

**HHS COMMENTS: S. 1057,  
"INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2006"**

NOTE: Except as otherwise specified, all statutory references are to the Indian Health Care Improvement Act as proposed in S. 1057 (Senate draft bill/Manager's Amendment; #ARP06A15.LC, 9/14/06).

**TITLE I of S. 1057**

**Expanded requirements for negotiated rulemaking and consultation.** The additional mandates listed below are unnecessary and resource-intensive. The Department is committed to ongoing consultation with Tribes under existing Executive Orders.

Recommendation: Strike requirements from the following provisions for consultation and negotiated rulemaking that are not in current law and make conforming changes.

Negotiated Rulemaking

- 202. Catastrophic Health Emergency Fund (p. 95)
- 301. Consultation; Construction and Renovation of Facilities; Reports
- 302. Sanitation Facilities
- 802. Regulations.

Consultation

- 104. Indian Health Professions Scholarships (p. 22)
- 126. Behavioral Health Training and Community Education Programs (p. 86)
- 210. Comprehensive School Health Education Program (p. 110).
- 211. Indian Youth Program (p. 114)
- 301. Consultation: Construction and Renovation of Facilities; Reports (p. 133)
- 302. Sanitation Facilities (p. 144)
- 304. Expenditure of Non-Service Funds for Renovation (p. 157)
- 706. Indian Women Treatment Programs (p. 257)
- 707. Indian Youth Program (p. 259)
- 713. Child Sexual Abuse and Prevention Treatment Programs (p. 283)
- 714. Behavioral Health Research (p. 284)
- 803. Plan of Implementation (p. 294).

**New requirements using "shall" instead of "may".** The draft bill contains new requirements (i.e., not in current law) that limit the Secretary's flexibility to prioritize the delivery of health care.

Recommendation: Strike the following new requirements, and, as applicable, retain the language in current law if the provision already exists.

- 112(b). Recruitment Activities (p. 62)
- 113(a). Indian Recruitment and Retention Program (p. 63)
- 116. Tribal Cultural Consultation (p. 68)

- 121(c). Community Health Aide Program/Program Review (p. 80)
- 126(c)(1). Behavioral Health Training and Community Education Programs (p. 86)
- 201(c)(1). Indian Health Care Improvement Fund (p. 91)
- 206(a). Health Services Research (p. 105)
- 207. Mammography and Other Cancer Screening (p. 105)
- 214. Indian Women's Health Care (p. 120)
- 301. Consultation; Construction and Renovation of Facilities; Reports (p. 133)
- 704. Mental Health Technician Program (p. 255)
- 707. Indian Youth Program (p. 259)
- 709. Inpatient and Community-Based Mental Health Facilities Design, Construction, and Staffing (p. 275)
- 710. Training and Community Education (p. 275)
- 713. Child Sexual Abuse and Prevention Treatment Programs (p. 283)
- 712(b)-(e). Fetal Alcohol Disorders (pp. 281-283)
- 714. Behavioral Health Research (p. 284)
- 103 of S. 1057. Native American Health and Wellness Foundation (p. 315).

**Use of the term "funding" in place of "grant".** There are several provisions in the draft bill that authorize "funding" where current law authorizes "grants". Additionally, several new provisions authorize "funding" rather than "grants".

Recommendation: Revise the following provisions to authorize grants rather than "funding":

- 212. Prevention, Control...of Communicable and Infectious Diseases (p. 114)
- 213. Authority for Provision of Other Services (p. 117)
- 306. Indian Health Care Delivery Demonstration Project (p. 165)
- 710. Training and Education (p. 271).

**Authorities for Urban Indian Programs.** The President's FY 2007 Budget does not include funds for the continuation of the Urban Indian Health program, and instead focuses investments on improving the health status of Indian people living on or near reservations. Unlike those living in isolated rural areas, urban Indians may access to health care through a wide variety of Federal, State, local, and private providers. The Budget provides \$3.2 billion in budget authority for the Indian Health Service, an increase of 4 percent over FY 2006 levels. In light of the overall budgetary context and the Administration's goal to hold down the growth of discretionary spending, the Budget request for the Indian Health Service (IHS) demonstrates that Indian health is a high priority. The Budget supports full staffing of newly constructed health facilities and expands clinical and preventive health services to a growing population of American Indians and Alaska Natives.

**Expansion of Authorities for Urban Indian Organization.** The Administration does not support any provision in the draft bill that would amend current statutory authority to add urban Indian organizations to such authority. We recommend that any such provision be amended to strike the proposed inclusion of urban Indian organizations.

**New permissive authorities.** A number of provisions expanding permissive authorities for new types of services could detract effort and resources from services delivered by IHS.

Recommendation: Strike the following new provisions, and, as applicable, retain the language in current law if the provision already exists.

- 121(d). Community Health Aide Program/Nationalization of Program (p. 82)
- 205. Shared Services for Long-Term Care (p. 103)
- 208. Patient Travel Costs (p. 107)
- 213. Authority for Provision of Other Services (p. 117).

**Traditional Health Care Practices.** We continue to have concerns about the expanded use of the term "traditional health care practices" in provisions of the draft bill that go beyond current law.

Recommendation: Strike "traditional health care practices" in the following provisions.

- 126. Behavioral Health Training and Community Education Programs (p. 88)
- 201. Indian Health Care Improvement Fund. (p. 91)
- 211. Indian Youth Program (p. 114)
- 704. Mental Health Technician Program (p. 255)
- 706. Indian Women Treatment Programs (p. 257)
- 708. Indian Youth Telemental Health Demonstration Project (p. 266)
- 711. Behavioral Health Program (p. 277)
- 712. Fetal Alcohol Disorder Programs (p. 278)
- 713. Child Sexual Abuse and Prevention Treatment Programs (p. 283).

**Report requirements.** The draft bill contains new (i.e., not in current law) report requirements that restrict the Secretary's flexibility to deliver health care services to American Indians and Alaska Natives

Recommendation: Strike the report requirements in the following provisions where such requirements go beyond current law.

- 110(n). Indian Health Service Loan Repayment Program (p. 59)
- 126(f). Behavioral Health Training and Community Education Programs (p. 86)
- 201(f). Indian Health Care Improvement Fund/Report (p. 93)
- 225(c) Office of Indian Men's Health (p. 132)
- 301. Consultation; Construction and Renovation of Facilities; Reports  
(p. 139, line 16; p. 141, line 4)
- 507. Reports and Records (p. 225).

#### **Sec. 4: Definitions.**

- **Sec. 4(16)** (p. 15) defines "**reservation**" to include "Alaska Native Regions established pursuant to the Alaska Native Claims Settlement". This definition is broader and therefore inconsistent with how the courts have interpreted the term (*see Alaska v. Native Village of Venetia Tribal Government*, 522 U.S. 520 (1998)).

Recommendation: Strike from the definition "Alaska Native Regions established pursuant to the Alaska Native Claims Settlement".

- **Sec. 4(11)(xxix)** (p. 13) defines as an element of “**health promotion**” such other activities identified by the Service, a Tribal Health Program, or Urban Indian Organization to promote achievement of certain health objectives. This definition provides overly broad discretion to the tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA) (25 U.S.C. 450 et seq.) to determine what activities promoted health, thus limiting the Department’s discretion on such ISDEAA determinations. For example, under this provision, if such a tribal organization decided that a tangentially related activity provided certain health objectives, the Department would not have the authority to affect selection of that activity.

Recommendation: Strike this provision.

#### **Sec. 104: Indian Health Professions Scholarships.**

- **Sec. 104(b)(1), Obligation Met**, provides for reducing the current service obligation to a year-for-year obligation, which is inconsistent with sec. 338A of the Public Health Service (PHS) Act (42 U.S.C. 2541), the cited benchmark provision (relating to the National Health Service Corps) that requires an obligation of the greater of year-for-year or 2 years.

It is important for the IHS service obligation to be no less than other health professions scholarship service obligation requirements so it may be as successful in achieving the dual goals of producing Indian health professionals while providing a supply of providers for at least two years in health manpower shortage areas like Indian reservations. A year-for-year obligation will not ensure that Indian/Tribal/Urban (ITU) health programs have an adequate supply of Indian providers for reasonable time period of at least 2 years

Recommendation: (p. 23, line 15) Strike “on an equivalent year-for-year obligation” and insert “equal to 1 year for each school year for which the participant receive a scholarship award under this part, or 2 years, whichever is greater”.

- **Sec. 104(c) (1), Obligation Deferred**, authorizes Area Offices to determine the part-time equivalent of 4 years for which part-time students may receive scholarships assistance. With restoration of central administration of the scholarship funding and program, it is the Secretary, not Area Offices, who makes the determination.

Recommendation: (p. 26, line 10) Strike “Area Office” and replace with “Secretary”.

- **Sec. 104(c)(2)(A), B Obligation Deferred**, requires that a person who attends school on a part-time basis has an obligation for at least 2 years and creates a disparity between full-time and part-time students in that full-time students only have an obligation of year-for-year. For example, if a full time student receives the scholarship for one year, that individual has a one-year obligation. However, if a part-time student only attends school for one year, that individual incurs a two-year obligation.

Recommendation: (p. 26, lines 13-17) Strike subparagraphs (A) and (B), and replace with the following:

”(A) the part-time equivalent of one year for each year for which the individual was provided a scholarship (as determined by the Secretary); or

”(B) two years; and “.

**Sec. 104(d)(4), Waivers and Suspensions**, adds a new requirement for the IHS to consult with “the affected Area Office, Indian Tribes, Tribal Organizations, and Urban Indian Organizations” to determine whether a scholarship recipient is in default. Determination of default is an inherent governmental function. The service obligation is to the Federal Government, not to any of the mentioned bodies/organizations. Existence of default should be determined through the internal waiver review process.

Recommendation: (p. 28, lines 20-22) Strike the phrase “, in consultation with the affected Area Office, Indian Tribes, Tribal Organizations, and Urban Indian Organizations,” .

#### **Section 106: Scholarship Programs for Indian Tribes.**

- **Subsection (d)(1)(A), Contract**, provides that tribal scholarship recipients shall serve their obligations in the tribal program’s Service Area. Flexibility to permit recipients under this section to serve outside their Service Area, with agreement by IHS and the Tribe, would address instances where placement opportunities may not exist in the recipient’s tribal service area and, with tribal agreement. ITU programs in other service areas could offer placement alternatives.

Comment [A1]: Their?

Recommendation: (p. 34, line 21) After “located,” insert “or, if the tribe and the Secretary agree, the person may serve their obligation in another service area,” .

- **Subsection (d) (1) (A), Contract**, amends the existing service obligation time requirements by deleting the phrase “equal to the number of years”, which results in a minimum 2 year obligation for recipients under this section instead of the more flexible year for year or minimum of 2 years as provided by current law.

Recommendation: (p. 34, line 23) Insert “equal to the number of years” after the phrase “a number of years”.

#### **Sec. 107: Indian Health Service Extern Program.**

**Subsection (a), Employment Preference**, changes the job entitlement in current law to employment preferences. The current job entitlement is crucial to ensuring that the programs budget for and support, on a priority basis, positions for scholarship recipients as part of the Extern Program. Preference language would make it optional and reduce opportunities for on-the-job experience for IHS scholarship recipients.

Recommendation: (p. 39, line 12) Strike subsection (a) and retain relevant current law.

**Sec. 110: Indian Health Service Loan Repayment Program.**

**Subsection (d) (2), Approvals**, provides that the Secretary shall make Loan Repayment Program awards “notwithstanding” the priority list required to be created for the program. The proposed language requires an annual list of priorities to be established by identifying the vacancies and then rank those positions in order of priority. The approval will be based on other priorities which completely negate the annual list to be initially determined.

Recommendation: (p. 46, line 20) Strike “Notwithstanding” and insert “Consistent with”.

**Sec. 119: Retention Bonus.**

**Subsections (a)(3), (4), Bonus**, authorize the Secretary to provide to a scholarship recipient or Loan Repayment Program (LRP) participant a retention bonus after the individual has completed the service obligation, which, for scholarship recipients, could be as little as two years and for LRP participants is 2 years. Individuals who are hired on regular basis (non-scholarship or LRP) have to serve 3 years before they become eligible. At best, this is inequitable treatment of staff. It will also be a disincentive for recruitment and retention of non-scholarship or Loan Repayment Program individuals. The retention bonus eligibility should start after 2 years of employment for everyone.

Recommendation: (p. 74, line 15) Strike “3” and insert “2”.

**Sec. 120: Nursing Residency Program.**

**Subsection (b), Service Obligation**, creates a year-for-year obligation for both non-professionals and professionals. This approach does not take into account the differing amount of investment needed for the non-professionals and professionals and needs to be amended to make the service obligation commensurate with level of investment. A period of obligated service equal to two years for every year that professional nurses (associate degree and bachelor prepared registered nurses) receives program support is more appropriate and is equal to the amount of time that a Commissioned Officer serves as a recipient of Long Term Training.

Recommendation: (p. 76, line 21) Strike “to the amount of time during which the individual” and insert “one year for every year that non-professional employees (licensed practical nurses, licensed vocational nurses, nursing assistants, and various health care technicians), or two years for every year that professional nurses (associate degree and bachelor-prepared registered nurses)”.

**Sec. 124: National Health Service Corps** (p. 84). This provision references “the Secretary, acting through the Service, Indian Tribes, or Tribal Organizations”. The phrase is unclear and it presents a significant constitutional concern. When Congress purports to delegate executive responsibility or power outside of the Executive Branch, it raises potential constitutional concerns under the Appointments Clause and the Take Care Clause of the Constitution. We are not aware of any provision in the U.S. Code that requires any “Secretary” to act through a non-Federal entity, as this bill purports to do.

Recommendation: In each instance in the bill in which the phrase “the Secretary, acting through the Service, Indian Tribes, or Tribal Organizations” appears, strike “Indian Tribes, or Tribal Organizations”.

**Sec. 204: Diabetes Prevention, Treatment, and Control.**

**Subsection (c) , Diabetes Projects**, states that the Secretary shall maintain funding for all diabetes programs operating on the date of enactment of the bill. The Administration strongly objects to the provision as written.

Recommendation: (p. 101, line 1) Strike “shall” and insert “may”. Additionally, amend subsection (c) to authorize the Secretary to determine which projects maintain funding based on performance.

**Sec. 215: Environmental and Nuclear Health Hazards** (p. 120). This provision expands current law to include environmental hazards in the monitoring and study responsibilities of the Secretary and the Service and thus is not limited to nuclear hazards. The time and the resources required to conduct the study would limit ongoing activities to improve health conditions in tribal communities. There have already been studies conducted on nuclear health hazards resulting in legislation. The environmental hazards noted in the provision are addressed by the existing Environmental Health Services Program.

Recommendation: Strike all requirements relating to studies in sec. 215.

**Sec. 302: Sanitation Facilities.**

- **Sec. 302(c)(4), Funding:** This provision adds new authority to permit the Secretary to place funding accepted from any source – other federal, state or private – that is designated for sanitation facilities and services in ISDEAA contracts or compacts. This would allow such funds to be placed in tribal general funds, with no assurance that those funds would address the priority for which they were provided. The loss of program fund identity, oversight, and accountability may serve as a detriment to the willingness of other agencies to contribute funds to IHS or tribes. It also means that IHS has tort liability for use of these funds.

Given the ramifications of the use of ISDEAA contracts or compacts for non-IHS funds, it would be more appropriate to address this issue through amendments to the ISDEAA to give the Federal Government, Tribes and other parties an opportunity to consider the proposal in the proper context. For these reason, we recommend that sec. 302(c)(4) be revised.

Recommendation: (p. 147, lines 23-25) Amend sec. 302(c)(4) by striking “and place these funds into contracts or compacts under the Indian Self-Determination and Education Assistance Act (25 U.S.C.450 et seq.)”.

- **Subsection (302)(c), Funding**, needs clarification of IHS authority to use contributed funds to pay for sanitation facilities construction project support activities. The Indian Sanitation Facilities Act (P.L. 86-121) allows the IHS to enter into cooperative agreements with other Federal agencies, States, local

communities, and Tribes for the funding and the provision of sanitation facilities for Indian people. This authority historically has been interpreted to allow use of the funds contributed under these agreements for the same purposes for which IHS uses appropriated sanitation construction project funds. Up to 12% of all project funds, including contributed funds, have been used to pay for support activities, including personnel costs for engineering technicians, draftsmen, and construction inspectors. In addition, these funds are used to pay other ancillary costs, such as vehicle and equipment costs.

**Comment [A2]:** This sentence is convoluted. Please revise before submitting to the committee.

Recent legal guidance has recommended a need to clarify that the authority provided by P.L. 86-121 includes all related costs as an authorized use of the funding received from all other sources for sanitation facility construction.

Recommendation: (p.148, line 22) Add the following new paragraph (9):

“(9) the Secretary of Health and Human Services is authorized to accept payments for goods and services furnished by the Indian Health Service from appropriate public authorities, nonprofit organizations or agencies, or Indian tribes, as contributions by that authority, organization, agency, or tribe to agreements made under Section 7 of the Act of August 5, 1954, and such payments shall be credited to the same or subsequent appropriation account as funds appropriated under the authority of Section 7 of the Act of August 5, 1954.”.

- **Subsection 302(e), Financial Assistance, and**
- **Subsection 302(f), Operation, Management, and Maintenance of Facilities.** The provisions appear to make the Federal Government responsible for operation and maintenance of sanitation facilities; however, 42 U.S.C. 2004a specifies that all sanitation facilities constructed by the IHS are to be transferred to the individual, and/or tribe, who are responsible for the facility’s operation and maintenance.

Recommendation: (p.149, lines 3-22) Strike subsections (e) and (f).

- **Sec. 302(h)(1), Report, Required Contents,** adds a new requirement for consultation with the Secretary of Housing and Urban Development (HUD) and Indian housing authorities, and for the Secretary to report on the amount and the most effective use of all funds, regardless of source, needed to accommodate the sanitation facilities needs of new homes built with HUD funds by Indian Housing Authorities. Current law authorizes an IHS inventory of the sanitation facilities deficiencies associated with existing Indian homes and a report on the funding needed to address the need identified for the existing homes. The IHS inventory and report do not address the sanitation facility needs of new homes built with HUD funding by Indian Housing Authorities because HUD provides funding for those costs as part of the cost of building the new homes.

These changes to current law appear to shift the responsibility to identify funding for the sanitation facilities needs of Indian homes built with HUD funds from the HUD Secretary to the HHS Secretary and IHS. This represents a significant change in longstanding Federal policy placing full responsibility for new Indian

HUD funded homes with the HUD Secretary and responsibility for existing Indian homes' sanitation deficiencies with Health and Human Services.

Recommendations:

-Maintain current law (i.e., sec. 302(g) of IHCA).

-(p.150, lines 9-10 and lines 11-14) Strike "Secretary of Housing and Urban Development," and "tribally designated housing entities (as defined in section 4 of the Native American Housing and Assistance and Self Determination Act of 1996 (25 U.S.C. 4103))".

- (p.151, lines 4-9) Strike "necessary to accommodate the sanitation facilities needs of new homes assisted with funds under the Native American Housing and Assistance and Self Determination Act, and".

- **Sec. 302(h)(3), Sanitation Deficiency Levels**, amends the current law definitions for 5 levels of sanitation facilities deficiencies. These definitions conflict and are unclear. We believe current law language for the deficiency levels is clear and should not be replaced by the provisions in this bill.

Recommendation: (pp. 151-154) Strike paragraph (3) and replace with the current relevant provisions of sec. 302(g)(4) of IHCA.

**Sec. 305: Funding for the Construction, Expansion, and Modernization of Small Ambulatory Care Facilities.**

- **Section 305(b)(1), Allowable Uses** (p. 161), amends current law to set two minimum thresholds (i.e., one for number of patient visits and another for the number of eligible Indians). In order to be eligible under the criteria of S 1057, a facility must provide at least 150 patient visits annually in a service area with not less than 1500 eligible Indians. These are both minimum thresholds and somewhat contradictory, and use of these terms makes implementation difficult. First, the IHS cannot validate patient visits unless the applicant participates in the Resource and Patient Management System (RPMS). Since some tribes do not participate in the RPMS, it is difficult to ensure a fair evaluation of all applicants. Second, the term eligible Indians refers to the census population figures, which cannot be verified, since they are based on the individual's statement regarding ethnicity.

Recommendation: (pp. 161-162) Strike subsection (b)(1)(C)(iii).

- **Sec. 305(b)(2), Additional Allowable Use** (p. 162), allows tribes to use funds authorized under this section to reduce outstanding debt for facility construction. Evaluating and prioritizing debt reduction for already-constructed facilities will be difficult because measures of need for each type of facility are different. Additionally, the new allowable use of debt reduction may encourage the accumulation of debt.

Recommendation: Retain the language in current law (i.e., sec. 306 of IHCA).

**Sec. 311: Joint Venture Facilities Program.** Subsection (a)(1) permits tribes that have begun the facility acquisition or construction process to apply for participation in the Joint Venture Facilities Program. This means that a tribe could begin the process of

acquisition for a facility that may or may not comply with IHS planning criteria, then apply for IHS staffing, equipment, and operating funds under the Joint Venture Facilities Program. As a result, IHS could be placed in the position of accepting facilities that are more expensive for the government to maintain, inefficient for staff to operate, and poorly designed to meet the federal staffing and equipment requirements.

Recommendation: (p. 173, lines 14-16) Strike paragraph (1) from sec. 311(a).

**Sec. 314: Tribal Management of Federally Owned Quarters** (p. 177), permits tribes operating federally owned staff quarters to set rental rates. The bill contains no provision to identify a method for establishing rental rates for federally-owned quarters. P.L. 93-638, as amended, enables tribes in Alaska to amend the rate setting process set forth in OMB Circular A-45. 5 U.S.C. 5911 prescribes that rents should be collected and that the rents are fair and reasonable. Without some guidelines, such as OMB Circular A-45, a preference for direct appraisal or the regional survey appraisal method, there is no way to ensure that all tenants (both IHS and tribal) have rental rates comparable to similar (and sometimes identical) quarters occupied by Bureau of Indian Affairs on the same reservation.

Under subsection (b)(1)(D), Tribes are permitted to set rates based on maintenance that includes capital repairs and replacement. In federal quarters, capital costs are not included in the calculation to determine what should be collected for quarters use. This increases the possibility that rents collected from different sites will not be equitable

It should be reiterated that Tribes operating health care programs (via P.L. 93-638) have the opportunity to take title to the government quarters necessary for the staff needed to operate health facilities. Once the title passes to the tribe/tribal organization, the rents, maintenance, and collection activities are subject only to tribal management and tribal preferences regarding the rent establishment and collection procedures.

Recommendation: Strike sec. 314.

**Sec. 401(d)(2)(C): Identification of Source of Payment** (p. 187).

**Sec. 401(d)(3)(B): Coordination of Information** (p. 188).

The Senate Indian Affairs Committee accepted our previous recommendation and deleted unnecessary references to Urban Indian Organizations in sec. 401(d) because such Organizations could always directly bill and receive payments. However, there are two provisions in this subsection that are not part of the direct billing process. It would be helpful to restore Urban Indian Organizations to these two provisions: (1) Indian health programs to furnish their Centers for Medicare and Medicaid Services provider numbers to IHS; and (2) IHS to provide CMS lists of such numbers and other available data. This information would assist HHS in developing more accurate cost and other estimates for future Indian health proposals.

Recommendation: (p. 187, line 12) After "Any Tribal Health Program," insert "or Urban Indian Organization health program"; and (p. 188, line 14) after "Tribal Health Programs," insert "and Urban Indian Organization health programs".

**Sec. 407: Payor of Last Resort** (p. 202). With respect to Medicaid, IHS is currently a payor of last resort. This provision would amend and expand this requirement to treat

urban Indian organizations as a payor of last resort also. This would undermine the long-standing legal requirement that Medicaid is the payor of last resort and could increase Medicaid spending. HHS does not support any precedent-setting modifications to current law with respect to Medicaid as payor of last resort. In addition, urban Indian organizations are providers not payors and the intent of this provision is, therefore, unclear and unnecessary.

We are concerned by the anticipated interaction between this provision and the Medicare Modernization Act (MMA). This provision should be clarified to make clear that benefits provided by IHS would not count as an incurred true out-of-pocket cost for Medicare Part D coverage, which would be consistent with the MMA final rule.

Recommendation: (p. 202, line 16) Strike “Urban Indian Organizations“. Clarify language, as noted.

**Sec. 408: Nondiscrimination in qualifications** (p. 202). This provision, which would extend the current exception to tribes, tribal organizations and urban Indian programs, would allow these entities to avoid state licensure. Extending this flexibility to Tribes, Tribal Organizations and Urban Indian organizations is not consistent with maintaining quality of care for beneficiaries.

Recommendation: Strike sec. 408.

**Sec. 409: Consultation** (p. 205). This provision cross-references sec. 1139(d) of the Social Security Act (SSA), which, as added by sec. 206(a) of S. 1057, requires consultation with the Tribal Technical Advisory Group (TTAG). Consistent with our recommendation to strike sec. 206(a) of title II of the bill, because such requirement changes the existing structure of TTAG and is unnecessary, this provision should be deleted.

Recommendation: Strike sec. 409.

**Sec. 410: SCHIP Outreach** (p. 205). This provision cross-references various provisions of the SSA on which we comment later in this document. This provision should conform with such comments on sections 202 and 203(a)-(c) of the bill.

Recommendation: Amend sec. 410 to conform with HHS comments on sections 202 and 203(a)-(c) of title II of the bill.

**Sec. 412: Premium and Cost Sharing Protections (p. 207).** This provision cross-references various provisions of the SSA that are amended by sec. 204 of title II of the bill. As noted in our comments on sec. 204, we have some concerns about such section and the Administration’s position on it is under development.

**Sec. 413: Treatment under Medicaid and SCHIP Managed Care** (p. 208). This provision cross-references various provisions of the SSA on which we comment later in this document. This provision should conform with such comments on section 208 of title II of the bill.

Recommendation: Amend sec. 413 to conform with HHS comments on sec. 208 of title II of the bill.

**Sec. 414: Navajo Nation Medicaid Agency Feasibility Study** (p. 208). This provision allows the Secretary to determine the feasibility of treating the Navajo Nation as a State for purposes of operating as a Medicaid State agency. This provision is unnecessary, as States already have programs that serve AIs/ANs.

Recommendation: Strike section 414.

**Sec. 802: Regulations** (p. 292). Provisions prohibiting the Secretary from developing regulations for certain titles of the bill would limit the Secretary's ability to manage these programs effectively.

Recommendation: Strike this prohibition: "Except...titles VI and VIII." (p. 293, lines 2-4).

**Sec. 803: Plan of Recommendation** (p. 294). The section requires the Secretary to submit a plan for implementation of the Act (S. 1057), including a schedule of appropriation requests. The Secretary should not be required to predict and report on appropriation requests that have not yet occurred. Decisions about agency budget requests are made on an annual basis.

Recommendation: Strike the portion of this section that requires the Secretary to submit a schedule of appropriation requests.

**Sec. 804: Availability of Funds** (p. 294). This section states that funds appropriated for IHClA are available until expended. Because most of the IHS budget is directed toward implementation of IHClA, the majority of their funding is appropriated until expended. The IHS appropriation now in current law does not specify which part of the appropriated funds are for implementing the IHClA. This allows an undefined sum of money to be available until expended.

Recommendation: Strike this section, as there is no rationale for making funds available until expended.

**Sec. 814: Establishment of the National Bipartisan Commission on Indian Health Care.** (p. 304). This provision is unnecessary. HHS and IHS are committed to continually identifying ways to improve delivery of services to AI/ANs to elevate the health status of the population.

Recommendation: Strike this provision.

## **TITLE II of S. 1057**

**(Note: The following comments and recommendations under title II of S. 1057 may require additional conforming changes in the cross-referencing provisions of title IV of the proposed IHClA.)**

**Sec. 201 of S. 1057: Expansion of Payments under Medicare, Medicaid, and SCHIP for All Covered Services Furnished by Indian Health Programs.** This provision amends sections 1911, 2107 and 1880 of the Social Security Act (SSA).

- **Section 1911(a):** This provision updates current law and revises Medicaid statute to identify urban Indian organizations as eligible for payment for medical assistance under a State plan or under waiver authority. Currently, eligible urban Indian organizations can receive Medicaid reimbursement under State plans and this addition is therefore unnecessary. Additionally, amending statute to identify urban Indian organizations is precedent-setting as the Medicaid statute does not identify other types of providers as eligible for reimbursement. IHS is specifically mentioned in statute as eligible for payment under current law because it is reimbursed differently than other eligible providers.
- **Sections 1911(b) and 1880(b) of the SSA: Compliance with conditions and requirements** (pp. 327-332). These provisions amend current law to reinstate long-expired provisions (that allowed IHS facilities a brief period of time after enactment of the IHCA to develop and implement plans for coming into compliance with Medicare and Medicaid requirements and to receive payments from those programs during that period). The bill extends application of the reinstated provisions indefinitely and also applies them to tribally-owned and -operated facilities and urban Indian organizations.

These provisions are unnecessary. IHS and Tribal facilities have long been in compliance with conditions of participation for Medicare and Medicaid. Those that encounter difficulties can and do receive technical assistance from IHS, the Centers for Medicare & Medicaid Services (CMS), and other sources to resolve such difficulties. Urban Indian health programs have always been treated like those of other providers to the extent that they participate in Medicare and Medicaid and meet conditions of participation and they, too, can receive technical assistance if they have difficulty doing so.

Recommendation: Strike “urban Indian organizations” from 1911(a). Strike proposed sections 1911(b) and 1880(b) of the SSA.

- **Sec. 1911(c): Secretarial Authority to Enter into Agreements with States** (pp. 328-329). This provision specifies that agreements entered into by the Secretary include services provided “directly, through referral, or under contracts or other arrangements between the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, and another health care provider”. This language is confusing and unnecessary.

Recommendation: Strike proposed sec. 1911(c) of the SSA.

- **TECHNICAL: Sections 1911(e) and 1880(d): Direct Billing:** These subsections contain a cross-reference to the IHCA provisions which allow Tribal and urban Indian health programs to opt out of the Special Fund process to interact directly with Medicare carriers and fiscal intermediaries and State Medicaid and SCHIP agencies for billing and payment.

Recommendation: To conform with previously-made changes to proposed sec. 401 of IHCA, Treatment of Payments Under Social Security Act Health Benefits

Programs, strike cross-references to Urban Indian Organization in the corresponding SSA cross-references. (p. 329, lines 20-21; p. 332, lines 14-15; p. 332, line 17).

**Sec. 202 of S. 1057: Increased Outreach to Indians under Medicaid and SCHIP and Improved Cooperation in the Provision of Items and Services to Indians under Social Security Act Health Benefit Programs** (p. 334). This provision adds a new section 1139 to the SSA to increase outreach to and enrollment of eligible Indians in Medicaid and SCHIP by encouraging States to take steps to provide for enrollment on or near the reservations. The section requires CMS to take necessary steps to facilitate cooperation with, and agreements between, States and the IHS, Indian Tribes, Tribal Organizations, or Urban Organizations when these entities provide covered items and services to Indians.

It is not clear how activities under sections 1139(a) and 1139(b) would be funded. There is a cross-reference to this section in new section 2105(c)(2)(C) (p. 336, line 9) that suggests both Medicaid and SCHIP activities under section 1139 would be funded with SCHIP dollars under section 2105(c)(2)(C). Given the scarcity of SCHIP funds, this could be problematic.

Recommendation: Strike these provisions .

**Sec. 203 of S. 1057: Additional Provisions to Increase Outreach and Enrollment of Eligible Indians in Medicaid and SCHIP.**

- **Sec. 203(a): Nonapplication of 10 Percent Limit on Outreach and Certain Other Expenditures** (p. 336). The authorization for SCHIP expires at the end of fiscal year 2007. HHS believes that improving the enrollment of Indian children in SCHIP should be discussed in the context of SCHIP reauthorization in the 110<sup>th</sup> Congress. The Department prefers to address outreach through the President's Cover the Kids initiative.
- **Sec. 203(b) and Sec. 203(c)**: These provisions are consistent with current practices and, therefore, are unnecessary.
- **Sec. 203(d): Satisfaction of Medicaid Documentation Requirements** (p. 337). This subsection amends section 1903(x)(3)(B) of the SSA regarding Medicaid documentation requirements considered satisfactory evidence of U.S. citizenship as a condition of Medicaid eligibility. Many Indians who are U.S. citizens lack documents such as birth certificates, passports, and State-issued driver's licenses commonly used by other U.S. citizens and recognized as acceptable evidence in sec. 1903(x)(3)(B). Thus, this provision permits the use of evidence of membership or enrollment in, or affiliation with, a Federally-recognized Indian tribe.

This provision is unworkable as drafted. Some of these tribes along the U.S. border with Mexico (and perhaps Canada as well) enroll Mexican or Canadian nationals as members. As a result, using tribal enrollment documents would not serve the purposes of alternative evidence of U.S. citizenship for Medicaid. This issue was carefully considered in the development of the interim final rule implementing this statutory provision and specific tribal documents that are considered to be sufficient proof of citizenship are included in the rule.

Recommendation: Strike subsections (a), (b), (c) and (d) of section 203.

**Sec. 204 of S. 1057: Premiums and Cost Sharing Protections under Medicaid, Eligibility Determinations under Medicaid and SCHIP, and Protection of Certain Indian Property from Medicaid Estate Recovery.**

We have some concerns about this provision and the Administration's position is under development.

**Sec. 205 of S. 1057: Nondiscrimination in Qualifications for Reimbursement for Services under Federal Health Care Programs** (p. 345). This provision indicates that entities need not obtain State licensure, but will be deemed to have fulfilled their State or local licensure and recognition requirements if they are operated by the Service, Indian Tribe, Tribal Organization, or Urban Indian Organization and meet all applicable standards for licensure as determined by the State licensing authority or the Medicaid agency.

This provision, which would extend the current exception to tribes, tribal organizations and urban Indian programs, would allow these entities to avoid State licensure. Extending this flexibility to Tribes, Tribal Organizations and Urban Indian organizations is not consistent with maintaining quality of care for beneficiaries.

Recommendation: Strike section 205.

**Sec. 206 of S. 1057: Consultation on Medicaid, SCHIP, and Other Social Security Act Health Care Programs.** Subsection (a) codifies CMS's current Tribal Technical Advisory Group (TTAG) and specifies certain requirements for it. Subsection (b) directs States to establish a process to seek regular advice from IHS, Tribal, and urban Indian health programs relating to Medicaid and SCHIP matters likely to have a direct effect on them. The TTAG has been established by CMS and is operating effectively. In codifying structural requirements for TTAG, this provision would limit the Department's ability to make necessary changes in the future.

Recommendation: Strike section 206(a) (p. 348).

**Sec. 207 of S. 1057: Exclusion Waiver Authority for Affected Indian Health Programs and Safe Harbor Transactions under the Social Security Act.** Section 207(b) amends section 1128B of the SSA to specify certain transactions involving IHS and Tribal health programs would not be subject to the Federal anti-kickback statute (sec. 1128B(b) of the SSA) sanctions for prohibited practices.

- Sec. 1128B(b)(4)(A): Provides that, for specified purposes, certain transfers "of anything of value between or among an Indian Health Program, Indian Tribe, Tribal Organization or Urban Indian Organization" shall not be considered remuneration. It is unclear how a "waiver" of a premium or cost sharing amount is a "transfer" of something of value. While a waiver has an economic benefit to the party otherwise responsible for paying the waived amount, there is actually no "transfer" of value from one party to another.

Recommendation: (p. 352, lines 15-16) Strike "Transfers of anything of value between or among an Indian..." and insert "Remuneration between or among an

Indian . . .”. This formulation would be consistent with the existing statutory language, which uses the broad term “remuneration”. Conforming changes in the same subsection would be needed: (1) p.352, lines 11, strike “transfers; (2) p. 352, line 13, change “Transfers” to “Remuneration”; (3) p. 352, line 21, change “consist” to “consists”. Similar changes could also be made in subparagraphs (B), (C), and (D), so that section 207(b) focuses on “remuneration” rather than “transfers”.

- **Sec. 1128B(b)(4)(B)(ii): Safe harbor for housing patients when necessary for timely treatment and CMS regulations regarding incentives for preventive care** (p. 354). This provision proposes a safe harbor where the transfer consists of expenditures related to providing housing for the patient (including a pregnant patient). The purpose of, and need for, the parenthetical in this provision is unclear.

Recommendation: Clarify language and intent.

- **Sec. 1128B(b)(4)(B)(iii): Safe harbor for payment of premiums and cost sharing on behalf of patients** (p. 354). It is unclear what clause (iii) is intended to do with respect to conditions under contract health services (CHS). Additionally, it is unclear why CHS is mentioned in the context of paying of premiums directly to patients, since CHS is by nature payment to other providers for actual care provided. CHS is not indemnity coverage, nor is it paid to the patient

Recommendation: Clarify language and intent.

- **Sec. 1128B(b)(4)(C)(ii)** (p. 355): The intent of the language limiting transfers to fair market value is unclear. Is the intent to safe harbor transactions in which the one party pays fair market value to the other party for the items or services? In the case of preventive care items and services (such as vision tests or vaccines), is the intent to limit the safe harbor to transactions in which one party gives the other party items and services for which the fair market value (e.g., retail value) approximates the value of avoided future health care costs? In the later case, it is not clear how the parties would measure the avoided future costs.

Recommendation: Clarify language and intent.

- **Sec. 1128B(b)(4)(D), Other Transfers** (p. 355): This provision is unnecessary as it replicates legal authority already given to the Secretary in section 1128B(b)(3)(E) of the SSA

Recommendation: Strike this provision.

**Sec. 208 of S. 1057: Rules Applicable Under Medicaid and SCHIP to Managed Care Entities with Respect to Indian Enrollees and Indian Health Care Providers and Indian Managed Care Entities** (p. 356). This section adds a new subsection (h) to sec. 1932 of the SSA to address various difficulties that both Indian providers and Indian beneficiaries experience under current Medicaid and SCHIP managed care arrangements. Many of the provisions of subsection (h) are similar to those in S. 1057, as reported, which reflected substantial technical assistance from the Administration. We note several problems related to new or amended bill language.

HHS supports leaving to the States decisions about managed care, including with whom to contract and which beneficiaries to enroll. With this provision's dictating and encouraging limitations in contracts and enrollment, we believe that competition and consumer choice would be limited.

Recommendation: Revise the statutory language to encourage, not require, States and MCOs to undertake the activities described in this section (i.e., insert "may", and substitute "may" for "shall").

- **Sec. 1932(h)** limits the provisions only to managed care organizations (MCOs) with a significant percentage of Indian enrollees. Indian Health Programs experience the same financial difficulties if they are paid inappropriately or not at all, regardless of whether Indian enrollees are a small or significant percentage of the MCO's enrollees. While this provision appears intended to address problems Tribes have raised during consultations regarding Indian MCO enrollees served by Indian Health Programs, the statutory language here does not clearly indicate that.

Recommendation: (p. 357, lines 12-14) Strike "that has a significant percentage of Indian enrollees (as determined by the Secretary),"; and (p. 358, line 7) before "enrollees" insert "Indian".

- **Sec. 1932(h)** allows the MCO to demonstrate that it has a sufficient number of participating Indian health care providers as an alternative to paying non-participating Indian Health Programs appropriately. Indian Health Programs may be denied participation or unable to accept an offer to participate due to the Anti-Deficiency Act (IHS), participating provider payment rates below their costs, or other reasons. This alternative approach would allow MCOs to "cherry pick" among Indian Health Programs, leaving many still without appropriate payment or any at all for covered services provided to Indian MCO enrollees they cannot turn away.

Recommendation: (pp. 357-358) Strike sec. 1932(h)(2)(A)(i), and revise sec.1932(h)(2)(A)(ii) to cover both participating and non-participating Indian Health Programs.

- **Sec. 1932(h)(2)(D)(i)** adopts a previous HHS recommendation to require compliance by Indian Health Programs with generally applicable requirements, not only of title XIX but also of the State plan and the MCO. However, the bill then added provisions at sec. 1932(h)(2)(D)(ii) that limit these requirements in an unclear manner and to an unacceptable degree.

Recommendation: (pp. 359-360) Strike clause (ii) of sec. 1932(h)(2)(D).

- **Sec. 1932(h)(2)(E)(ii)** adds provisions, similar to State supplementation for Federally-qualified health centers, for State supplementation if an MCO pays an Indian Health Program that elects to use the OMB-approved encounter rate less than the full amount of that rate. This encounter rate is an administrative mechanism that has not previously been recognized in statute, and may have serious policy and budget consequences that cannot be adequately considered in the context of this bill. Moreover, this encounter rate is but one of a number of ways that Indian Health Programs can be paid under a State plan.

Recommendation: Substitute more general references to approved provider payment rates under the State plan for specific references to the encounter rate.

**Sec. 209 of S. 1057: Annual Report on Indians Served by Social Security Act Health Benefit Programs** (p. 371). The section amends section 1139 of the SSA to provide for an annual report on Indians served by health benefit programs funded under the SSA. This provides a new requirement to which the Administration has previously objected. CMS and IHS do not have this data and it would be extremely difficult and burdensome to collect it.

Recommendation: Strike sec. 209.