ALASKA NATIVE
TRIBAL HEALTH
CONSORTIUM

Federal Indian Health Policy & the Tribal Health Care Delivery System

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ANTHC Intergovernmental Affairs

Presentation Overview

1. Federal Trust Responsibility for Health Care
2. Overview of the IHS System
3. The Alaska Tribal Health System
4. Health and Funding Disparities
5. Discussion/Q&A

Federal Trust Responsibility

Origins --

- U.S. Constitution
  - Indian Commerce Clause
  - Treaty Clause
  - Supremacy Clause
- Treaties, Executive Orders, Court Decisions
- Cession of over 400 million acres of land by tribes to the United States

Federal Trust Responsibility

- No single definition or context
- No bright-line parameters
- Encompasses political, social, economic interaction between Federal Government and Indian tribes

Federal Trust Responsibility

- Existence of Federal Trust responsibility is recognized in--
  - Court decisions
  - Federal laws
  - Federal and State regulations
  - Executive Orders; Presidential directives
  - Agency policy statements
  - Course of dealings with Indians
- Acknowledged by all branches of Federal Government

Federal Trust Responsibility

Judicial recognition of Federal Trust Responsibility

Cherokee Nation v. Georgia (Sup. Ct. 1831)

- Described Indian tribes as "domestic dependent nations"
- Tribe-U.S. relationship "resembles that of a ward to his guardian"

Federal Trust Responsibility

Morton v. Mancari (Sup. Ct. 1974)

- Established "rationally related" standard of review for Indian-specific laws
- Law will not be disturbed if rationally tied to Congress's "unique obligation" to Indians
- political rather than racial classification

Federal Trust Responsibility

Statutory recognition

- Snyder Act (1921)
  - permanent authorization of appropriations "for the benefit, care, and assistance of the Indians throughout the United States"
  - "conservation of health"
  - employment of physicians
  - recognized that U.S. has a responsibility to perform regarding Indians

Federal Trust Responsibility

- DOI Authority to contract with Private and Public entities to provide health care services to Indian people (1934)
- Transfer Act (1954)
  - transferred responsibility for Indian health from BIA to Department of HEW (now HHS)
  - objective: improve health care for Indians
  - creation of Indian Health Service

Federal Trust Responsibility

Self-Determination Era (1970's-today)

"[W]e have turned from the question of *whether* the Federal government has a responsibility to Indians to the question of *how* that responsibility can best be fulfilled."

President Nixon, 1970

Federal Trust Responsibility

- Themes of Nixon Message
  - recognized U.S. "solemn obligations" to Indians
  - U.S. must do better job at performing these obligations
  - involve Indians in --
    - policymaking
    - program operations
    - financial management

Federal Trust Responsibility

Indian Self-Determination Act (1975)

- Federal domination obstructs Tribal progress
- Authority for tribal operation of programs
  - IHS and BIA directed to contract with tribes
- Preserved trust responsibility
- Amendments further enhanced tribal authorities

Tribal Self-Governance Era (1987 & 1994)

Federal Trust Responsibility

Indian Health Care Improvement Act (1976)

- Permanently Reauthorized by the Patient Protection and Affordable Care Act (ACA)
  - Recognized health disparities in Indian Country
  - Re-affirmed U.S. legal obligation for health care for Indian people
  - Framework and direction for delivery of health services
  - Tribal involvement in health programs
  - Reauthorization effort is constant and continues today

Federal Trust Responsibility

- Medicare, Medicaid
  - First part of IHCIA (1976)
  - IHCIA creates authority for IHS, tribes to collect M+M
  - Active efforts to increase Tribal enrollment in M+M
  - Congress intent to improve Indian health facilities
  - 100% FMAP for Medicaid
    - U.S. obligation for Indian health
    - Linked to "...services provided <u>through</u> IHS facilities..."

Federal Trust Responsibility

- Children's Health Insurance Program
  - Enacted 1997
  - Access for low-income Indian children
  - CMS bars cost-sharing for Indian children
    - Unique federal relationship with Indian tribes
    - November 3, 2000 HCFA Tribal Leader Letter
    - October 6, 1999 SMD Letter
    - Carve-out of CHIP grants to Tribes

Federal Trust Responsibility

- Medicare Modernization Act (2003)
  - express access for IHS, tribal, urban Indian organization (I/T/U) pharmacies
    - authority for Secretary to issue standards to assure access to Rx Drug Plans
  - CMS requirements for Rx Drug Plans to offer network contracts to I/T/U pharmacies
    - Model tribal addendum in regulation
  - Medicare-like Rates for Purchased and Referred Care Services linked to Medicare participation

American Reinvestment & Recovery Act

- Indian Specific Provisions
  - Provided over $5 billion in Tribal set-asides
  - $500 million for Indian health
- Social Security Act Amendments
  - Exempts AI/AN from cost sharing in Medicaid, and CHIP
  - Estate Recovery Exemptions
  - Established a TTAG to consult with Centers for Medicare & Medicaid Services
  - Indian Managed Care Entities

Affordable Care Act

- Permanent authorization of the IHCIA
- Individual Mandate
  - National requirement* to have health insurance coverage but exempts AI/AN from tax penalty
- Insurance Exchanges – 3 key provisions
  - Exempts Indians from cost-sharing up to 300% FPL & under PRC referral (any FPL) & thru I/T/U
  - Special enrollment period – monthly (Portability of coverage)
- Tax exemption on Tribal-provided resources
  - Excludes from gross income the value of health benefits, care, coverage provided by IHS and Tribal organizations (ISDEAA)

Federal Trust Responsibility

Presidential Policy Statements

- Unique relationship with Indian tribes recognized by all recent Presidents
  - Executive Orders, Memoranda to agencies
- Government-to-Government relationship
- Tribal consultation policies
  - Department of Health and Human Services
  - Indian Health Service, Bureau of Indian Affairs
  - Centers for Medicare & Medicaid Services; and the CMS Tribal Technical Advisory Group
  - All U.S. Departments and most all Executive Agencies have a Tribal Consultation policy

Federal Trust Responsibility - Conclusion

- Constitution, court decisions, special statutes, and regulations set the foundation for the IHS and the Tribal health system
- U.S. has obligation to --
  - "assure highest possible health status for Indians“
  - "provide all resources necessary“
  - When operating federal programs states share responsibility
- Trust responsibility for Indian health --
  - Justifies protection of Medicaid & SCHIP revenues for Indian health programs
  - Significant health disparities demands such protection

Future Challenges

- Policy shift by Congress and Administration not to provide adequate health funding
  - Abrogation of federal trust relationship
  - Subjecting Tribes to grants vs. appropriations
  - Discretionary vs. entitlement funding
  - More reliance on Medicaid/Medicare—alternate resources
- Civil Rights issues associated with federal trust relationship
- Growing population and eligibility issues
- Misconception of gaming & Tribes getting “rich”

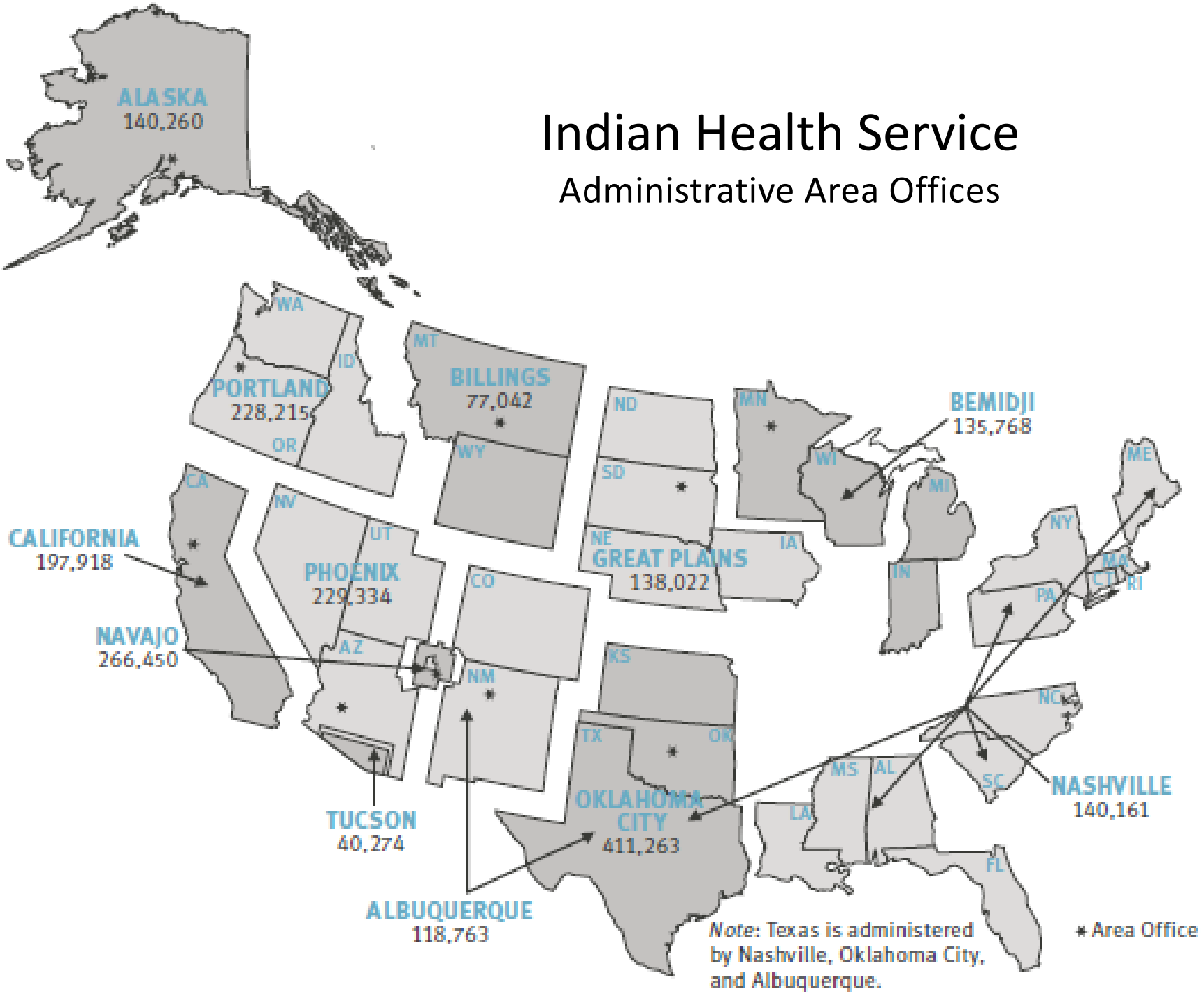
Overview of the IHS System

The Indian Health System

- IHS established in 1955 (after Transfer Act passed)
- Provides health care for 574 federally recognized tribes
- Over 600 health facilities in 35 different states
  - 46 hospitals and 556 ambulatory clinics
    - 335 health centers; 16 school health centers; 78 health stations, and 127 Alaska village clinics
  - 34 Urban Indian Health programs
- Divided into 12 administrative units call--“Areas Offices”
  - Alaska Area is the entire state
  - Most IHS Areas encompass several states
  - Navajo Nation is one Area Office covering 3 states
  - Tucson Area – 2 tribes

Indian Health Service

Administrative Area Offices

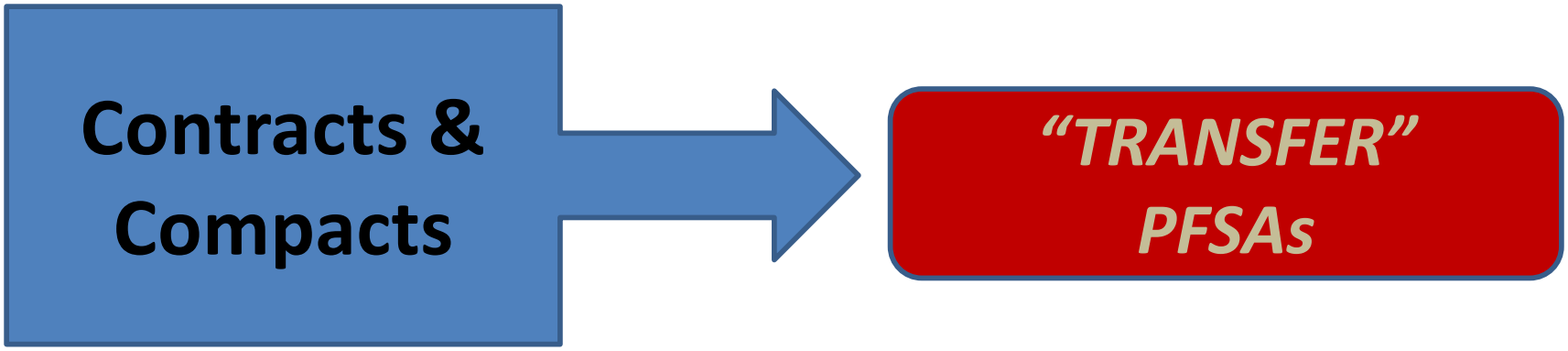


Indian Health Delivery System

- Indian Health Programs can be grouped into 3 categories:
  1. IHS Directly Operated
  2. Tribally Operated (P.L. 93-638)
     - Title I contracting – Self-Determination programs
     - Title V compacting – Self-Governance programs
  3. Urban Indian Health Organization
- Commonly referred to as the “I/T/U”

Structure of the Indian Health System

- **Direct Service =** Health Programs operated by the Federal Government (Indian Health Service)
- **Contracts** = Programs operated by Tribes under the ISDEAA (Title I, P.L. 93-638)
- **Compacts** = Programs operated by Tribes under Self-Governance process (Title V, P.L. 93-38)



Indian Health System

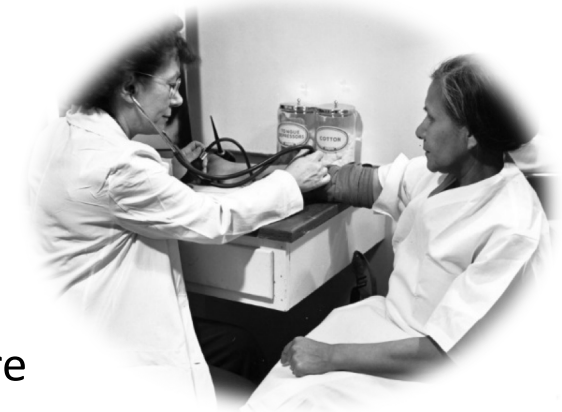
- Types of Health Services
  - Ambulatory Primary Care (outpatient care)
  - Inpatient care - Hospitals
  - Medical specialties
  - Dental and Vision Care
  - Behavioral health services
  - Specialty Care Services (PRC)
  - Traditional healing practices
  - Outreach and referral programs (UIHOs)

Alaska Tribal Health System

Next slides courtesy of Alaska Native Health Board; and
TSGAC presentation by Dave Mather and Lee Olson

Alaska Native health Delivery history

- 1900-1970: Health care for Alaska Natives was provided by the U.S. government



- 1970-1998: Alaska Native tribes established health care organizations under Self-Governance legislation and gradually assumed management and ownership of health services at regional and tribal levels

- 1998-2015: All Alaska Native health care is provided by Alaska Native organizations
  - Represents 229 Tribes
  - Serves 170,000 Alaska Natives/American Indians
  - 586,412 square miles of predominantly road-less land

Self-Determination in Alaska

- Alaska has a long history of regional and statewide tribal political activism, self-determination and working together dating back to before the Alaska Federation of Natives (AFN) was founded in 1966 to respond to indigenous land claims which were eventually recognized in the Alaska Native Claims Settlement Act (ANCSA) in 1971.
- The Yukon Kuskokwim Health Corporation and Norton Sound Health Corporation first contracted to operate the IHS Community Health Aide program in 1972.
- Following passage of the ISDEAA Alaska Tribal Organizations began the self determination process by contracting village and community health services.
- Throughout the 1980s and early 1990s the Alaska Tribal Health System was focused on assuming Tribal control of IHS operations in Alaska.
- By 1995 the Alaska Compact was created and all IHS operating units in Alaska were operated by Tribal Health Organizations (THO's) except the Anchorage Service Unit, and the statewide Alaska Native Medical Center (ANMC).

Self-Determination in Alaska

- In 1997 the Alaska Native Tribal Health Consortium was authorized by Congress to contract for the statewide health services of the Alaska Area Office and, in cooperation with the Southcentral Foundation, operate the Alaska Native Medical Center.
- The Alaska Tribal Health System is now fully tribally controlled and operated.
- The ATHS is focused on continually improving quality and access to care, providing comprehensive environmental and sanitation services, and increasing the level of Native health services throughout Alaska.

The Alaska Compact

- Established in FY1995 to support and encourage all tribal health providers in Alaska to support statewide and local tribal control of an integrated health care system.
- Established to avoid competition between Alaska Tribes and Tribal Organizations (at a time when the Tribal Self-Governance demonstration project was underway and limited the number of Tribes eligible each year).
- When established a multiparty compact was not envisioned by the IHS – but the Alaska Compact was supported by the Area Director.
- Was open to any Alaska T/TO eligible for Self-Governance.
- Was designed to support local control and sovereignty (individual funding agreements) while supporting and enhancing the statewide Native Health Care System (consensus decision making, joint negotiations and common resource distribution recommendations).

The Alaska Compact

- Single Title V Compact Agreement and 25 separate co-signer Funding Agreements with individual funding tables for each co-signer.
- Authorized by 221 of 229 Alaska tribes and serves all AN/AIs in the Alaska Area.
- Includes over $750 million dollars or 98% of the IHS funding in the state.
- The Alaska Compact represents over 40% of all Self-Governance funding in the United States.

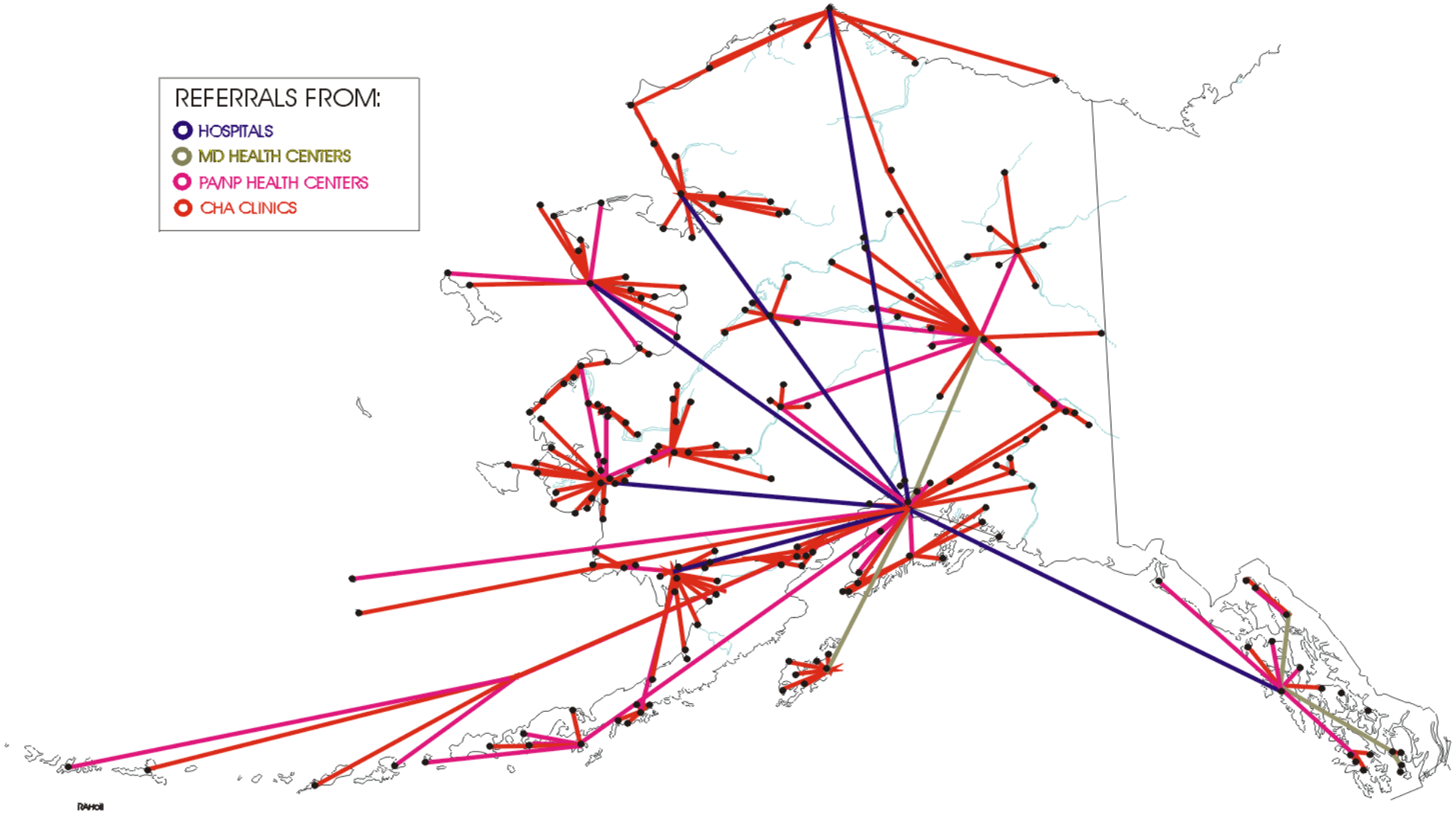
Alaska Co-signers

- All co-signers rely on the common Alaska Tribal Health Compact- a perpetual agreement. There are no other Title V compacts in the Alaska Area and only a few very small Title I contracts for single villages or programs.
- Co-signers negotiate individual Funding Agreements (annually or less frequently) and annual funding tables.
- Co-signers are extremely diverse, ranging in size from small single villages serving less than ~50 members to the Alaska Native Tribal Health Consortium serving the entire state (over 150,000).
- Financially the co-signers are very different as well ranging from small community health programs under $60,000; to a large statewide medical center and environmental health program with over 2,000 employees and a budget over $400 million.

Alaska Statewide Health System

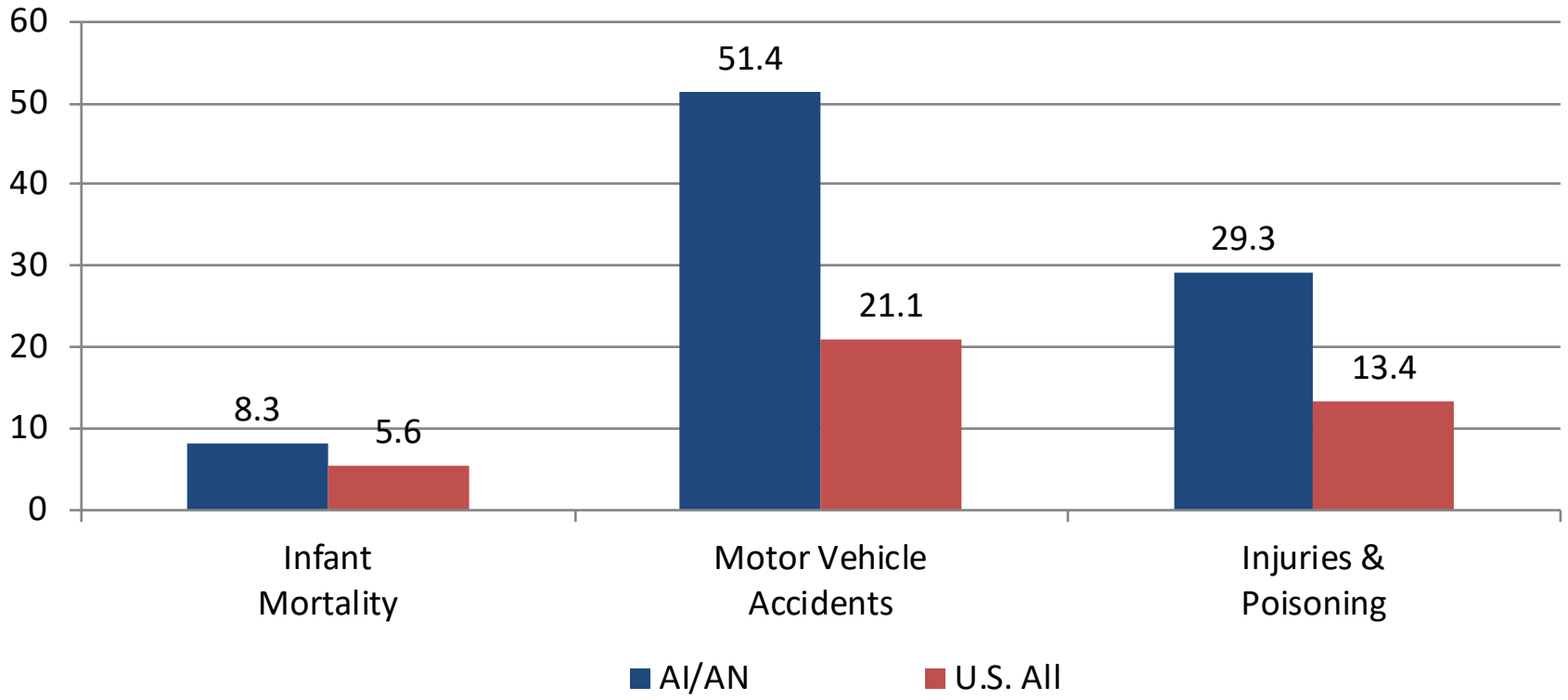
- The Alaska Compact is designed to support an integrated statewide Tribal Health System.
- The Alaska Tribal Health System (compact) has over 7,500 employees in Alaska. The IHS has 35 (residual and transitional) federal employees at Area Office.
- The Alaska Tribal Health System (compact) has:
  - 180 small community primary care centers in village clinics
  - 25 subregional mid-level care centers
  - Seven (7) multi-physician health centers
  - Six (6) regional hospitals
  - Alaska Native Medical Center: tertiary care center
  - Referrals to private medical providers and other states for complex care ("purchased and referred care")

Alaska Tribal Health System Referral Patterns



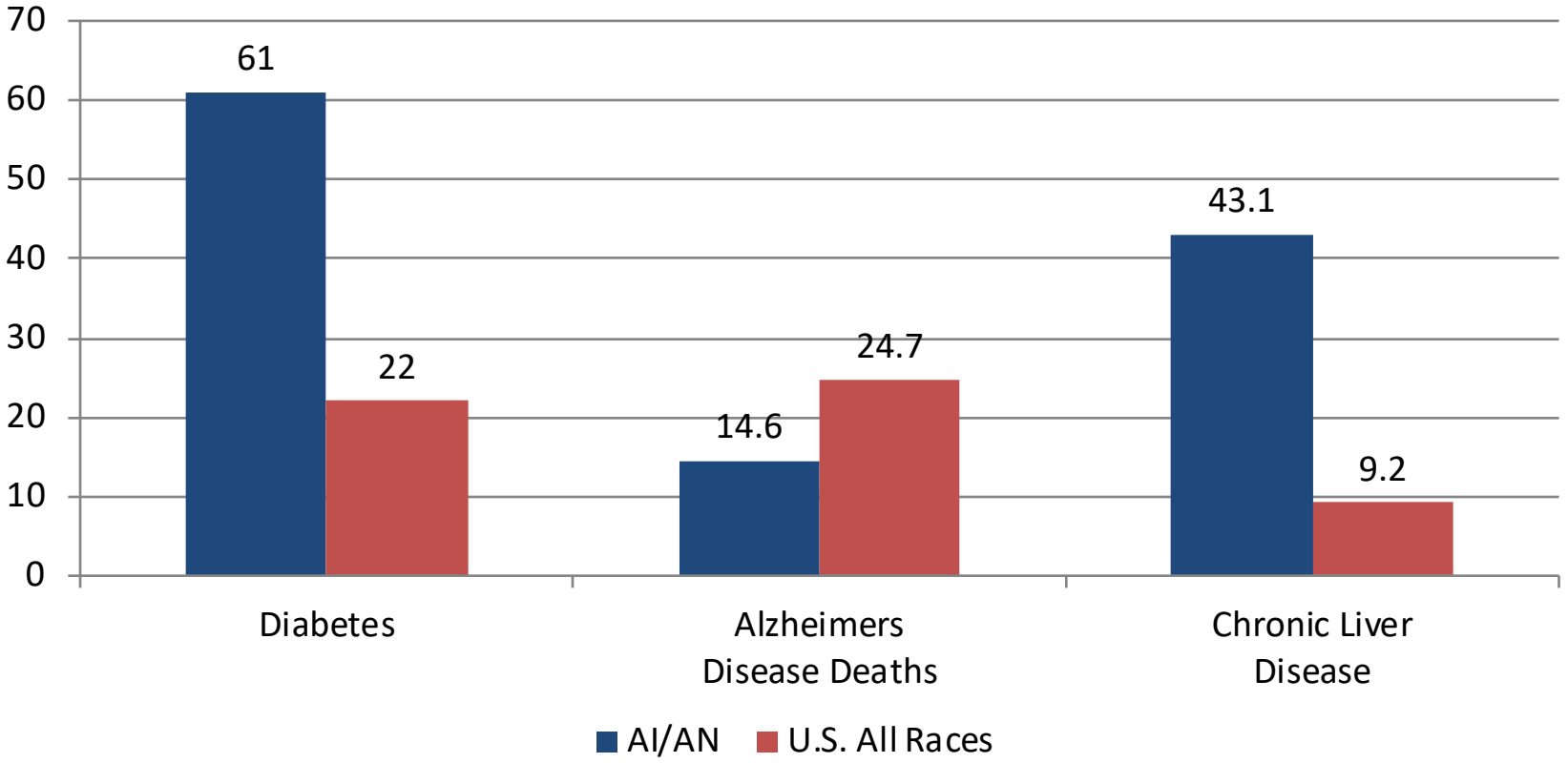
Significant Health and Funding Disparties

Indian Health Disparities
Preventive Health



Source: "Trends for Indian Health 2014 Edition," Indian Health Service, available www.ihs.gov.
AI/AN, IHS Service Areas, and U.S. All Races (Age-Adjusted Death Rates per 100,000 Population).

Indian Health Disparities
Chronic Disease



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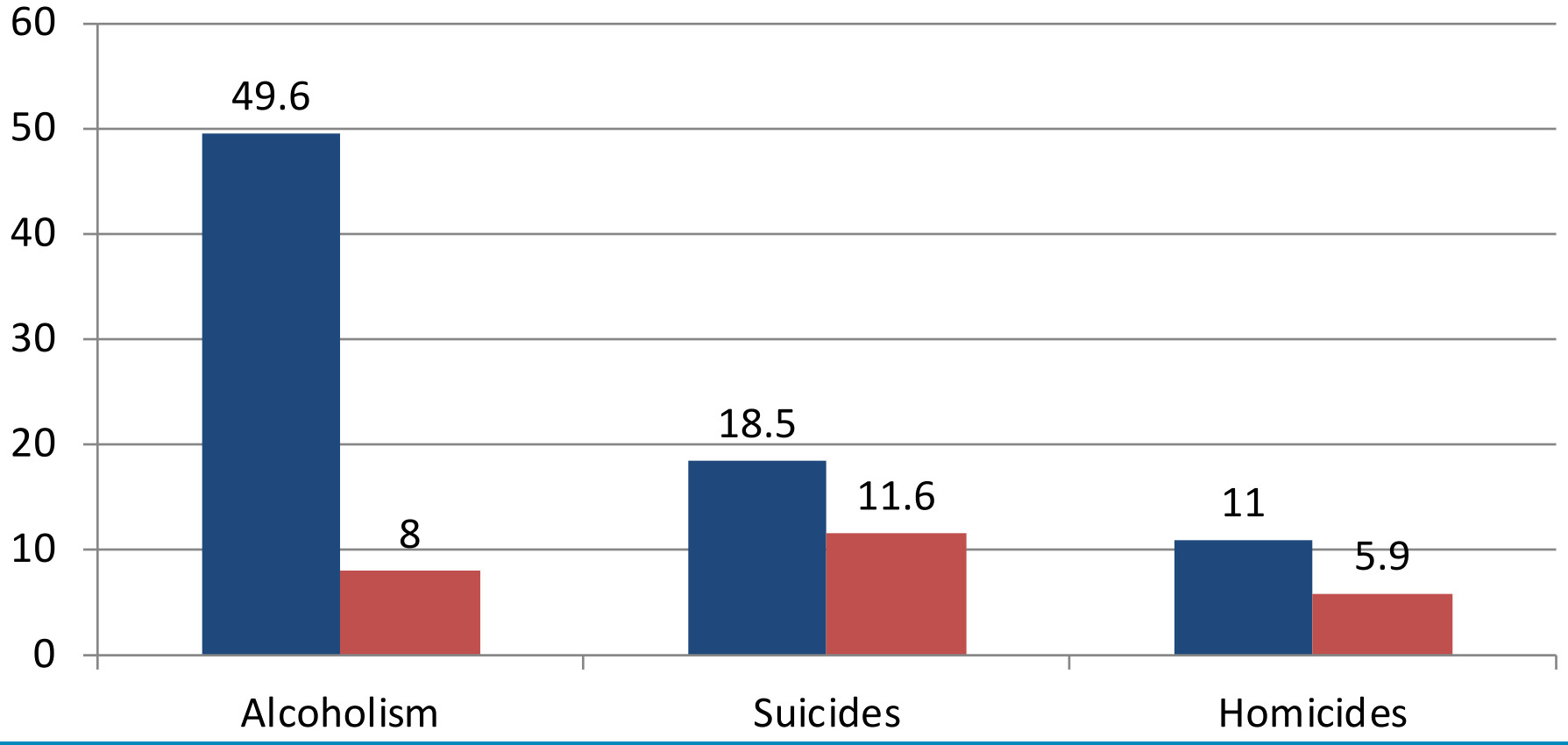
AI/AN, IHS Service Areas, and U.S. All Races (Age-Adjusted Death Rates per 100,000 Population).

Indian Health Disparities
Behavioral Health



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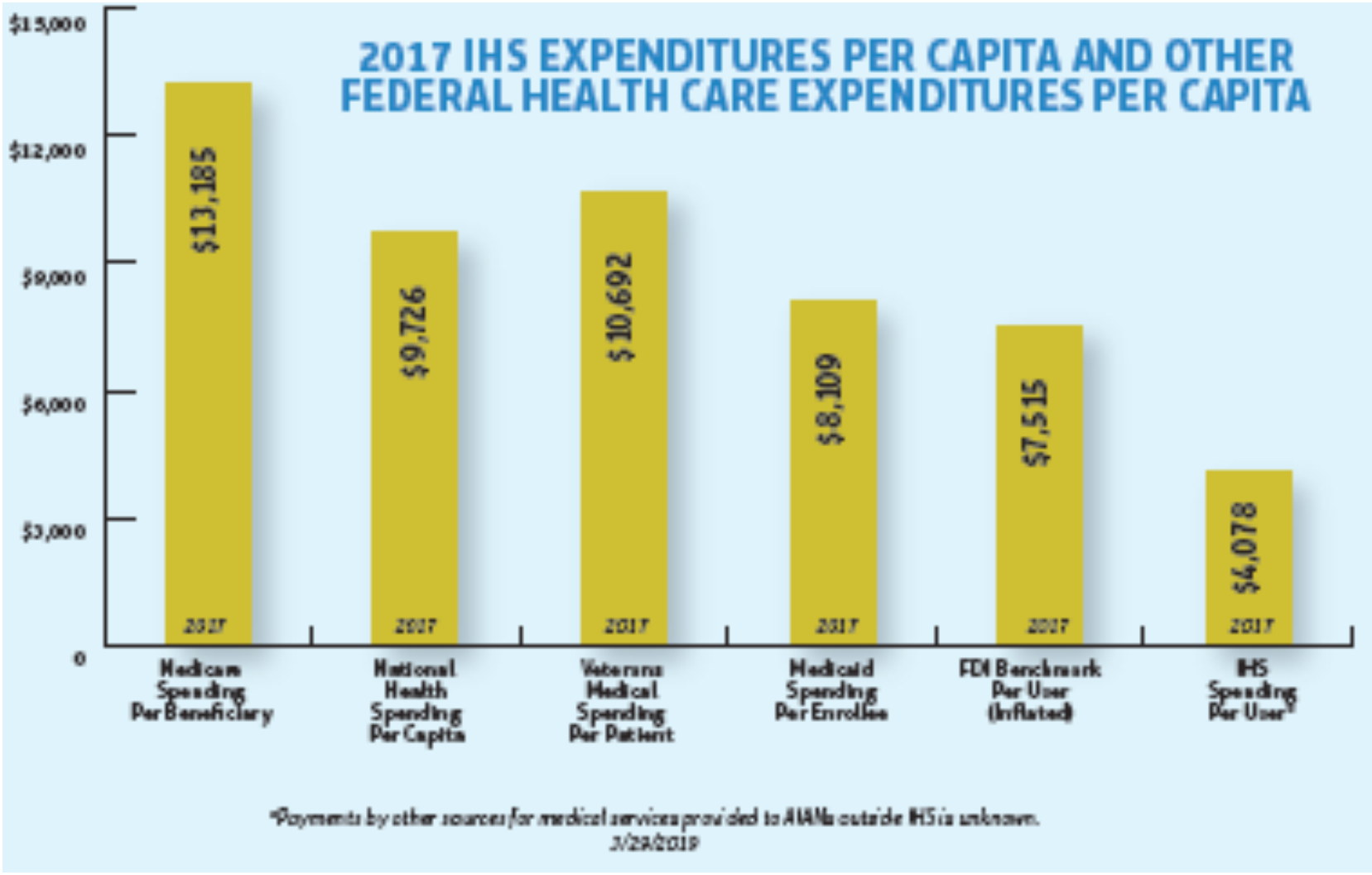
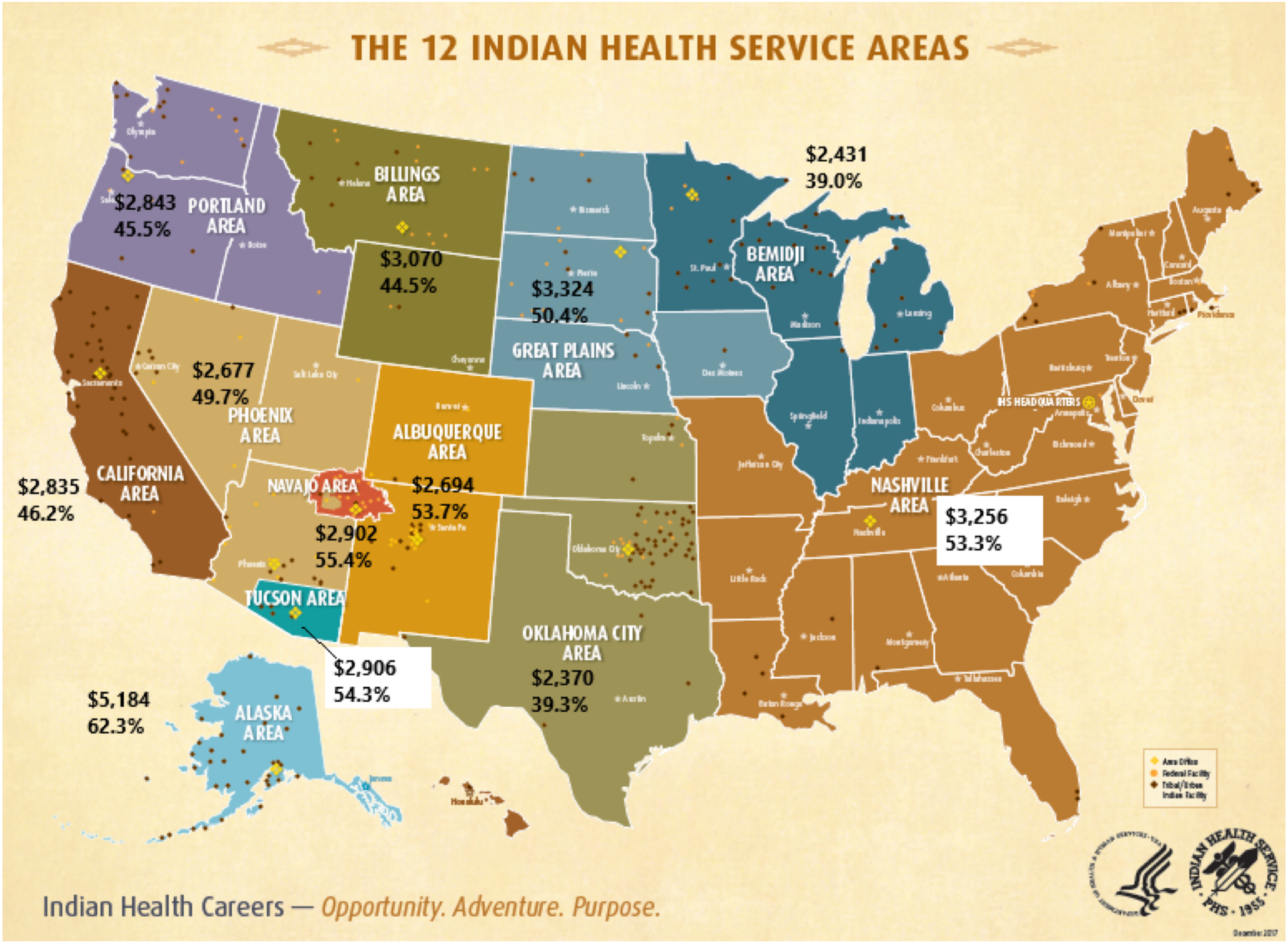
Indian Health System – Disparities



THE 12 INDIAN HEALTH SERVICE AREAS



Indian Health Careers — *Opportunity. Adventure. Purpose.*

December 2017

Table 4B -- Indian Health Care Improvement Fund Allocations by Area

Roll-up by IHS Area: $ Needed, $ Alternate, Net $ Needed, $ Available, LNF %, $ Allocation

$72,281,000 Allocated to 40 Sites Having LNF% < 34.84%

Applying Individual State Estimates of Medicaid, Medicare and Other Public Coverage -- Source ACS

A		B	C	D	E	F	G	H	I	J	K	L	L
			GROSS RESOURCES NEEDED (For the Population)		ALTERNATE RESOURCES (From Other Payers)		NET RESOURCES NEEDED (For the IHS System)		RESOURCES AVAILABLE (For the IHS System)		AVERAGE LNF RATE	FY 2018 IHCIF ALLOCATION	
IHS Area	# Local Service Areas	Population	$ / Person	Total $ B x C (millions)	$ / Person	Total $ B x E (millions)	Net $ / Person C - E	Net Total $ B x G (millions)	$ / Person	Total $ B x I (millions)	For the IHS System I / G	# of Recipient Service Areas	Recipient Allocations Subtotal
ALASKA	34	166,431	13,130	2,185	4,811	801	8,319	1,384	5,184	863	62.3%	0	$ -
ALBUQUERQUE	9	84,379	9,526	804	4,508	380	5,018	423	2,694	227	53.7%	0	$ -
BEMIDJI	34	120,684	9,782	1,181	3,544	428	6,238	753	2,431	293	39.0%	9	$ 6,623,820
BILLINGS	8	73,534	10,050	739	3,146	231	6,904	508	3,070	226	44.5%	1	$ 2,807,581
CALIFORNIA	30	90,678	9,672	877	3,542	321	6,130	556	2,835	257	46.2%	7	$ 2,280,111
GREATPLAINS	19	133,994	10,468	1,403	3,875	519	6,594	884	3,324	445	50.4%	1	$ 2,173,378
NASHVILLE	29	63,448	9,186	583	3,074	195	6,112	388	3,256	207	53.3%	5	$ 1,731,625
NAVAJO	22	227,926	9,306	2,121	4,072	928	5,234	1,193	2,902	661	55.4%	0	$ -
OKLAHOMA	26	385,520	8,545	3,294	2,514	969	6,031	2,325	2,370	914	39.3%	13	$ 48,987,791
PHOENIX	23	175,995	9,152	1,611	3,769	663	5,383	947	2,677	471	49.7%	1	$ 2,252,108
PORTLAND	44	116,660	9,927	1,158	3,681	429	6,246	729	2,843	332	45.5%	3	$ 4,423,586
TUCSON	2	26,687	9,272	247	3,915	104	5,356	143	2,906	78	54.3%	0	$ -
L48 States	246	1,499,505	9,348	14,018	3,447	5,169	5,901	8,848	2,742	4,111	46.5%	40	$ 71,280,000
All States	280	1,665,936	9,726	16,203	3,584	5,970	6,142	10,233	2,986	4,974	48.6%	40	$ 71,280,000

Questions/Discussion

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OUR VISION:

Alaska Native people are the healthiest people in the world.

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