CF-16-17

RESOLUTION OF THE
NAVAJO NATION COUNCIL

23rd NAVAJO NATION COUNCIL - Third Year, 2017

AN ACTION

RELATING TO CESSATION OF DIRECT SERVICES; RESPECTFULLY REQUESTING CONGRESS RETAIN THE BI-PARTISAN SUPPORTED INDIAN HEALTHCARE IMPROVEMENT ACT AS ENACTED WITHIN THE AFFORDABLE CARE ACT OF 2010

WHEREAS:

A. The Navajo Nation Council is the governing body of the Navajo Nation. 2 N.N.C. § 102(A).

B. Pursuant to 2 N.N.C. §164 (A)(16) "[m]atters constituting an emergency shall be limited to the cessation of law enforcement services, and disaster relief services, fire protection services or other direct services required as an entitlement under Navajo Nation or Federal law, or which directly threaten the sovereignty of the Navajo Nation. Such an emergency matter must arise due to the pressing public need for such resolution(s) and must be a matter requiring final action by the Council."

C. The Navajo Nation has a government-to-government relationship with the United States of America, Treaty of 1868, Aug. 12, 1868, 15 Stat. 667.

D. The Indian Healthcare Improvement Act (IHCIA) was first enacted in 1976 and permanently enacted in 2010 as part of the Affordable Care Act (Section 10221).

E. The IHCIA states, "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." *See* 25 U.S.C. § 1602.

F. The IHCIA provides the foundational authority for the Indian Health Service (IHS) 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 Native Americans such as substance abuse, diabetes and suicide, as stated within the attached documents labeled **Exhibit A**.

G. The 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. *Id.*

H. The IHCIA 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. *Id.*

I. The IHCIA provides many essential cost-saving provisions for IHS and Tribes, such as the authority for the IHS, Tribal, and Urban Indians (collectively known as I/T/U) health providers to be licensed in any state and practice at an I/T/U facility. *Id.*

J. The IHCIA authorizes IHS and Tribes to enter into arrangements with the Department of Veterans Affairs and Department of Defense to share medical facilities and services which increases government efficiency and ensures that American Indian and Alaskan Native Veterans (who serve at a percentage than any other group) are taken care of. *Id.*

K. The IHCIA allows the I/T/U providers to be eligible for participation in any federal healthcare program and for reimbursement from third party payers which is critical to bring in additional resources into the I/T/U system. *Id.*

L. Repealing the IHCIA would have disastrous consequences for the I/T/U which would lose critical third party revenue, legal authorities and life-saving programs. *Id.*

M. It is in the best interest of the Navajo Nation and the Navajo people to retain the bi-partisan supported Indian Healthcare Improvement Act as enacted within the Affordable Care Act of 2010.

NOW THEREFORE, BE IT RESOLVED:

A. The Navajo Nation respectfully requests the United States Congress to retain the bi-partisan supported Indian Healthcare Improvement Act as enacted within the Affordable Care Act of 2010. *See* **Exhibit A**.

B. The Navajo Nation hereby authorizes the Navajo Nation President, the Navajo Nation Speaker, the Navajo Nation Chief Justice and their designees, to advocate that the United States Congress to retain the bi-partisan supported Indian Healthcare Improvement Act as enacted within the Affordable Care Act of 2010.

CERTIFICATION

I hereby certify that the foregoing resolution was duly considered by the Navajo Nation Council at a duly called meeting in Window Rock, Navajo Nation (Arizona) at which a quorum was present and that the same was passed by a vote of 14 in favor and 0 opposed, this 16th day of February 2017.

Edmund Yazzie, Speaker Pro Tem
Navajo Nation Council

2/21/17
Date

Motion: Honorable Davis Filfred
Second: Honorable Jonathan Perry

(8)

23nd Navajo Nation Council
Special Session

DATE: February 16, 2017

Legislation 0039-17 **(Main Motion)**

Motion: Davis Filfred

Second: Jonathan Perry

ALL DELEGATES:

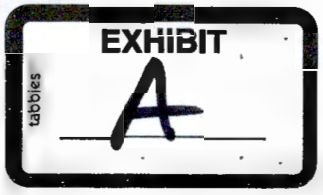
	Yea	Nay
BATES, LoRenzo	✓	
BEGAY, Kee Allen Jr.		
BEGAY, Norman M.	✓	
BEGAYE, Nelson		
BENNETT, Benjamin L.	✓	
BROWN, Nathaniel	✓	
CHEE, Tom T.		
CROTTY, Amber K.	✓	
DAMON, Seth		
DANIELS, Herman	✓	
FILFRED, Davis	✓	
HALE, Jonathan L.	✓	
JACK, Lee Sr.		
PERRY, Jonathan	✓	
PETE, Leonard H.	✓	
PHELPS, Walter		
SHEPHERD, Alton Joe		
SLIM, Tuchoney Jr.		
SMITH, Raymond Jr.	✓	
TSO, Otto	✓	
TSOSIE, Leonard		
WITHERSPOON, Dwight	✓	
YAZZIE, Edmund		
YAZZIE, Peterson	✓	

GRAND TOTAL | 14 | 0

CERTIFICATION:

Honorable Edmund Yazzie
Speaker Protem

23rd Navajo Nation Council



January 13, 2017

The Honorable Paul Ryan
Speaker of the House
U.S. House of Representatives
H-232 The Capitol
Washington, DC 20515

The Honorable Mitch McConnell
Majority Leader
U.S. Senate
S-230 The Capitol
Washington, DC 20515

Re: Preservation of the Indian Healthcare Improvement Act and other Affordable Care Act provisions serving American Indians and Alaska Natives

Dear Speaker Ryan and Majority Leader McConnell:

In support of the National Indian Health Board (NIHB) and the 567 Tribes the board serve, I write today to ask you to support the retention of the Indian Healthcare Improvement Act (IHCIA) in any efforts to repeal or replace the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148). I am a delegate to Navajo Nation Council and serve on the Health, Education and Human Services Committee of the Council. The IHCIA is unrelated to the overall ACA, and revoking this law would have catastrophic consequences for the Indian health system and American Indians and Alaska Natives (AI/ANs) nationwide. 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.

First enacted in 1976, the Indian Healthcare Improvement Act 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. 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" [1] 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 Native Americans 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. 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. The law also authorizes IHS and Tribes to enter into arrangements with the Department of Veterans Affairs and Department of Defense to share medical facilities and services which increases government efficiency and ensures that American Indian and Alaska Native Veterans (who serve at a percentage than any other group) are taken care of. 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 resources into the I/T/U system.

Other provisions also exist within the ACA, separate from IHCIA, we strongly believe must be preserved to ensure that the Indian health delivery system remains viable. These provisions are also unrelated to the overall healthcare reform legislation and are as follows:

- Section 2901 which states that any I/T/U be the payer of last resort for services provided notwithstanding any Federal, State, or local law to the contrary.
- Section 2902 which grants 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.
- Maintaining Medicaid Benefits for AI/ANs. Under current law, the federal government reimburses States for 100 percent of the cost of providing Medicaid services to AI/ANs. 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 obligation is not shifted to the States.

Repealing these provisions and the IHCIA now would have disastrous consequences for the Indian health system. I/T/Us would lose critical 3rd party revenue, legal authorities, and life-saving programs. As you consider a path forward on healthcare reform, I, as a leader of Navajo Nation, urge you to ensure that this law is preserved so the Indian health system can continue to operate under a framework appropriate for 21st century healthcare delivery and honors the United States' trust responsibility to provide healthcare to American Indians and Alaska Natives.

---

[1] 25 U.S.C. § 1602.

Thank you for your attention to this important matter. I, along with other officials of Navajo Nation, look forward to working with you on these critical efforts in the 115th Congress and beyond. Should you have any questions about this, please contact NIHB's Executive Director Stacy A. Bohlen at (202) 507-4070 or sbohlen@nihb.org.

Sincerely,

Jonathan L. Hale,
23rd Navajo Nation Council

Cc:
Chairman Greg Walden, Incoming Chairman, House Energy and Commerce Committee
Chairman Kevin Brady, House Ways and Means Committee
Chairman Rob Bishop, House Natural Resources Committee
Chairman Orrin Hatch, Senate Finance Committee
Chairman Lamar Alexandra, Senate Health Labor and Pensions Committee
Chairman John Hoeven, Senate Committee on Indian Affairs
NIHB Board of Directors
Honorable John McCain, United States Senator from Arizona
Honorable Jeff Flake, United States Senator from Arizona (R-Arizona)
Honorable Tom Udall, United States Senator from New Mexico and a member of the Democratic Party Honorable Martin Heinrich, U.S. Senator for New Mexico, Democratic party
Honorable Orrin G. Hatch, United States Senator Utah (R- Utah)
Honorable Mike Lee, United States Senator (R- Utah)

Inter Tribal Council of Arizona, Inc.
21 TRIBAL NATIONS

December 5, 2016

The Honorable Douglas Ducey
1700 West Washington Street
Phoenix, Arizona 85007

RE: Request to Appoint Members to the Arizona Advisory Council on Indian Health Care

Dear Governor Ducey:

Thank you for signing HB 2312 and SB 1238 on May 11, 2016. The legislation updated the statutes of the Arizona Advisory Council on Indian Health Care (AACOIHC). Specifically, the new statutes simplified the appointment process and clarified the responsibilities and duties of the Council. The bills were supported by the Tribes in Arizona. In addition, the Inter Tribal Association of Arizona which represents 21 member Tribes in Arizona, and the Navajo Nation adopted resolutions of support.

We respectfully request an update when you will begin to process the appointments to the AACOIHC. As of this writing, the Inter Tribal Council of Arizona, Inc. which re-nominated Ms. Alida Montiel on December 1, 2015, has not been apprised of an appointment; except that she was informed by the AACOIHC staff on April 28, 2016, that the Arizona Boards and Commissions instructed all applicants to reapply and submit a signed background check authorization form. She completed these on May 2, 2016.

ITCA is requesting, in addition to Ms. Montiel, that all pending nominations made by the Tribes or organizations pursuant to A.R.S. 36-2902-01, be appointed as soon as possible. According to AACOIHC the following individuals have completed the new application process instituted by the Arizona Boards and Commissions.

1. Raquel Aviles, Assistant Health Director, Pascua Yaqui Tribe
2. Amanda Barrera, Councilwoman, Colorado River Indian Tribes
3. Jonathan Hale, Councilman Hale, Navajo Nation,
4. Marietta Jean Pagilawa, Councilwoman, Hualapai Tribe
5. Lorencita Joshweseoma, Health Director, Hopi Tribe
6. Alida Montiel, Health Systems Director, Inter Tribal Council of Arizona
7. Daniel L.A. Preston III, Councilman, Tohono O'odham Nation
8. Jessica Rudolpho, Health Director, White Mountain Apache Tribe
9. Deanna Sangster, Director, Native Health
10. Thomas Siyuja, Councilman, Havasupai Tribe

Ak-Chin Indian Community
Cocopah Indian Tribe
Colorado River Indian Tribes
Fort McDowell Yavapai Nation
Fort Mojave Indian Tribe
Gila River Indian Community
Havasupai Tribe
Hopi Tribe
Hualapai Tribe
Kaibab Band of Paiute Indians
Pascua Yaqui Tribe
Pueblo of Zuni
Quechan Tribe
Salt River Pima-Maricopa Indian Community
San Carlos Apache Tribe
San Juan Southern Paiute Tribe
Tohono O'odham Nation
Tonto Apache Tribe
White Mountain Apache Tribe
Yavapai-Apache Nation
Yavapai-Prescott Indian Tribe

2214 North Central Avenue ◎ Phoenix, Arizona 85004 ◎ p 602.258.4822 ◎ f 602.258.4825 ◎ www.itcaonline.com

Background

As stated above, AACOIHC was notified by Boards and Commissions staff on April 28, 2016, through an email that there were no current members of the AACOIHC. This was disconcerting news. A.R.S. 38-295 states, "Every officer shall continue to discharge the duties of the office, although the term has expired, until a successor has qualified." Current members should be able to continue their work based on this statute and join State agency representatives already appointed by their respective Directors to carry out A.R.S. 36-2902.01 and A.R.S. 38-2902.02. The current state appointments are listed below. These include:

1. Michael Allison, Native American Liaison, ADHS
2. Bonnie Talakte, Tribal Relations Liaison, AHCCCS
3. Archie Mariano, Tribal Nations Instructor Liaison, ADES
4. Candida Hunter, Senior Director of Tribal Affairs, AzFTF

ITCA looks forward to your new appointments and notice of reinstatement of current appointments in order to continue this agency's role in providing advisement to your office and state health and human service agencies. Again, I thank you for signing of HB 2312 and SB 1238 which shows commitment to the Tribes in Arizona.

If you require more information and assistance on this matter, please contact me at (602) 258-4822 or Maria.Dadgar@itcaonline.com.

Sincerely,

Maria Dadgar, MBA
Executive Director

Enclosures: ITCA Letter of Nomination and ITAA Tribal Resolution

cc:
Shan Lewis, President, Inter Tribal Association of Arizona
Thomas Beauty, President, Inter Tribal Council of Arizona, Inc.
Christine Corieri, Senior Policy Advisor, Office of the Governor
Kristine Fire Thunder, Native American Affairs Policy Advisor, Office of the Governor
Ryan Peters, Director, Boards and Commissions
Russell Begay, President, Navajo Nation
Jonathan Hale, Councilman, Navajo Nation
Kim Russell, Executive Director, AACOIHC

Inter Tribal Council of Arizona, Inc.
21 TRIBAL NATIONS

December 1, 2015

Kim Russell, Executive Director
Arizona Advisory Council on Indian Health Care
1740 West Adams Street, Suite 409
Phoenix, AZ 85007

Dear Ms. Russell,

Pursuant to A.R.S. 36-2902.01, the Inter Tribal Council of Arizona, Inc. (ITCA) submits its recommendation of Alida Montiel, for consideration by the Governor of the State of Arizona for appointment to the Arizona Advisory Council on Indian Health Care (AACOIHC) for a two-year term of 2015-2017. Upon approval of her appointment Ms. Montiel will be advising our organization of the Advisory Council's activities. Ms. Montiel is the Health Systems Director of the ITCA.

The Inter Tribal Council of Arizona (ITCA) was established in 1952 by Tribal Leaders to provide a forum for tribal governments in the State of Arizona to address common issues of concern. In 1975, the Council established a non-profit corporation to promote Indian self-reliance and public policy development. Addressing health issues has been a priority concern and ITCA supported as one of its policy recommendations, the establishment of the ACOIHC. This was accomplished in 1989, with the passage of A.R.S. 36-2902.01 and A.R.S. 36-2902.02. Mr. John R. Lewis, the former Executive Director of ITCA, served on the ACOIHC through 1994 and Ms. Montiel succeeded him through appointment by former Governor Fife Symington on January 13, 1995. She has been reappointed by each successive Governor and the ITCA seeks her reappointment to continue the valuable collaboration between the two organizations.

ITCA continues to work with the ACOIHC as it affords a mechanism through which the member Tribes may advise and work with the state of Arizona to improve policies and the delivery of state funded health and human service programs in tribal communities.

ITCA appreciates this opportunity to maintain its membership on the ACOIHC. If you have questions, please contact me at (928) 567-3649, or contact Maria Dadgar, ITCA Executive Director at (602) 258-4822. Thank you for your consideration on this matter.

Sincerely,

Thomas Beauty

Thomas Beauty, President
Inter Tribal Council of Arizona, Inc.
Chairman, Yavapai Apache Nation

cc: Maria Dadgar, Executive Director, MBA
Inter Tribal Council of Arizona, Inc.

Ak-Chin Indian Community
Cocopah Tribe
Colorado River Indian Tribes
Fort McDowell Yavapai Nation
Fort Mojave Indian Tribe
Gila River Indian Community
Havasupai Tribe
Hopi Tribe
Hualapai Tribe
Kaibab Band of Paiute Indians
Pascua Yaqui Tribe
Pueblo of Zuni
Quechan Tribe
Salt River Pima-Maricopa Indian Community
San Carlos Apache Tribe
San Juan Southern Paiute Tribe
Tohono O'odham Nation
Tonto Apache Tribe
White Mountain Apache Tribe
Yavapai-Apache Nation
Yavapai-Prescott Indian Tribe

FAIR CREDIT REPORTING ACT DISCLOSURE AND AUTHORIZATION TO CONDUCT BACKGROUND INVESTIGATION

PLEASE REVIEW CAREFULLY BEFORE SIGNING AUTHORIZATION

The Office of the Governor of the State of Arizona ("the Office") may obtain background information about you for employment purposes or other purposes permitted by law from a third-party consumer reporting agency. Thus, by signing below, you agree that you may be the subject of a "consumer report" which may contain information regarding your credit history, criminal history, social security verification, motor vehicle records, verification of your education or employment history, or other background checks. Credit history may be requested if such information is relevant to the duties and responsibilities of the position for which you are applying. The scope of this notice and authorization allows the Office to obtain from any outside organization all manner of consumer reports now and throughout the course of your employment or other relationship with the Office, if applicable, to the extent permitted by law.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of this FCRA DISCLOSURE AND AUTHORIZATION TO CONDUCT BACKGROUND INVESTIGATION and certify that I have read and understand it. I hereby authorize the obtaining of "consumer reports" by the Office at any time after receipt of this authorization and throughout my employment or other relationship, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by an outside organization acting on behalf of the Office, and/or the Office itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

Last Name Montiel First Alida Middle Victoria

Signature Alida V. Montiel Date 5-2-16

Contact Phone Number 602-307-1575 Email Alida.Montiel@itcaonline.com

Inter Tribal Association of Arizona

21 TRIBAL NATIONS

Ak-Chin Indian Community
Cocopah Tribe
Colorado River Indian Tribes
Fort McDowell Yavapai Nation
Fort Mojave Indian Tribe
Gila River Indian Community
Havasupai Tribe
Hopi Tribe
Hualapai Tribe
Kaibab Band of Paiute Indians
Pascua Yaqui Tribe
Pueblo of Zuni
Quechan Tribe
Salt River Pima-Maricopa Indian Community
San Carlos Apache Tribe
San Juan Southern Paiute Tribe
Tohono O'odham Nation
Tonto Apache Tribe
White Mountain Apache Tribe
Yavapai-Apache Nation
Yavapai-Prescott Indian Tribe

Resolution No. 0116

Support for the Arizona Advisory Council on Indian Health Care Statute Amendments

WHEREAS, the Inter Tribal Association of Arizona, an association of 21 tribal governments in Arizona, provides a forum for tribal governments to advocate for national, regional and specific tribal concerns and to join in united action to address these issues; and

WHEREAS, the Member Tribes of the Inter Tribal Association of Arizona have the authority to act to further their collective interests as sovereign tribal governments; and

WHEREAS, the Inter Tribal Association of Arizona has the charge to support and represent particular member Tribes on matters directly affecting them upon their request; and

WHEREAS, the Arizona Advisory Council on Indian Health Care (AACOIHC) was established in 1989 by the Arizona State Legislature; and

WHEREAS, the members of the AACOIHC are appointed by the Governor of the State of Arizona and are comprised of representatives of Tribal governments, and Tribal and urban Indian health organizations; and

WHEREAS, the mission of the AACOIHC is to, "Advocate for wellness and access to high quality healthcare for all American Indians in Arizona" with regard to the development of Tittle XIX (Medicaid) and Title XXI (Children's Health Insurance Program) demonstration programs, services, and polices; and

WHEREAS, the AACOIHC statutes provide authorities to the AACOIHC to recommend and advocate for health care related policy and legislation in Arizona that will beneficially impact Tribes in Arizona; and

WHEREAS, the AACOIHC is one of two state agencies/commissions of the Arizona State government that work directly with Tribal governments in Arizona to address American Indian issues and concerns; and

2214 North Central Avenue, Phoenix, Arizona 85004 p 602.258.4822 f 602.258.4825

WHEREAS, the relationship between the State of Arizona and Tribes is important for collaborative governance to elevate the health status of all American Indians in Arizona, who comprise 5.3% of the population, but who have the most significant and disproportionate rates of health disparities of any racial or ethnic group in the state; and

WHEREAS, the hopes of the Tribes in Arizona envisioned with the establishment of the AACOIHC in 1989 have begun with Tribes leading efforts to develop and implement comprehensive health care delivery and financing systems on behalf of their communities; and

WHEREAS, the role of the AACOIHC has evolved over the last 26 years and changes in federal and state health care policies and program development efforts of Tribes and urban Indian health programs now require the AACOIHC statutes reelect these changes; and

WHEREAS, the AACOIHC has solicited feedback and recommendations to amend ARS 36-2902.01 and ARS 36-2902.02 from Tribes in Arizona during a half day Tribal Consultation Meeting on Monday, June 15, 2015, and through a 45-day open comment process; and

WHEREAS, the AACOIHC seek that legislation be entered into the Arizona State Legislature in the 2016 legislative session to amend A.R.S. 36-2902.01 and A.R.S. 36-2902.02 to be current and supportive of Tribes and urban Indian organizations in Arizona and their progressive and evolving medical and public health care systems; and

NOW THEREFORE BE IT RESOLVED, the member Tribes of the Inter Tribal Association of Arizona supports the amendments to update A.R.S. 36-2902.01 and A.R.S. 36-2902.02.

CERTIFICATION

The foregoing resolution was presented and duly adopted at a meeting of the Inter Tribal Association of Arizona, where a quorum was present on **Friday, February 19, 2016.**

Shan Lewis
President, Inter Tribal Association of Arizona
Vice-Chairman, Fort Mojave Indian Tribe

COMMUNITY CATALYST

Repealing the Affordable Care Act Would Harm American Indians and Alaska Natives

The Affordable Care Act (ACA) helps make health insurance coverage more affordable and accessible for millions of Americans. For American Indians and Alaska Natives (AIs/ANs), the law addresses inequities and increases access to quality, affordable health coverage, invests in prevention and wellness, and gives AI/AN individuals and families more control over their care. Because of the ACA, hundreds of thousands of AIs/ANs now have access to affordable, quality health insurance coverage and care through Marketplaces and the expansion of Medicaid. The ACA also permanently reauthorized the Indian Health Care Improvement Act, providing tribes with many new opportunities to manage their health care programs and systems.
A repeal of the law without a meaningful replacement plan, as promised by the new Congress and the incoming Trump administration, could reverse these gains.

- **An estimated 650,000 AIs/ANs would lose coverage**
    - Through use of the budget reconciliation process, virtually all of the ACA's coverage accomplishments could be repealed. In this case, approximately 650,000 AIs/ANs would lose coverage as a result of the termination of federal financial assistance and a rollback of Medicaid expansion. The uninsurance rate for AIs/ANs would increase from 14 percent under the ACA to 26 percent without it. AIs/ANs who face significant physical and/or mental health problems, including being overweight or obese, having diabetes or cardiovascular disease and experiencing frequent mental distress or substance use disorders would have efforts to treat and prevent these conditions undermined by the loss of coverage.

- **The Indian Health Service would face dramatic funding cuts, jeopardizing care for AI/ANs.**
    - IHS is chronically underfunded to meet the health care needs of its population. Medicaid serves as a key source of additional revenue for Indian Health Service (IHS) providers. Unlike IHS funding which is limited at a fixed amount and subject to annual Congressional appropriations, Medicaid funds are available on an ongoing basis for covered services provided to AIs/ANs. Indeed, since the ACA passed, as many as 440,000 AIs/ANs who were previously uninsured are now covered by Medicaid (this includes newly eligible adults in Medicaid expansion states, as well as those who were

previously eligible but not enrolled in both expansion and non-expansion states.) In states that expanded Medicaid, especially those with a large AI/AN population (such as Alaska, Arizona, Montana, New Mexico and North Dakota), eliminating Medicaid expansion would increase financial barriers for IHS providers to cover needed operational costs, including provider payments and infrastructure development. This would impede their ability to meet demands for care and maintain care capacity.

- **A full repeal of the ACA would eliminate the Indian Health Care Improvement Act (IHCIA), resulting in further cuts to IHS funding and services.** (Note that the budget reconciliation vetoed by President Obama in early 2016 did not include IHCIA.)

  - The IHCIA reauthorization allows the IHS to use Medicare, Medicaid, the Veterans Administration and private insurance as funding sources (or third-party payers) to increase resources for Indian health programs. For the fiscal year 2017, the IHS budget includes $1.19 billion in third-party collections, which includes $807 million from the Medicaid program. Because the IHCIA requires that funds generated through third-party collections remain at the local clinic that generated them, this funding source is critical for the IHS, especially when appropriated dollars are not sufficient or have been exhausted for the year.

  - Additionally, an estimated 2.2. million AIs/ANs would lose access to critical preventive services as a result of a rollback of the IHCIA. To meet the health care needs of AIs/ANs, the IHCIA reauthorization creates new or expands existing programs such as dental health services, mental and behavioral health treatment and prevention, long-term care services (including home health care, assisted living and community-based care) and dialysis services. Rolling back these programs would be a serious setback for the health of AIs/ANs across the country.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: December 14, 2016

FROM: Vikki Wachino
Director
Center for Medicaid & CHIP Services

SUBJECT: Indian Provisions in the Final Medicaid and Children's Health Insurance Program Managed Care Regulations

The Center for Medicaid and CHIP Services (CMCS) is issuing this Informational Bulletin to summarize the relevant Indian provisions of the final Medicaid and the Children's Health Insurance Program (CHIP) managed care regulation into one document, clarify current statute and regulation regarding mandatory enrollment of Indians into managed care, and provide sample language for an Indian Addendum that can be offered to managed care plans on a voluntary basis when executing network provider agreements with Indian health care providers (IHCPs).

Introduction

On April 25, 2016, CMS published a final rule on managed care in Medicaid and CHIP. The final rule is available at https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

The final rule codifies a range of Indian managed care protections, including those in section 1932(h) of the Social Security Act (Act), as added by section 5006 of American Recovery and Reinvestment Act of 2009 (ARRA). These provisions allow Indians enrolled in Medicaid and CHIP managed care plans to continue to receive services from an IHCP and ensures IHCPs are reimbursed appropriately for services provided.

The final rule addresses other Tribal issues, such as sufficient network and payment requirements for managed care plans that serve Indians, network provider agreements with IHCPs, state-Tribal consultation requirements, and referrals and prior authorization requirements. The Indian-specific provisions are located in the Medicaid rules at §438.14, and made applicable in CHIP by a cross reference in the CHIP rules at §457.1209. They are titled: "Standards for Contracts Involving Indians, Indian Health Care Providers and Indian Managed Care Entities." These provisions must be implemented for Medicaid managed care plans by the start of the rating period for contracts starting on or after July 1, 2017, noting that the Indian managed care protections in 1932(h) were effective July 1, 2009. (The rating period is the 12 month contract period during which a particular rate is certified.) States with separate CHIP programs[1] that have plans that contract separately from their Medicaid managed care plans must

[1] If you have further questions concerning a CHIP program in a particular state, contact the state CHIP program.

come into compliance with these provisions no later than the state fiscal year beginning on or after July 1, 2018.

CMS engaged with Tribes throughout the rulemaking process and received several comments from Tribes and Tribal organizations which were incorporated into the final rule to the extent possible. CMS also engaged with Tribes in the development of this Informational Bulletin.

Specific Provisions in the Final Rule Applicable to Medicaid and CHIP that Impact American Indians and Alaska Natives and Indian Health Care Providers.

The final rule implements section 1932(h) of the Social Security Act (the Act) which added additional protections for the treatment of Indians, Indian health care providers and Indian managed care entities in Medicaid and CHIP managed care programs. Section 1932(h) was added to the Act by section 5006(d) of the American Reinvestment and Recovery Act of 2009 (ARRA). The rule applies the Indian protections in section 1932(a)(2)(C) and 1932(h) of the Act, to all types of managed care programs, including Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), Primary Care Case Management programs (PCCM), and Primary Care Case Management Entities (PCCM Entities), as applicable. In this bulletin, we collectively refer to these entities as, "managed care plans."

Definitions

The final rule defines the following terms consistent with statutory and existing regulatory definitions.

"Indian" means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual is a member of a federally recognized Indian Tribe or resides in an urban center and meets one or more of the following criteria:

- Is a member of a Tribe, band, or other organized group of Indians, including those Tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member;
- Is an Eskimo or Aleut or other Alaska Native;
- Is considered by the Secretary of the Interior to be an Indian for any purpose;
- Is determined to be an Indian under regulations issued by the Secretary;
- Is considered by the Secretary of the Interior to be an Indian for any purpose; or
- Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

"Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

"Indian Managed Care Entity (IMCE)," means a MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

Network Sufficiency Standards and Provider Choice

The final rule at §§438.14(b)(1) and 457.1209 requires every MCO, PIHP, PAHP, or PCCM entity, to the extent the PCCM entity has a provider network, to demonstrate that there are sufficient IHCPs participating in the network to ensure timely access to services available under the contract from IHCPs for Indian enrollees who are eligible to receive services. In the event that timely access to IHCPs in network cannot be guaranteed due to few or no network participating IHCPs, §§438.14(b)(5) and 457.1209 provides that the sufficiency standard in §§438.14(b)(1) and 457.1209 is satisfied if (1) Indian enrollees are permitted by the MCO, PIHP, PAHP, or PCCM entity (if applicable) to access out-of-state IHCPs or (2) this circumstance is deemed a good cause reason under the managed care plan contract for Indian enrollees to disenroll from the state's managed care program into fee-for-service in accordance with §§438.56(c) and 457.1212.

The final rule at §§438.14(b)(3) and 457.1209 permits any Indian who is enrolled in a non-Indian managed care plan and eligible to receive services from a network IHCP to choose that IHCP as his or her primary care provider, as long as that provider has the capacity to provide the services.

Payment and Contracting

When an IHCP is enrolled in Medicaid or CHIP as a federally qualified health center (FQHC) but is not a participating provider with a MCO, PIHP, PAHP, or PCCM entity, §§438.14(c)(1) and 457.1209 requires that the IHCP be paid the FQHC payment rate under the state plan, including any supplemental payment due from the state.

When an IHCP is not enrolled in Medicaid or CHIP as a FQHC, and regardless of whether the IHCP participates in the network of an MCO, PIHP, PAHP and PCCM entity, §438.14(c)(2) and §457.1209 requires that the IHCP receive the applicable encounter rate published annually in the Federal Register by IHS, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the state plan's FFS payment methodology.

Per §§438.14(c)(3) and 457.1209, when the amount an IHCP receives from a MCO, PIHP, PAHP, or PCCM entity is less than the applicable encounter or fee-for-service rate, whichever is applicable, the state must make a supplemental payment to the IHCP to make up the difference between the amount the MCO, PIHP, PAHP, or PCCM entity pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

Indian Managed Care Entity (IMCE)

The rule at §§438.14(d) and 457.1209 codifies provisions of section 1932(h) that define IMCEs and set out a special rule for enrollment in an IMCE. The special enrollment rule permits an IMCE to restrict its enrollment to Indians in the same manner as IHCPs may restrict the delivery of services to Indians.

Avoiding Duplicate Visits for Referrals

The final rule at §§438.14(b)(6) and 457.1209 adds a new requirement to specify that MCOs, PIHPs, PAHPs, and PCCM entities (if applicable)s must permit an out-of-network IHCP to refer an Indian to a network provider for covered services. This provision is intended to avoid duplicate visits to a network provider to obtain a referral and any delay in treatment when referrals are made under these circumstances.

Auto-assignment

When auto-assigning Indians to primary care physicians (PCP), managed care plans should review their auto-assignment algorithm to ensure that an appropriate logic is used to accomplish the most appropriate PCP assignment. Such criteria could include an enrollee's historical relationship with a PCP. Additionally, managed care plans should ensure that information on the process for changing PCPs is easily accessible and, at a minimum, described in the enrollee handbook and on the managed care plan's website as required in §§438.10(f)(2)(x), §438.10(f)(3), and 457.1207.

Mandatory Enrollment of Indians into Medicaid Managed Care

To require Medicaid or CHIP beneficiaries to enroll in managed care to receive coverage, a state must obtain approval from CMS either through a Medicaid state plan amendment, a 1915(b) waiver, or through the section 1115 demonstration authority. States also have the option to exempt Indians from mandatory managed care. Consistent with the CMS Tribal Consultation Policy, and the requirements of section 1902(a)(73) of the Act, added by ARRA §5006(e), states are required to engage in a meaningful consultation process with federally recognized Tribes and/or IHCPs located in their state prior to the submission of a SPA, waiver, or demonstration having Tribal implications.

The final rule reiterates previous CMS guidance and transparency requirements for Medicaid demonstrations and Medicaid waivers that impact Indians and Tribes. States must consult with Tribes in accordance with the state's Tribal consultation policy if the state is proposing to mandate Indians into managed care (MCOs, PIHP, or PIHP) to receive coverage. Because states have authority to exclude Indians from mandatory enrollment into managed care, states should, through Tribal consultation, consider such factors as access to specialty providers, contracting and payment difficulties with MCEs, and ensuring continued access to culturally appropriate providers before a decision is made to mandatorily enroll Indians into managed care.

Medicaid State Plan

Through a state plan amendment that meets standards set forth in section 1932 of the Act, states can implement a mandatory managed care delivery system for certain populations. However, section 1932(h) of the Act prohibits states from mandatory enrollment of an individual who is an Indian unless the MCO, PIHP, PAHP, PCCM or PCCM entity contracted with the state is an IMCE.

1915(b) Waiver

CMS may grant a waiver under section 1915(b) of the Act that permits a state to require all Medicaid beneficiaries to enroll in a managed care delivery system, including Indians. However, states have the option to exempt Indians from a 1915(b) mandatory managed care waiver request in light of the special statutory treatment of Indians in federal statutes and other considerations listed above. In reviewing such waiver requests, CMS will consider any input the state received through its state-Tribal consultation process. Frequently, through Tribal consultation, a state and the Tribes could reach mutual consensus to exempt Indians from 1915(b) managed care waivers.

1115(a) Demonstration

Section 1115(a) of the Act authorizes the Secretary to waive provisions of section 1902 of the Act and grant expenditure authority to treat demonstration costs as federally matchable expenditures under section 1903 of the Act. As part of a section 1115(a) demonstration project, CMS may authorize mandatory enrollment in managed care programs for Medicaid beneficiaries, including for dually eligible

beneficiaries, Indians, and children with special health care needs. Demonstration approval is discretionary, and must be based on a finding that the demonstration is likely to promote objectives of the Medicaid program. Similar to the 1915(b) authority, CMS will consider any input the state received in the Tribal consultation process. In addition, there are opportunities for Tribal consultation through the CMS consultation process and the public comment process at the federal level under the Medicaid procedural rules at §431.416. States have the option to exempt Indian populations from mandatory enrollment in a managed care delivery system (permitting Indian populations to obtain access to health care through a fee for service delivery system) in light of the special statutory treatment of Indians in federal statutes concerning Medicaid managed care.

Historically, as a result of state-Tribal consultation and CMS-Tribal consultation with participation from the state, CMS has not approved section 1115(a) demonstrations that have mandated Indians into managed care; instead managed care enrollment has been voluntary. We strongly encourage states and Tribes to engage in meaningful consultation when considering mandating Indians into managed care. States are required to consult consistent with the process outlined in its approved ARRA Tribal consultation state plan amendment.

CHIP State Plan

Section 1932(h) of the Act (made applicable to CHIP through section 2107(e)(1)(M) of the Act) prohibits states from mandatory enrollment of an individual who is an Indian unless the MCO, PIHP, PAHP, PCCM or PCCM entity contracted with the state is an IMCE. CMS expects that states will continue to submit any planned managed care program changes through the state plan amendment process and comply with their Tribal consultation process.

Indian Managed Care Addendum

Consistent with the rule, this guidance provides sample language for a Medicaid and CHIP Indian Managed Care Addendum ("ITU Addendum"). Indian Tribes are entitled to special protections and provisions under federal law, which are described further in Section II of the ITU Addendum. The ITU Addendum outlines all the federal laws, regulations, and protections that are binding on MCOs, PIHPs, PAHPs, and PCCM entities (if applicable) and identifies several specific provisions that have been established in federal law that apply when contracting with IHCP. The use of this ITU Addendum benefits both MCOs, PIHPs, PAHPs, PCCM entities and IHCPs by lowering the perceived barriers to contracting, assuring that key federal laws are applied when contracting with IHCPs, and minimizing potential disputes. For example, MCOs, PIHPs, and PAHPs typically require participating providers to have private malpractice insurance. However, the ITU Addendum explains that IHCPs, when operating under a contract or compact with IHS to carry out programs, services, functions, and activities, (or programs thereof) of the IHS, are covered by federal tort immunity and private malpractice insurance is not required.

We anticipate that offering contracts that include an ITU Addendum will provide managed care plans with an efficient way to establish network provider agreements with IHCPs, and that such agreements include the federal protections for IHCPs. Furthermore, the ITU Addendum helps to integrate IHCPs into managed care networks and ensures that Indian beneficiaries have access to a comprehensive and integrated benefits package and ensure that Indians can continue to be served by their IHCP of choice. Indians enrolled in managed care plans will be better served when IHCPs can coordinate their care through the managed care provider network.

ATTACHMENTS:

Model Medicaid and CHIP Managed Care Addendum for Indian Health Care Providers

Model Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (IHCPs)

1. Purpose of Addendum; Supersession.
The purpose of this Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the network provider agreement by and between _____(herein "Managed Care Plan") and _____ (herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the Managed Care Plan's network provider agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.[2]

2. Definitions.
For purposes of this Addendum, the following terms and definitions shall apply:

(a) "Indian" means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual is a member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:

- Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
- Is an Eskimo or Aleut or other Alaska Native;
- Is considered by the Secretary of the Interior to be an Indian for any purpose;
- Is determined to be an Indian under regulations issued by the Secretary.

The term "Indian" also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

(b) "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(c) "Managed Care Plan" includes a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Manager (PCCM) or Primary Care Case Managed Entity (PCCM entity) as those terms are used and defined in 42 C.F.R. 438.2, and any subcontractor or instrumentality of such entities that is engaged in the operation of a Medicaid managed care contract.

(d) "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCIA Section 601, 25 U.S.C. § 1661.

---

[2] Please note that if the contract includes Medicaid and separate CHIP beneficiaries this Addendum can be used for both populations if references to Medicaid are modified to reference both Medicaid and CHIP. If you have a separate managed care contract for CHIP that includes IHCPs, please use this addendum and replace the references to Medicaid with references to CHIP.

(e) "Indian tribe" has the meaning given in the IHCIA Section 4(14), 25 U.S.C. § 1603(14).

(f) "Tribal health program" has the meaning given in the IHCIA Section 4(25), 25 U.S.C. § 1603(25).

(g) "Tribal organization" has the meaning given in the IHCIA Section 4(26), 25 U.S.C. § 1603(26).

(h) "Urban Indian organization" has the meaning given in the IHCIA Section 4(29), 25 U.S.C. § 1603(29).

3. Description of IHCP.
The IHCP identified in Section 1 of this Addendum is (check the appropriate box):

/_/ IHS.

/_/ An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. §450 et seq.

/_/ A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C.§450 et seq.

/_/ A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).

/_/ An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.

4. Cost-Sharing Exemption for Indians; No Reduction in Payments.
The Managed Care Plan shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services. Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, (42 U.S.C. §1396o-(j)), 42 C.F.R. 447.56 and §457.535.

5. Enrollee Option to Select the IHCP as Primary Health Care IHCP.
The Managed Care Plan shall allow any Indian otherwise eligible to receive services from an IHCP to choose the IHCP as the Indian's primary health care provider if the IHCP has the capacity to provide primary care services to such Indian, and any referral from such IHCP to a network provider shall be deemed to satisfy any coordination of care or referral requirement of the Managed Care Plan. Section 1932(h)(1) of the Social Security Act, (42 U.S.C. § 1396u-2(h)), 42 CFR 438.14((b)(3), and 457.1209.

6. Agreement to Pay IHCP.
The Managed Care Plan shall pay the IHCP for covered Medicaid managed care services in accordance with the requirements set out in section 1932(h) of the Social Security Act, (42 USC 1396u-2(h)), 42 CFR 438.14 and 457.1209.

7. Persons Eligible for Items and Services from IHCP.
(a) Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136.

(b) No term or condition of the Managed Care Plan's network provider agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The Managed Care Plan acknowledges that pursuant to 45 C.F.R. 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

8. Applicability of Federal Laws not Generally Applicable to other Providers.
Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving MCO enrollees. Applicable provisions may include, but are not limited to, those laws cited in Appendix A.

9. Non-Taxable Entity.
To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a Managed Care Plan to collect or remit any federal, state, or local tax.

10. Insurance and Indemnification.
(a) Indian Health Service. The Indian Health Service (IHS) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the managed care plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.

(b) Indian Tribes and Tribal Organizations. A provider which is an Indian tribe or a tribal organization operating under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed Care Plan will be held harmless from liability. This is because Indian tribes and tribal organizations operating under a contract or compact to carry out programs, services, functions, and activities, (or programs thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450, are covered by the FTCA, which means the United States consents to be sued in place of employees of a tribe or tribal organization (including contractors) for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of employees acting within the scope of their employment. Nothing in the Managed Care Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate such provider, any employee of such provider, or any personal services contractor to perform any act outside the scope of his/her employment.

(c) Urban Indian Organizations. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability to the extent the provider attests that it is covered by the FTCA. Nothing in the Managed Care Plan network provider agreement or any

addendum thereto shall be interpreted to authorize or obligate such provider or any employee of such provider to perform any act outside the scope of his/her employment.

11. Licensure and Accreditation.
Pursuant to 25 USC 1621t and 1647a, the managed care organization shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, the managed care organization shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State.

12. Dispute Resolution.
In the event of any dispute arising under the Managed Care Plan's network provider agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Notwithstanding any provision in the Managed Care Plan's network agreement, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.

13. Governing Law.
The Managed Care Plan's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail. Nothing in the Managed Care Plan's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

14. Medical Quality Assurance Requirements.
To the extent the Managed Care Plan imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCIA (25 U.S.C. § 1675).

15. Claims Format.
The Managed Care Plan shall process claims from the IHCP in accordance with Section 206(h) of the IHCIA (25 U.S.C. § 1621e(h)), which does not permit an issuer to deny a claim submitted by a IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

16. Payment of Claims.
The Managed Care Plan shall pay claims from the IHCP in accordance section 1932(h)(2) of the Act, (42 U.S.C. §1396u-2(h)), 42 C.F.R. 438.14(c)(2), and 457.1209, and shall pay at either the rate provided under the State plan in a Fee For Service payment methodology, or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is higher.

17. Hours and Days of Service.
The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the Managed Care Plan as to its hours and days of service. At the request of the Managed Care Plan, such IHCP shall provide written notification of its hours and days of service.

18. Coordination of Care/Referral Requirements.
The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the Managed Care Plan.

19. Sovereign Immunity.
Nothing in the Managed Care Plan's network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

20. Endorsement.
IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the managed care plan.

APPROVALS

For the Managed Care Plan:

Date: _____

_____

For the IHCP:

Date: _____

_____

APPENDIX A

(a) The IHS that is an IHCP:
(1) Anti-Deficiency Act, 31 U.S.C. § 1341;
(2) ISDEAA, 25 U.S.C. § 450 et seq.;
(3) Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(6) IHCIA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is an IHCP:
(1) ISDEAA, 25 U.S.C. § 450 et seq.;
(2) IHCIA, 25 U.S.C. § 1601 et seq.;
(3) FTCA, 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(6) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is an IHCP:
(1) IHCIA, 25 U.S.C. § 1601 et seq.
(2)Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(3) HIPAA, 45 C.F.R. Parts 160 and 164.

Inter Tribal Council of Arizona, Inc.
21 TRIBAL NATIONS

2214 North Central Avenue, Phoenix, Arizona 85004
p 602.258.4822, f 602.258.4825

Arizona Tribal Health Policy Forum

Thursday, January 12, 2017
Phoenix, Arizona

Implications of the CMS Medicaid Managed Care Final Rule and 100% FMAP Available to Non-IHS/Tribal Facilities

https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/All-Tribes-Calls.html

- **February 26, 2016 - CMS State Health Official letter (SHO #16-002) - Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives**
- IHS/Tribal facilities may enter into *care coordination agreements* with non-IHS/Tribal providers, including UIO's, to furnish services for AI/AN Medicaid beneficiaries. The amounts paid by the state for services per the agreements would be eligible for the enhanced federal matching authorized by 1905(b) of the Social Security Act at a rate of 100 percent.
- Previously the service had to be a "facility service" that a Medicaid facility can provide under Medicaid law and regulation.
- In the new interpretation, any service can be considered to be "received through" an IHS/Tribal facility for 100 percent FMAP, if they are IHS/Tribally authorized services covered by the Medicaid State Plan, including Long Term Services and Emergency and Non-Emergency Medical Transportation.

- **October 5, 2016 - CMS All Tribes Call (Webinar) - Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (Effective Date 7/25/16). Includes "Standards for Contracts Involving Indians, Indian Health Care Providers and Indian Managed Care Entities" to be phased in on or after 7/1/17.**
- When an IHCP is enrolled in Medicaid/CHIP as a FQHC, but is not in a MCO network, the IHCP must be paid the FQHC payment rate under the State plan, including any supplemental payment due from the state.
- When an IHCP is not enrolled in Medicaid/CHIP as a FQHC, and regardless of whether the IHCP participates in the network, the IHCP must receive the applicable IHS encounter rate published annually in the Federal Register.
- If the amount an IHCP receives from a MCO is less than the encounter or fee-for-service rate, the state must make a supplemental payment to the IHCP to make up the difference.

- **MCO's, must permit an out-of-network IHCP to refer an Indian to a network provider for covered services.**
- To require Medicaid/CHIP beneficiaries to enroll in managed care to receive coverage, a state must obtain approval from CMS through a Medicaid state plan amendment, a 1915(b) waiver, or through the section 1115 demonstration authority.
- States have authority to exclude Indians from mandatory managed care enrollment. Historically, CMS has not approved section1115(a) demonstrations that have mandated Indians into managed care.

Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

Administration and Congressional ACA-Related Actions in 2017 and 2018

January 24, 2017

Presented by Doneg McDonough, Technical Advisor
Tribal Self-Governance Advisory Committee
TribalSelfGov.org; DonegMcD@outlook.com

Administration and Congressional Health Care Actions in 2017

- Affordable Care Act
  - Medicaid Expansion
  - Marketplace provisions
    - Premium tax credits
    - Cost-sharing protections
      - General population
      - Indian-specific protections
    - Special monthly enrollment periods
  - Indian Health Care Improvement Act
  - Other Indian-specific ACA provisions
- Medicare
- Medicaid (non-Medicaid expansion)

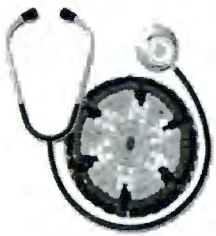
Net Premium Costs under Affordable Care Act

(Example of Norman, Oklahoma; 2017)

Figure A: Net Annual Household Premium Contribution for Lowest Cost Marketplace Bronze Plan; Norman, Oklahoma (2017)[1]				
Household (HH) size:		1-person HH	2-person HH	3-person HH
Number enrolled:		1 enrollee	2 enrollees	3 enrollees
FPL				
Medicaid or nothing	0% - 100%	$0 or $4,185	$0 or $8,370	$0 or $12,556
Medicaid or PTC	101% - 138%	$0	$0	$0
Premium Tax Credit (PTC) eligible	139%	$0	$0	$0
	150%	$0	$0	$0
	175%	$0	$0	$0
	200%	$0	$0	$0
	225%	$223	$0	$0
	250%	$704	$0	$0
	300%	$1,720	$1,189	$659
	350%	$2,295	$1,965	$1,635
	400%	$2,871	$2,741	$2,612
No PTCs	Over 400% or other non-PTC eligible	$4,185	$8,370	$12,556

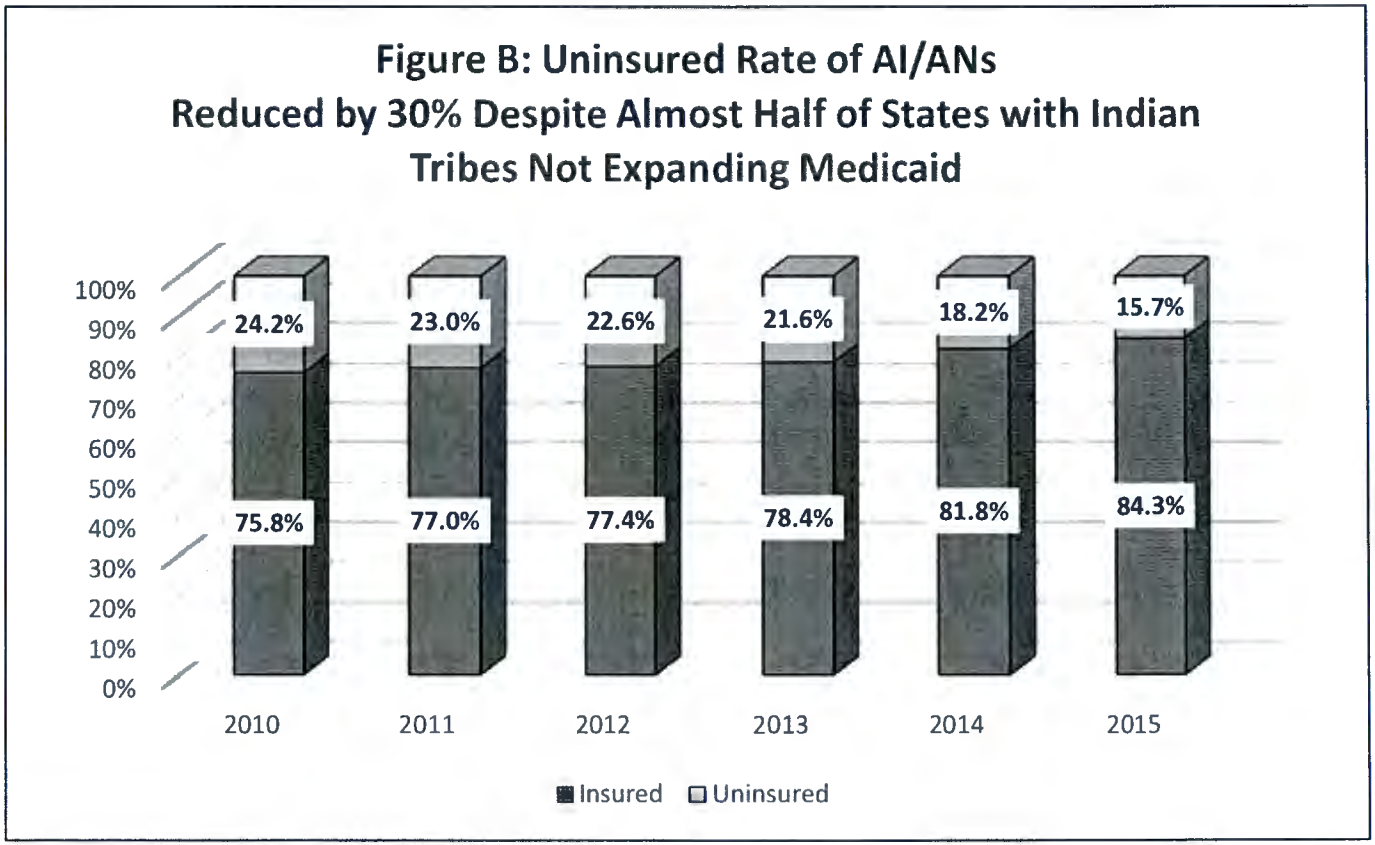
[1] Blue Advantage Bronze PPO 105 (BC BS of Oklahoma) for 40 year-old non-smoker enrollees.

See TribalSelfGov.org: http://www.tribalselfgov.org/wp-content/uploads/2017/01/TSGAC-Memo-Net-Marketplace-Premium-Costs-Hold-or-Lower-in-2017-2017-01-1....pdf

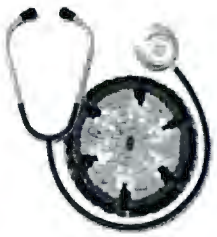


Nationally, Uninsured Rate of American Indians and Alaska Natives Down 30% Since 2010

Rate decreased 8.5 percentage points, from 24.2% (2010) to 15.7% (2015)

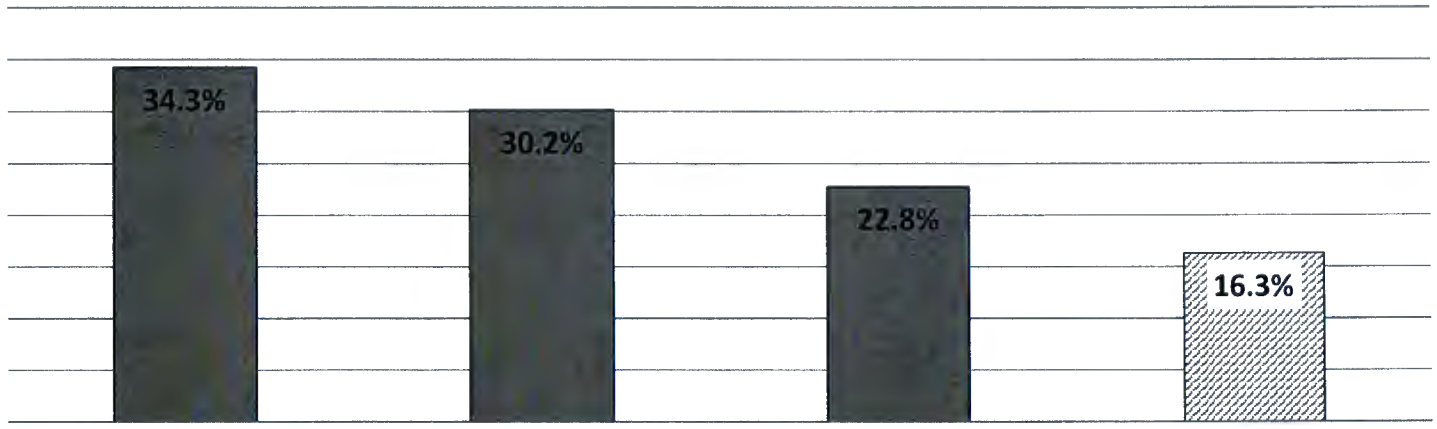


- Source: U.S. Census Bureau, 2010-2015 American Community Survey, 1-Year Estimates, includes self-identified American Indians and Alaska Natives ("alone or in combination").



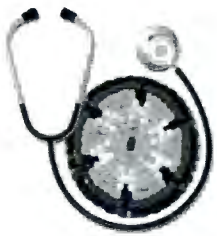
Impact of Medicaid Expansion and Affordable Care Act on Insurance Status of AI/AN in Alaska

Figure C: Uninsured Rate Among AI/ANs in Alaska Is Moving Downward Under the ACA and Medicaid Expansion



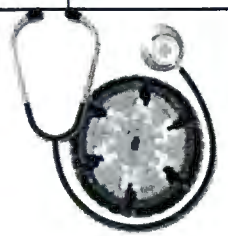
- Medicaid expansion implemented in September 2015.
- More than 27,000 individuals enrolled in the program as of December 2016, with more than 10,000 of these enrollees estimated to be AI/ANs.
- $316 million in federal funds has been paid out for health care services over the initial 16 months of the Medicaid expansion, an average of $7.5 million per month.
- Of this total, $119 million is estimated to have been expended serving AI/ANs, with $47 million projected to have been paid to Tribal health organizations for services to AI/ANs.

Source: Alaska Department of Health and Social Services, "Medicaid in Alaska Dashboard".



Potential Action on Major Health Care Legislation in 2017

Recent Legislative Vehicle	Program	Elements	Status	Vehicle / Process, if repealed
Affordable Care Act	Medicaid Expansion	- All households 0% - 138% federal poverty level	At risk of defunding	Reconciliation; 50+ votes
Affordable Care Act	ACA Marketplace provisions	- Premium tax credits - Cost-sharing protections - General population - Indian-specific protections - Monthly special enrollment periods - Full payment to I/T/Us (no reductions for patient co-payments)	At risk of eliminating and replacing with lower assistance levels	Reconciliation; 50+ votes
Affordable Care Act	Indian Health Care Extension and Reauthorization Act	- Permanent reauthorization of IHCIA - Established authority for continuum of care through integrated behavioral health programs - Authority for I/T/U health providers to be licensed in any state and practice at an I/T/U facility - Authorizes IHS and Tribes to enter into arrangements with VA and DoD to share medical facilities - Allows I/T/U providers to be eligible for participation in any federal healthcare program and for reimbursement from 3rd party payers - Other provisions	Low risk	Regular legislation; 60+ votes
Affordable Care Act	Other Indian-specific provisions	- Section 9021 Exclusion of Health Benefits Provided by Indian Tribal Governments as Taxable Income - Section 2902 Elimination of Sunset for Reimbursement for all Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics - Section 2901(b) Payor of Last Resort - Section 2901(c) Facilitating Enrollment of Indians under the Express Lane Option	At risk (provisions in red)	- For Sec. 9021 and Sec. 2902: Reconciliation; 50+ votes - Other provisions: likely require 60+ votes
Various (Social Security Act)	Medicare	- All	Low risk. Potential "voucher", with limits on annual growth	Reconciliation; 50+ votes
Various (Social Security Act)	Medicaid (non-Medicaid expansion)	- Entitlement for health care services for certain low-income persons - Preserve 100 percent federal reimbursement rate (i.e., 100% FMAP) for Medicaid services provided to American Indians and Alaska Natives that are received through the Indian health system.	At risk from potential block grants	Reconciliation; 50+ votes

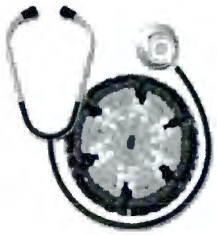


Comparison of ACA to Representative Price's Plan

-- Example of two 40-year-old adults; two 20-year-old kids

Comparison of Federal Financial Assistance for Health Insurance Costs (Individual Market): Affordable Care Act (ACA) vs. Rep. Price Plan[1]						
Example of 4-Person AI/AN Family in Norman, OK (Cleveland County); 2017						
Two 40-year-olds; two 20-year-olds; all meet ACA definition of Indian						
	Household Income	**Total Plan Premium[2]**	**Average Out-of-Pocket (OOP) Costs[3]**	**Premium Tax Credit (PTC)[4, 5]**	**Net Premium Costs**	**Net Total Costs**
ACA (Current)	$25,000 (103% FPL)	$12,529	$0	$12,529	$0	$0
Rep. Price Plan			$5,241	$6,752	$5,777	$11,018
DIFFERENCE: Rep. Price plan vs. ACA:					**$5,777**	**$11,018**
ACA (Current)	$50,000 (206% FPL)	$12,529	$0	$12,529	$0	$0
Rep. Price Plan			$5,241	$6,752	$5,777	$11,018
DIFFERENCE: Rep. Price plan vs. ACA:					**$5,777**	**$11,018**
ACA (Current)	$75,000 (309% FPL)	$12,529	$0	$10,453	$2,076	$2,076
Rep. Price Plan			$5,241	$6,752	$5,777	$11,018
DIFFERENCE: Rep. Price plan vs. ACA:					**$3,701**	**$8,942**
ACA (Current)	$150,000 (617% FPL)	$12,529	$0	$0	$12,529	$12,529
Rep. Price Plan			$5,241	$6,752	$5,777	$11,018
DIFFERENCE: Rep. Price plan vs. ACA:					**-$6,752**	**-$1,511**

See notes on following page.



Comparison of ACA to Representative Price's Plan
(analysis notes)

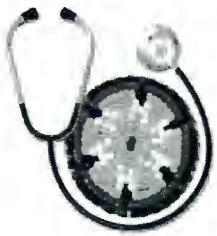
[1] Rep. Price plan is the Empowering Patients First Act, introduced in May 2015 (H.R. 2300).

[2] Premium is for the lowest-cost bronze PPO (Blue Advantage Bronze PPO 105) on the Marketplace in 2017, with all four family members enrolling in the plan. The plan has an annual deductible of $6,800 per individual/$14,300 per family and an OOP maximum of $7,150 per individual/$14,300 per family.

[3] ACA eliminates cost-sharing for Marketplace enrollees who meet the definition of Indian. Average OOP costs for Rep. Price plan are based on average cost-sharing payments made to providers by the federal government on behalf of AI/AN Marketplace enrollees in Oklahoma.

[4] The PTCs shown for ACA are generated by HealthCare.gov and capped at the amount of the total plan premium. Additional PTCs might be available under ACA for a higher-cost plan.

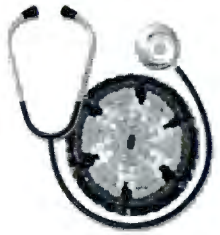
[5] The PTCs shown for Rep. Price Plan include an adjustment to the initial proposed amounts (for 2016) to account for inflation, as indicated by H.R. 2300. Rep. Price plan also makes available a one-time tax credit of up to $1,000 for individuals who qualify for a tax deduction for payments made (or payments made on their behalf) to a health savings account (HSA).



Comparison of ACA to Representative Price's Plan

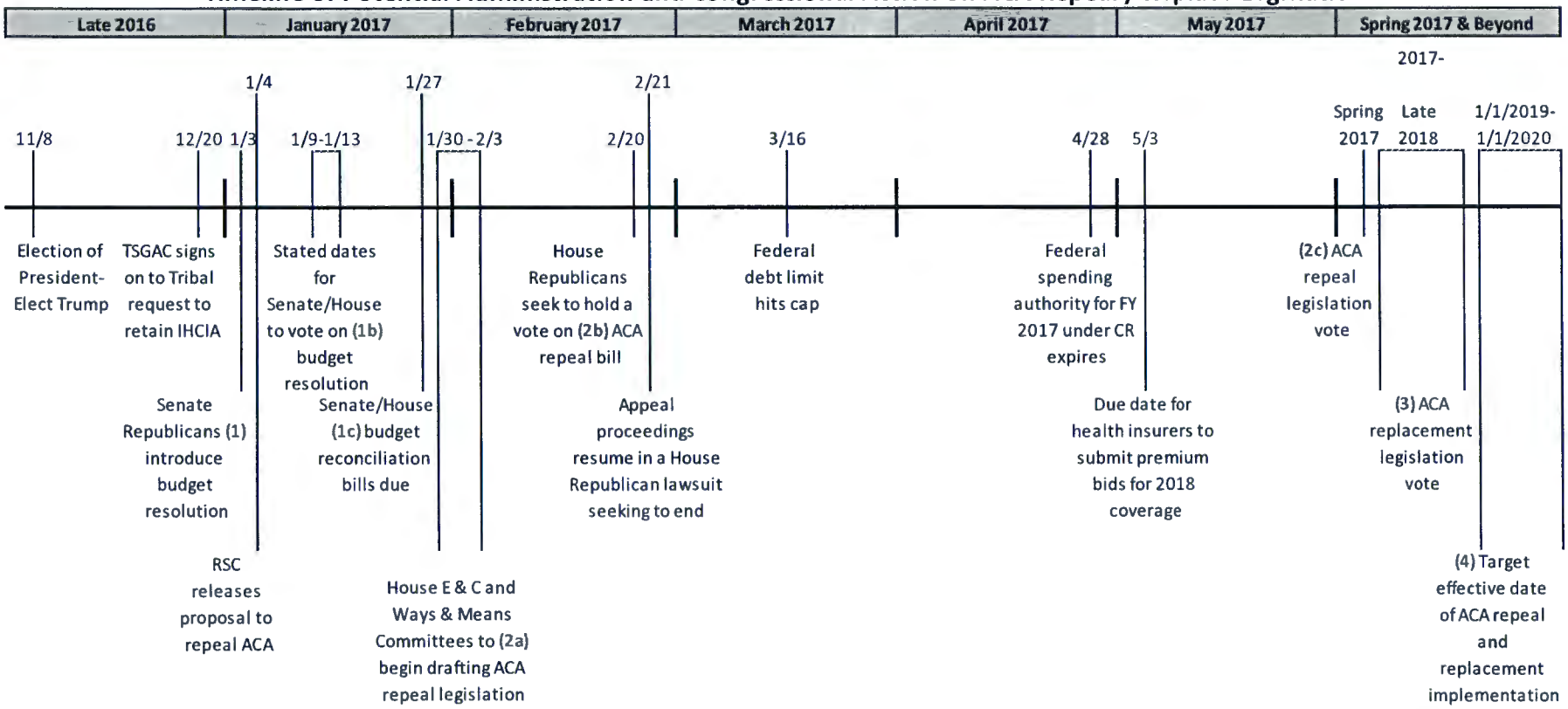
-- Example of two 60-year-old adults; two 20-year-old kids

Comparison of Federal Financial Assistance for Health Insurance Costs (Individual Market): Affordable Care Act (ACA) vs. Rep. Price Plan[1]						
Example of 4-Person AI/AN Family in Norman, OK (Cleveland County); 2017						
Two 60-year-olds; two 20-year-olds; all meet ACA definition of Indian						
	Household Income	Total Plan Premium[2]	Average Out-of-Pocket (OOP) Costs[3]	Premium Tax Credit (PTC)[4, 5]	Net Premium Costs	Net Total Costs
ACA (Current)	$25,000 (103% FPL)	$21,935	$0	$21,935	$0	$0
Rep. Price Plan			$5,241	$8,594	$13,341	$18,582
DIFFERENCE: Rep. Price plan vs. ACA:					$13,341	$18,582
ACA (Current)	$50,000 (206% FPL)	$21,935	$0	$21,935	$0	$0
Rep. Price Plan			$5,241	$8,594	$13,341	$18,582
DIFFERENCE: Rep. Price plan vs. ACA:					$13,341	$18,582
ACA (Current)	$75,000 (309% FPL)	$21,935	$0	$21,935	$0	$0
Rep. Price Plan			$5,241	$8,594	$13,341	$18,582
DIFFERENCE: Rep. Price plan vs. ACA:					$13,341	$18,582
ACA (Current)	$150,000 (617% FPL)	$21,935	$0	$0	$21,935	$21,935
Rep. Price Plan			$5,241	$8,594	$13,341	$18,582
DIFFERENCE: Rep. Price plan vs. ACA:					-$8,594	-$3,353

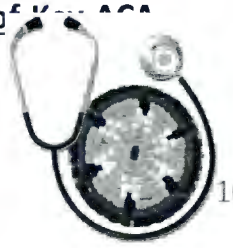


Timeline for Administration / Congressional Action

Timeline of Potential Administration and Congressional Action on ACA Repeal / Replace Legislation

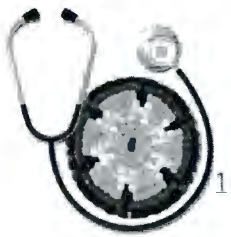


See TribalSelfGov.org: http://www.tribalselfgov.org/wp-content/uploads/2017/01/TSGAC-Timeline-of-Key-ACA-Related-Congressional-Activities-2017-01-12b....pdf



Income Thresholds: federal poverty levels (FPL)

Household (HH) Size / Income (2017 Marketplace)				
FPL	1-person HH	2-person HH	3-person HH	4-person HH
140%	$16,632	$22,428	$28,224	$34,020
150%	$17,820	$24,030	$30,240	$36,450
175%	$20,790	$28,035	$35,280	$42,525
200%	$23,760	$32,040	$40,320	$48,600
225%	$26,730	$36,045	$45,360	$54,675
250%	**$29,700**	$40,050	$50,400	$60,750
300%	**$35,640**	$48,060	$60,480	$72,900
350%	**$41,580**	$56,070	$70,560	$85,050
400%	**$47,520**	$64,080	$80,640	$97,200



Potential Action on Major Health Care Legislation in 2017				
Recent Legislative Vehicle	**Program**	**Elements**	**Status**	**Vehicle / Process, if repealed**
Affordable Care Act	**Medicaid Expansion**	**- All households 0% - 138% federal poverty level**	At risk of defunding	Reconciliation; 50+ votes
Affordable Care Act	**ACA Marketplace provisions**	**- Premium tax credits** **- Cost-sharing protections** **- General population** **- Indian-specific protections** - Monthly special enrollment periods - Full payment to I/T/Us (no reductions for patient co-payments)	At risk of eliminating and replacing with lower assistance levels	Reconciliation; 50+ votes
Affordable Care Act	**Indian Health Care Extension and Reauthorization Act**	- Permanent reauthorization of IHCIA - Established authority for continuum of care through integrated behavioral health programs - Authority for I/T/U health providers to be licensed in any state and practice at an I/T/U facility - Authorizes IHS and Tribes to enter into arrangements with VA and DoD to share medical facilities - Allows I/T/U providers to be eligible for participation in any federal healthcare program and for reimbursement from 3rd party payers - Other provisions	Low risk	Regular legislation; 60+ votes

Potential Action on Major Health Care Legislation in 2017				
Recent Legislative Vehicle	**Program**	**Elements**	**Status**	**Vehicle / Process, if repealed**
Affordable Care Act	**Other Indian-specific provisions**	**- Section 9021 Exclusion of Health Benefits Provided by Indian Tribal Governments as Taxable Income** **- Section 2902 Elimination of Sunset for Reimbursement for all Medicare Part B Services Furnished by Certain Indian Hospitals and Clinics** - Section 2901(b) Payor of Last Resort - Section 2901(c) Facilitating Enrollment of Indians under the Express Lane Option	At risk (provisions in red)	- For Sec. 9021 and Sec. 2902: Reconciliation; 50+ votes - Other provisions: likely require 60+ votes
Various (Social Security Act)	**Medicare**	- All	Low risk. Potential "voucher", with limits on annual growth	Reconciliation; 50+ votes
Various (Social Security Act)	**Medicaid (non-Medicaid expansion)**	**- Entitlement for health care services for certain low-income persons** **- Preserve 100 percent federal reimbursement rate (i.e., 100% FMAP) for Medicaid services provided to American Indians and Alaska Natives that are received through the Indian health system.**	At risk from potential block grants	Reconciliation; 50+ votes

SENATE JOINT MEMORIAL 23

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

Benny Shendo, Jr.

A JOINT MEMORIAL

CALLING ON THE UNITED STATES CONGRESS TO PROTECT THE FEDERAL INDIAN HEALTH CARE IMPROVEMENT ACT.

WHEREAS, the health care needs of American Indians are unique and include many unaddressed issues; and

WHEREAS, according to the department of health, American Indians in New Mexico bear a disproportionate share of poor health status and disease; and

WHEREAS, access to health care services varies greatly between urban Indians and Indians who reside on reservations; and

WHEREAS, funding for Indian health services has historically been inadequate in New Mexico and throughout the United States; and

WHEREAS, the passage of the federal Patient Protection and

underscored material = new
[bracketed material] = delete

Affordable Care Act and the permanent reauthorization of the federal Indian Health Care Improvement Act offer significant opportunities for tribes and Native American communities to contribute to the improved health and well-being of American Indians in New Mexico; and

WHEREAS, the health and well-being of American Indians in New Mexico have benefited from increased tribal participation in and expansion of tribal health programs; and

WHEREAS, the support, funding and opportunities provided by the passage of the Patient Protection and Affordable Care Act and the permanent reauthorization of the Indian Health Care Improvement Act have expanded and strengthened Indian sovereignty by allowing New Mexico Indian pueblos, tribes and nations to take ownership of the resources now available and to contribute in a meaningful way to the improved health of all American Indians in New Mexico; and

WHEREAS, the efforts of the United States congress to repeal the Patient Protection and Affordable Care Act jeopardize the permanent reauthorization of the Indian Health Care Improvement Act; and

WHEREAS, the protection of the Indian Health Care Improvement Act ensures that tribes and Native American communities can continue to contribute to the improved health and well-being of American Indians in New Mexico;

NOW, THEREFORE, BE IT RESOLVED BY THE LEGISLATURE OF THE

underscored material = new
[bracketed material] = delete

STATE OF NEW MEXICO that it protect health care for American Indians in New Mexico; and

BE IT FURTHER RESOLVED that the New Mexico congressional delegation be called upon to urge their colleagues in the United States congress to support measures to protect the Indian Health Care Improvement Act; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the president of the United States, the governor and the members of the New Mexico congressional delegation.

underscored material = new
[~~bracketed material~~] = delete

HOUSE MEMORIAL 52

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

Sharon Clahchischilliage

A MEMORIAL

REQUESTING THAT THE UNITED STATES CONGRESS KEEP THE INDIAN HEALTH CARE IMPROVEMENT ACT INTACT.

WHEREAS, the federal Indian Health Care Improvement Act was made permanent on March 23, 2010 as part of the federal Patient Protection and Affordable Care Act; and

WHEREAS, the Indian Health Care Improvement Act constitutes the cornerstone legal authority for the provision of health care to American Indians and Alaska Natives; and

WHEREAS, the Indian Health Care Improvement Act is critical to modernizing and improving the health care provided to American Indians and Alaska Natives; and

WHEREAS, the Indian Health Care Improvement Act is a key component of the federal government's trust responsibility and honors the obligations of the United States' government-to-

underscored material = new
[bracketed material] = delete

government relationship with American Indian tribes, including the promise of adequate health care; and

WHEREAS, key components of the Indian Health Care Improvement Act include major changes and improvements to facilitate the delivery of health care services; and

WHEREAS, now, the Indian Health Care Improvement Act provides authorization for hospice, assisted living, long-term care and home- and community-based care; and

WHEREAS, the Indian Health Care Improvement Act extends the ability to recover costs from third parties to tribally operated facilities and updates current law regarding collection of reimbursements from medicare, medicaid and the children's health insurance program by Indian health facilities; and

WHEREAS, the Indian Health Care Improvement Act authorizes the Indian health service to enter into arrangements with the United States department of veterans affairs and department of defense to share medical facilities and services; and

WHEREAS, the Indian Health Care Improvement Act allows for the establishment of a community health representative program for urban Indian organizations to train and employ American Indians to provide health care services; and

WHEREAS, the Indian Health Care Improvement Act directs the Indian health service to establish comprehensive behavioral health, prevention and treatment programs for American Indians;

underscored material = new
[~~bracketed material~~] = delete

and

WHEREAS, the Indian health service provides a comprehensive health service delivery system for approximately one million nine hundred thousand of the Unites States' estimated three million three hundred thousand American Indians and Alaska Natives; and

WHEREAS, provisions exist within the Patient Protection and Affordable Care Act that are separate from the Indian Health Care Improvement Act that help to ensure that the Indian health delivery system remains viable; and

WHEREAS, Section 2901 of the Patient Protection and Affordable Care Act states that any Indian health service, tribal or urban Indian health system be the payer of last resort for services provided, notwithstanding any federal, state or local law to the contrary; and

WHEREAS, Section 2902 of the Patient Protection and Affordable Care Act grants Indian health service, tribal or urban Indian health providers with the permanent authority to collect reimbursements for all medicare Part B services; and

WHEREAS, Section 9021 of the Patient Protection and Affordable Care Act ensures that any health benefits provided by a tribe to its members are not included as taxable income; and

WHEREAS, under current law, the federal government reimburses the states for one hundred percent of the cost of

underscored material = new
[bracketed material] = delete

providing medicaid services to American Indians and Alaska Natives;

NOW, THEREFORE, BE IT RESOLVED BY THE HOUSE OF REPRESENTATIVES OF THE STATE OF NEW MEXICO that the New Mexico congressional delegation be urged to keep the federal Indian Health Care Improvement Act intact; and

BE IT FURTHER RESOLVED that the house of representatives of the state of New Mexico call upon the United States congress to protect Sections 2901, 2902 and 9021 of the Patient Protection and Affordable Care Act and urge the New Mexico congressional delegation to support measures to protect Sections 2901, 2902 and 9021 of the Patient Protection and Affordable Care Act; and

BE IT FURTHER RESOLVED that the house of representatives of the state of New Mexico call upon the United States congress to ensure that any plan to change the manner in which state medicaid costs are reimbursed by the federal government include a carve-out for services provided to American Indians and Alaska Natives so that the federal government obligation is not shifted to the states and that the New Mexico congressional delegation be urged to support such a carve-out; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the New Mexico congressional delegation, the interim legislative health and human services committee and any other appropriate interim committee.

underscored material = new
[bracketed material] = delete