship for Medicaid
 - HHS required to issue regulations for any additional documents required for tribes in states on international border if tribe admits non-US citizens to membership



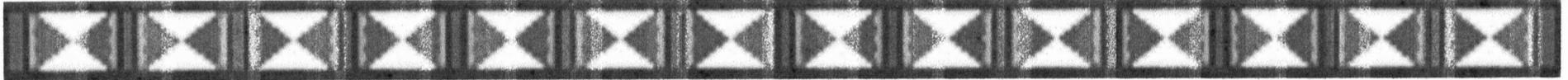
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 - Modeled on existing SCHIP cost-sharing exemption for Indian children
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 - No loss of funding to State Medicaid Plans since 100% FMAP applies



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- Disregards certain Indian-specific property for Medicaid eligibility
 - Modeled on CMS Medicaid Manual exemption of the same Indian property from Medicaid estate recovery
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- Participation of Indian health programs in all federally-funded health programs on same basis as other qualified providers



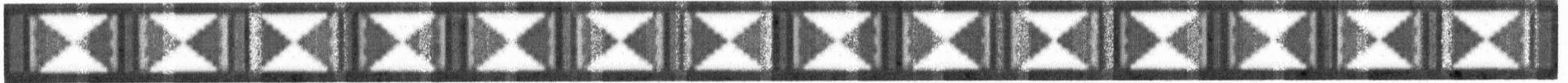
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Budget Impact

- Very small increase in direct spending estimated:
 - >\$9 million in first year
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- Significant decrease in cost from earlier bills
 - 2001 bill: >505 million in first year;
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- Enormous potential return for small investment
 - enhanced program effectiveness : improve health care, reduce health status deficiencies
 - utilize resources more efficiently



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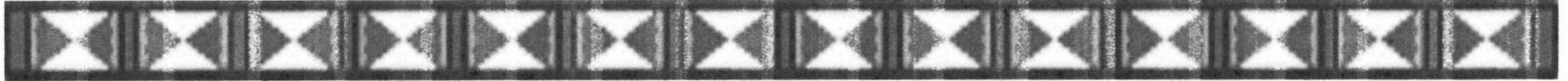
Kitty Marx, Legislative Director
National Indian Health Board
kmarx@nihb.org
(202) 742-4262

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INDIAN HEALTH CARE

Families USA Staff Briefing
December 13, 2007



National Indian Health Board
Advancing the health of all Tribal Citizens and
American Indians/Alaska Natives in their quest to provide quality health care.

NATIONAL INDIAN HEALTH BOARD

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House Report 94-1026
April 9, 1976

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NATIONAL INDIAN HEALTH BOARD

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NATIONAL INDIAN HEALTH BOARD

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NATIONAL INDIAN HEALTH BOARD

Treaty with the Tribes of Middle Oregon, June 25, 1855

The United States agree to erect...suitable hospital buildings,...a physician, ...medicines and hospital stores.

NATIONAL INDIAN HEALTH BOARD

Treaty with the Klamath, etc., October 14, 1864

The United States further agree that there shall be erected...hospital buildings as may be necessary, which buildings shall be kept in repair at the expense of the United states...The United States...[shall] pay for the services and subsistence...of one physician.

NATIONAL INDIAN HEALTH BOARD

Treaty with the Seneca, Mixed Seneca and Shawnee, Quapaw, etc., February 23, 1867

The children of the tribe between the ages of six and eighteen shall be...attended in sickness

NATIONAL INDIAN HEALTH BOARD

7

Federal trust responsibility to provide health care to Indians

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- This special relationship is based on the U.S. Constitution, and reconfirmed in treaties and federal statutes.

NATIONAL INDIAN HEALTH BOARD

8

History of Indian Health Care

- Federal responsibility for health care first assigned to the War Department.
- In 1849, responsibility for health care was transferred to the Bureau of Indian Affairs.
- In 1954, responsibility for health care was transferred to the Public Health Service.
- In 1998, the Indian Health Service (IHS) was created as a separate agency, within HHS, responsible for health care for Indians.

NATIONAL INDIAN HEALTH BOARD

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Snyder Act of 1921

- First time Congress formulated broad Indian health policy and provided authority for appropriations for Indians.
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NATIONAL INDIAN HEALTH BOARD

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NATIONAL INDIAN HEALTH BOARD

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NATIONAL INDIAN HEALTH BOARD

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NATIONAL INDIAN HEALTH BOARD

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Behavioral Health Disparities

- **Suicide:** Indian youth ages 15-34 make up 40% of all suicides within AI/AN populations.
- **Fetal Alcohol Syndrome:** 1.5 to 2.5 Native children per 1,000 live births are afflicted with FAS
 - General U.S. population is 0.2 to 1.0 per 1,000
- **Substance Use:** 19% of the Native population 12 and over are substance abuse dependent
 - General U.S. population is 9%
- **2% of the Native population currently abuses methamphetamine**
 - General U.S. population is 0.07%
- **Mental Health:** 30% of Native adults have had a serious psychological distress
 - General U.S. population is 11%

NATIONAL INDIAN HEALTH BOARD

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IHCIA reauthorization is necessary to address health disparities

- The IHCIA, enacted in 1976, was last reauthorized in 1992 – 15 years ago.
- Since the bill was first enacted, American health care has evolved.
- Indians who live in the most remote, rural, and poorest parts of this Country deserve to have a health care delivery that is available to the general U.S. population.

NATIONAL INDIAN HEALTH BOARD

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Indian Health Current Status

- Indian Health Care Improvement Act (IHCIA) expired in 2001.
- The IHS continues to provide health care to American Indians and Alaska Natives (AI/ANs) based on the broad authority of the Snyder Act and IHS appropriations that fund existing IHCIA programs.

NATIONAL INDIAN HEALTH BOARD

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Indian Health Service programs

- IHS provides comprehensive primary health care services, through a direct delivery health care system.
- For services that cannot be provided directly, the IHS pays for services through referrals to non-IHS providers under its contract health services (CHS) program.

NATIONAL INDIAN HEALTH BOARD

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Indian Health Service programs

- IHS provides services to 1.8 million AI/ANs, compared to 2.6 million AI/ANs identified per Census records.
- IHS is considered a "cradle to grave" health care system – Indian people are born in IHS hospitals, receive care throughout their lives, and die in IHS hospitals.
- IHS is a "public health service" system: immunizations, flu and disease pandemics, emergency preparedness, water and sanitation

NATIONAL INDIAN HEALTH BOARD

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Indian Health Service programs

- IHS system consists of 49 hospitals, over 500 health centers and 34 urban Indian health centers.
- Health facilities are located "on or near" Indian reservations in 35 states.
- 50% of the IHS programs are operated by Tribes and tribal organizations by contract or compact under the Indian Self-Determination and Education Assistance Act (P.L. 93-638)
- 34 urban program are operated by contract under Title V of the IHCA

NATIONAL INDIAN HEALTH BOARD

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Indian Health Service appropriations

- IHS receives appropriated dollars through the Department of Interior, not HHS.
- FY 2008 Appropriations are approximately \$3.4 billion:
 - \$3.1 bil lion in health services funding
 - \$4 mil lion in health facility construction, renovation, sanitation, and maintenance and improvement funding.
- IHS is not an entitlement program, funds are discretionary.
- CHS services are limited to emergency or "life and limb" priorities and money in most areas of Indian Country runs out by June 1st.

NATIONAL INDIAN HEALTH BOARD

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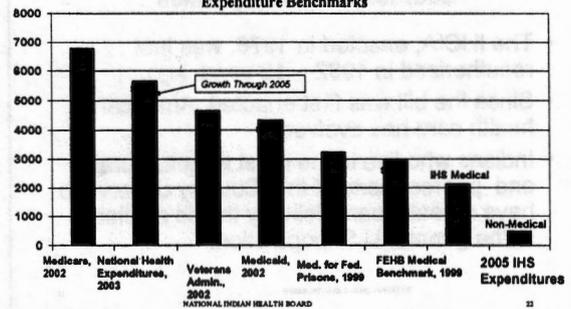
IHS and Medicare & Medicaid

- IHS and Tribes have authority to bill and receive reimbursement for Medicare & Medicaid services provided in IHS and Tribal facilities.
- Medicare services billed at DRG, Part B physician rates, or an outpatient Medicare all-inclusive rate.
- Medicaid services billed at a Medicaid all-inclusive rate (OMB or encounter rate).
- 100% FMAP for services provided in IHS facilities.
- IHS residual payor to Medicare and Medicaid.

NATIONAL INDIAN HEALTH BOARD

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2005 IHS Expenditures Per Capita Compared to other Federal Health Expenditure Benchmarks



NATIONAL INDIAN HEALTH BOARD

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NIHB Hot Issues

- Reauthorization of the IHCA
- Reauthorization of Special Diabetes Program for Indians
- Reauthorization of SAMSHA
- Children's Health Agenda
- Appropriations Summit – March 6 Wash, DC
- Public Health Summit – May 20-21 Green Bay, WI
- NIHB Annual Consumer Conference – September 22- 25, 2008 Pechanga, CA

NATIONAL INDIAN HEALTH BOARD

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110th Congress (2007-08)

S. 1200: Sen. Dorgan

- Introduced April 24, 2007, 28 co-sponsors
- Reported by Indian Affairs Committee 5/10/07
- Finance Committee unanimously reported out on 9/12/07

H.R. 1328 -Reps. Pallone, Rahall, Young

- Introduced March 6, 2007, 53 co-sponsors
- Reported by Natural Resources Committee 4/25/07
- Energy & Commerce hearing 6/7/07
- Health Subcommittee favorably reported bill out as a Manager's Amendment on 11/7/07

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Major Components of IHCIA bills

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NATIONAL INDIAN HEALTH BOARD

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NATIONAL INDIAN HEALTH BOARD

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NATIONAL INDIAN HEALTH BOARD

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NATIONAL INDIAN HEALTH BOARD

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Special Diabetes Program for Indians

- Congress established the SDPI through the Balanced Budget Act of 1997 at \$30 million per year.
- Extended the program in 2001 (\$70 - \$100 million); and again in 2004 for five years.
- The SDPI is currently funded at \$150 million per year and this funding expires October 1, 2008.



Special Diabetes Program for Indians

- S. 1494 and HR 2762 introduced that would amend the PHS Act to reauthorize the Special Diabetes programs for type 1 research and Indians at \$200 m. per year for 5 years.
- NIHB is collaborating with the Juvenile Diabetes Research Foundation (JDRF) and the American Diabetes Association "Awakening the Spirit Team."
- Senate Finance support for including the Special Diabetes programs in Medicare package being negotiated with the House.



Special Diabetes Program Achievements

- SDPI consists of 399 grant programs for screening, prevention and treatment
- From 1996 to 2006:
 - Decrease of 1.3% in the mean blood sugar level (A1C) for Indians resulting in 40% reduction in diabetes related complications.
 - Reduction in number of Indian people going into dialysis for end-stage renal dialysis (ESRD) compared to rise in number for gen'l population



SAMSHA reauthorization

- HELP Committee drafting SAMSHA reauthorization – mark up scheduled Jan 24
- Sec 506 American Indian/Alaska Natives
 - Technical grant writing assistance from SAMSHA
 - Tribal Advisory Group
 - Tribal Liaison position
 - Behavioral Health Tribal Grant program – in addition to discretionary grants available for tribes



Inquiries may be directed to:

Stacy Bohlen, Executive Director
sbohlen@nihb.org

Kitty Marx, Legislative Director
kmarx@nihb.org

(703) 486-5706
www.nihb.org



National Indian Health Board
Advancing the health of all Tribal Communities and American Indian/Alaska Natives in their quest to promote healthy lives.



"The most basic human right must be the right to enjoy decent health. Certainly any effort to fulfill Federal responsibilities to the Indian people must begin with the provision of health services. In fact, health services must be the cornerstone upon which rest all other Federal programs for the benefit of Indians."

H.R. Rep. No. 94-1026, pt. 1, at 13 (1976).

1



FEDERAL TRUST RESPONSIBILITY
FOR INDIAN HEALTH
through the
INDIAN HEALTH CARE IMPROVEMENT ACT

Briefing for House Staff
September 8, 2006

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Federal Trust responsibility to Indians --

- Rubric that encompasses political, social, economic obligation of the Federal Government to Indian tribes and Indian people
- No single definition or context
- Broad obligation; no bright-line parameters

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Origins of Federal Trust Responsibility --

- U.S. Constitution
 - Indian Commerce Clause
 - Treaty Clause
 - Supremacy Clause
- Treaties with Indian Nations
- Cession of vast tracts of land by Indian tribes

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Existence of Federal Trust responsibility is recognized in --

- Court decisions
 - Laws
 - Regulations
 - Executive Orders; Presidential memoranda
 - Agency policy statements
 - Course of dealings with Indians
- Acknowledged by all branches of Federal Government**

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Judicial recognition of Federal Trust Responsibility

***Cherokee Nation v. Georgia* (Sup. Ct. 1831)**

- Described Indian tribes as "domestic dependent nations"
- Tribe-U.S. relationship "resembles that of a ward to his guardian"

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***U.S. v. Kagama* (Sup. Ct. 1886)**

- "duty of protection"
- "From their very weakness and helplessness, so largely due to the course of dealings of the federal government with [tribes], and the treaties in which it has been promised, there arises the duty of protection, and with it the power [of protection]."

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***Morton v. Mancari* (Sup. Ct. 1974)**

- Recognized Indian tribes as a political rather than racial classification in lawmaking
- Established "rationally related" standard of review for Indian-specific laws
- Law will not be disturbed if rationally tied to Congress's "unique obligation" to Indians

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**Federal Trust Responsibility
Health Statutes**

1921 -- Snyder Act (25 USC §13)

- Permanent authorization of appropriations "for the benefit, care, and assistance of the Indians throughout the United States", including "conservation of health"

1954 -- Transfer Act (42 USC §2001)

- Indian health responsibility transferred from BIA to Department of HEW (now HHS)
- Creation of Indian Health Service

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1970 -- Indian Self-Determination Era

"[W]e have turned from the question of *whether* the Federal government has a responsibility to Indians to the question of *how* that responsibility can best be fulfilled."

President Nixon, Special Message to Congress, 1970

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Themes of Nixon Message to Congress:

- Recognized U.S. "solemn obligations" to Indians
- U.S. must do better job at performing these obligations
- Involve Indians in --
 - policymaking
 - program operations

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1975 --Indian Self-Determination Act

- Enhanced authority for tribal operation of Indian programs
- IHS and BIA directed to contract program operations to tribes, upon request
- Reduce Federal domination of Indian programs
- Codified at 25 USC 450, et seq.

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1976 -- Indian Health Care Improvement Act

- Re-affirmed U.S. legal obligation for Indian health
- Responded to deplorable state of Indian health and woeful inadequacy of Indian health facilities
- Provided direction for the delivery of health services to Indians through IHS
- Encouraged tribal involvement in health program operation
- Codified at 25 USC §1601, et. seq

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Medicare + Medicaid payment authority

- 1976 IHCA amended Social Security Act to authorize M+M payment to IHS and tribal health facilities
- Objectives:
 - increase Indian enrollment in M+M
 - enable Indians to utilize M+M at IHS and tribal facilities that provide their health care
 - improve Indian health facilities
- 100% FMAP for Medicaid -- recognized total Federal obligation for Indian health

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1997 -- Children's Health Insurance Program (SCHIP)

- requires States to assure SCHIP access for low-income Indian children
- CMS regulations prohibit any cost-sharing for Indian children in recognition of unique Federal relationship with Indian tribes and need to assure access

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Indian Health Policymaking

- Congress
- Dept. Health & Human Services
 - annual consultation with Tribes attended by all departmental agencies
 - annual budget consultation with Tribes
- Indian Health Service
 - regular consultation with Tribes
 - workgroups on special topics
- Centers for Medicare & Medicaid Services
 - Tribal Technical Advisory Group

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American Indians/Alaska Natives (AI/AN)

- 563 Federally-recognized Indian tribal governments
- located in 34 States
- nearly all in remote areas
- high levels of poverty, unemployment
- low levels of education
- worst health status in United States

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Indian Health Care System

- Health programs operated by IHS, tribes, urban Indian organizations
- Serves 1.6 million American Indians/Alaska Natives
- No charge to beneficiaries
 - Indian health is considered "pre-paid"
- Uses public health model
 - medical care, preventive care, health education, sanitation

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Indian Health Care System

- Only 49 hospitals in 34 states
- Most health facilities are ambulatory clinics
 - health stations in remote Alaska Native Villages
- Limited scope of services at most locations
 - limited resources, facilities
- Contract Health Services Program
 - Must purchase health care from other providers where not available at Indian facilities
 - care is severely rationed due to limited funding

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Indian Health Care Funding

- Annual appropriations from Congress
 - part of discretionary programs budget
- Funded at <60% of level of need
- Medicare + Medicaid are critical supplemental funding sources for Indian health
 - Medicaid = 17% of clinical services budget (FY05)
 - Medicare = 5% of clinical services budget (FY05)
 - M+M represent >30% of clinical services funds in some programs

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Indian Health Disparities

- Indians more likely to die from certain diseases than general population --
 - alcoholism -- 770% higher
 - tuberculosis -- 650% higher
 - diabetes -- 420% higher
 - accidents -- 208% higher
 - pneumonia, influenza -- 52% higher
- Indian life expectancy is 5 years less than general population

Source: US Comm. on Civil Rights, "Broken Promises: Evaluating the Native American Health Care System, Sept. 2004, at 7-8.

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IHCIA reauthorization effort, 1998-present

- 1998 -- IHS initiated tribal consultation with tribal leaders, health program experts, and IHS officials
- National Tribal Steering Committee (NSC) comprised of tribal leaders to lead reauthorization effort
- NSC delivered comprehensive reauthorization proposal to Congress in October, 1999
- Bills introduced in every Congress since 1999

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Guiding principles of NSC --

- NO REGRESSION from current law authorities
- Improve Indian health care delivery system and facilities to --
 - reflect 21st Century best practices
 - address health care needs in Indian Country

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109th Congress Legislation

- S. 1057 (Sens. McCain and Dorgan) favorably reported by Indian Affairs, Finance, and HELP Committees
 - Senate floor action expected soon
- H.R. 5312 (Rep. Don Young); favorably reported by Resources Committee
 - now pending with Energy & Commerce and Ways & Means for provision under their jurisdiction

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Why the IHCIA should be amended and reauthorized --

- fulfill U.S. obligation for Indian health
- reflect advancements in methods of health care delivery
- improve program operations
- close health disparities gap
- comprehensive behavioral health programs

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Why IHCIA should be amended/reauthorized (cont'd)

- expand facilities construction options
- improve quality of care
- enhance tribal decision-making
- enhance ability to recruit, retain qualified health care professionals
- update the existing law

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Major Components of IHCIA bills

- Complete re-write of existing law using current law format of 8 topical Titles
- Retains many provisions, concepts of current law
- Amendments to SSA regarding Indian health program participation in Medicare, Medicaid, and SCHIP
 - developed and approved by Finance Committee
 - included in H.R. 5312

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Topical Titles of IHCIA in H.R. 5312

- I -- Human Resources + Development
- II -- Health Services
- III -- Health Facilities
- IV -- Access (to 3rd party collections)
- V -- Urban Indian Health
- VI -- IHS Organizational Improvements
- VII -- Behavioral Health
- VIII -- Miscellaneous

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IHCIA Title I -- Human Resources

- Aid recruitment, retention of health professionals for IHS, tribal and urban Indian programs
- Encourage and enable Indian people to enter health professions to serve in Indian programs
- Community Health Aide Program (CHAP)
 - continue program in Alaska
 - authority to establish CHAP for Lower 48 Tribes

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Dental Health Therapist (DHT) Program

- Operated only in Alaska
 - Intensive training program for DHTs
 - Address severe shortage of dentists in remote Alaska Native Villages
- American Dental Association/Alaska Native Tribal Health Consortium compromise in HR 5312 --
 - DHTs can extract adult teeth after consultation with a licensed dentist in medical emergency that cannot be resolved through palliative treatment
 - DHTs prohibited from performing other oral or jaw surgeries

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Title II -- Health Services

- Indian Health Care Improvement Fund
 - eliminate health status deficiencies
- Catastrophic Health Emergency Fund
 - meet extraordinary medical costs
- Diabetes prevention, treatment
- Epidemiology Centers
- Health promotion, disease prevention programs
- Mammography and other cancer screenings
- Modern methods of health care delivery
 - long-term care, hospice, home/community-based care

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Title III -- Facilities

- priorities for construction of health facilities and sanitation facilities
- small ambulatory clinic construction
- innovative options for financing facilities projects
- IHS/tribal Joint Venture Program for facilities construction

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Title IV-- Access to Health Services

- Implement authority to collect Medicare and Medicaid reimbursements
- Grants for M + M outreach activities
- Authority to collect reimbursements from other third party payors
- Sharing arrangements with other Federal agencies, e.g., DoD, DVA
- IHS payor of last resort

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Title V -- Urban Indian Programs

- grants to urban Indian organizations for health services to Indians in urban areas
- over 30 urban centers in operation
- permanent status for Tulsa + OK City urban programs
- grants for Diabetes prevention services and for community health representatives

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Title VI -- IHS Organization

- Created Indian Health Service (1976)
- Elevate IHS Director to Assistant Secretary for Indian Health, DHHS
- IHS automated information systems
 - financial management, cost accounting, billing
 - patient care
 - training

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Title VII -- Behavioral Health

- Comprehensive approach for behavioral health assessment, treatment, prevention
- Comprehensive mental health programs
- Addresses behavioral health needs of all age groups
- Innovative programs with focus on Indian youth
- Child sexual abuse prevention, treatment
- Address fetal alcohol disorders
- Cooperation with Secretary of Interior (BIA)

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Title VIII -- Miscellaneous

- Reports to Congress on Indian health
- Negotiated Rulemaking for development of some regulations
- Health services for non-beneficiaries under certain circumstances consistent with current authorities

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Social Security Act Amendments in HR 5312

- Contained in Title II at the end of the bill
- Amendments to Medicare, Medicaid, SCHIP parts of SSA
- Identical to provisions of S. 3524 approved by Finance Committee for addition to Senate IHCA bill, S. 1057
- Objective: address access needs that are unique to the Indian health system

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Social Security Act Amendments in HR 5312

- Authority for Indian health programs to receive payment for all M+M and SCHIP services
 - retains current law limitation on payment for some Medicare Part B service through 2009, only
- Increased outreach for M+M and SCHIP enrollment
- Tribal enrollment documents as proof of US citizenship
 - But HHS required to issue regulations for acceptable documents regarding a tribe in a state with international border if tribe admits non-US citizens to membership

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Social Security Act Amendments in HR 5312

- Protects Indians served by Indian health facilities from Medicaid premiums and co-pays
 - Modeled on existing SCHIP cost-sharing exemption for Indian children
 - Needed to remove dis-incentive to enroll since IHS programs do not charge Indians for care
 - No loss of funding to State Medicaid Plans since 100% FMAP applies

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Social Security Act Amendments in HR 5312

- Disregards certain Indian-specific property for Medicaid eligibility
 - Modeled on CMS Medicaid Manual exemption of same Indian property from Medicaid estate recovery
- Codifies CMS Medicaid Manual exemption of Indian property from estate recovery
- Access for Indian health programs to Federally-funded health programs on same basis as other qualified providers

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Social Security Act Amendments in HR 5312

- Consultation with Indian health programs --
 - with CMS regarding Medicare, Medicaid, SCHIP, through the existing Tribal Technical Advisory Group
 - with States regarding Medicaid and SCHIP
- Medicaid Managed Care participation for Indian health programs
- Annual HHS report to Congress on Indian enrollment in M+M and SCHIP

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HR 5312 Congressional Budget Office Score

- Very small increase in direct spending estimated:
 - >\$8 million in first year
 - >\$67 million for 2007 – 2011
 - >\$163 million for 2007 – 2016
- Potential return for small investment is enormous -- in the form of enhanced program effectiveness and opportunities for more efficient operations

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