AMERICAN BAR ASSOCIATION
Health Law Section

THE HEALTH LAWYER

IN THIS ISSUE

Volume 28, Number 1,
October 2015

REIMBURSING CLINICIANS FOR ADVANCE-CARE-PLANNING CONSULTATIONS: THE SAGA OF A HEALTHCARE REFORM PROVISION

Janet Dolgin, Esq.
Maurice A. Deane School of Law
at Hofstra University
Hofstra North Shore-LIJ School
of Medicine
Hempstead, NY

Introduction

Advance care planning is part of good healthcare. Thus, paying clinicians to talk with patients about advance care planning makes sense: it enhances advance care planning and thereby serves to effect good healthcare. "If end-of-life discussions were an experimental drug," writes Atul Gawande in his recent book, *Being Mortal*, "the FDA would approve it."[1]

Yet efforts to provide for reimbursement to clinicians for time and attention given to advance-care-planning conversations with Medicare patients have been stymied since 2009 (at least until quite recently) by the politics of healthcare reform. It seems now that Medicare will move forward by relying on regulatory processes to offer reimbursement for this care. This will be an important development toward better healthcare for Medicare patients and could provide a model on which other healthcare insurers, not already offering a similar reimbursement opportunity, might rely in creating comparable coverage plans.

An early House bill[2] in the process that led to the Patient Protection and Affordable Care Act ("PPACA")[3] provided for Medicare's paying for advance-care-planning consultations.[4] However, the implications of the provision were reshaped as part of the national debate about healthcare reform – itself part of a larger national debate about a slew of matters implicating personhood, family, and reproduction, as well as dying and death.[5] As a result, the provision was omitted from PPACA.

This article briefly describes state-law provisions for advance care planning. It then reviews the message put forth by a set of conservative voices in 2009, aimed at undermining the provision to pay clinicians for advance-care-planning consultations with Medicare patients. The article contextualizes that response within the ideological debate about "Obamacare" that shook the nation during the summer of 2009. It then examines efforts to revivify the deleted provision that had proposed reimbursing clinicians for

continued on page 3

NEW OPPORTUNITIES FOR INNOVATIVE HEALTHCARE PARTNERSHIPS WITH INDIAN TRIBES AND TRIBAL ORGANIZATIONS

Starla Kay Roels, Esq.
Hobbs, Straus, Dean & Walker, LLP
Portland, OR

Liz Malerba
United South and Eastern Tribes, Inc.
Washington, DC

There has long been a crisis in inadequate funding and availability of healthcare services affecting Native Americans within the federal Indian Healthcare system. The Indian Health Service and the Indian tribes and tribal organizations ("T/TOs")[1] who are providing services under the Indian Self-Determination and Education Assistance Act continue to struggle with limited funding and lack of available services.

The good news is that recent changes in the law are aimed at addressing some of these issues, and have made it much easier for private sector healthcare providers and other entities to work together with T/TOs in potentially meaningful and mutually beneficial ways. These changes have resulted in some exciting partnerships and new opportunities for increased quality and quantity of healthcare services. T/TOs now have increased flexibility to work together with healthcare providers in the private sector to improve the quality and availability of healthcare services. They are able to participate in qualified health plan networks to help ensure that Indian people can continue to be served by their providers of choice for culturally relevant care,[2] and they are helping their beneficiaries to secure greater access to care through private health insurance in the marketplaces. The law has now also relaxed restrictions on the ability to extend care to non-Natives in their communities, which assists in the development of crucial health infrastructure and improved healthcare accessibility in rural areas.

This article will briefly discuss the statutory and regulatory framework under which many T/TOs deliver healthcare services, and then describe a few changes in the law, namely the Indian Health Care Improvement Act ("IHCIA") and the Patient Protection and Affordable Care Act ("PPACA"), that have made it possible to knock down the previous "silos" of care so that T/TOs and the private healthcare sector can work together more closely than ever before.

Healthcare Delivery in Indian Country[3]

The provision of healthcare to eligible Indians is currently delivered through a federal/tribal relationship that exists under a number of Indian-specific statutes, regulations and other laws. Federal responsibilities for health services to Indian people arise not only out of the many treaties and settlements entered between the federal government and individual tribes, but also out of the Indian Commerce Clause in Article I, Section 8 of the United States Constitution, which provides, "The Congress shall have the power to … [r]egulate commerce with foreign nations, and among the several states, and with the Indian tribes."[4] The federal government's long-standing trust responsibility to tribes is also one of the legal underpinnings of federal healthcare for Indian people.[5]

The United States government began providing healthcare to Indians in the early 1800s, in large part to rein in deadly outbreaks of smallpox.[6] This was originally within the purview of the War Department, until the responsibility was transferred to the newly created U.S. Department of the Interior in 1849.[7] The first legislation specifically appropriating funds for Indian health appeared in fiscal year 1911, with permanent appropriations for Indian health being made by the Snyder Act of 1921.[8] The Snyder Act remains one of the key laws supporting the appropriation of funds for Indian healthcare. The 1954 Transfer Act then shifted responsibility for providing healthcare, and custody of several federal healthcare facilities, from the Bureau of Indian Affairs in the Department of the Interior to the Public Health Service under the Department of Health, Education and Welfare.[9] Today, the primary federal responsibility for Indian healthcare resides with the Indian Health Service ("IHS"), an agency within the Department of Health and Human Services.

Two other laws of special significance to the delivery of healthcare in Indian country were initially passed in the mid-1970s: the Indian Self-Determination and Education Assistance Act ("ISDEAA") in 1975[10] and the IHCIA in 1976.[11]

ISDEAA

The ISDEAA authorizes federally recognized tribes, including Alaska Native villages and tribal organizations sanctioned by tribes, to contract with the IHS to take over the management and operation of federal health programs for the benefit of eligible Indian people. Under the ISDEAA, T/TOs can assume the funds and responsibilities for providing healthcare to their members and other eligible Indians that were previously provided on their behalf by the IHS. T/TOs can then redesign those services in the way they think is best to deliver quality healthcare in their own communities — targeting their own communities' specific healthcare needs, with an eye for cultural competence.[12] T/TOs operate a wide

continued on page 26

continued from page 25

variety of healthcare programs under the ISDEAA, such as hospital and clinic services; licensed physician coverage; dental; pharmacy; substance abuse and mental health programs; maternal child health; traditional healing; vaccinations; preventative screening; and health/diabetes education.

The ISDEAA is administered through contractual agreements between the IHS and the individual T/TO, which transfer funding from the federal government to the T/TO in order to carry out specific healthcare scopes of work. These ISDEAA agreements are based on the federal trust responsibility and the government-to-government relationship, and are grounded in the recognition of Tribal sovereignty. They are not federal procurement contracts and are not subject to the Federal Acquisition Regulations, but instead have their own statutory and regulatory structure.[13] In FY 2015, the IHS's overall appropriation from Congress was $4,642,381,000,[14] over half of which was transferred to T/TOs under the ISDEAA.[15]

Not all T/TOs throughout Indian country have taken over all of the healthcare programs previously delivered on behalf of Indian people by the IHS. Some T/TOs only assume control of selected health programs and some do not manage any healthcare services. In those situations, the IHS retains responsibility for the provision and management of healthcare services. There are a variety of reasons T/TOs might choose to leave responsibility for certain services with the IHS, including their governmental capacity, lack of adequate funding, or a strong belief that the federal government remains responsible for carrying out its trust responsibility to tribes.

Health service delivery within Indian country thus generally consists of a combination of "direct care" and "purchased/referred care" ("PRC") that is provided by the IHS or a T/TO that has contracted with the IHS under the ISDEAA.[16] Direct care services are those that are provided directly by the IHS or a T/TO in an IHS/tribally operated healthcare facility. PRC, which until fairly recently was called "contract health services," consists of any specialty or other services that are not available in a direct care facility, but must be purchased on the open market by the IHS or a T/TO from an outside healthcare provider or hospital.

The level of services available from a T/TO that has contracted with the IHS under the ISDEAA varies widely. Some T/TOs operate very small clinics with only basic healthcare services, while others may own and operate full-blown hospitals, specialty care clinics or long-term care facilities.[17] With funding for the IHS at just 59 percent of need,[18] the amount and variety of services offered is often dependent on a T/TO's ability to generate additional revenue.[19]

IHCIA

The IHCIA is another central piece of federal legislation for addressing healthcare needs in Indian country. A major goal of the Act has been to elevate the quantity and quality of healthcare services to raise the health status of Indians.[20] The IHCIA was recently permanently reauthorized by Congress in a single line of text appearing in PPACA.[21] The IHCIA addresses a wide range of issues affecting healthcare, including programs designed to increase recruitment of healthcare professionals;[22] scholarships for Native American students who choose to enter the health professions;[23] health promotion and disease prevention, like diabetes treatment and prevention;[24] reimbursements from third-party payors such as Medicare, Medicaid and private insurance;[25] construction of healthcare facilities and sanitation facilities;[26] licensure of health professionals providing care at tribally-operated healthcare facilities;[27] health services to Indians living in urban areas;[28] and behavioral health programs.[29] The purpose of the Act is to "implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging the maximum participation of Indians in such programs, and for other purposes."[30]

Innovative Partnerships: The IHCIA

The recent, permanent reauthorization of the IHCIA has substantively changed the way in which T/TOs can interact with their communities and other providers by giving T/TOs that are operating their own healthcare programs greater flexibility to provide services to non-Indians. Before the reauthorization occurred, T/TOs providing services under the ISDEAA were limited to providing those services to eligible Indian beneficiaries, with a few narrow exceptions. To be eligible for direct services from a T/TO, an individual has to be a "person of Indian descent belonging to the Indian community served."[31] This could include tribal members and their descendants or other persons, as determined by individual tribes. Additional eligibility requirements must be met in order to receive services through a T/TO's PRC program, such as residence within an Indian reservation or residence within a T/TO's "contract health service delivery area" and maintaining close social and economic ties to that T/TO.[32]

The circumstances in which T/TOs could provide services to persons who do not meet these eligibility criteria were quite restricted. For example,

T/TOs could provide care to a non-Indian member of an eligible Indian's household as necessary to control an acute infectious disease or another public health hazard.[33] Care and treatment could be provided in an emergency,[34] and to children under the age of 19 in certain situations.[35] T/TOs could also choose as a matter of tribal law to provide services to spouses of eligible Indians.[36]

Services to others (generally referred to as "non-beneficiaries") could be provided by a T/TO only if the IHS and the T/TO made a joint decision that the provision of services to non-beneficiaries would not result in any denial or diminution of services to eligible Indians and there are no other reasonable, alternative health facilities available in the area to meet the needs of the non-beneficiaries.[37] This limitation was set forth in the former Section 813(b) of the IHCIA. It was at that time rather difficult to get agreement between the IHS and the T/TOs that wished to serve non-beneficiaries, particularly with respect to the issue of what constitutes "reasonable alternative health facilities" in the area. As a result, not many of the T/TOs contracting with the IHS under the ISDEAA were able to offer any services to non-beneficiaries.

Now that the IHCIA has been reauthorized, the language in Section 813 has changed: the decision to serve non-beneficiaries is now solely a tribal decision – there no longer has to be a joint decision requiring the agreement of the IHS, and T/TOs need only consider whether extending services to non-beneficiaries would result in a denial or diminution of care to eligible Indians.[38] To provide services to non-beneficiaries, T/TOs typically take these issues into consideration in a "Section 813 Resolution," making the decision a matter of tribal law that can be reconsidered as warranted by any developments in the future.[39]

In many tribal communities, this has resulted in eliminating the need for separate silos of healthcare: one silo for eligible Indian patients and one silo for non-beneficiaries. Integrated care is now a realistic and viable opportunity. In extending healthcare services to non-beneficiaries, T/TOs charge the non-beneficiaries for the services provided — or the individual's available third-party payors — and reinvest those collections into their healthcare delivery system. The increased resources are resulting in greater availability and variety of healthcare services for everyone in the community — Indian and non-Indian alike, and broader overall involvement by T/TOs in their communities, as well.

These changes are leading to new opportunities for innovation and partnerships with the private healthcare sector. For example, it has led to construction of new facilities, joint ventures with other practitioners, expanded scope of services, and options for new or collaborative care, such as urgent care centers, drug rehabilitation facilities, long-term care facilities, and specialty clinics.[40] These opportunities are developing into real changes in rural communities, with the T/TOs working together with the local healthcare providers and local governments to the benefit of all involved.[41]

Innovative Partnerships: PPACA

In addition to the permanent reauthorization of the IHCIA, PPACA contains other provisions aimed at improving access to and the quality of care for American Indians and Alaska Natives. On top of benefits available to the U.S. general population, the law provides additional incentives for members of Federally Recognized Tribes[42] to purchase private insurance, many for the first time, through the marketplaces.[43] Tribal members may enroll in a qualified health plan ("QHP")[44] one time per month, instead of only during open enrollment periods.[45] They may also use the income-based premium tax credits available to individuals and families under 400 percent of the federal poverty level to purchase the most affordable QHP, a bronze level plan.[46] A bronze level plan has the lowest premiums, but higher copayments and deductibles. This, however, is not a factor for Tribal members, who are exempt from cost-sharing in most circumstances when insured through a zero or limited cost-sharing QHP.[47] In many Tribal communities, health insurance is a direct benefit to patients. Due to the underfunding of the IHS, care — especially specialty care — must often be rationed or delayed.[48] With this health insurance as the first payor, the insured patient has greater access to more timely and a wider range of services.

The Indian-specific provisions under PPACA provide an unprecedented opportunity to insure Tribal members who receive services through IHS or T/TOs.[49] When insured Tribal members access care through an Indian health provider, IHS and T/TOs may bill the insurer for the cost of the care. Collections from third party payors enable Indian health providers to fill in the gaps of federal underfunding and provide more services to more patients.

However, since enrollment on the marketplaces began in 2013, the enrollment rate for American Indians and Alaska Natives has remained low.[50] This is likely due to a variety of factors, including some failures to adequately address tribal issues raised in Tribal comments during the federal rulemaking process, the overall cost of the plans to individual tribal members despite any credits as compared to the ability to obtain free care accessed through Indian health providers, and the notion that the purchase of health insurance does not represent fulfillment of the federal government's trust responsibility.[51] In order to overcome these barriers, one option available to T/TOs is the

continued on page 28

continued from page 27

sponsorship of Tribal member premiums. Under a Tribal sponsorship model, the T/TOs pay a portion of the QHP premium on behalf of its uninsured citizens.

This model is not exactly new in Indian country. Following the creation of the Medicare Part D prescription drug program, some savvy T/TOs used this method to strengthen the delivery of prescription drugs to their elders.[52] During the implementation of PPACA, the Centers for Medicare & Medicaid Services ("CMS") ensured that T/TOs have the opportunity to implement sponsorship programs during the PPACA rulemaking process. Regulations made final last year require issuers offering QHPs on marketplaces to accept premium and cost-sharing payments from certain third parties, including T/TOs and Urban Indian Health organizations.[53] Similarly, regulations also allow for marketplaces to facilitate Tribal sponsorship, including premium aggregation, so that insurance for Tribal members is easily consolidated into one monthly payment.[54] A few state-based marketplaces have even built in electronic methods of premium aggregation for T/TOs and others,[55] but the Federally-Facilitated Marketplace has yet to implement this mechanism.

Regardless of whether they are located in a state operating its own marketplace or not, a number of T/TOs are instituting Tribal sponsorship programs. In order to effectively begin a sponsorship program, T/TOs first identify their uninsured population, eliminating those with employer-sponsored insurance or who are eligible for other government programs. Next, they generally select a single QHP for sponsorship. The T/TOs then collaborate with the QHP issuer to develop a relationship that includes the T/TO as an in-network provider and establishes a convenient premium payment mechanism, if one does not currently exist on the marketplace. A well-built relationship between issuers and T/TOs is valuable, as it facilitates the mutual benefit of both parties. For the first time, T/TOs are able to insure their entire patient population. Issuers are able to assist in increased access to care for a medically-underserved population, while spreading risk over a greater number of people and expanding profits.[56]

A healthy relationship between T/TOs and issuers is also important to fulfilling the law's network adequacy requirements. In order to receive QHP certification each plan year, issuers must include a sufficient number of Essential Community Providers ("ECPs") in their plan networks.[57] ECPs are those health providers providing care to primarily low income and medically-underserved individuals.[58] For the 2016 plan year, QHPs operating on the Federally-Facilitated Marketplace must contract with at least 30 percent of ECPs within a service area.[59] All Indian health providers are considered ECPs and count towards this threshold. Additionally, it is also a requirement for QHPs to extend a "good faith" offer to contract to all Indian health providers in their service areas. This ensures that American Indians and Alaska Natives may continue to see the culturally competent provider of their choice, while also having access to a robust provider network for specialty care. "Good faith" means the offer has terms "that a willing, similarly-situated, non-ECP provider would accept or has accepted."[60] QHPs are expected to provide verification of these offers to CMS, if requested.

However, despite direction and assistance from CMS, including the creation of a national list of ECPs,[61] many Indian health providers report not receiving offers to contract from all (or sometimes any) QHPs within their regions. As preparation for the 2017 plan year begins, Indian health providers will continue to work with CMS to ensure that QHPs meet their network adequacy requirements.

In addition, the use of an Indian addendum, otherwise known as the "Model QHP Addendum,"[62] is required when contracting with Indian health providers. The Model QHP Addendum is a document that has been developed by CMS and Tribes to facilitate QHP contracting with Indian Health providers. Some elements of traditional contracts run contrary to laws applicable to Indian Health providers,[63] so the addendum re-states relevant Indian law to ensure that all parties are on the same page. Using the Model QHP Addendum provides clarity and certainty to both issuers and Indian Health providers by removing perceived obstacles to contracting and promoting issuer compliance with federal Indian law, which limits conflict between parties. Through these new and improved relationships formed between Indian health providers and QHP issuers under PPACA, American Indian and Alaska Native people across the country stand to have greater access to healthcare.

A Few Legal Considerations

In thinking about the expanded ways in which it may now be possible to partner with T/TOs for the provision of healthcare services, there are a number of legal considerations that should be kept in mind. First and foremost, it is important to remember that every T/TO is different, their provision of healthcare and the way in which they are delivering healthcare is different, and so are their priorities and those of their communities. It is worth reaching out to any T/TO to learn more about their specific healthcare delivery system and whether it is possible to work together with them toward a common goal.

Even though the federal healthcare system has its own statutory and

regulatory scheme, one must also keep in mind whether a particular relationship would run afoul of healthcare fraud and abuse laws, such as the Stark Laws or the federal Anti-Kickback Statute, and consider possible structures of that relationship under one of the available exceptions or safe harbors.[64] State laws, such as certificate of need requirements, may or may not apply to a particular arrangement being contemplated. The structure of the partnerships with T/TOs may also raise a number of issues depending on where the activities are taking place — on or off an Indian reservation or other trust land. For example, the site could affect jurisdictional issues, application of state licensure and certification requirements, and taxation matters.

One could also consider whether a proposed partnership might be structured in a way to fall under a T/TO's ISDEAA agreement to take advantage of certain benefits such as the Federal Tort Claims Act ("FTCA"),[65] billing authorities, and flexible licensure requirements for health professionals.[66] For example, when a T/TO has a contract or compact under the ISDEAA, the T/TO's employees (including persons providing services through a personal services contract) are covered by the FTCA against liability for torts that arise from carrying out the ISDEAA contract or compact, thus reducing the need for separate, comprehensive liability or malpractice insurance.[67]

Conclusion

New laws and authorizations are changing the delivery of healthcare in Indian Country and beyond. As T/TOs take on greater responsibility for the management of their own healthcare systems and apply creative solutions to problems of access and funding, they are able to expand their reach beyond their own people to the communities in which they live. Similarly, insurers and others who partner with T/TOs have the opportunity to form lasting partnerships with Tribal governments and to improve the lives of our nation's first people.

Starla Kay Roels is a partner with Hobbs, Straus, Dean & Walker, LLP in the firm's Portland, Oregon office. She practices federal Indian law with an emphasis on healthcare and the Indian Self-Determination and Education Assistance Act. She advises Tribal clients on patient privacy and security of medical records, facilities construction, and Medicare Like Rates in billing for "purchased and referred" services. She also assists clients with entering innovative partnerships for increased access to health services in Indian communities. She earned her J.D. in 1996 from the Northwestern School of Law of Lewis & Clark College, and her B.A. *cum laude* in 1992 from Arizona State University. She may be reached at *sroels@hobbsstraus.com*.

Liz Malerba is the Director of Policy and Legislative Affairs for United South and Eastern Tribes ("USET"), a non-profit, inter-tribal organization representing 26 federally recognized American Indian Tribes from Texas across to Florida and up to Maine. She is located in Washington, DC, where she advances a comprehensive legislative and regulatory agenda on behalf of USET member Tribes. During the implementation of the Patient Protection and Affordable Care Act, Ms. Malerba provided extensive outreach and education to USET Tribes on opportunities, benefits, and requirements of the law, as well as advocacy on behalf of Tribes during the federal rulemaking process. For this work, she has received awards from the Indian Health Service and National Indian Health Board. Ms. Malerba is a citizen of the Mohegan Tribe of Indians of Connecticut, and she may be reached at *Lmalerba@usetinc.org*.

Endnotes

1 Under the Indian Self-Determination and Education Assistance Act, "Indian Tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians." 25 U.S.C. § 450b(e) "Tribal Organization" means "the recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities: Provided, That in any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian tribe, the approval of each such Indian tribe shall be a prerequisite to the letting or making of such contract or grant." 25 U.S.C. § 450b(l).

2 In Indian country, as with other communities, culturally relevant or competent healthcare delivery depends on a provider's ability to recognize and respond to a patient's cultural beliefs, values, attitudes, customs, spoken or preferred language, and health traditions, incorporating these factors into a treatment plan. T/TOs and the Indian Health Service frequently seek to integrate traditional healing with western medicine. For example, a patient may receive care jointly from a medicine man and a doctor. Additionally, whenever possible, facilities hire members of a particular Tribal community to assist with the provision of culturally competent care.

3 "Indian country" is formally defined at 18 U.S.C. § 1151 as "(a) all land within the limits of any Indian reservation under the jurisdiction of the United States Government, notwithstanding the issuance of any patent, and, including rights-of-way running through the reservation, (b) all dependent Indian communities within the borders of the United States whether within the original or subsequently acquired territory thereof, and whether within or without the limits of a state, and (c) all Indian allotments, the Indian titles to which have not been extinguished, including rights-of-way running through the same." However, "Indian country" is often used more generally relative to Indian healthcare to collectively refer to the broad areas in which tribes and tribal organizations across the lower 48 states and Alaska carry out healthcare programs and other services.

4 U.S. CONST. art I, § 8, cl. 3.

5 The federal government's trust responsibility to tribes is discussed by Chief Justice John Marshall in the United States Supreme Court's decision in *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831). The trust responsibility is a legal obligation under which the United States "has charged itself with moral obligations of the highest responsibility and trust" toward Indian tribes. *Seminole Nation v. United States*, 316 U.S. 286 (1942).

continued on page 30

continued from page 29

6 Indian Health Service, *Indian Health Manual* § 1-3.1(A).

7 *Id.*

8 *Id.;* The Snyder Act of 1921, P.L. 67-85 (42 Stat. 208) (codified at 25 U.S.C. § 13). The Snyder Act of 1921 is not to be confused with the Snyder Act of 1924, P.L. 68-175 (43 Stat. 253) (codified at 8 U.S.C. § 1401(b)), which relates to full U.S. citizenship for non-citizen Indians.

9 Pub. L. No. 83-568, 68 Stat.674 (1954). The Act states, "all functions, responsibilities, authorities, and duties…relating to the maintenance and operation of hospital and health facilities for Indians, and the conservation of Indian Health…shall be administered by the Surgeon General of the United States Public Health Service."

10 Pub. L. No. 93-638, as amended (codified at 25 U.S.C. §§ 450-458aaa-18).

11 Pub. L. No. 94-437, as amended (codified at 25 U.S.C. §§ 1601-1680v).

12 There is significant variation in the healthcare needs of T/TOs across the country. Due to a variety of factors, including genetics, economics, and environment, one Tribe may have particularly high rates of type-2 diabetes, while another may be grappling with high rates of dental caries. The ISDEAA allows T/TOs to focus spending on their most pressing needs, rather than depending on a more bureaucratic, one-size-fits-all approach.

13 25 U.S.C. §§ 450-458aaa-18; 25 C.F.R. Part 900; 25 C.F.R. Part 1000; 42 C.F.R. Part 137. The Federal Acquisition Regulations (FAR) are a substantial and complex set of rules governing the federal government's purchasing process. It provides uniform acquisition policies and procedures for use by all executive agencies.

14 Consolidated and Further Continuing Appropriations Act, 2015, Division F, Public Law 113-235. This amount represents $4,182,147,000 for Services and $460,234,000 for Facilities.

15 *See, e.g.,* http://tribalselfgov.org/wp/wp-content uploads/2015/05/3_Self-Governance-101-ISDEAA-Overview-PP-9-29-14_final.pdf (last visited on August 31, 2015).

16 The provision of services to Indian people living in urban areas by "urban Indian organizations," which is addressed in part under Title V of the IHCIA, 25 U.S.C. §§ 1651-1660h, is not specifically discussed in this article.

17 For an example, please see the IHS Description of Alaska Area Healthcare Facilities, page 8, www.ihs.gov/alaska/includes/themes/newihstheme/display_objects/documents/hf/area.pdf (last visited on August 31, 2015).

18 U.S. Commission on Civil Rights *A Quiet Crisis – Federal Funding and Unmet Needs in Indian Country*, July 2003 (www.usccr.gov/pubs/na0703/na0204.pdf) (last visited on August 31, 2015); The National Congress of American Indians Fiscal Year 2016 Budget Request, January 22, 2015 (www.ncai.org/policy-issues/tribal-governance/budget-and-appropriations/07_FY2016_Health_NCAI_Budget.pdf) (last visited on August 31, 2015).

19 Tribes can seek to generate additional funding for use in their own healthcare programs through a variety of different options, such as third-party billing (*e.g.*, Medicare, Medicaid, reimbursement agreements with the Veterans Administration, private insurance) or use of tribal funds obtained through tribal economic development (*e.g.*, casinos, gas stations, convenience stores, water parks).

20 25 U.S.C. § 1602.

21 Patient Protection and Affordable Care Act, § 10221, Pub. L. No. 111-148 (March 23, 2010). The reauthorized Indian Health Care Improvement Act is now codified at 25 U.S.C. § 1601, *et seq.*

22 25 U.S.C. § 1612.

23 25 U.S.C. §§ 1613, 1613a, 1616a.

24 25 U.S.C. §§ 1621b, 1621c.

25 25 U.S.C. § 1621e. *See also* Title IV of the IHCIA, 25 U.S.C. §§ 1641-1647d.

26 *See generally* Title III of the IHCIA, 25 U.S.C. §§ 1631-1638g.

27 25 U.S.C. §§ 1621t, 1647a(a).

28 25 U.S.C. §§ 1651-1660h.

29 *See generally* Title VII of the IHCIA, 25 U.S.C. §§ 1665-1665n.

30 Pub. L. No. 94-437 pmbl., as amended and reauthorized by § 10221, Pub. L. No. 111-148 (March 23, 2010).

31 42 C.F.R. § 136.12(a)(1).

32 42 C.F.R. § 136.23(a). PRC used to be called "contract health services," which is how they are still referenced in the IHS eligibility regulations found at 42 C.F.R. Part 136.

33 42 C.F.R. § 136.12(a)(1).

34 42 C.F.R. § 136.14(a).

35 25 U.S.C. § 1680c(a).

36 25 U.S.C. § 1680c(b).

37 Section 813(b)(1)(b), 25 U.S.C. § 1680(b)(1)(b) (2009).

38 25 U.S.C. § 1680c(c)(2).

39 Even after the reauthorization of the IHCIA, T/TOs may also still provide services to non-beneficiaries in other situations, such as in an emergency, to certain children under 19, to control an acute infectious outbreak, and others in specific situations. *See* text accompanying notes 33-36.

40 While there are many such programs being carried out in Indian country today, one example of a tribal facility serving larger community needs is the Jamestown Family Health Clinic on the Olympic Peninsula in Washington State. *See* www.jamestowntribe.org/programs/hhs/hhs_clinic.htm (last visited on August 31, 2015).

41 *See* note 40.

42 Alaska Native Claims Settlement Act (ANCSA) Shareholders are included in the definition of member of a Federally Recognized Indian Tribe.

43 In order to address the high rate of uninsured Americans, as well as unchecked costs and lack of transparent pricing in the U.S. insurance industry, PPACA established health insurance marketplaces, federal or state-operated web-based portals where consumers and businesses can compare and purchase insurance plans. The marketplaces also facilitate enrollment in Medicaid and the Children's Health Insurance Program (CHIP), as well as the distribution of premium tax credits.

44 A QHP is a health insurance plan certified by and offered on a health insurance marketplace that meets requirements under PPACA, including offering essential health benefits, an adequate network of providers, and limiting patient cost-sharing.

45 45 C.F.R. § 155.420(d).

46 26 U.S.C. § 36B. These are the same tax credits challenged in *King v. Burwell,* 135 S.Ct. 2480 (2015). Had the delivery of tax credits via Federally-Facilitated Marketplaces been struck down, many of the American Indians/Alaska Natives (AI/ANs) enrolled in QHPs would be without coverage.

47 45 C.F.R. § 155.350.

48 In Fiscal Year 2013, the IHS denied or deferred an estimated 146,928 services to eligible AI/ANs due to limited PRC dollars. Since Tribally-operated facilities are not required to report these numbers, the number is likely much higher. *See* www.ihs.gov/budgetformulation/includes/themes/newihstheme/documents/FY2016CongressionalJustification.pdf (last visited on August 31, 2015).

49 25 U.S.C. § 1623.

50 Obtaining reliable data on AI/AN enrollment in QHPs has been difficult, as many enrollees leave the race question blank, self-identified AI/ANs are not always enrolled in federally-recognized Tribes, and it is unclear whether the marketplaces are correctly identifying those eligible for the special AI/AN provisions in PPACA. For the 2015 open enrollment period, the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) reported that 26,314 self-identified AI/ANs selected a QHP on the Federally-Facilitated Marketplace.

See http://aspe.hhs.gov/sites/default/files/pdf/83656/ib_2015mar_enrollment.pdf (last visited on August 31, 2015).

For the initial open enrollment period in 2013 and 2014, ASPE estimated that AI/ANs comprised 1% of the QHP-eligible population in Federally-Facilitated Marketplace states. However, in its initial enrollment report, ASPE data suggests that only 0.3% of Federally-Facilitated Marketplace QHP enrollees were AI/AN. *See* http://aspe.hhs.gov/sites/default/files/pdf/76876/ib_2014Apr_enrollment.pdf (last visited on August 31, 2015).

51 For example, after numerous reports of

misinformation given to AI/ANs about their benefits and protections under PPACA, T/TOs have repeatedly called upon the Department of Health and Human Services to improve the AI/AN experience at the healthcare.gov call center, including providing an AI/AN-specific help desk staffed by a small number of experts. To date, this has not been established. In addition, individuals providing outreach and education in Indian Country continue to have difficulty encouraging enrollment among AI/ANs. Care delivered by Indian health providers is usually free of cost, while there is nearly always a cost to enrolling in a QHP, however nominal. Many AI/ANs also point to treaties, laws, and Supreme Court decisions upholding the federal trust responsibility to provide free health care to AI/ANs in exchange for the cession of Tribal lands as a reason not to pay the costs of enrollment and argue that funding should go to improving the IHS rather than affordable health insurance.

52 See http://nihb.org/tribalhealthreform/wp-content/uploads/2013/06012011/TTAG%20-%20Enabling%20an%20Indian%20Sponsorship%20Option%20DIST%202011-04-13.pdf (page 3) (last visited on August 31, 2015).

53 45 C.F.R. § 156.1250.

54 45 C.F.R. § 155.240(b).

55 *See* http://wahbexchange.org/about-us/board-and-committees/board-meetings/policy-issues/premium-aggregation/ (last visited on August 31, 2015).

56 *See* http://tribalselfgov.org/health-reform/success-stories/fond-du-lac-press-release/ (last visited on August 31, 2015).

57 45 C.F.R. § 156.235(a).

58 *Id.*

59 *See* Centers for Medicare & Medicaid Services FINAL 2016 Letter to Issuers in the Federally-Facilitated Marketplaces. It can be accessed at: https://cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf (last visited on August 31, 2015).

60 FINAL 2016 Letter to Issuers in the Federally-Facilitated Marketplaces, page 26.

61 A description of the list and the final non-exhaustive list for 2016 are available at https://cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html (last visited on August 31, 2015) under "Other QHP Application Resources."

62 The Model QHP Addendum can be accessed at: www.cms.gov/CCIIO/Programs-and-Initiatives/Files/Downloads/Model_QHP_Addendum_04_04_13.pdf (last visited on August 31, 2015).

63 For example, many contracts require that providers be licensed to practice in the state in which they are located, but Section 221 of the IHCIA provides that licensed health professionals employed by a tribal health program are exempt from the licensing requirements of the state in which the tribal health program performs services, so long as the health professional is licensed in any other state. 25 U.S.C. § 1621t. As another example, contracts often include anti-discrimination provisions that do not apply to tribes (*e.g.*, tribes are specifically exempt from Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e, and have Indian preference requirements with which they must comply under the ISDEAA. 25 U.S.C. § 450e). *See* Model QHP Addendum explanatory document for additional information: https://cms.gov/CCIIO/Programs-and-Initiatives/Files/Downloads/Model_QHP_Addendum_Explanatory_Document_04_04_13.pdf (last visited on August 31, 2015).

64 42 U.S.C. § 1320a-7b, 42 C.F.R. Part 1001; 42 U.S.C. § 1395nn, 42 C.F.R. §§ 411.350 - 411.389.

65 Congress extended coverage under the FTCA to T/TOs carrying out Title I contracts and Title V compacts, including for medical and non-medical torts, via Section 102 of the ISDEAA. 25 U.S.C. § 450f(d). *See also* 25 U.S.C. § 458aaa-15(a); 25 C.F.R. Part 900, Subpart M.

66 25 U.S.C. §§ 1621t, 1647a(a).

67 *See* note 65. Coverage under the FTCA means that in any lawsuit filed against the T/TO or its employees, the federal government will substitute itself as the defendant and the T/TO and its employees will not be liable.