DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Indian Health Service
Rockville MD 20852

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Dear Tribal Leader:

I am writing to update you on activities that the Indian Health Service (IHS) is undertaking to deliver the benefits made possible by the **Indian Health Care Improvement Reauthorization and Extension Act of 2009, which amended the Indian Health Care Improvement Act (IHCIA), and was included in the Affordable Care Act**. The IHCIA provides authorities that assist the IHS and Tribes to advance our shared goal for improving the health of American Indian and Alaska Native (AI/AN) people.

Significant planning and coordination, consultation, and collaboration are necessary to implement many of the IHCIA provisions, especially those that provide new or expanded authorities for our health care programs. Since the Affordable Care Act was passed by Congress and signed by the President in March, we have identified milestones, timelines, and opportunities to coordinate with other agencies and partners. We have also identified initial actions which may involve consultation with Tribes to fully implement over the next months and years. During our initial implementation planning, we have identified some provisions that we believe are **self-implementing and some provisions** that require minimal actions to implement. This is the first in a series of letters to notify you of these types of provisions.

This letter focuses on the Agency's overall implementation of selected provisions to benefit all patients served by IHS, Tribal, and urban Indian health programs as specified in the law. Please note that consideration of IHCIA authorities during negotiations with Tribes on fiscal year 2011 funding agreements is a much broader discussion than the content of this letter and may include additional provisions not mentioned in this letter. IHS is committed to negotiating new IHCIA authorities with Tribes that would like to compact or contract for those authorities to the extent that we are able at the time of the negotiations. Please do not infer that the provisions mentioned in this letter are the only authorities we are willing to negotiate. In fact, we have already negotiated agreement on provisions that are not mentioned in this letter. In the summaries that follow, the IHCIA section is cited and described briefly with the action the IHS is undertaking toward completing implementation.

The following section was added by Title I, Subtitle A, Indian Health Manpower:

Sec. 113, Exemption from payment of certain fees, requires federal agencies to exempt Tribes from paying licensing, registration, and other fees imposed by federal agencies. Prior to the new law, Tribes have paid a registration fee to the Drug Enforcement Agency (DEA) for each primary care provider that prescribes controlled substances. The DEA has notified their field offices and the IHS that it will no longer charge Tribal providers for this fee.

The five sections that follow amended by **Title I, Subtitle B, Health Services:**

Sec. 125, Reimbursement from certain third parties of costs of health services allows IHS, Tribal programs and urban Indian organizations to be reimbursed from third parties for reasonable charges billed for services provided to beneficiaries of these plans. This provision also permits Tribes and urban Indian organizations to recover the cost of care provided to beneficiaries injured by a third party in accordance with the Federal Medical Care Recovery Act. Because this provision now allows Tribal self-insurance plans to pay IHS for services to plan beneficiaries, Tribes can volunteer to provide authorization for IHS to bill their self-insurance plan in a Public Law 93-638 contract, the Annual Funding Agreement, or by written letter to the respective IHS health facility that provided the services.

Sec. 126, Crediting of reimbursements under various programs, including those under Titles XVIII, XIX, and XXI. This provision clarifies that reimbursements be returned to the service unit, the IHS, a Tribal program or an urban Indian health organization and that there be no offsets or limit on the amount obligated to the service unit. IHS Area Offices and service units will be instructed to document compliance with this provision.

Sec. 127, Behavioral health training and community education, directs IHS to develop a plan to increase the staff providing behavioral health services by at least 500 positions within five years of enactment of the IHCIA. I have approved an initial plan/strategy that will include consultation with Tribes and other stakeholders, to develop a final hiring plan for the positions, as specified, across the IHS/Tribal behavioral health care system within five years, of which at least 200 will be devoted to children, adolescents and families. The plan can then be implemented when resources for those positions become available.

Sec. 129, Patient travel costs, continues to authorize funds to be used for travel costs of patients receiving health care services provided either directly by IHS, under contract health care, or through a contract or compact, and expands this authority to include reimbursement for costs for qualified escorts and transportation by private vehicle (where no other transportation is available), specially equipped vehicle, ambulance or by other means required when air or motor vehicle transport is not available. The decision to pay for newly authorized patient travel expenses depends on local budget and priorities within the respective Contract Health Services (CHS) program.

Sec. 135, Liability for payment, clarifies that a provider has no further recourse against the patients for services authorized by the IHS under CHS. The IHS has been and will continue to notify providers that CHS-referred patients cannot be billed for any deductibles or fees or co-pays for CHS-referred care. The current notification letter from IHS-managed programs will be reviewed and updated, as necessary, to ensure that the standard language meets the statutory requirements of the IHCIA. Tribes that have assumed control and operation of CHS programs through the Indian Self Determination and Education Assistance Act (ISDEAA) compacts and contracts are encouraged to note this new law and to modify their notifications to comply with the law. IHS encourages Tribal CHS programs that have not been issuing such notices to begin to issue such notices in accordance with the law.

The three sections that follow are amended and added by **Title I, Subtitle D, Access to Health Services:**

Sec. 151, Treatment of payments under the Social Security Act (SSA) health benefits programs, reemphasizes that the IHS and Tribes update provider enrollment numbers and must provide the numbers to the HHS Secretary in order to receive reimbursements for payments from Medicaid, Medicare, Children's Health Insurance Program, and other third-party payers for services. IHS will work with Tribes to determine a strategy to ensure compliance with this provision.

Sec. 156, Nondiscrimination under federal health care programs in qualifications for reimbursement for services, prohibits discrimination against Tribal health programs under federal health care programs if they meet the generally applicable state or other requirements for participation. This provision eliminates the requirement for licensure if standards for licensure are otherwise met. IHS may consider future implementation measures to ensure that this provision is consistently observed by all federal health care programs.

Sec. 157, Access to Federal insurance, allows a Tribe or Tribal organization carrying out a program under the ISDEAA and an urban Indian organization carrying out a program under Title V of the IHCIA to purchase coverage for its employees from the Federal Employees Health Benefits Program. While the law creates this new authority, a mechanism needs to be developed to administer this option for Tribes and urban Indian organizations. IHS recognizes that Tribes are very interested in this provision and we have been working with the Office of Personnel Management to implement this provision and will consult with Tribes in the near future.

Title I, Subtitle E, Health Services for Urban Indians.

Sec. 162, Treatment of certain demonstration projects, made the Tulsa and Oklahoma City clinic demonstration projects permanent service units. They are not subject to contracting or compacting under the ISDEAA. The Oklahoma City Area IHS will communicate further with the two Program Directors and the Tribes in the Oklahoma City Area on how to formally incorporate these programs as service units in the Area.

Sec. 171, Establishment of the Indian Health Service as an Agency of the Public Health Service expands the authorities of the IHS Director to: (1) facilitate advocacy for the development of appropriate Indian health policy and; (2) promote consultation on matters related to Indian health. These provisions are a significant step in acknowledging the importance of the government-to-government relationship between the U.S. and Indian Tribes and give the IHS Director broader responsibilities for advising the Secretary on matters related to Indian health, and to collaborate and coordinate with other agencies and programs of the Department. I recently discussed this provision with the Secretary and she supports my expanded role in advocating for Indian health issues and policy within the Department. This was a goal of mine when I first was appointed the IHS Director, and I have already met with several agency heads

and am at the table at all meetings with agency heads where decisions are made. The Agency's partnership and consultation activities with Tribes ensure that I can maximize the impact of this new and expanded role on improving health for American Indians and Alaska Natives across the entire Department of Health and Human Services.

I am committed to effective and meaningful consultation with Tribes to fully implement this important legislation as soon as possible. In a letter to Tribal leaders on May 12, HHS and IHS initiated a formal consultation to ensure a strong partnership during implementation and requested your input on the consultation process and on priorities for implementation. The letter is posted at http://www.ihs.gov/TribalLeaders/triballetters/index.cfm. If you have not provided input, I encourage you to do so in writing or by email to consultation@ihs.gov. Although the July 1 deadline has passed, your input is still welcome. Your input will support our consultation effort and move us toward timely and inclusive implementation of the IHCIA.

Finally, I want to underscore my commitment throughout this process to strengthen our partnership with Tribes by making the Agency's work accountable and transparent. I will continue to update you as progress is made on implementation of the IHCIA. I will send you another letter detailing more provisions in the near future.

Sincerely yours,

/Yvette Roubideaux/

Yvette Roubideaux, M.D., M.P.H.
Director