AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 812
(I-23)

Introduced by: Medical Student Section

Subject: Indian Health Service Improvements

Referred to: Reference Committee J

Whereas, the Indian Health Service (IHS) serves 2.6 million American Indian and Alaska Native (AI/AN) patients in facilities operated by the federal government, tribes, and Urban Indian organizations (UIO)[1-2]; and

Whereas, unlike Medicaid, Medicare, and the VA, the IHS is not an insurance or entitlement program with an established benefits package[3-5]; and

Whereas, the IHS is a payer of last resort, thus their patients must exhaust all other public or private coverage for which they are eligible before receiving IHS payment, including the 36% of AI/AN adults under 65 who are on Medicaid[6-8]; and

Whereas, since 1976, all state Medicaid programs have been fully reimbursed at 100% Federal Medical Assistance Percentage (FMAP) for services at IHS/Tribal facilities[9-10]; and

Whereas, the 1976 100% FMAP legislation specifically excluded UIOs, even though 70% of AI/AN adults live in areas served by these facilities[8,10]; and

Whereas, in 2016, CMS expanded 100% FMAP to services from non-IHS/Tribal physicians if first requested by an IHS/Tribal physician with a care coordination agreement[10-11]; and

Whereas, the American Rescue Plan temporarily extended 100% FMAP to UIOs for 2 years, with the federal government saving 22 states an estimated $70 million[10,12]; and

Whereas, Congress is considering permanently extending 100% FMAP for UIOs, which is estimated to save states $547 million over 10 years[10]; and

Whereas, Washington State currently reinvests their $16 million in annual savings from 100% FMAP into into a tribally-driven health improvement fund[13-14]; and

Whereas, 100% FMAP expansion for UIOs will not negatively impact appropriations and services at Indian Health Service and Tribal Health Programs[13]; and

Whereas, pharmacoequity is also a serious concern for many Tribal leaders and advocates for AI/AN health[15]; and

Whereas, the IHS National Pharmacy and Therapeutics Committee (NPTC) sets the IHS National Core Formulary (NCF) for baseline pharmaceutical coverage at federal IHS facilities, but does not maintain parity with other federal health programs[16]; and

Whereas, the IHS NPTC added emergency contraception to the NCF 4 years after reports of complete lack availability at over half of all IHS facilities and 2 years after over-the-counter approval without age limits by the Food and Drug Administration[17-19]; and

Whereas, the IHS NPTC added testosterone and estradiol to the NCF 5 years after the release of consensus specialty clinical guidelines on gender-affirming medication[20-21]; and

Whereas, our American Medical Association supports "enforc[ing] the Medicare Part D Prescription Drug Program statutory requirement that all Part D plans include at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients"; and

Whereas, in 1997, Congress created the IHS Special Diabetes Program for Indians (SDPI), an $150 million annual program funding diabetes prevention and treatment, which now comprises 301 community programs serving 780,000 adults and children in 35 states[22]; and

Whereas, in the 20 years since SDPI implementation, diabetes prevalence in AI/AN adults has consistently declined, diabetes-related mortality decreased 37%, diabetes-related hospitalizations decreased 84%, diabetic eye disease decreased 50%, and specifically diabetes-related kidney failure decreased 54% (the greatest reduction for any racial or ethnic group), which alone saved Medicare $520 million over 10 years[22-23]; and

Whereas, SDPI is subject to reauthorization every 2 years, affecting continuity of care during prolonged Congressional negotiations and exacerbating existing staffing issues because IHS is the only federal health program without advance appropriations[24]; and

Whereas, SDPI funds have stagnated at $150 million since 2004 without inflation-based adjustments, limiting program expansion, decreasing grant value, and forcing grantees and IHS programs to unsustainably absorb 20 years of inflationary cost increases[25-26]; and

Whereas, similar to SDPI, other IHS grants, such as the 5-year health professions grant Indians Into Medicine, are discretionary (not mandatory) and are also subject to repeated Congressional reauthorization, lack of funding increases, and struggles with inflation[27]; therefore be it

RESOLVED, that our American Medical Association advocate to permanently increase the Federal Medical Assistance Percentage (FMAP) to 100% for medical services which are received at or through an Urban Indian Organization that has a grant or contract with the Indian Health Service (IHS) (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage state and federal governments to reinvest Medicaid savings from 100% FMAP into tribally-driven health improvement programs (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for greater physician and federal oversight of the IHS National Core Formulary, ensuring that the pharmacy benefit for American Indian and Alaska Native patients represents the standard-of-care for prevalent diseases and medical conditions in this population (Directive to Take Action); and be it further

RESOLVED, that our AMA work with IHS and appropriate agencies and organizations to ensure that their National Core Formulary includes at least two standard-of-care drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients (Directive to Take Action); and be it further

RESOLVED, that our AMA support permanent reauthorization of the Special Diabetes Program for Indians (New HOD Policy); and be it further

RESOLVED, that our AMA support biannual inflationary increases for public health and health profession grants sponsored by IHS. (New HOD Policy)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 09/27/23

REFERENCES

1. Indian Health Service: Information on Third-Party Collections and Processes to Procure Supplies and Services. U.S. Government Accountability Office. Published online 2022. https://www.gao.gov/assets/gao-22-104742.pdf
2. Federal Register Volume 87, Issue 19 (January 28, 2022). Office of the Federal Register, National Archives and Records Administration. Published online 2022. https://www.govinfo.gov/app/details/FR-2022-01-28/2022-01789
3. Patient Resources. Indian Health Service. Accessed 2023. https://www.ihs.gov/forpatients/faq
4. Purchase/Referred Care (PRC): Requirements: Eligibility. Indian Health Services. Published online 2022. https://www.ihs.gov/prc/eligibility/requirements-eligibility
5. Indian Health Service (IHS) FY2022 Budget: Request and Funding History: In Brief. Congressional Research Service. Published online 2022. https://crsreports.congress.gov/product/pdf/R/R47004
6. Purchase/Referred Care (PRC). Indian Health Services. Published online 2022. https://www.ihs.gov/prc/
7. Requirements: Alternate Resources | Eligibility. Purchased/Referred Care (PRC). Accessed March 2023 https://www.ihs.gov/prc/eligibility/requirements-alternate-resources
8. Health Insurance Coverage and Access to Care for American Indians and Alaska Natives: Current Trends and Key Challenges. ASPE Office of the Assistant Secretary for Planning and Evaluation. Published online July 22, 2021. https://aspe.hhs.gov/sites/default/files/2021-07/aspe-aian-health-insurance-coverage-ib.pdf
9. 100% FMAP for LTSS — Educate Your State. Centers for Medicare and Medicaid Services. Published online November 15, 2022. https://www.cms.gov/outreach-and-education/american-indian-alaska-native/aian/ltss-ta-center/info/100-percent-fmap-educate-your-state#:~:text=CMS%20reimburses%20each%20state%20for,typically%20have%20a%20higher%20FMAP
10. Kalweit, Andrew, Chandos Culleen, and Isaiah O'Rear. Recent Trends in Third-Party Billing at Urban Indian Organizations: Impact of the American Rescue Plan Act and 100% FMAP Provisions. National Council for Urban Indian Health. Washington DC, 2022.
11. Urban Indian Organizations. Indian Health Service. https://www.ihs.gov/Urban/urban-indian-organizations
12. H.Res.1319 American Rescue Plan Act of 2021. US House. March 11, 2021. https://www.congress.gov/bill/117th-congress/house-bill/1319
13. Seattle Indian Health Board. Payment Parity for Indian Health Care Providers. Published online April 16, 2020. https://www.sihb.org/wp-content/uploads/SIHB-FMAP_FAQ_20200416_2.pdf
14. Lundberg, Laura, Sara Gentzler. Washington's Indian Health Improvement Act, explained. Washington State Wire. Published online June 5, 2019. https://washingtonstatewire.com/washington-state-passes-indian-health-improvement-bill
15. Calac A, Gasca L, Calac D. Reducing Health Disparities Through Achieving Pharmacoequity. JAMA. 2022;327(6):588-589. doi:10.1001/jama.2021.24516
16. Indian Health Service: About. National Pharmacy & Therapeutics Committee. Accessed March 2023. https://www.ihs.gov/nptc/about
17. Indian Health Services Releases Long-Awaited Update to Policy on Emergency Contraception. American Civil Liberties Union. Accessed March 2023. https://www.aclu.org/press-releases/indian-health-services-releases-long-awaited-update-policy-emergency-contraception
18. Indian Health Service: Chapter 15 - Emergency Contraception | Part 1. The Indian Health Manual (IHM). Published 2015. https://www.ihs.gov/IHM/pc/part-1/p1c15
19. Kingfisher P, The Native American Women's Health Education Resource Center. Indigenous Women' S Dialogue: Roundtable Report on the Accessibility of Plan B® as an over the Counter (OTC) within Indian Health Service.; 2012. http://www.nativeshop.org/images/stories/media/pdfs/Plan-B-Report.pdf
20. Indian Health Service. National Pharmacy and Therapeutics Committee Formulary Brief: Gender-Affirming Medications. Published February 2022. https://www.ihs.gov/sites/nptc/themes/responsive2017/display_objects/documents/guidance/NPTC-Formulary-Brief-Gender-Affirming-Medications.pdf
21. Wylie C Hembree, Peggy T Cohen-Kettenis, Louis Gooren, Sabine E Hannema, Walter J Meyer, M Hassan Murad, Stephen M Rosenthal, Joshua D Safer, Vin Tangpricha, Guy G T'Sjoen, Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, The Journal of Clinical Endocrinology & Metabolism, Volume 102, Issue 11, 1 November 2017, Pages 3869–3903, https://doi.org/10.1210/jc.2017-01658
22. Special Diabetes Program for Indians 2020 Report to Congress: Changing the Course of Diabetes: Charting Remarkable Progress [Internet]. Rockville (MD): Indian Health Service (US); 2020.

23. Bullock, A. et al. “Prevalence of diagnosed diabetes in American Indian and Alaska Native adults, 2006-2017.” BMJ open diabetes research & care vol. 8,1 (2020): e001218.
24. Advance Appropriations. National Indian Health Board. Accessed September 22, 2022. https://www.nihb.org/legislative/advance_appropriations.php
25. National Clinical Care Commission. Report to Congress on Leveraging Federal Programs to Prevent and Control Diabetes and Its Complications. Department of Health and Human Services. Published 2021. Accessed August 31, 2022. https://health.gov/sites/default/files/2022-01/NCCC%20Report%20to%20Congress.pdf
26. FY 2023 National Tribal Budget Formulation Workgroup. Indian Health Service. Published February 12, 2021. Accessed September 22, 2022. https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2023NationalTribalBudgetFormulationWorkSessionMaterials.pdf
27. National Indian Health Board. Increasing Funding for the Indians Into Medicine (INMED) Program. Resolution 22-05. Published 2022. Accessed August 31, 2022. https://www.nihb.org/docs/02252022/22-05%20NIHB%20Resolution%20on%20Increasing%20Funding%20for%20the%20Indians%20Into%20Medicine%20(INMED)%20Program.pdf

RELEVANT AMA POLICY

D-350.992 Medicaid Coverage for American Indian and Alaska Native Children
Our AMA will advocate for immediate changes in Medicaid regulations to allow American Indian/Alaska Native (AI/AN) children who are eligible for Medicaid in their home state to be automatically eligible for Medicaid in the state in which the Bureau of Indian Affairs boarding school is located. [BOT Action in response to referred for decision Res. 102, A-06; Reaffirmed: Res. 221, A-07; Reaffirmed: CMS Rep. 01, A-17]

H-350.948 Purchased and Referred Care Expansion
Our AMA will advocate for increased funding to the Indian Health Service Purchased/Referred Care Program and to the Urban Indian Health Program to enable the programs to fully meet the healthcare needs of American Indian/Alaska Native (AI/AN) patients. [Res. 209, A-23]

D-330.933 Restoring High Quality Care to the Medicare Part D Prescription Drug Program
Our AMA will:
a. work to eliminate prior authorizations under the Medicare Part D Prescription Drug Program which undermine a physician's best medical judgment;
b. work with the Centers for Medicare and Medicaid Services (CMS) to enforce the Medicare Part D Prescription Drug Program statutory requirement that all Part D plans include at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients;
c. work with CMS to place reasonable copays in the Medicare Part D Prescription Drug Program;
d. work with other interested parties to simplify the CMS prior authorization process such that a diagnosis or reason written on the prescription should be accepted as documentation for non formulary request; and
e. work with CMS to develop a one-page form for physicians and patients to utilize in appealing a prescription coverage denial. [Res. 106, A-07; Reaffirmation A-08; Reaffirmation A-14]

D-350.987 Strong Opposition to Cuts in Federal Funding for the Indian Health Service
1. Our AMA will strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers.
2. Our AMA will ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service.
3. Our AMA adopts as new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction.
4. In the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA will consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service.
5. Our AMA will request that Congress: (A) amend the Indian Health Care Improvement Act to authorize Advanced Appropriations; (B) include our recommendation for the Indian Health Service (HIS) Advanced

Appropriations in the Budget Resolution; and (C) include in the enacted appropriations bill IHS Advanced Appropriations. [Res. 233, A-13; Appended: Res. 229, A-14]

H-440.844 Expansion of National Diabetes Prevention Program
Our AMA: (1) supports evidence-based, physician-prescribed diabetes prevention programs, (2) supports the expansion of the NDPP to more CDC-certified sites across the country; and (3) will support coverage of the NDPP by Medicare and all private insurers. [Sub. Res. 911, I-12; Reaffirmed: CSAPH Rep. 1, A-22]

H-350.976 Improving Health Care of American Indians
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations. [CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09, A-23]