EXECUTIVE BUSINESS MEETING TO CONSIDER AN ORIGINAL BILL ENTITLED "THE MEDICARE, MEDICAID, AND SCHIP INDIAN HEALTH CARE IMPROVEMENT ACT OF 2007", H.J. RES. 43, INCREASING THE STATUTORY LIMIT ON THE PUBLIC DEBT; AND TO DISCUSS SUBCOMMITTEE ASSIGNMENTS

WEDNESDAY, SEPTEMBER 12, 2007

U.S. Senate,

Committee on Finance,

Washington, DC.

The meeting was convened, pursuant to notice, at 10:32 a.m., in room 215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Conrad, Lincoln, Wyden, Stabenow, Salazar, Cantwell, Grassley, Hatch, Snowe, Kyl, and Bunning.

I N D E X

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OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The Chairman. The committee will come to order.

The committee meets today to consider three items: first, an original bill entitled, "The Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2007"; second, H.J.Res. 43, "Increasing the Statutory Limit on the Public Debt"; and, third, subcommittee assignments.

In his 1802 address to Indian nations, Thomas Jefferson said, "Made by the same Great Spirit and living in the same land with our brothers, we consider ourselves as of the same family. We wish to cherish their interests as our own." But when it comes to the health care of our Native American brethren, the government has hardly cherished their interests as our own.

Native Americans suffer from tuberculosis at rates 7.5 times higher than non-Indian populations. The Native American suicide rate is 60 percent higher than the general population. Medicare spends about $6,800 per person a year, Medicaid spends about $4,300 per person a year, the Bureau of Prisons spends about $3,200, but the Bureau of Indian Affairs spends only $2,100. That is less than a third of Medicare, less than half of

Medicaid, and less than a third of what the government pays for health care for prisoners.

Funding for Indian Health Service is so low that a tribal member better not get sick after June of any given year. That is because, after June, there is no health care available in Indian Health Service facilities, except for life-or-death situations.

We could reduce some of the financial and human costs of these disparities with better access to health care, and moving our part of the Indian Health Act would be a good start. So once again we are marking up the Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act.

The committee reported pretty much the same bill by unanimous vote in the last Congress. We intend this bill to become part of the larger Indian Health bill, and the Indian Affairs Committee ordered that bill reported on May 10th of this year.

Congress passed the original Indian Health Act in 1976. For the last 15 years, however, Native Americans have been waiting for Congress to reauthorize that law. The provisions that we deal with today are the ones within the Finance Committee's jurisdiction. Our bill deals with Medicare, Medicaid, and CHIP.

These provisions improve access through high-quality

and culturally appropriate health care throughout Indian country. This bill is crucial for the more than 66,000 Native Americans who live in Montana, and it is crucial for the millions of Native Americans throughout America.

The bill also provides for the urban Indians, who comprise approximately 60 percent of the Native American population in the United States. As the report for the Indian Health Care amendments of 1987 said, "Responsibility for the provision of health care does not end at the borders of an Indian reservation.

Rather, government relocation policies have, in many instances, forced Indian people to relocate in urban areas and the responsibility for the provision of health care services follows them there." We owe the first inhabitants of this Nation better access to quality health care. We owe them medical care consistent with the medical care found in mainstream hospitals and clinics. We owe them the same medical care that we provide to other members of our family.

Today we also need to mark up legislation to increase the Federal debt limit. We have no choice about this. Treasury Secretary Paulson has written to Congress. We must increase the debt limit by early October or the U.S. Government will default for the first time in its history.

The House has sent the Senate legislation increasing the debt limit by $850 billion. This increase would carry us into calendar year 2009, and that would avoid the need to raise the debt limit during the election year when the issue might--not only might, but probably--become a political football.

The increase of $850 billion would be the third largest debt limit increase in U.S. history. Including this latest increase, we will have raised the debt ceiling by $3 trillion since 2001. During that time we will have raised it from $6 trillion to $9 trillion, a 50 percent increase.

We clearly must do better with our fiscal policies. We must not lower the standard of living of our children and our grandchildren. Yet, we need to pass this debt limit increase promptly. Delay would force the Treasury to use extraordinary measures to avoid hitting the debt ceiling, and that could create uncertainty in the financial markets.

I want to underline that point: it could create uncertainty in the financial markets. When global financial markets are already concerned about the value of subprime mortgage securities, it is no time to generate additional uncertainty in the credit markets. So, I urge my colleagues to pass this debt limit

increase.

And, finally, we need to complete the committee's organization of our subcommittees in the wake of the death of our late friend and colleague, Craig Thomas. We will also do that once we have achieved a quorum and voted on other matters.

Senator Grassley?

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator Grassley. Thank you for bringing this very important work, these two bills, before our committee. And with the Indian Health Care Improvement Act, we are building and doing our share of the Finance Committee's work on a bill that has already been introduced and gone through the Indian Affairs Committee, so we are doing the work that is within the jurisdiction of this committee.

This legislation today helps us keep our commitment to providing quality health care to Indians by allowing the tribes to be better able to use money for Medicare and Medicaid to maximize improvements of the care provided to Indians. This legislation provides for increased outreach to Indian tribes to assist their members in applying for Medicaid and SCHIP.

This legislation provides relief for Indians from Medicare and Medicaid cost sharing and premiums, if that in incomes, to Medicaid by contract or referral. This is a fair and balanced policy, as those Indians would not be subject to cost-sharing or premiums if their care was provided by an Indian health care provider. This legislation creates incentives for Medicare managed care plans to enroll Indians, to include in that Indian health

providers in their networks. Indians have relationships with their health care providers that are very important to maintain.

Finally, the legislation requires reporting of data on Indians served, the status of their health care, and efforts being made to upgrade facilities that may not be in compliance with Social Security Act requirements. This is valuable information that will aid us in ensuring that we are providing quality care to Indians. So, I appreciate the efforts of Senator Baucus in bringing us this legislation, but we should also thank Senators Dorgan and Murkowski and their respective committee work as well.

I would be remiss if I did not remind our members that this process began in the Indian Affairs Committee this session, where our dear colleague, the late Senator Thomas, was Ranking Member. The work that has gone into today's mark-up has been a bipartisan process involving both committees and the assistance of all these members has been invaluable.

Now, our second bill is a bill that occasionally comes before Congress because it is necessary, under law, to increase the debt limit. Increasing the debt limit is necessary, as Senator Baucus said, to maintain the full faith and credit of our country.

Critics sometimes object to raising the debt limit. But let me tell you, it is this simple: refusing to raise the limit is like refusing to pay your credit card bill after you have used the credit card. We cannot pass tax bills and spending bills and then refuse to pay our bills. The time to control the debt is at those earlier times when we are looking at tax bills and spending bills. Once the action has been taken on them, raising the debt limit is something that we have to do to assume our full responsibility.

Thank you, Mr. Chairman.

The Chairman. Thank you, Senator Grassley.

Do other Senators wish to make statements? Senator Conrad?

OPENING STATEMENT OF HON. KENT CONRAD, A U.S. SENATOR FROM NORTH DAKOTA

Senator Conrad. Just very briefly, Mr. Chairman. I want to talk primarily on the debt limit question. First of all, I would just like to point out, this is the fifth increase of the debt limit under President Bush. We have now raised the debt limit of the United States nearly $4 trillion on his watch. In fact, under his fiscal policy, the debt of the United States, the debt limit has been raised $3.865 billion. This most recent increase of $850 billion is one of the biggest increases we have ever had.

I recall, the President told us that he would have maximum pay-down of the debt if his fiscal plan was adopted. Well, that has not worked out. Not only has there been no pay-down of the debt, in fact, the debt has exploded. And let us just look. We have been talking about the debt limit, but if we look at what has happened to the gross debt of the United States under the President's plan, here it is.

It has gone from $5.8 trillion at the end of his first year--do not hold him responsible for his first year--to $8.9 trillion at the end of this year. That is how much the debt of the United States has soared under

this fatally flawed fiscal policy, and all of this at the worst possible time, right before the baby boomers retire.

Now, with that said, we have no choice but to pass the debt limit. What the Chairman and Ranking Member have said is true. These are debts that have already been accrued and we are responsible for them. If we fail to act in a timely way on raising the debt limit, the creditworthiness of all United States instruments would be called into question. Now, that could have a very severe effect on already-shaky financial markets.

So, I would say to my colleagues, I think it is very important that we make note of where the fiscal policy of this President has led us, how seriously flawed it has been. But at the end of the day, we need to approve the extension of the debt limit, and do it in a timely way so there is absolutely no question in the financial markets of the United States that we are going to be responsible for the bills that have been run up.

Senator Rockefeller. Would the Senator yield?

Senator Conrad. I would be happy to yield.

Senator Rockefeller. Is it not also the case that, after the 2002 increase on the President's watch, the previous raising of the debt limit went back five years, to 1997?

Senator Conrad. That is correct. And so now we see more frequent increases in the debt because, again, the debt of the United States is absolutely skyrocketing.

Senator Kyl. Mr. Chairman, this is a very interesting discussion that has just begun. About 20 minutes ago, most of the members of this committee just voted for a bill that is well over the President's budget. He says he will veto it. The way to stop increasing our debt is to stop spending the money that Congress spends. The President cannot spend a nickel that we do not appropriate. So you cannot blame the debt on the President. If we did not appropriate the money, he would not be able to spend it. It is not his debt, it is our debt.

Now, I did not vote for that bill. I intend to vote to sustain the President's veto when he vetoes it because it is about $4 billion over his budget. Let us be careful about playing political games and placing blame on the President for spending that Congress initiates. Now, you can always say, well, on balance, what we should do is spend that money but cut it back someplace else, or we should raise taxes, or whatever, whatever.

But Congress spends the money and Congress passes the tax bills. The President has said, I have not vetoed very many bills up to now, but it is time to start and I

am going to start trying to get us on a path to fiscal responsibility. I agree with everybody here, we have got the debt. We have no choice but to extend the debt limit.

But let us be careful about playing political games here and blaming one party or one person for what is, in fact, the responsibility for every one of us here. I ask everybody to think about what they just voted on 20 minutes ago.

Senator Grassley. Mr. Chairman?

The Chairman. Senator Grassley?

Senator Grassley. I would suggest, if we can get one more person here, that we vote these bills out. If anybody wants to speak, I will be glad to stay around and listen to other speeches so that they have an audience.

The Chairman. That is good Iowa wisdom.

I note the presence of 11 Senators. Now, before we actually vote, does any Senator wish to make a very brief statement--I mean very brief--or offer an amendment to any one of the three measures before us?

Senator Rockefeller. Mr. Chairman?

The Chairman. Senator Rockefeller?

Senator Rockefeller. I will be very brief. I am astounded by the argument that was just given. Four billion dollars over what the President suggested. If we

had not done it, or other things of that sort, everything would be fine. Then if you would just start looking at what has been cut and what has been spent, which has not been in the budget, and what has been supplementally appropriated, your argument does not stand and I cannot be silent.

The Chairman. All right. Any other Senator have either an amendment or something that he or she just has to say at this moment? Senator Stabenow?

Senator Stabenow. Mr. Chairman, I will take your admonishment. I just want to say thank you for the Indian Health bill. It is incredibly important. And number two, I am so proud that we passed the Transportation bill. It is fully paid for. Thank you.

The Chairman. All right.

The question before us is the Indian Health Care Improvement Act. All those in favor, say aye.

[Chorus of ayes]

The Chairman. Those opposed, say no.

[No response]

The Chairman. The ayes have it. The measure is agreed to. [Applause].

The Chairman. Thank you. Thank you. Thank you. The ayes have it. The measure is agreed to. I ask consent that the staff have authority to make technical

and conforming changes.

[No response]

The Chairman. Without objection, that is so ordered.

Now we have the next measure before us, which is the motion that the committee report H.J. Res. 43, Increasing the Statutory Limit on the Public Debt. Those in favor, say aye.

[Chorus of ayes]

The Chairman. Those opposed, no.

[No response]

The Chairman. The ayes have it. The Joint Resolution is ordered reported.

Senator Grassley. Mr. Chairman, I have been requested on that if I could have a member on my side to be labeled as voting "no", Senator Ensign.

The Chairman. All right. That will be noted.

Now we are going to Committee Rule 17. The Chair makes the advised appointments to the subcommittees that appear on the list that has been distributed to all Senators. I will entertain a motion that the committee approve the list.

Senator Grassley. I so move.

The Chairman. If there is no further debate, then without objection the subcommittee assignments are

approved.

[No response]

The Chairman. Once again, I thank all Senators very, very much. I know that you all had other plans, you could have been other places, and I thank Senators for making this quorum.

Senator Grassley. And does anybody want me to stay and listen to their speech? I will do it. [Laughter].

[Applause].

The Chairman. The committee is adjourned.

[Whereupon, at 10:50 a.m. the meeting was concluded.]

UNITED STATES SENATE
COMMITTEE ON FINANCE

Max Baucus, Chairman

Wednesday, September 12, 2007

219 Dirksen Senate Office Building

Agenda for Business Meeting

I. An original bill entitled, "The Medicare, Medicaid and SCHIP Indian Health Care Improvement Act of 2007"

II. H.J. Res 43, "Increasing the Statutory Limit on the Public Debt"

III. Subcommittee Assignments

The Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2007

Section 1. Short Title; Table of Contents

Current Law

No provision.

Chairman's Mark

This act may be cited as the "Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2007."

Section 2. Expansion of payments under Medicare, Medicaid and SCHIP for All Covered Services Furnished by Indian Health Programs

(a) Medicaid

Current Law

A facility of the Indian Health Service (IHS) (including hospitals, nursing facilities or any other type of facility that provides services that are coverable under the Medicaid state plan), whether operated by the IHS or by an Indian tribe (IT) or a tribal organization (TO), as defined in Section 4 of the Indian Health Care Improvement Act (IHCIA), is eligible for Medicaid reimbursement under the state Medicaid plan, if and for so long as it meets all of the conditions and requirements generally applicable to such facilities under Title XIX of the Social Security Act (SSA).

Section 1911(b) of the SSA provides that if a facility of the IHS which does not meet all of the conditions and requirements of Title XIX which are generally applicable to such a facility, that submits to the Secretary of Health and Human Services (HHS), an acceptable plan for achieving compliance with such conditions and requirements, must be deemed to meet such conditions and requirements, and to be eligible for Medicaid reimbursement, without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.

Under Section 1911(c) of the SSA, the Secretary of HHS is authorized to enter into agreements with the state Medicaid agency for purpose of reimbursing such agency for Medicaid services provided in IHS facilities to Indians who are eligible for Medicaid under the state Medicaid plan.

The Medicaid statute (Section 1911(d) of the SSA) points to Section 405 of the IHCIA, which describes the provisions relating to the authority of certain ITs, TOs, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services covered by Medicaid and provided by a hospital or clinic of such entities.

Chairman's Mark

These provisions would completely replace their counterparts (described above) in current law.

The provision would require that the IHS and ITs, TOs and Urban Indian Organizations (UIOs) be reimbursed for Medicaid items and services provided under the state plan or a waiver, if the provision of those services meets all the conditions and requirements generally applicable to the delivery of such care.

A facility of the IHS or an IT, TO, or UIO which is eligible for Medicaid reimbursement, but which does not meet all of the conditions and requirements of Medicaid under the state plan or a waiver which are generally applicable to such a facility, must make such improvements as are necessary to achieve or maintain compliance in accordance with a plan submitted to and accepted by the Secretary for meeting such conditions and requirements. The Secretary may deem a facility compliant for an initial twelve month period as under current law.

The provision would also allow the Secretary of HHS to enter into an agreement with a state for the purpose of reimbursing that state for Medicaid services provided by the IHS, an IT, TO or UIO, directly, through referral, or under contracts or other arrangements between these entities and another health care provider to Indians eligible for Medicaid under the state Medicaid plan or a waiver.

The provision would also provide a cross-reference to a special fund into which are placed payments to which a facility of the Indian Health Service is entitled under Medicaid. These provisions describe the authority of the Secretary to place Medicaid payments for which IHS facilities are eligible into a special fund, requires the Secretary to ensure that 100% of the payment for which facilities are eligible are paid out, and further requires facilities to use any amounts in excess of the amount necessary to achieve or maintain compliance for the purposes of improving IHS facilities. These requirements are outlined in subparagraphs (A) and (B) of Section 401(c)(1) of the IHCIA.

The provision would also point to Section 401(d) of the IHCIA for rules relating to the authority of a Tribal Health Program (THP) or UIO to elect to directly bill for, and receive payment for, health care items and services reimbursable under Medicaid.

Finally, the bill would point to Section 4 of the IHCIA for definitions of the following terms: Indian Health Program, Indian Tribe, Tribal Health Program, Tribal Organization, and Urban Indian Organization.

(b) Medicare

Current Law

The Social Security Act generally prohibits payment to any federal agency for services which would otherwise be covered under Medicare. However, Section 1880 of the Act provides an exception for IHS facilities. Section 1880(a) provides an exception for hospitals and skilled nursing facilities (SNF) whether operated by the Service or by an Indian tribe or tribal organization if and for so long as the entity meets the conditions and requirements for payments generally applicable to such facilities under Medicare. Section 1880(b) established a temporary provision for submission of an acceptable compliance plan for a hospital or SNF not meeting all of these conditions and requirements in 1976. Section 1880(c) specifies that payments to which any hospital or SNF of the IHS is otherwise entitled is to be placed in a special fund to be held by the Secretary. The Secretary is to use the payments (to the extent provided in appropriations Acts) exclusively for the purpose of making improvements in hospitals and SNFs which may be needed to achieve compliance with Medicare conditions and requirements. The provision would cease to apply when the Secretary determined and certified that substantially all the hospitals and SNFs of the IHS are in compliance. Section 1880(d) specifies that the annual report of the Secretary (required by the Indian Health Care Improvement Act) is to include a detailed statement of the status of hospitals and SNFs in terms of their compliance and of their progress toward achievement of such compliance.

Section 1880(e) extends payment, effective July 1, 2001, to certain services furnished in hospitals and ambulatory care clinics (whether provider-based or free-standing) operated by the IHS or by an Indian tribe (IT) or tribal organization (TO). The specified services are those provided by physicians, nonphysician practitioners, and physical and occupational therapists and which are paid for under the physician fee schedule. Effective for the five-year period beginning January 1, 2005, the authority is extended to all services for which payment may be made under Medicare Part B.

Section 1880(f) provides a cross-reference to Section 405 of the IHCIA for provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native Health organizations to elect to directly bill for and receive payments for health care services provided by a hospital or clinic of such tribe or organization.

Chairman's Mark

The provision would rewrite Section 1880 of the Social Security Act. New Section 1880(a) would specify that the Indian Health Service, and an Indian Tribe, Tribal Organization, or an Urban Indian Organization would be eligible for Medicare payments for services furnished by such entities, provided such services met all the conditions and requirements generally applicable to the furnishing of such services under Medicare. Application of the provision would be subject to the revised Section 1880(e).

New Section 1880(b) would require facilities of the Indian Health Service, or an Indian Tribe, Tribal Organization, or an Urban Indian Organization, which are eligible for reimbursement under Medicare, but which do not meet all of the conditions and requirements generally applicable to such facilities, to make improvements. The improvements would be in accordance with a plan submitted to and accepted by the Secretary for achieving or maintaining compliance with such conditions and requirements. The Secretary could deem a facility compliant for an initial twelve month period as under current law.

New Section 1880(c) would provide a cross reference to the special fund established under Section 401(c)(1) of the IHCIA for provisions relating to the authority of the Secretary to place payments to which a facility of the Indian Health Service is entitled under Medicare in a special fund. It would provide a further cross reference to section 401(c)(1)(A and B) of the IHCIA, which require the Secretary to ensure that 100% of the payment for which facilities are eligible are paid out, and further requires facilities to use any amounts in excess of the amount necessary to achieve or maintain compliance for the purposes of improving IHS facilities.

New Section 1880(d) would provide a cross reference to Section 401(d) of the IHCIA for provisions relating to the authority of a Tribal Health Program (THP) or Urban Indian Organization to elect to directly bill for, and receive payment for, health care items and services provided by such program or organization for which payment would be made under Medicare.

The provision would make a conforming change to the existing Section 1880(e) to specify that Section 401(c)(1) of the IHCIA, as well as new Section 1880(c), would not apply to payments made under Section 1880(e).

New Section 1880(f) would specify that the following terms have the meanings given to these terms in Section 4 of the IHCIA: Indian Health Program, Indian Tribe, Service Unit, Tribal Health Program, Tribal Organization, and Urban Indian Organization.

(c) Application to SCHIP

Current Law

No provision.

Chairman's Mark

This provision would apply all but one subsection of these Medicaid provisions to the SCHIP program, including: (1) the provision regarding eligibility of Indian entities to receive reimbursement (as defined in the new Section 1911(a)); (2) the provision regarding compliance with conditions and requirements (as defined in the new Section 1911(b)); (3) the provision regarding the authority of the Secretary of HHS to enter into

agreements with states to provide Medicaid reimbursement to Indian entities (as defined in the new Section 1911(c)); (4) the provision regarding direct billing (as defined in the new Section 1911(e); and (5) the provision defining terms referring to Indian entities (as defined in the new Section 1911(f)). The provision regarding the special fund for improving IHS facilities (as defined in the new Section 1911(d)) would not apply to SCHIP.

Section 3. 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.

Current Law

No provision in Social Security Act.

Section 404(a) of the IHCIA requires the Secretary to make grants or enter into contracts with Tribal Organizations for establishing and administering programs on or near federal Indian reservations and trust areas and in or near Alaska Native villages. The purpose of the programs is to assist individual Indians to enroll in Medicare, apply for Medicaid and pay monthly premiums for coverage due to financial need of such individuals. Section 404(b) of the IHCIA directs the Secretary, through the IHS, to set conditions for any grant or contract. The conditions include, but are not limited to: (1) determining the Indian population that is, or could be, served by Medicare and Medicaid; (2) assisting individual Indians to become familiar with and use benefits; (3) providing transportation to Indians to the appropriate offices to enroll or apply for medical assistance; and (4) developing and implementing both an income schedule to determine premium payment levels for coverage of needy individuals and methods to improve Indian participation in Medicare and Medicaid. Section 404(c) of the IHCIA authorizes the Secretary, acting through the IHS, to enter into agreements with tribes, Tribal Organizations, and Urban Indian Organizations to receive and process applications for medical assistance under Medicaid and benefits under Medicare at facilities administered by the IHS, or by a tribe, Tribal Organization or Urban Indian Organization under the Indian Self-Determination Act.

Chairman's Mark

The provision would add a new Section 1139 to the Social Security Act (replacing the current Section 1139 provision dealing with an expired National Commission on Children).

The new Section 1139(a) would encourage states to take steps to provide for enrollment of Indians residing on or near a reservation in Medicaid and SCHIP. The steps could include outreach efforts such as: outstationing of eligibility workers; entering into agreements with the Indian Health Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations to provide outreach; education regarding eligibility and

benefits; and translation services. Nothing could be construed as affecting arrangements between states and the Indian Health Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations for them to conduct administrative activities under Medicaid or SCHIP.

The new Section 1139(b) would require the Secretary, acting through CMS, to take such steps as necessary to facilitate cooperation with and agreements between states, and the IHS, Indian Tribes, Tribal Organizations, or Urban Indian Organizations relating to the provision of benefits to Indians under Medicare, Medicaid, and SCHIP.

The New Section 1139(c) would specify that the following terms have the meanings given to these terms in Section 4 of the Indian Health Care Improvement Act: Indian Tribe, Indian Health Program, Tribal Organization, and Urban Indian Organization.

Section 4. Additional Provisions to Increase Outreach to, and Enrollment of, Indians in SCHIP and Medicaid

(a) Nonapplication of 10% Limit on Outreach and Certain Other Expenditures

Current Law

Title XXI of the Social Security Act provides states with annual federal SCHIP allotments based on a formula set in law. State SCHIP payments are matched by the federal government at an enhanced rate that builds on the base rate applicable to Medicaid. The SCHIP statute also specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance that meets certain requirements. States may also provide benefits to SCHIP children, called targeted low-income children, through enrollment in Medicaid. Apart from these benefit payments, SCHIP payments for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, SCHIP statute specifies that payments for these four other specific health care activities cannot exceed 10% of the total amount of expenditures for benefits (excluding payments for services rendered during periods of presumptive eligibility under Medicaid) and other specific health care activities combined.

Chairman's Mark

The provision would exclude from the 10% cap on SCHIP payments (for the four specific health care activities described above) the following activities: (1) expenditures for outreach activities to families of Indian children likely to be eligible for separate SCHIP programs or Medicaid expansions under SCHIP authority, or under related waivers, and (2) related informing and enrollment assistance activities for Indian children

under such programs, expansions, or waivers, including such activities conducted under grants, contracts, or agreements entered into under the new grant program delineated in the Section 1139(a) of this Act (described in Section 3 above).

(b) Assurance of Payments to Indian Health Care Providers for Child Health Assistance

Current Law

Among other assurances, the state SCHIP plan must include a description of the procedures to be used to ensure the provision of child health assistance to targeted low-income children in the state who are Indians (as defined in Section 4(c) of the IHCIA).

Chairman's Mark

The provision would strike the reference to Section 4(c) of the IHCIA, and would expand this assurance to include how the state will ensure that payments are made to IHPs and UIOs providing SCHIP benefits in the state.

(c) Inclusion of Other Indian Financed Health Care Programs in Exemption from Prohibition on Certain Payments

Current Law

To prevent duplicative payments, the SCHIP statute specifies that no payments shall be made to a state for expenditures for child health assistance when that payment has been made or can reasonably be expected to be made promptly under any other federally operated or financed health care insurance program, other than an insurance program operated or financed by the IHS, as identified by the Secretary.

Chairman's Mark

This provision would add ITs, TOs and UIOs, to the exemption from the prohibition on SCHIP payments in the same manner currently applicable to the IHS.

(d) Satisfaction of Medicaid Documentation Requirements

Current Law

Under the Deficit Reduction Act of 2005 (DRA), states are prohibited from receiving federal Medicaid reimbursement for an individual who has not provided satisfactory documentary evidence of citizenship or nationality. Satisfactory evidence includes one document (from a list specified in the law) that provides reliable documentation of identity and proof of U.S. citizenship or nationality. Satisfactory evidence also includes one document (from a list specified in the law) that provides proof

of U.S. citizenship or nationality and one document (also from a list specified in the law) that provides reliable documentation of identity.

Section 6036(a)(2) of DRA specifies that the requirements do not apply to an alien who is (1) eligible for Medicaid and is entitled to or enrolled for Medicare benefits, (2) eligible for Medicaid on the basis of receiving Supplemental Security Income (SSI) benefits, or (3) eligible for Medicaid on such other basis as the Secretary of HHS may specify that satisfactory evidence had been previously presented.

The provision applies to initial determinations and to redeterminations of eligibility for Medicaid made on or after July 1, 2006.

Chairman's Mark

For the purpose of establishing Medicaid eligibility, this provision would add "a document issued by a federally-recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood)" to the list of accepted documents that provide reliable documentation of identity and proof of U.S. citizenship or nationality.

With respect to those federally-recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, the Secretary shall, after consulting with such tribes, issue regulations authorizing the presentation of such other forms of documentation (including tribal documentation, if appropriate) that the Secretary determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subsection.

During the period that begins on July 1, 2006, and ends on the effective date of final regulations issued under subclause (II) of section 1903(x)(3)(B)(v) of the Social Security Act (42 U.S.C. 1396b(x)(3)(B)(v)) (as added by paragraph (1)), an individual who is a member of a federally-recognized Indian tribe described in subclause (II) of that section who presents a document described in subclause (I) of such section that is issued by such Indian tribe, shall be deemed to have presented satisfactory evidence of citizenship or nationality for purposes of satisfying the requirement of subsection (x) of section 1903 of such Act.

(e) Definitions.

Current Law

Under SCHIP statute, definitions of specific terms are provided, including for example, "child," "creditable health coverage," "low-income," etc.

Chairman's Mark

For SCHIP purposes, the provision would specify that the terms "Indian," "Indian Health Program," "Indian Tribe," "Tribal Organization," and "Urban Indian Organization" have the same meanings given those terms in Section 4 of the IHCIA.

Section 5. Premiums and Cost Sharing Protections Under Medicaid, Eligibility Determinations Under Medicaid and SCHIP, and Protection of Certain Indian Property from Medicaid Estate Recovery.

(a) Premiums and Cost Sharing Protection Under Medicaid

Current Law

Under Medicaid, premiums and enrollment fees are generally prohibited for most beneficiaries classified as categorically needy. Nominal premiums and enrollment fees specified in regulations can be collected from persons classified as medically needy, certain families qualifying for transitional medical assistance, and pregnant women and infants with income over 150% of the federal poverty level. Premiums and enrollment fees can exceed these nominal amounts for persons classified as workers with disabilities (up to other specified limits), and for individuals covered under Section 1115 waivers.

Service-related cost-sharing (e.g., deductibles, copayments, and coinsurance) is prohibited for children under 18, for pregnant women, and for selected services (i.e., in a hospital, long-term care facility or other institution if spend-down is required; for hospice care; for emergency services; and for family planning services and supplies) provided to individuals classified as categorically needy or medically needy. For most other groups and services, nominal cost-sharing amounts are allowed as specified in regulations. For individuals classified as workers with disabilities, and those covered under Section 1115 waivers, service-related cost-sharing can exceed these nominal amounts.

Finally, the DRA of 2005 added a new state option for alternative premiums and cost-sharing, effective as of March 31, 2006. Generally, this new option provides states with additional flexibility to apply premiums and service related cost-sharing for certain Medicaid subgroups. Special cost-sharing rules apply to prescription drugs and to non-emergency services delivered in an emergency room.

Chairman's Mark ·

The provision would add a new subsection specifying that no enrollment fee, premium or similar charge, and no deduction, co-payment, cost-sharing, or similar charge shall be imposed against an Indian who receives Medicaid-coverable services or items directly from the IHS, an IT, TO, or UIO, or through referral under the contract health service. In addition, Medicaid payments due to the IHS, an IT, TO, or UIO, or to a health care provider through referral under the contract health service for providing services to a Medicaid-eligible Indian, could not be reduced by the amount of any enrollment fee,

premium or similar charge, or by the amount of any cost-sharing or similar charge that would otherwise be due from an Indian, if such charges were permitted.

Nothing in this provision shall be construed as restricting the application of any other limitations on the imposition of premiums or cost-sharing that may apply to a Medicaid-enrolled Indian.

This provision would stipulate that the terms "contract health service," "Indian," "Indian Tribe," "Tribal Organization," and "Urban Indian Organization" have the meanings given those terms in Section 4 of the IHCIA.

Finally, the provision would stipulate that these provisions would not be superseded by the new state option for alternative premiums and cost-sharing added by the DRA of 2005.

(b) Treatment of Certain Property for Medicaid and SCHIP Eligibility

Current Law

The Federal Medicaid statute defines more than 50 eligibility pathways. For some pathways, states are required to apply an assets test. For other pathways, assets tests are a state option. When assets tests apply, some pathways give states flexibility to define specific assets that are to be counted and which can be disregarded. For other pathways, primarily for people qualifying on the basis of having a disability or who are elderly, assets tests are required. Assets under those tests are specifically defined in the Supplemental Security Income (SSI) statute in Title XVI of the Social Security Act. Under SSI law, several types of assets are excluded, including: (1) any land held in trust by the United States for a member of a federally-recognized tribe, or any land held by an individual Indian or tribe and which can only be sold, transferred, or otherwise disposed of with the approval of other individuals, his or her tribe, or an agency of the federal government; and (2) certain distributions (including land or an interest in land) received by an individual Alaska Native or descendant of an Alaska Native from an Alaska Native Regional and Village Corporation pursuant to the Alaska Native Claims Settlement Act. All other property, except for the applicant's primary residence, is required to be counted.

There is no similar provision in current SCHIP law.

Chairman's Mark

Notwithstanding any other federal or state law, the provision would prohibit consideration of four different classes of property in determining Medicaid eligibility of an individual who is an Indian. These classes include: (1) property that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including any federally recognized Indian Tribe's reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act (ANCSA), and

Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs; (2) for any federally recognized Tribe not described in the first class, property located within the most recent boundaries of a prior federal reservation; (3) ownership interests in rents, leases, royalties, or usage rights related to natural resources, including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish, resulting from the exercise of federally protected rights; and (4) ownership interest in or usage rights to items not covered in the previous classes that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional life style according to applicable tribal law or custom.

The provision would also apply this new language to SCHIP in the same manner in which it applies to Medicaid.

(c) Continuation of Current Law Protections of Certain Indian Property From Medicaid Estate Recovery

Current Law

Under Medicaid, the Secretary is allowed to specify standards for a state hardship waiver of asset criteria for Medicaid estate recovery purposes.

Chairman's Mark

The provision would provide that certain income, resources, and property would remain exempt from Medicaid estate recovery if they were exempted under Section 1917(b)(3) of the Social Security Act (allowing the Secretary to specify standards for a state hardship waiver of asset criteria) under instructions regarding Indian tribes and Alaskan Native Villages as of April 1, 2003. The provision would also allow the Secretary to provide for additional estate recovery exemptions for Indians under Medicaid.

Section 6. Nondiscrimination in Qualifications for Payment for Services Under Federal Health Programs.

Current Law

No provision.

Chairman's Mark

The provision would add an additional subsection to New Section 1139, as added by Section 3 of this bill. New Section 1139(c) would require a federal health care program to accept an entity that is operated by the IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization as a provider eligible to receive payment on the same basis as any other provider qualified to participate as a provider under the

program. This requirement would apply if the entity met generally applicable state or other requirements for participation as a provider of health care services under the program. Any requirement that an entity be licensed or recognized under state or local law where the entity is located would be deemed to be met in the case of an entity operated by the IHS, Indian Tribe, Tribal Organization, or Urban Indian Organization, if the entity met all applicable standards for such licensure or recognition regardless of whether the entity obtains a license or other documentation under state or local law. Under certain circumstances, the fact that a health care professional employed by the entity did not have licensure under the state or local law where the entity was located would not be taken into account for purposes of determining whether the entity met the standards. Specifically, the absence of such licensure would not be taken into account if the professional was licensed in another state. This would be in accordance with Section 221 of the IHCIA.

The provision would prohibit payments under federal health care programs for services to Indians to any entity operated by the IHS, Indian Tribe, Tribal Organization, or Urban Indian Organization, if the entity was excluded from participation in any federal health care program. The prohibition would also apply if the entity's state license was either under suspension or revoked. Further, no individual excluded from participation in any federal health care program or whose state license was under suspension or revoked would be eligible to receive payment under any federal health care program for services furnished to an Indian.

The provision would define the term federal health care program as the term is defined under Section 1128B(f) of the Social Security Act, except that the exclusion of the federal employees health benefits program would not apply. Section 1128B(f) specifies that the term means any plan or program that provides health benefits directly, through insurance or otherwise, which is funded directly in whole or in part by the U.S. government. Section 1128B(f) specifies that the term also includes the following state health care programs; Medicaid, any program receiving funds under the maternal and child health services block grant program or from an allotment to a state under such program, any program receiving funds under the social services block grant program or from an allotment to a state under such program, or a state child health plan approved under the SCHIP program.

Section 7. Consultation on Medicaid, SCHIP and Other Health Care Programs Funded Under the Social Security Act Involving Indian Health Programs and Urban Indian Organizations.

Current Law

There are no provisions in current Medicaid or SCHIP statutes regarding a Tribal Technical Advisory Group (T-TAG) within the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicare, Medicaid and SCHIP programs. Current federal guidance requires states submitting waivers under Section 1915 or 1115 of the Social Security Act to engage in the following activities related to

consultation with Tribal Governments in their state: (1) notify in writing all federally-recognized Tribal Governments maintaining a primary office in the state at least 60 days before submitting the waiver or renewal of the state's intent to submit such waiver or renewal to CMS; (2) ensure the notice to the tribal Government describes the purpose of the waiver or renewal and anticipates the impact on tribal members; (3) ensure the notice also describes a method for appropriate Tribal representatives to provide official written comments and questions in a timeframe allowing state analysis and consideration and discussion between the states and the Tribes responding to the notice; (4) provide Tribal Governments with a reasonable period of at least 30 days in which to respond to the notice; and (5) provide an opportunity for an in-person meeting with Tribal representatives to discuss issues.

Chairman's Mark

The provision would require the Secretary to maintain within CMS a Tribal TAG, previously established in accordance with requirements of a charter dated September 30, 2003. The provision also would require that the TAG include a representative of the UIOs and IHS. The UIO representative would be deemed an elected official of a tribal government for the purposes of applying Section 204(b) of the Unfunded Mandates Reform Act of 1995, which exempts elected tribal officials from the Federal Advisory Committee Act for certain meetings with federal officials.

The provision would also require certain states to establish a process for obtaining advice on a regular, on-going basis from designees of IHPs and UIOs on matters relating to the application of Medicaid law likely to have a direct effect on those entities. Applicable states would include those in which the IHS operates or funds health programs, or in which one or more IHPs or UIOs provide health care for which Medicaid can be billed. This process would include seeking advice prior to submission of state Medicaid plan amendments, waiver requests or proposed demonstrations likely to directly affect Indians, IHPs, or UIOs. This process could include appointment of an advisory panel and of a designee of IHPs and UIOs to the Medicaid medical care advisory committee advising the state on its state Medicaid plan.

The provision would also apply this new language to SCHIP in the same manner in which it applies to Medicaid.

Finally, the provision would prohibit construing these amendments as superseding existing advisory committees, working groups, guidance, or other advisory procedures established by the Secretary or any state with respect to the provision of health care to Indians.

Section 8. Exclusion Waiver Authority for Affected Indian Health Programs and Safe Harbor Transactions under the Social Security Act.

Current Law

Section 1128 of the Social Security Act provides for mandatory and permissive exclusions under federal health programs for individuals and entities for certain prohibited activities. Under certain circumstances, primarily in cases of access issues, waivers may be requested.

Section 1128B(b) of the Social Security Act authorizes criminal penalties for anyone knowingly and willfully soliciting or receiving remuneration in return for: (1) referring any individual for services for which federal health program payment may be made; or (2) purchasing, leasing, or ordering or arranging for purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made under a federal health care program. The law further specifies certain actions to which the penalties do not apply.

Chairman's Mark

The provision would amend Section 1128 to permit the Secretary to waive an exclusion in the case of an Indian Health Program. The action could be taken upon the request of the administrator of the affected Indian Health Program who determined that the exclusion would impose a hardship on individuals entitled to benefits under or enrolled in a federal health program.

The provision would specify that certain transactions involving Indian Health Care Programs would not be treated as remuneration for purposes of applying Section 1128B(b) or 1128A(a) of the Social Security Act. These safe harbors would be subject to such terms and conditions as the Secretary may promulgate from time to time to prevent fraud and abuse. Safe harbors would be established for certain transfers of anything of value between or among an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization that were made for the purpose of providing necessary health care items and services to a patient served by such Program, Tribe, or Organization. Covered transfers would be: services in connection with the collection, transport, analysis, or interpretation of diagnostic specimens or test data; inventory or supplies; staff; or a waiver of all or part of premiums or cost sharing.

Safe harbors would also be established for certain transfers of anything of value between an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization and any patient served or eligible for services from such entity, including any patient served or eligible for service pursuant to Section 807 of the IHCIA. The safe harbor would only apply if one of the following three criteria were met. First, the transfer consisted of expenditures related to providing transportation for the patient for the provision of necessary health care items or services. Second, the transfer consisted of expenditures related to providing housing to the patient (including a pregnant patient) and immediate family members or an escort necessary to assuring the timely provision of health services to the patient. In both cases, the provision of services could not be advertised, nor be an incentive whose value was disproportionately large in relation to the value of the health care item or service (with respect to the value itself, or for preventive

services, future health care costs reasonably expected to be avoided). The third permissible type of transfer would be for the purpose of paying premiums or cost sharing on behalf of a patient; the payment could not be subject to conditions other than those under a contract for the delivery of contract health services.

A safe harbor would be established for a transfer of anything of value negotiated as part of a contract entered into between an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization, or the IHS and a contract care provider. The contract would be for the delivery of contract health services authorized by the Indian Health Service. However, the transfer could not be tied to the volume or value of referrals or other business generated by the parties. Further, the transfer would have to be limited to the fair market value of the health care items or services provided (or in the case of preventive care, the value of the future health care costs reasonably expected to be avoided).

Additional safe harbors would be established for other transfers of anything of value involving an Indian Health Program, Indian Tribe, Tribal Organization, or Urban Indian Organization or patient served or eligible for service from such an entity. The Secretary, in consultation with the Attorney General, would have to determine the transfer appropriate, taking into account the special circumstances of Indian Health Programs, Indian Tribes, Tribal Organizations, or Urban Indian Organizations and patients served by such entities.

Section 9. 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.

(a) In General (for Medicaid) .

Current Law

Section 1903(m)(1) of Title XIX defines: (1) the term Medicaid managed care organization, (2) requirements regarding accessibility of services for Medicaid managed care organizations (MCO) beneficiaries vis-a-vis non-MCO Medicaid beneficiaries within the area served by the MCO; (3) solvency standards in general and specific to different types of organizations; and (4) the duties and functions of the Secretary with respect to the status of an organization as a Medicaid MCO.

Section 1905(t) of Title XIX defines another type of managed care arrangement called primary care case management (PCCM). Under such arrangements, states contract with primary care case managers who are responsible for locating, coordinating and monitoring covered primary care (and other services stipulated in contracts) provided to all individuals enrolled in such PCCM programs.

Section 1902(w) of Title XIX specifies requirements for advance directives applicable to Medicaid managed care organizations, institutional providers (e.g., hospitals, nursing facilities), providers of home health care or personal care services, and hospice programs.

Title XIX contains a number of additional provisions regarding managed care under Medicaid. Section 1932(a)(5) specifies rules regarding the provision of information about managed care to beneficiaries and potential enrollees. Such information must be in an easily understood form, and must address the following topics: (1) who providers are and where they are located, (2) enrollee rights and responsibilities, (3) grievance and appeal procedures, (4) covered items and services, (5) comparative information for available MCOs regarding benefits, cost-sharing, service area and quality and performance, and (6) information on benefits not covered under managed care arrangements. In addition, Section 1932(d)(2)(B) requires managed care entities to distribute marketing materials to their entire service areas.

Sections 1903(m) and 1932 provide cross-referencing definitions for the term "Medicaid managed care organization."

In general, Federally Qualified Health Centers (FQHCs) are paid on a per visit basis, using a prospective payment system that takes into account costs incurred and changes in the scope of services provided. Per visit payment rates are also adjusted annually by the Medicare Economic Index applicable to primary care services. When an FQHC is a participating provider with a Medicaid managed care entity (MCE), the state must make supplemental payments to the center in an amount equal to any difference between the rate paid by the MCE and the per visit amount determined under the prospective payment system.

Chairman's Mark

The provision would require that Indians enrolled in a non-Indian Medicaid managed care entity (MCE) with an IHP or UIO participating as a primary care provider within the MCE's network be allowed to choose such an IHP or UIO as their primary care provider when the Indian is otherwise eligible to receive services from such a provider and the IHP or UIO has the capacity to provide primary care services to that Indian. Contracts between the state and such MCEs or PCCMs must reflect this requirement, and Medicaid payments to these entities are conditional on meeting this requirement.

The provision would stipulate that contracts with Medicaid MCEs and PCCMs must require those entities with a significant percentage of Indian enrollees (as determined by the Secretary), to meet other requirements as a condition of receiving Medicaid payments. These conditions include: (1) such MCEs and PCCMs must demonstrate that the number of participating Indian health care providers is sufficient to ensure timely access to covered Medicaid managed care services for those enrollees who are eligible to receive services from such providers; or (2) such entities must agree to pay

non-participating Indian health care providers (excluding non-participating FQHCs) at a rate equal to the rate negotiated between such entity and the provider involved, or, if such a rate has not been negotiated, at a rate that is not less than the level and amount of payment which the MCE or PCCM would make for services rendered by a participating non-Indian health care provider. In addition, such MCEs and PCCMs must agree to make prompt payment (in accordance with applicable rules) to participating Indian health care providers or, in the case of non-participating Indian health care providers (excluding non-participating FQHCs), the second condition listed above must apply. The provision also stipulates that the submission of a claim or other documentation for services by the IHP or UIO (consistent with Section 403(h) of the IHCIA) would be deemed to satisfy any requirement for an enrollee to submit a claim or other documentation. The provision would also require that the IHP or UIO comply with Medicaid requirements with respect to covered services, as a condition of payment. However, an Indian health care provider would not be required to comply with these general requirements if such compliance conflicts with any other applicable statutory or regulatory requirements. In addition, Indian health care providers would need to comply only with those requirements necessary for the MCEs or PCCMs to comply with the state plan, such as those related to care management, quality assurance and utilization management.

Special Medicaid payment rules would apply to an Indian health care provider that is an FQHC that does not participate with a Medicaid managed care entity. Payments for covered Medicaid managed care services to such non-participating Indian FQHCs would be at rates otherwise applicable to participating non-Indian FQHCs. These provisions do not waive the existing requirement that any supplemental payments due to a FQHC for services rendered under a contract with an MCE be made.

Special payment provisions apply to certain Indian health care providers that are not FQHCs and that are treated as IHS providers under a July 11, 1996 memorandum of agreement (MOA) between HCFA (now CMS) and the IHS. When payments to such providers by an MCE for services rendered to an Indian enrollee with the MCE are less than the encounter rate applicable under the MOA, the state must pay to such providers the difference between the encounter rate and the MCE payment.

The provision would also prohibit waiving requirements relating to assurances that payments are consistent with efficiency, economy and quality.

Under this provision states must offer to enter into an agreement with Indian Medicaid MCEs to serve eligible Indians if: (1) the state elects to provide services through Medicaid MCEs under its Medicaid managed care program, and (2) an Indian health care provider that is funded in whole or in part by the IHS, or a consortium composed of one or more tribes, TOs, or UIOs as well as the IHS (if applicable), has established an Indian Medicaid MCE in the state that meets generally applicable standards required for such an entity under the state's Medicaid managed care program.

The provision also contains a number of special rules that would be applicable to Indian MCEs. With respect to enrollment, Indian Medicaid MCEs could restrict

enrollment to Indians and to members of specific tribes in the same manner as IHPs may restrict the delivery of services to such Indians and tribal members. Also, among Medicaid MCEs, the state could not limit the choice of an Indian only to Indian Medicaid MCEs, and the provision does not allow states to be more restrictive in the choice of MCEs offered to Indian versus non-Indian beneficiaries. Also, if enrollment of an Indian in a Medicaid MCE is mandatory, the provision would require such states to enroll Indians who are not otherwise enrolled in an MCE to be enrolled in an Indian Medicaid MCE. Such enrollment must be consistent with the Indian's eligibility for enrollment with such an entity based on the service area and capacity of the entity, and must take into consideration maintaining existing provider-individual relationships or relationships with providers that have traditionally served Medicaid beneficiaries. Finally, under procedures specified by the Secretary, the provision would also require states to grant requests by Indians enrolled with a non-Indian Medicaid MCE to switch to an Indian Medicaid MCE.

Additional special rules would apply to flexibility in application of solvency standards for Indian Medicaid MCEs. The provision would specify that such entities must demonstrate, to the satisfaction of the Secretary (rather than the state), that they have made adequate provision against the risk of insolvency, and as with other Medicaid MCEs, must assure that individuals eligible for benefits are in no case held liable for debts of the entity in case of the organization's insolvency. The provision would also deem Indian Medicaid MCEs to be public entities, and thus, exempt these MCEs from requirements to meet solvency standards established by the state for private health maintenance organizations, and from requirements that such MCEs be licensed or certified by the state as risk-bearing entities. The provision would continue to apply other rules in Section 1903(m)(1) to Indian Medicaid MCEs.

With respect to special rules for Indian Medicaid MCEs and advance directives, the provision would allow the Secretary to modify or waive requirements related to maintenance of written policies and procedures for such directives, if the Secretary finds that these requirements are not an appropriate or effective way to communicate such information to Indians.

With respect to special rules for Indian Medicaid MCEs and flexibility in information and marketing, the provision would allow the Secretary to modify requirements defined in Section 1932(a)(5) to ensure that information provided to enrollees and potential enrollees of Indian Medicaid MCEs is delivered in a culturally appropriate and understandable manner that clearly communicates individual rights, protections, and benefits. Also, in the case of an Indian Medicaid MCE that distributes appropriate materials only to those Indians potentially eligible to enroll with the entity in its service area, the requirements of Section 1932(d)(2)(B), with respect to distribution of marketing material to an entire service area, must be deemed to be satisfied.

In general, the provision specifies that under a Medicaid managed care program, if a health care provider is required to have medical malpractice insurance as a condition of contracting with a Medicaid MCE, an Indian health care provider that is (1) a FQHC

that is covered under the Federal Tort Claims Act (FTCA), (2) a provider that delivers services pursuant to a contract under the Indian Self-Determination and Education Assistance Act that are covered under FTCA, or (3) the IHS providing services covered under FTCA, would be deemed to satisfy such a requirement.

Finally, the provision provides definitions for several terms. An "Indian health care provider" means an IHP or UIO. The terms "Indian," "Indian Health Program," "Service," "Tribe, Tribal Organization," and "Urban Indian Organization" all have the meanings given such terms in Section 4 of the IHCIA. The term "Indian Medicaid managed care entity" means a MCE that is controlled by the IHP, a Tribe, TO, or UIO, or a consortium, which may be composed of one or more tribes, TOs, or UIOs, and which also may include the IHS, for which the term "control" means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1%. The term "non-Indian Medicaid managed care entity" means a MCE that is not an Indian Medicaid MCE. The term "covered Medicaid managed care services" means the items and services that are within the scope of benefits available under the contract between the entity and the state involved. The term "Medicaid managed care program" means a program under Sections 1903(m) and 1932, and includes a managed care program operating under a waiver under Sections 1915(b) or 1115 or otherwise.

(b) Application to SCHIP.

Current Law

Under Title XIX, Section 1932(a)(2)(C) stipulates the rules regarding Indian enrollment in Medicaid managed care. A state may not require an Indian (as defined in Section 4(c) of the IHCIA) to enroll in a managed care entity unless the entity is one of the following (and only if such entity is participating under the plan): (1) the IHS, (2) an IHP operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the IHS pursuant to the Indian Self-Determination Act, or (3) an urban IHP operated by a UIO pursuant to a grant or contract with the IHS pursuant to Title V of the IHCIA.

Chairman's Mark

The provision would apply specific sections of the Medicaid provisions to the SCHIP program, including: (1) Section 1932(a)(2)(C) regarding enrollment of Indians in Medicaid managed care, and (2) the new Section 1932(h) as added by Section 9 of this bill and described above.

Section 10. Annual Report on Indians Served by Social Security Act Health Benefit Programs .

Current Law

No provision.

Chairman's Mark

The bill would further amend new Section 1139 to add a new subsection 1139(e). Beginning January 1, 2008, the Secretary, acting through the Administrator of CMS and the Director of the IHS, would be required to submit an annual report to Congress. The report would cover the enrollment and health status of Indians receiving items or services under the health benefit programs funded under the Social Security Act during the preceding year. The report would include information on: (1) total number of Indians enrolled in or receiving items or services under each such program, (2) the number of such Indians also receiving benefits under programs funded by the IHS; (3) general information regarding the health status of these Indians, disaggregated with respect to specific diseases or conditions, presented consistent with privacy of individually identifiable health information; (4) a detailed statement on the status of facilities of the Indian Health Service, or an Indian Tribe, Tribal Organization, or Urban Indian Organization with respect to the facilities' compliance with the applicable conditions and requirements under Medicare, Medicaid and SCHIP (and, in the case of Medicaid and SCHIP, under the state plan or waiver authority) and of the progress being made by such facilities (under plans submitted under the new Sections 1880(b) and 1911(b) added by Section 2 of this bill, or otherwise) toward achievement and maintenance of compliance; and (5) such other information the Secretary determined appropriate.

Section 11. Effective Date

Current Law

No provision.

Chairman's Mark

The provision would specify that the effective date of this Act would be the same as that for the amendments made by the Indian Health Care Improvement Act Amendments of 2007.

Preliminary CBO Estimate of the Effects on Direct Spending of the Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2007

(Based on the draft legislative language ERN07783, provided by committee staff on September 5, 2007)

Notes:

1. Figures are federal outlays by fiscal year, in millions of dollars.
2. Components may not sum to totals because of rounding.
3. Costs or savings of less than $500,000 are noted with an asterisk.
4. Section numbers are noted in the left column.

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-12	2008-17
					Changes in Direct Spending							
	Medicaid											
204	Exempt Indians from some cost sharing / premiums	5	6	6	7	7	8	8	9	9	10	31	74
206	Consultation with Indian Health Programs	*	*	1	1	1	1	1	1	1	1	3	7
208	Managed care provisions	3	3	4	4	4	5	5	5	6	6	18	45
	Subtotal, Medicaid	9	9	11	11	12	13	14	14	16	17	52	126
	State Children's Health Insurance Program												
203	Exclude outreach spending from 10% cap	*	*	*	*	*	*	*	*	*	*	*	*
	Total direct spending	9	9	11	11	12	13	14	14	16	17	52	126

DESCRIPTION OF THE CHAIRMAN'S MARK OF H.J. Res. 43, "A JOINT RESOLUTION INCREASING THE STATUTORY LIMIT ON THE PUBLIC DEBT"

Scheduled for Markup
by the
SENATE COMMITTEE ON FINANCE
on September 12, 2007

Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION

September 10, 2007
JCX-66-07

CONTENTS

INTRODUCTION

The Senate Committee on Finance has scheduled a markup of H.J. Res. 43, "A Joint Resolution Increasing the Statutory Limit on the Public Debt." This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a description of the Chairman's Mark of H. J. Res. 43.

[1] This document may be cited as follows: Joint Committee on Taxation, *Description of the Chairman's Mark of H.J. Res. 43, "Joint Resolution Increasing the Statutory Limit on the Public Debt"* (JCX-66-07), September 10, 2007. This document can be found on our website at www.house.gov/jct.

B. Increase in Statutory Limit

Present Law and Background

The statutory limit on the public debt currently is $8.965 trillion. It was set at this level in P.L. 109-182, enacted into law on March 20, 2006. It is projected that the current debt limit will be reached in early October 2007.

House Rule 27 provides that when the Conference report on the Budget Resolution is adopted, the House is deemed to have passed a joint resolution causing the debt limit to increase by a specified amount. For the Conference Report on the Budget Resolution passed this year, that amount is $850 billion. This amount would increase the debt limit to $9.815 trillion.

Description of Proposal

The proposal would concur with the joint resolution and increase the statutory limit on the public debt by $850 billion to $9.815 trillion.

Effective Date

The proposal would be effective on the date of enactment.

UNITED STATES SENATE
COMMITTEE ON FINANCE
SUBCOMMITTEES

(The chairman and ranking minority member are ex officio members of all subcommittees)

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Debbie Stabenow, Michigan
Charles E. Schumer, New York

Gordon Smith, Oregon
Mike Crapo, Idaho
Olympia J. Snowe, Maine
Pat Roberts, Kansas
Jim Bunning, Kentucky

Statement for the Finance Committee Markup
of the "Medicare, Medicaid, and CHIP
Indian Health Care Improvement Act of 2007"
Senator Olympia J. Snowe
September 7, 2007

I would like to thank the Chairman and the Ranking Member for holding this mark-up this morning. The Indian Health Care Improvement Act is now nearly seven years overdue for reauthorization. Such delay cannot continue. The "trust relationship" between the federal government and our Native Americans has long included the provision of health care – going back to some of our earliest treaties. We must keep that commitment kept, and there is no doubt that with both a rise in the Native American population and the cost of health care, as well as the sweeping changes in health care today, it is critical that reauthorization proceeds promptly. I know Maine's Native American tribes are anxious for this process to move forward.

This legisation, first enacted in 1976, has played a key role in the improvement of of the health of Native Americans. It has addressed improving health care services, and has encouraged the recruitment and training of health care professionals and provision of faciltiies in which they may deliver care. Yet despite the tireless efforts of so many, the disparity today between the health of our tribes and the rest of America is still great. Native Americans have the *world's highest rate* of Type II diabetes, and they are more than *three times* more likely to die from it's complications. Mortality among tribal members due to tuberculosis, liver disease, and accidents is hundreds of percent higher than in the rest of our nation.

Accidents and suicides claim many lives as well, including many Indian youths. So we still have a long way to go.

When tribes are asked about the biggest problem facing tribal health, funding is at the top of that list. Is that any wonder when, according to a 2004 Washington Post editorial, the Indian Health Service spends only $1,914 per patient per year, **about half** of what the government spends on prisoners ($3,803) and **far below** what is spent on the average American ($5,065)! When you couple low financial resources with severe workforce shortages, you have huge problems with health care access. This is especially true in rural areas. For example-- members of Maine's Micmac tribe live in just about every pocket of Aroostook County where we are experiencing severe provider shortages.

When this legislation was first enacted, IHCIA (aye-KEE-ah) provided for Medicare and Medicaid reimbursement for Indian health care. *That is one of the most critical aspects of the legislation before us – providing that our Native Americans can utilize these entitlement programs effectively.*

As we consider the legislation before us today, I'm particularly encouraged by steps this bill takes to help increase Medicaid and SCHIP enrollment. American Indians and Alaska Natives have the highest rate of uninsurance. The bill we are considering takes steps to improve access of Indians residing on or near reservations to Medicaid and SCHIP programs by providing *easier enrollment* - at or near the reservation – bringing eligibility workers out them. This is critical in rural areas. The bill also *exempts natiev Americans* from Medicaid enrollment fees, premiums, deductions, co-payments, cost sharing, or similar charges for services

provided by the Indian Health Service or through contract or referral. Those charges – coupled with poverty – simply impede tribal members from receiving the care which we have long worked to provide. I hope that through greater outreach and education about Medicaid and SCHIP eligibility, we can make greater improvements in the health and well-being among all tribal members.

Throughout my years in Congress, I have enjoyed my relationship with Maine's Native American tribes – including both the Passamaquoddy and Penobscot Tribes, and Aroostook Band of Micmacs, and the Houlton Band of Maliseets. I believe that the combination of this bill, as well as the increased funding for tribal set-asides in the Promoting Safe and Stable Families Program, which we will consider next, will represent some real momentum on tribal issues.

At the end of the day, it is critical for Congress to continue to work with Native Americans to help build on these achievements, preserve the unique Native American way of life, and address the priorities of our communities.

Thank you.

SENATOR STABENOW
OPENING STATEMENT
The Medicare, Medicaid and SCHIP Indian Health Care Improvement Act of 2007

September 12, 2007

Mr. Chairman, I am pleased the Committee today is focusing upon the issue of health care in Indian Country. While many of us are in agreement that a crisis exists in the lack of access many Americans have to adequate health care, the situation is even more pronounced in the lives of the Native Americans.

The Indian Health Service (IHS) funds health services to about 1.8 million Indians from the nation's more than 500 federally recognized American Indian and Alaska Native tribes. The federal government provides these health services based on its trust responsibility to Indian tribes derived from federal treaties, statutes, court rulings, executive actions, and our Constitution, which assigns authority over Indian relations to Congress.

Reauthorization of the various Indian health care programs has languished for fifteen years in this body, so our work here today is a vital component in improving and updating health care services in Indian Country.

Since the mid-1970s, the Indian Health Service and tribes have had the authority to bill for and receive Medicare and Medicaid reimbursements for services provided to Native Americans. The measure before us today will update these authorities and make conforming amendments to the Medicare and Medicaid laws.

What this bill and Committee, however, can not do is mandate the necessary funding to ensure that the trust responsibility providing adequate healthcare to our tribal members is fully upheld. IHS' annual funding does not allow it to provide all the needed care for eligible Indians. Services have been rationed so that the most critical care and needs are funded first and foremost.

Yet preventative health care is so very important for our Native Americans due to the high incidents of chronic diseases such as diabetes and obesity within their communities, not to mention the higher incidence of premature mortality in these communities when compared to the general U.S. population. Additionally, IHS funding shortfalls for medical personnel have only further contributed to the unevenness in health care delivery. In 2005, there were job vacancy rates of 24% for dentists, 14% for nurses, and 11% for physicians and pharmacists according to IHS data.

I am pleased to be a cosponsor of the Indian Health Care Improvement Act Amendments of 2007 as it establishes objectives to address the health disparities between Indians as compared to other Americans and will enhance IHS' ability to attract and retain qualified health care professionals for Indian Country. As a government, I am also hopeful we will commit additional budgetary resources to Indian health care from this year forward.

Indian health care reauthorization proposals have been introduced in the past four Congresses to no avail. The time is now to pass this reauthorization.

Thank you.