Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

Tribal Medicare and Medicaid Legislative Priorities

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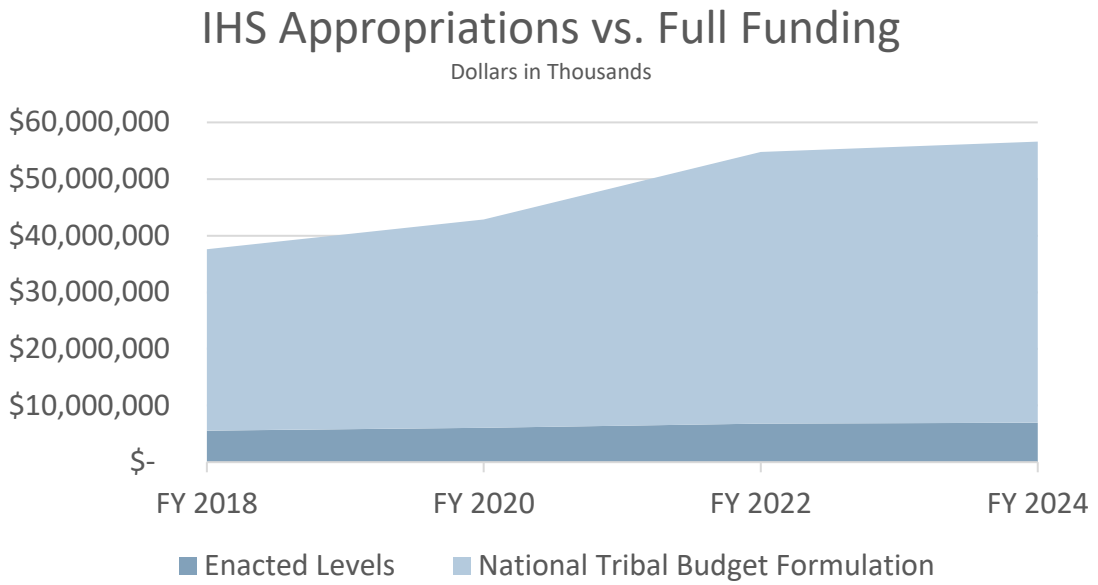
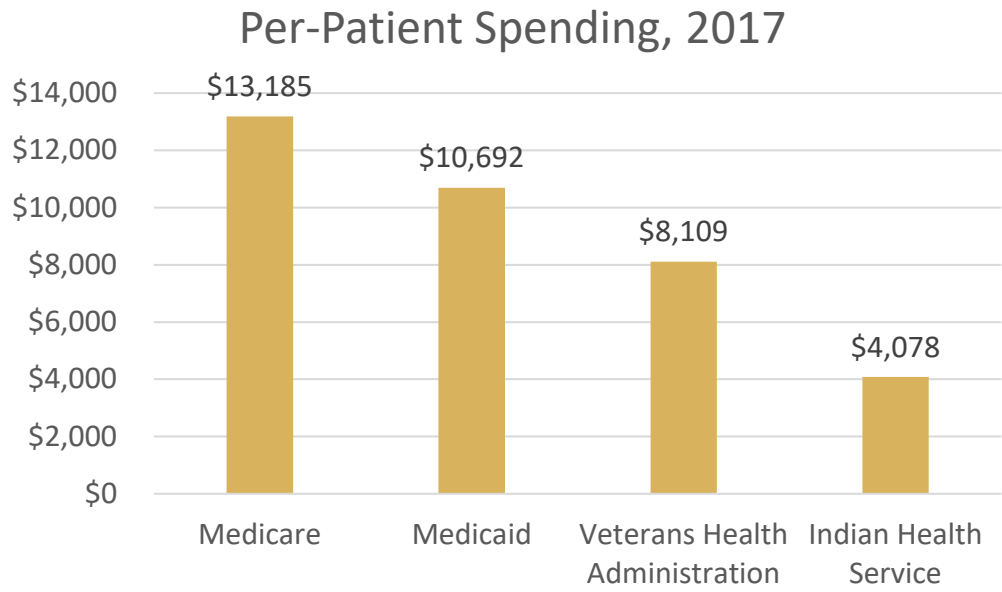
IHS Tribal Self-Governance Advisory Committee

Self-Governance Communication and Education

Indian Health System Appropriations

- Despite the federal trust and treaty obligation, the Indian health system has long been funded below its estimated needs.

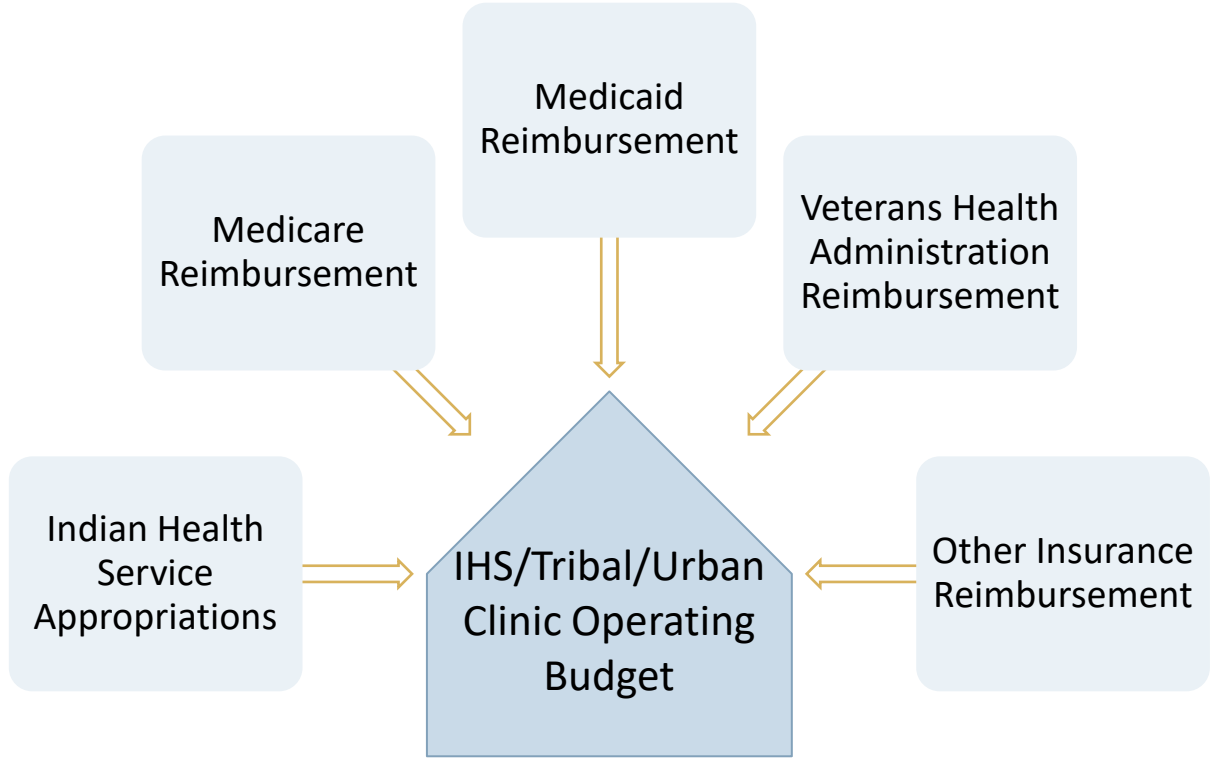




Source: GAO

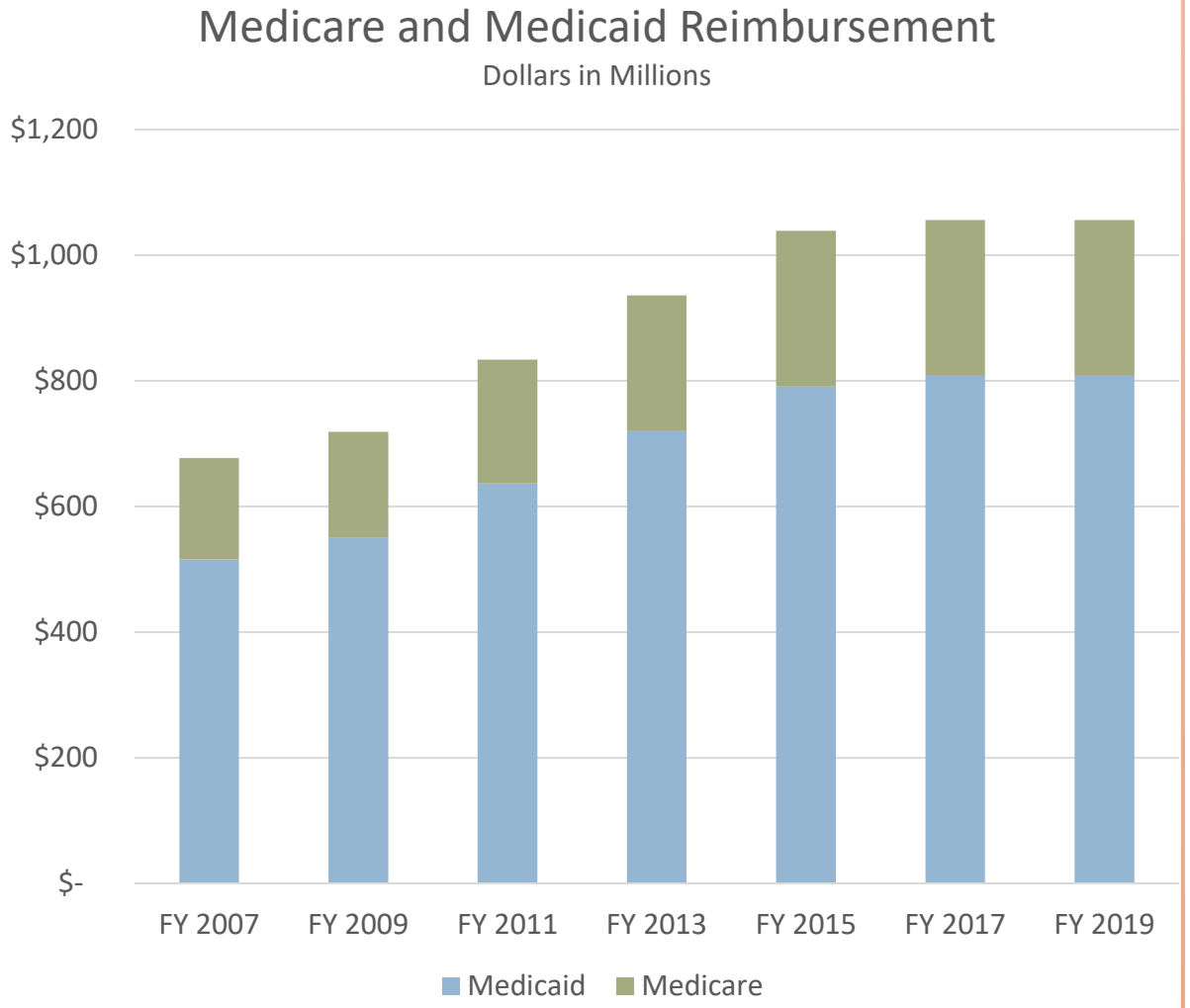
Medicare, Medicaid, & the Indian Health System

- Intending to offset this underfunding, Congress granted the Indian health system the authority to bill Medicare and Medicaid.
- IHS, Tribal, and Urban Indian facilities are also authorized to bill the Veterans Health Administration and private insurance.



Medicare, Medicaid, & the Indian Health System

- Third-party revenues allow Indian Health Care Providers to offer care they would not otherwise be able to.
- Therefore, Medicare and Medicaid help close the gap between the funding need of the Indian health system and actual IHS appropriations.



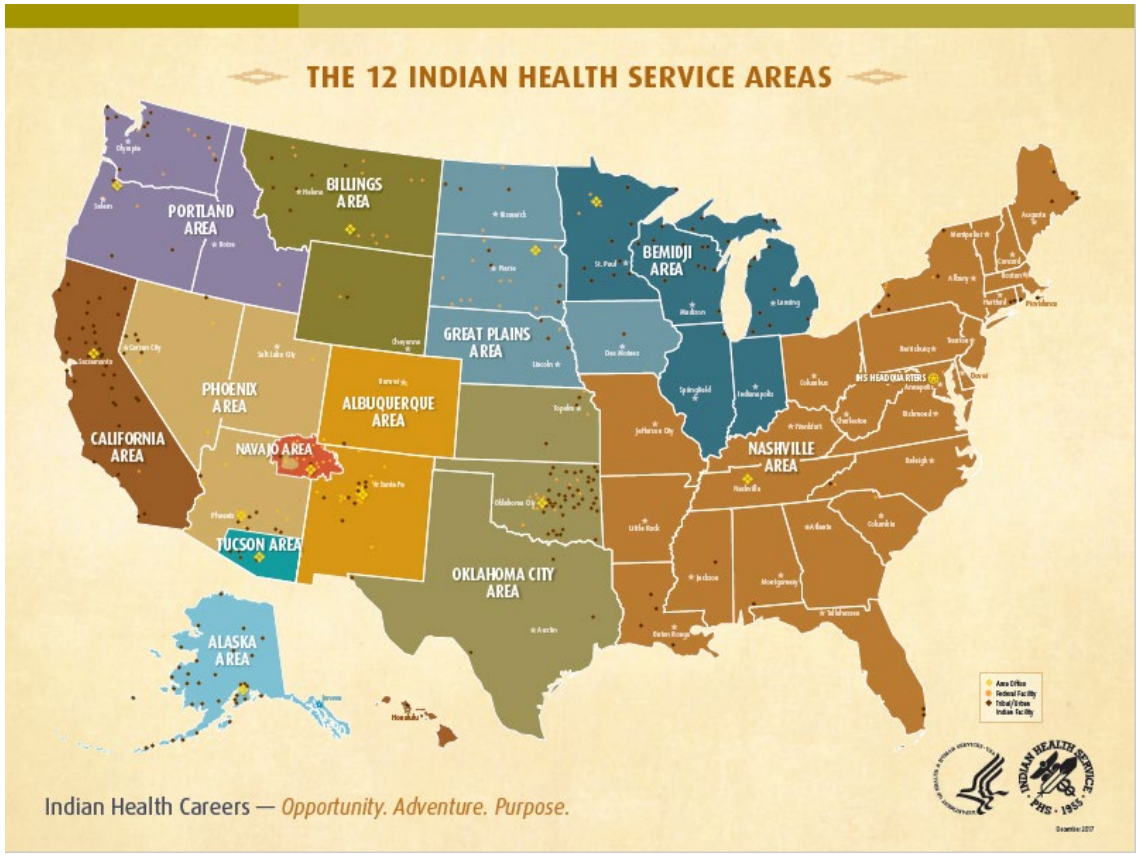
Source: IHS President's Budget Request

Technical Fixes

- Medicare and Medicaid were not designed with the Indian health system in mind.
- The Tribal Technical Advisory Group, a statutorily authorized advisory committee to CMS, developed a set of legislative priorities intended to make Medicaid and Medicare work better for Indian Country.

Technical Fixes

- Each Member of the TTAG represents an IHS Area or a National Organization.
  - Alaska
  - California
  - Portland
  - Phoenix
  - Tucson
  - Navajo
  - Billings
  - Albuquerque
  - Great Plains
  - Oklahoma City
  - Bemidji
  - Nashville
  - National Indian Health Board (NIHB)
  - National Council of Urban Indian Health (NCUIH)
  - National Congress of American Indians (NCAI)
  - Tribal Self-Governance Advisory Committee



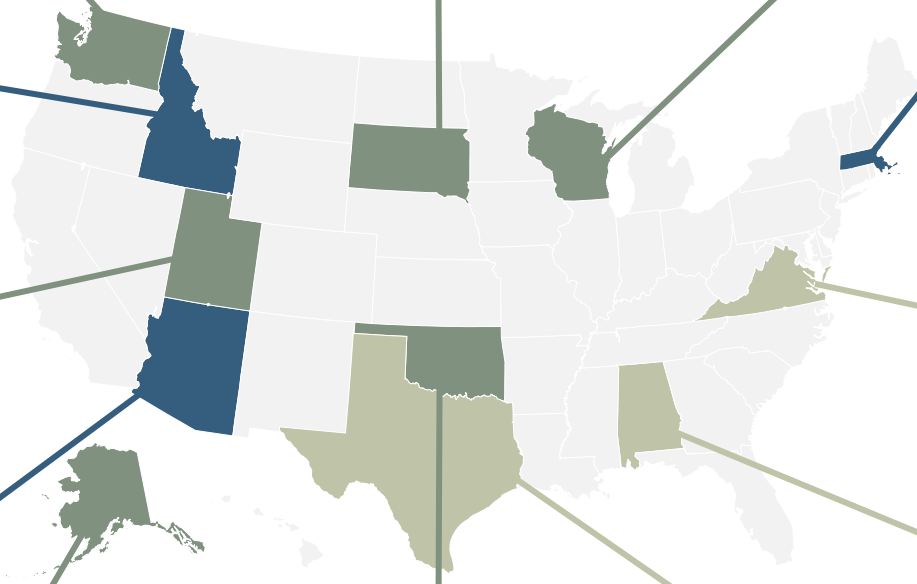
Medicaid Priorities

Medicaid #1: Equalize Medicaid Coverage Across Indian Country

- Medicaid coverage for AI/ANs varies depending on which state the patient is in.
- The *federal* trust and treaty obligation applies regardless of the State a Tribe is located in.
- **This priority would allow Indian Health Care Providers to bill Medicaid for all mandatory, optional, and IHCIA-authorized services, regardless of whether the state authorizes these services for other providers**.
- This would not impose any cost on states, which receive 100% FMAP when a Tribal citizen sees an Indian Health Care Provider.

Example: Optional Dental Coverage Varies Across Indian Country

2018



Limited prior authorization

Full coverage

Non-emergency services for pregnant and disabled only

Full coverage for Tribal citizens through IHS/Tribal facilities only

Prior authorization; $1,150/year cap for non-emergent adult care

Non-emergency services capped at $1000/year

Limits on how often care can be received

One cleaning annually with limits on other services

Full coverage

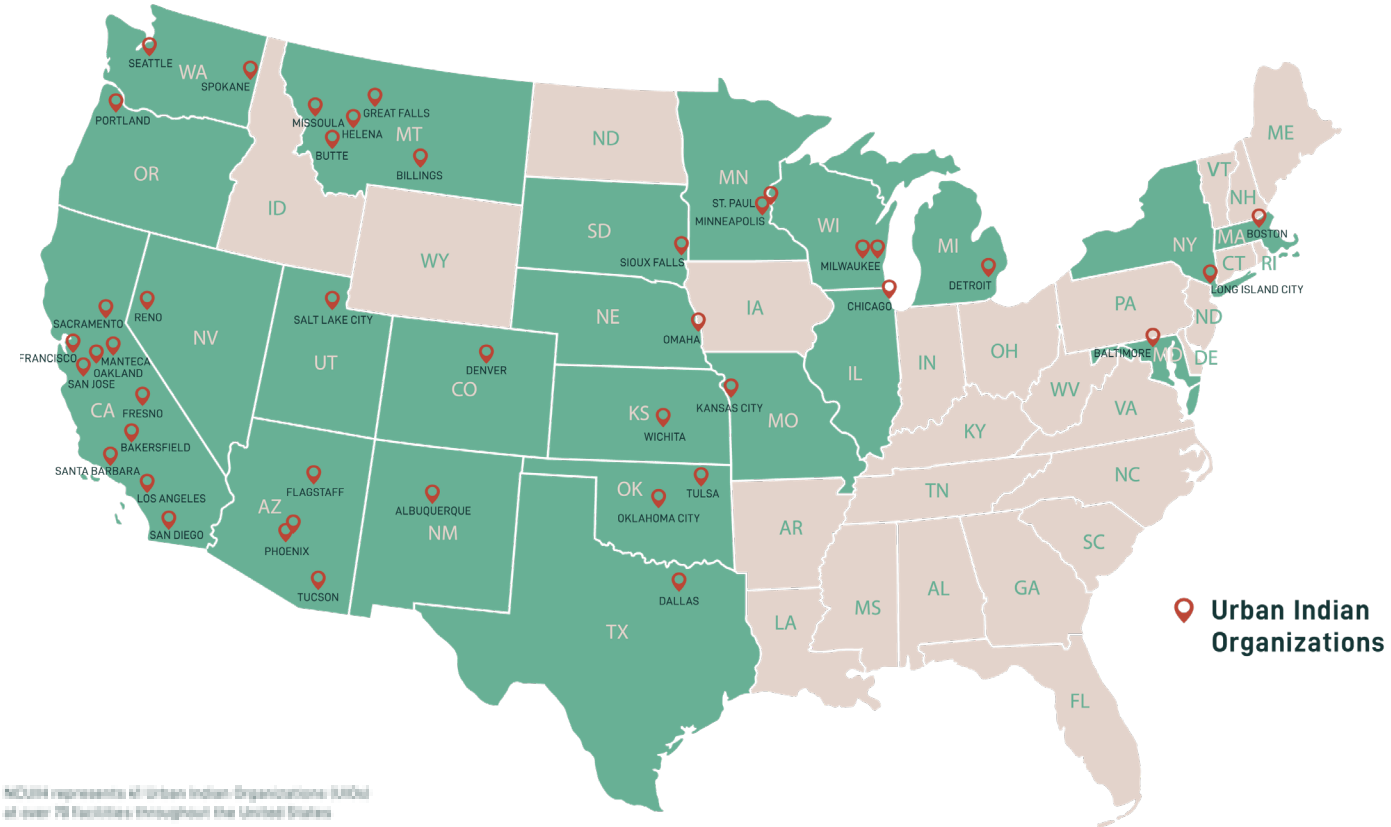
No coverage

No coverage

No coverage

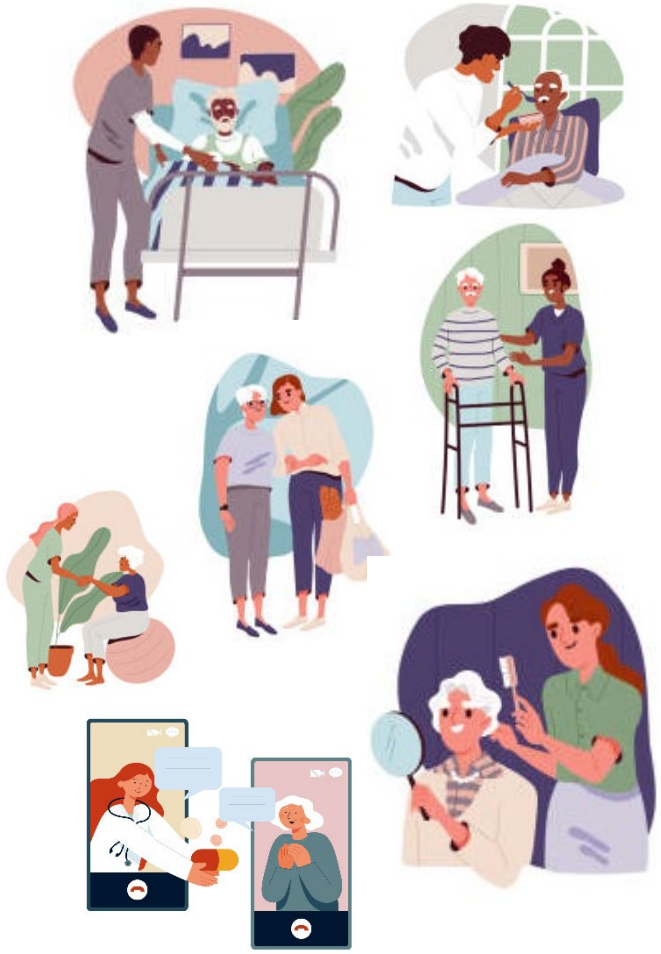
Medicaid #2: 100% Federal Reimbursement for Urban Indian Organizations

- The federal government has a treaty and trust responsibility to provide health care services to Tribal Nations and their citizens.
- The federal government currently covers the entire cost of Medicaid services provided to AI/AN beneficiaries at IHS and Tribal facilities, but not UIOs.
- **This priority would permanently authorize a 100% FMAP for services received through Urban Indian Organizations.**



Medicaid #3: Cover Services Delivered in Non-Facility Settings

- An essential part of the Indian health system is services provided in non-facility settings, including schools, community centers, and patient homes.
- Many Tribal communities are too small or remote to have a brick-and-mortar clinic, so all local services are provided in the community.
- CMS previously interpreted the definition of “clinic services” narrowly, prohibiting Medicaid coverage for services in the community.
- The CY2025 OPPS Final Rule fixed this administratively.
- **This priority would statutorily ensure the “clinic services” definition allows reimbursements for services furnished by IHS and Tribal clinics wherever the care is delivered.**



Anti-Kickback Statute Priority

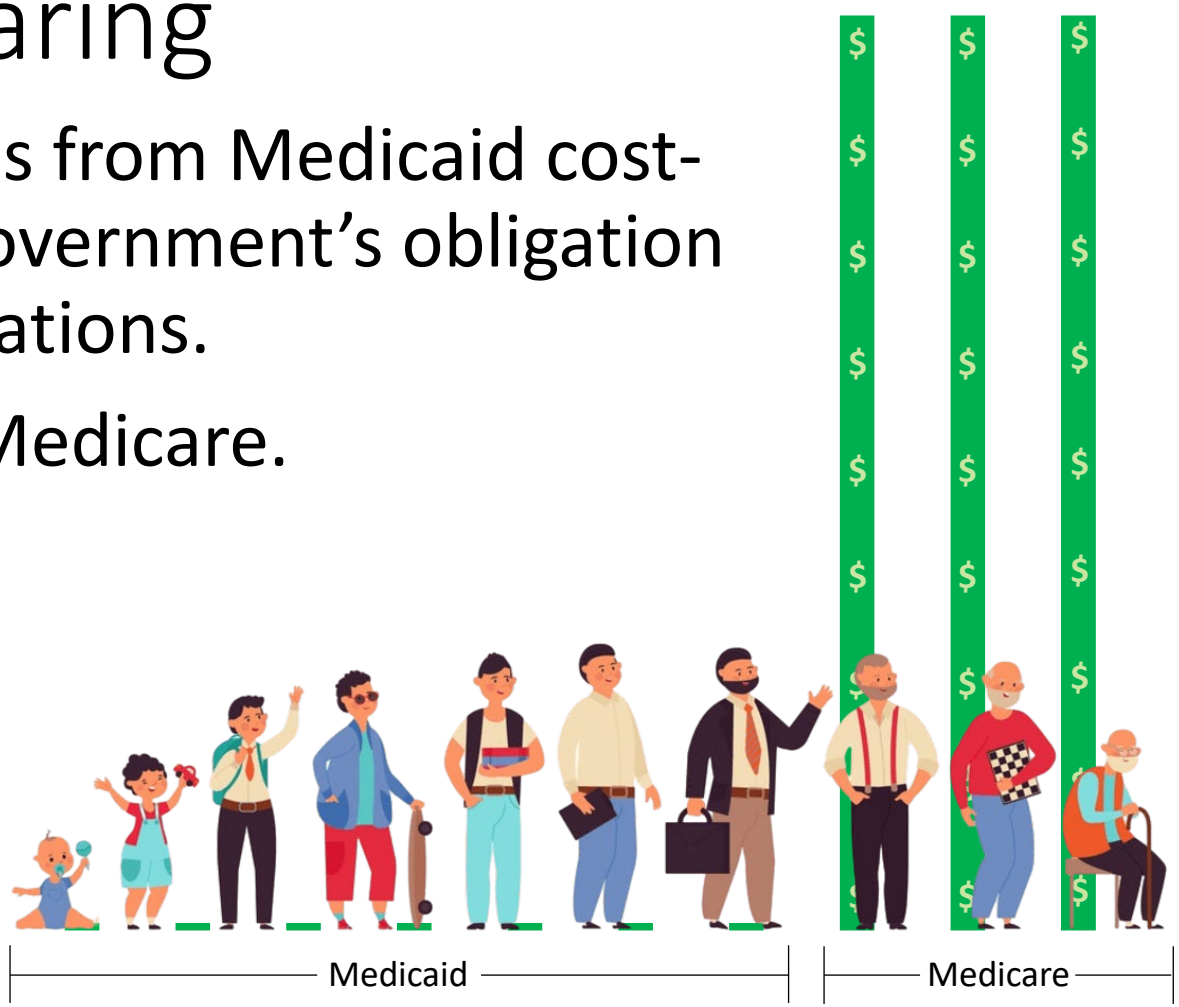
Anti-Kickback Statute: Enact a Tribal Safe Harbor

- Congress created a safe harbor for federally qualified health centers (FQHCs) in Section 431 of the Medicare Modernization Act of 2003.
- But, many Indian Health Care Providers do not have access to the FQHC safe harbor because the FQHC is not broad enough to include all IHS and Tribal health care providers, including hospitals.
- At present, compliance concerns prevent Indian Health Care Providers from expanding access to needed care from outside primary and specialty care providers.
- **This priority would establish an Anti-Kickback Statute safe harbor for Indian health care providers.**

Medicare Priorities

Medicare #1: Exempt Tribal Elders from Medicare Cost-Sharing

- Congress exempted Tribal citizens from Medicaid cost-sharing because of the federal government's obligation to provide healthcare to Tribal Nations.
- No similar exemption exists for Medicare.
- **This priority would exempt AI/AN beneficiaries from Medicare premiums and deductibles, as was done for Medicaid**.



Tribal citizens' cost-sharing skyrockets when enrolling in Medicare.

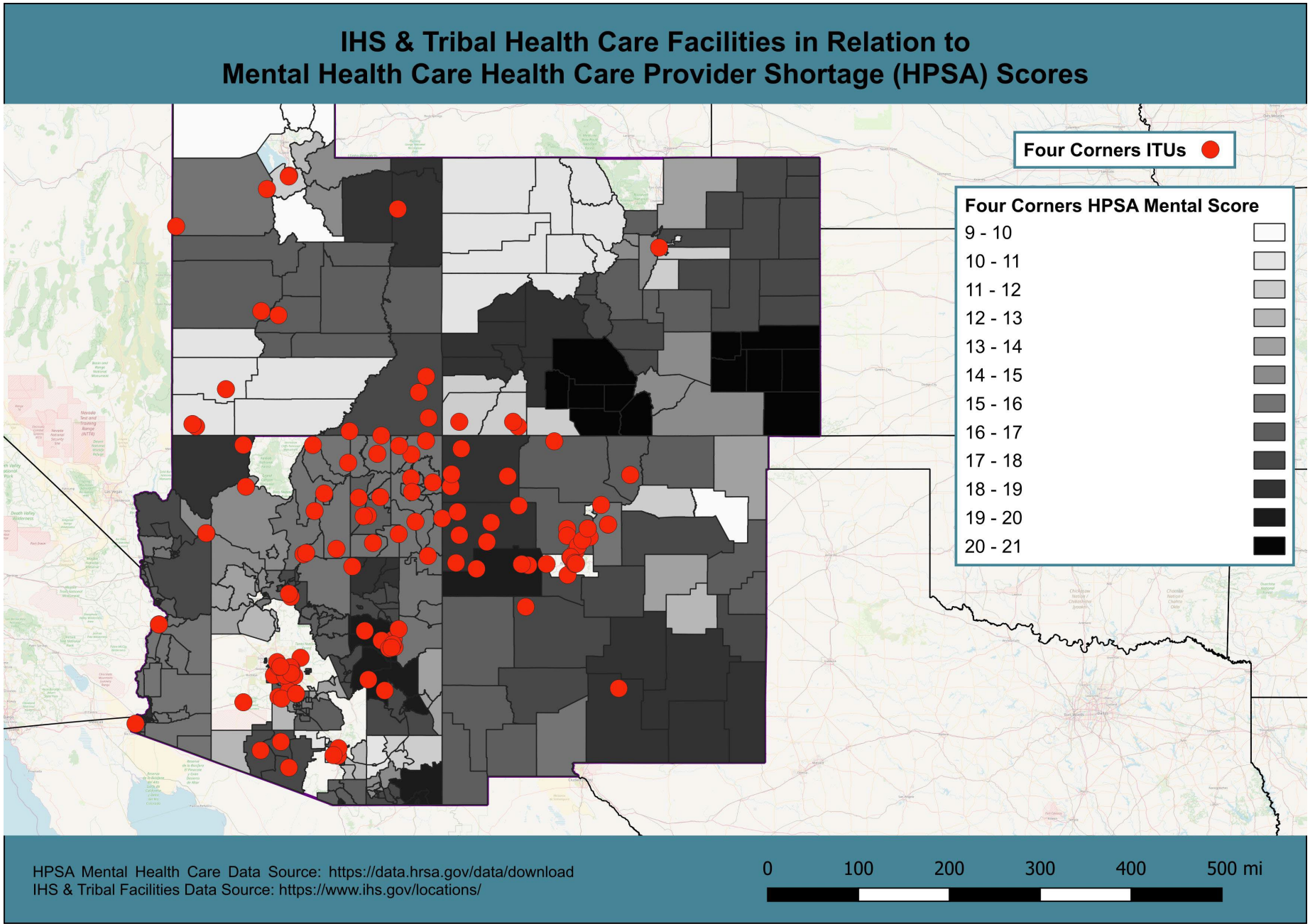
Medicare #2: Reimburse Indian Health Care Providers Fully for Care to Tribal Elders

- Indian Health Care Providers are only reimbursed for 80% of the cost of providing care to Medicare-enrolled Tribal elders.
- Medicare expects the patient to pick up the other 20% as the cost-share, but IHS *cannot* bill patients for the service, and Tribal providers *do not* collect from these patients.
- As a result, IHS and Tribal facilities are only being paid 80 cents on the dollar for Medicare services compared to other providers.
- **This priority would mandate Medicare reimburse Indian Health Care Providers at 100% of the cost of their services**.

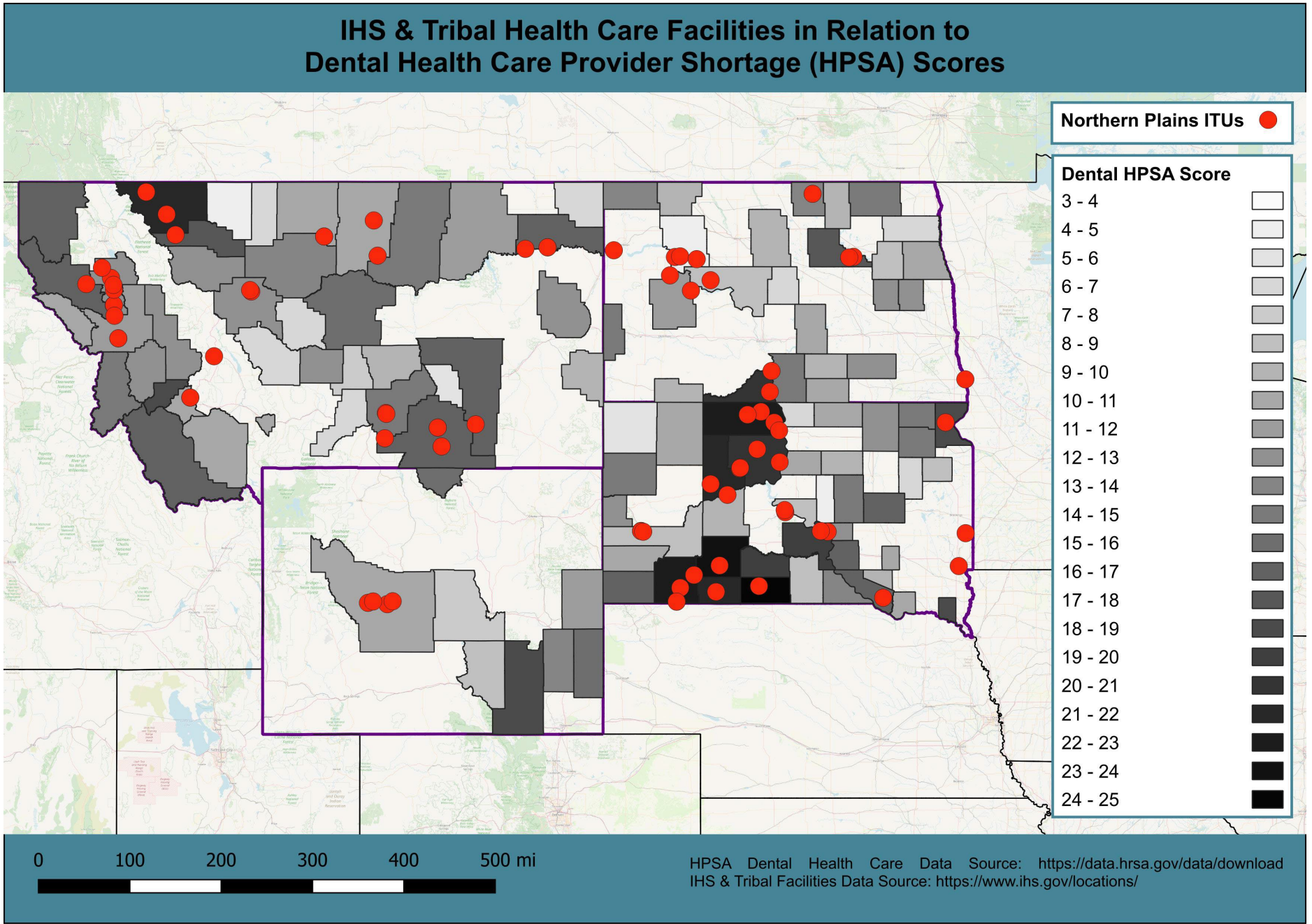
Medicare #3: Reimburse Tribal-Specific Provider Types

- Due to chronic understaffing and lack of adequate resources, Tribal-specific provider types regularly provide vital care to Tribal citizens.
  - **Community Health Aide/Practitioner (CHA/P)**: Primary, emergent, and chronic care.
  - **Behavioral Health Aide/Practitioner (BHA/P)**: Mental health education, prevention, intervention, and crisis management.
  - **Dental Health Aide Therapists (DHAT)**: Cleanings, fillings, basic extractions, etc.
  - **Indian Health Program Pharmacists**: Medication-assisted treatment for substance use disorders, Asthma stabilization, etc.

Example: Mental Health Care Provider Needs in the Four Corners Region



Example: Dental Health Care Provider Needs in the Northern Plains



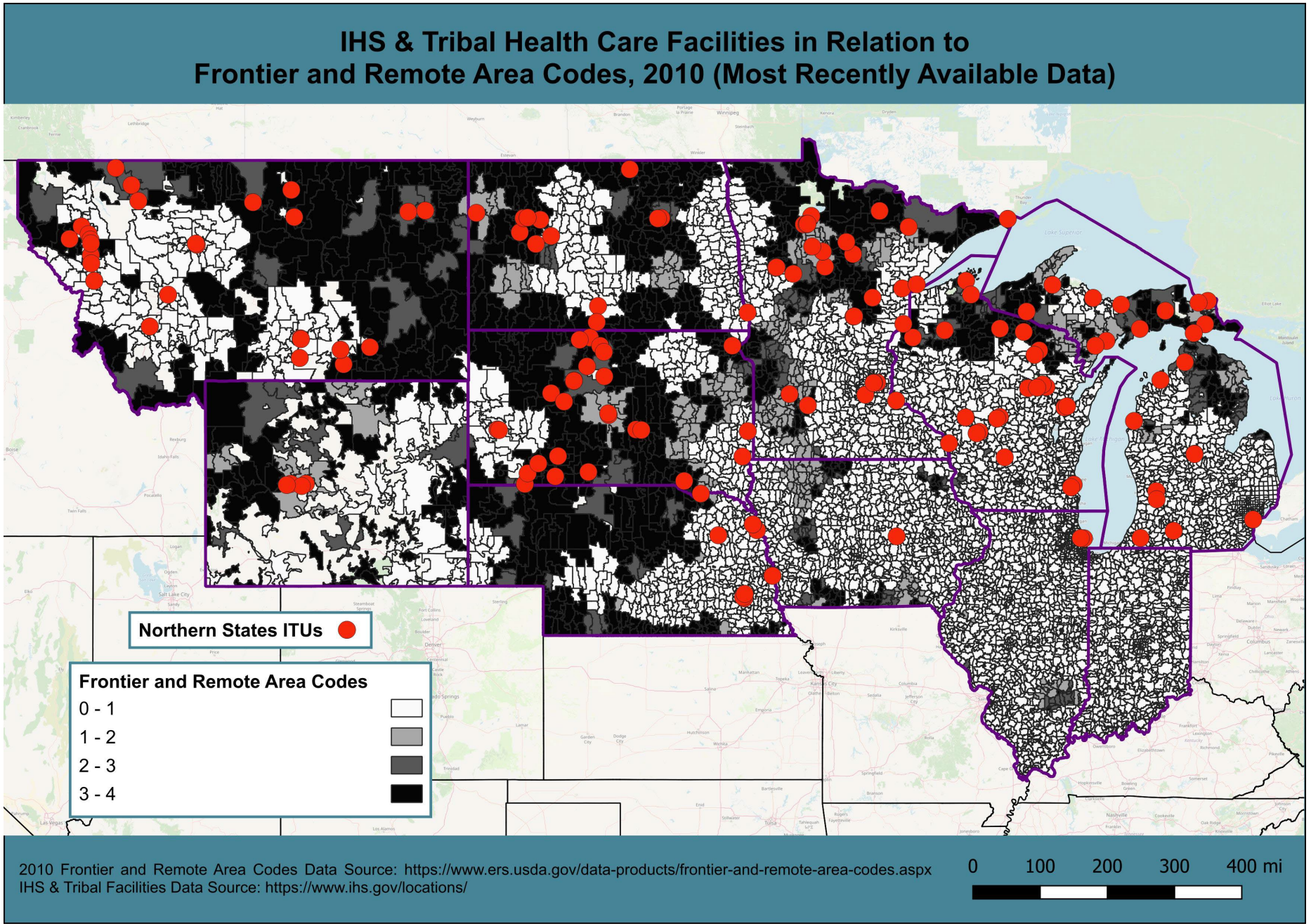
Medicare #3: Reimburse Tribal-Specific Provider Types

- For many remote communities, CHA/Ps, BHA/Ps, DHATs, and Indian Health Program Pharmacists are the only in-community providers.
- Medicaid reimburses for their services, but Medicare does not.
- **This priority would make these provider types eligible for Medicare reimbursement as Indian Health Care Providers**.

Medicare #4: Permanently Extend Medicare Telehealth Flexibilities

- Telehealth is critical for Tribal elders who are rurally located, without transportation services, or home-bound.
- **This priority would permanently authorize Medicare reimbursement of telehealth services provided through the IHS, Tribal, and Urban Indian facilities**.

Example: The Indian Health System Serves Rural Zip Codes



Mandatory Services	Optional Services	Optional Services (cont.)	Additional SSA-Authorized Services	IHCIA-Authorized Services
Transportation to medical care	Other licensed practitioner services	Community First Choice Option	In vitro diagnostic products	Long-term care services
Inpatient hospital services	Private duty nursing services	Personal care	Services furnished under a PACE program	Community Health Aide Program services
Outpatient hospital services	Clinic services	Primary care case management	Community supported living arrangements services	Health promotion and disease prevention services
Rural health clinic services	Dental services	Primary and secondary medical strategies, treatment, and services for individuals with sickle cell disease	Home and community care for functionally disabled elderly individuals	Diabetes prevention, treatment, and control services
Federally qualified health center services	Physical therapy	State plan home and community based services	Certified community behavioral health clinic services (jj)	Hospice care
Laboratory and X-Ray services	Occupational therapy	Self-directed personal assistance services		Assisted living services
Nursing facility services	Speech, hearing and language disorder services	Respiratory care for ventilator-dependent individuals		Community Health Representative Program services
Family planning services	Prescription drugs	Alternative Benefit Plan		Home-and community-based services
Early and Periodic Screening, Diagnostic, and Treatment services	Dentures	Health homes for enrollees with chronic conditions		Mental health prevention and treatment services
Tobacco cessation counseling for pregnant women	Prosthetics	Other services approved by Secretary: religious nonmedical health care institution		Prevention, control, and elimination of communicable and infectious diseases
Physician services	Eyeglasses	Other services approved by Secretary: critical access hospital		Behavioral health prevention and treatment services
Home health services	Other diagnostic, screening, preventive, and rehabilitative services	Other services approved by Secretary: emergency hospital services by a non-Medicare certified hospital		Domestic and sexual violence prevention and treatment
Nurse midwife services	Hospice			
Certified pediatric and family nurse practitioner services	Services in an intermediate care facility for individuals with intellectual disability			
Freestanding birth center services when licensed or otherwise recognized by the state	Inpatient psychiatric services for individuals under 21			
Medication Assisted Treatment	Case management			
Routine patient costs of items and services for beneficiaries enrolled in qualifying clinical trials	Services for individuals 65+ in an Institution for Mental Disease			
Alternative Benefit Plan (Expansion pop.)	TB-related services			

Questions?

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For more information on the TSGAC Affordable Care Act/IHCIA Project, please visit the Health Reform website at: Health Reform - Tribal Self-Governance (tribalselfgov.org)

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