Senator Dorgan Staff Concept Paper:
REFORMING THE INDIAN HEALTH CARE SYSTEM

History and Background on the Indian Health Care System

The United States federal government has a responsibility to provide a variety of services and benefits to American Indian Tribes, Alaska Native Villages and individuals. For the last two centuries, the United States has provided health care to American Indians and Alaska Natives (AI/AN) as a part of this responsibility.

The majority of health services for AI/ANs are provided through the Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS). The IHS provides a comprehensive health care delivery system serving approximately 1.9 million AI/ANs living on or near reservations in 35 states. Health care services are provided using three methods: [1]

- **Indian Health Service (IHS) direct health care services.** IHS services are administered through a system of 12 Area offices and 161 IHS and tribally managed service units.
- **Tribally-operated health care services.** Tribal facilities are operated under the authority of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended), Titles I and V. There are 73 Title V compacts, funded through 94 Funding Agreements, totaling over $1 billion. These compacts represent 323 Tribes, more than half of all the federally recognized Tribes. There are also approximately 238 Tribes and tribal organizations that contract under Title I, with a total funding amount of $425 million. Overall, over 40% of the appropriated IHS budget authority is administered by Tribes, primarily through Self-Determination contracts or Self-Governance compacts.
- **Urban Indian health care services and resource centers.** There are 34 urban programs, ranging from community health to comprehensive primary health care services. Approximately 600,000 AI/ANs reside in counties served by urban Indian health programs.

For over a decade, Indian Country and Congress have engaged in efforts to improve the current federal system for providing health care to AI/ANs. In the 110th Congress, the United States Senate passed a bill that reauthorized and improved the current system. Unfortunately, this bill was unable to be approved by the House of Representatives.

Since last Congress, the Senate Committee on Indian Affairs has continued the dialogue with Indian Country regarding how to move forward with improving the Indian health care system

[1] Indian Health Service Fact Sheet – Year 2009 Profile, January 2009

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and ensuring that the federal government fulfills its obligation to provide health care to its First Americans. Committee staff attended numerous national and regional meetings with tribal leaders and tribal organizations to discuss approaches to broader Indian health care reform beyond merely reauthorizing the current system. The Committee has also held at least three hearings on health care related matters this year.

This concept paper offers ideas, proposals and areas for further discussion for reforming certain aspects of the current health care system based upon the meetings between Committee staff and Indian tribes, Committee hearings, and correspondence received from Indian Country. The Committee hopes to soon draft legislation to address some of these issues.

The new bill will endeavor to improve and reform the current Indian health care system. Provisions that accomplish the following will be contained in a new Indian health care bill:

- Meet Indian Country Health Care Priorities;
- Increase Access to Care;
- Expand prevention, intervention and treatment activities;
- Increase Access to Alternate Resources;
- Address the needs of Urban Indian programs;
- Provide a framework for an Indian health care delivery system that complements and benefits from any system designed to address national health care reform; and
- Provide authorities for essential miscellaneous provisions.

The focus on national health care reform, by the President and Congress, presents a unique opportunity for Indian Country to look beyond merely reauthorizing the Indian Health Care Improvement Act (IHCIA). The Committee is committed to taking advantage of this unique political opportunity to advance the health care needs of Indian Country.

Meet Indian Country Health Care Priorities

The resounding priority of tribes/tribal organizations is to reauthorize the IHCIA. Unfortunately, history has proven that this will not be accomplished quickly or easily. The last major action regarding IHCIA occurred in 1992. In 2001, a simple one-year reauthorization was accomplished. During the 110th Congress, S. 1200, the Indian Health Care Improvement Act Amendments of 2007, was passed in the Senate, but the House was unable to pass the legislation.

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Were it not for the Snyder Act of 1921, the IHS would not have been authorized to receive appropriated resources to provide health care services to the AI/AN population after the expiration of the IHCIA in 2002. The IHCIA was initially enacted to address the alarming health disparities that plagued the AI/AN population as compared to the U.S. general population. The fact that many of those disparities still exist or have become worse[2] is indicative of the critical need to reauthorize the IHCIA as a first step toward meeting the U.S. federal government's commitment to raising the health status of AI/ANs.

The comprehensive Indian health care delivery system is chronically under-funded and the lack of authority to obtain funding for modern health care is absent. A number of existing authorities remain unfunded, as well, but without authorization funding cannot be appropriated.

Proposed solutions:

- **Amend and enhance the Indian Health Care Improvement Act for introduction within the 111th Congress.**
- **Elevate the IHS Director to Assistant Secretary and make the authorizations contained in the Act permanent.**

Increase Access to Care

Despite the comprehensive health care delivery system that exists to serve AI/AN people this population remains extremely vulnerable. A vast majority of the lands inhabited by American Indian Tribes and Alaska Native Villages are geographically remote and not easily accessible. In many cases, the IHS and/or tribally operated health care facility is the only place health services are provided on or near reservations/villages. The limited access to health care services is further exacerbated by the high clinician vacancy rates experienced by IHS/tribally operated facilities[3] and rural areas across the nation. To make matters worse, there is a lack of authority to request funding for services more easily accessible to the U.S. general population.

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[2] IHS Fact Sheet – Indian Health Disparities, June 2008 -- American Indians and Alaska Natives die at higher rates than other Americans from tuberculosis (750% higher), alcoholism (550% higher), diabetes (190% higher), unintentional injuries (150% higher), homicide (100% higher), and suicide (70% higher).

[3] As of January 2008 vacancy rate percentages were reported, by IHS, for the following categories: Dentist (32%), Nurse (19%), Physician (18%), Optometrist (13%), and Pharmacist (11%).

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Proposed solutions:

Authorize Long-term care services and support including, but not limited to, nursing home, home health, assisted living, community-based and hospice care. In current law, very little or no authorization exists for IHS/Tribal programs to use appropriated funds to offer these systems of care.

Develop methods to increase clinician recruitment and retention issues. Some of these methods could include tax-incentives for scholarship recipients, allowing tribally-operated programs to hire health care professionals licensed, in good standing, in at least one state, as the Indian Health Service does.

Extend Federal Tort Claims Act (FTCA) coverage. Extend FTCA coverage to health care professionals willing to donate their time, services and/or facilities to serving eligible IHS beneficiaries.

Develop a demonstration program with a goal of addressing the chronic shortages of health care professionals in the Indian health care delivery system. This demonstration program is intended to allow IHS/tribal programs to develop creative and innovative methods to offer quality health care utilizing qualified health care professionals, including training and support for alternative provider types, such as community health representatives, community health aides and behavioral health aides; and allowing Veteran's Affairs (VA) personnel to work within an IHS/tribal facility

Authorize tribes and tribal organizations to use appropriated funds and Medicare/Medicaid revenue to purchase health benefits coverage. This provision would authorize tribes and tribal organizations to use appropriated funds and Medicare/Medicaid revenue to purchase health benefits coverage for eligible IHS beneficiaries without tax penalties assessed against tribal governments or individual recipients.

Develop a demonstration program with a goal of allowing IHS/tribal facilities to offer alternative methods of delivering health care services. This demonstration program is intended to allow IHS/tribes to offer convenient health care services through extended clinic hours/weekends or in satellite clinics readily accessible to community members.

Develop a demonstration program with a goal of providing telemental health services. This demonstration program is intended to allow IHS/tribal programs to use telemedicine approaches to increase access to mental health services with the expressed focus on suicide prevention.

Develop methods to increase access to National Health Service Corps and U.S. Public Health Service Commission Corps health care professionals. Current formulas used to designate shortage areas for the National Health Service Corps preclude IHS/tribal programs because of small service populations. Additionally, some tribally-operated programs do not access U.S. Public Health Service Commission Corps due to costs associated with doing so.

Designate North Dakota and South Dakota as a contract health service delivery area (CHSDA). The Standing Rock Sioux reservation straddles the North and South Dakota state line which can create access problems for Standing Rock Sioux tribal members. Additionally, there are a number of North and South Dakota tribal members who are eligible IHS beneficiaries living within the states, but not in an identified CHSDA.

Authorize access to Federal Employees Health Benefits Program (FEHBP). This concept would allow tribal health programs established under the Indian Self-Determination and Education Assistance Act (ISDEAA) to offer FEHBP coverage to their individual employees.

Reforming the Contract Health Service program. The Senate Committee on Indian Affairs held a Contract Health Service (CHS) oversight hearing on June 26, 2008. During this hearing each testimonial concentrated on the lack of funding. It has been estimated that CHS is funded at a level of approximately 50% of need. Although there is definitely a need for additional funding for this program, it is not the only issue that needs to be addressed. In order to raise the health status of AI/AN people, Congress could look to innovative, new and more cost effective approaches to purchasing health care outside of the Indian health care delivery system. Considerations for reforming the contract health service program might include the manner in which it is funded, the purposes for which it is used, and how contract health funds are allocated among the area offices or service units.

Eligibility for Indian Health Care Services. There continue to be inquiries regarding eligibility as related to accessing services from the Indian health care delivery system. The discussion is not centered on who is eligible for tribal membership (as that is a sovereign issue for each tribal government to decide), but rather on which individual Indians (whether enrolled, or not enrolled) should receive health care services through the Indian health care system.

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Service provision to non-IHS eligible beneficiaries. There have been inquiries regarding providing health care services to non-IHS eligible beneficiaries. Considerations for evaluating services to non-IHS eligible beneficiaries in the context of the national health care reform may include 1) whether and how the FTCA should be expanded to cover the services to these individuals, and 2) how serving these individuals is affected by the shared services and facilities between the Indian health system and other systems such as the VA, and by expansions of Medicare, Medicaid, and SCHIP reimbursements.

Expand Prevention, Intervention and Treatment Activities

In the words of Benjamin Franklin, "an ounce of prevention is worth a pound of cure". That quote is especially important in today's society; when rates of preventable diseases and chronic conditions are skyrocketing at an alarming pace. The high rates of diseases and/or chronic conditions that AI/AN people suffer from are largely preventable and the long-term cost of prevention is much lower than the cost for treatment.

Targeted prevention efforts have been shown to work well within AI/AN communities. This was proven with the Special Diabetes Program for Indians (SDPI). The SDPI was able to demonstrate that key health indicators—including blood sugar control, cholesterol levels, and kidney function—have improved among AI/ANs with diabetes each year since the Special Diabetes Program for Indians was created in 1997. These improvements not only help people with diabetes achieve better health, but also help the Indian health system reach cost-effectiveness, realize cost savings, and reduce the cost burden of diabetes for all of society.[4]

Proposed solutions:

Authorize additional cancer screening. Current law only provides for mammographies and pap smears as a part of a women's health screening package. This provision would update current law standards for cancer screenings including, but not limited, to prostate, lung and liver cancers. [5]

Authorize a comprehensive behavioral health approach to mental health services. In current law, very little is offered for mental health services beyond those related to alcohol/substance abuse. Comprehensive behavioral health would provide a coordinated and wide-range of care that may be tailored for the patient and their families.

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[4] IHS Fact Sheet – Special Diabetes Program for Indians: Improving Diabetes Health Outcomes, June 2008

[5] AI/AN men were almost twice as likely to have liver and Intrahepatic Bile Duct (IBD) cancer than non-Hispanic white males and AI/AN women were 2.4 times as likely to have the same kind of cancer than non-Hispanic white women, OMH – Cancer and American Indians/Alaska Natives, April 1, 2009

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Designate Tribal Epidemiology Centers as Public Health Authorities. This revision to current law would give tribal epidemiology centers access to IHS health data which they need to do their jobs.

Authorize establishment of an Indian Men's Health program. An Indian Women's Health Program has been established within the IHS Maternal Child Health Program, but there is not a companion program for Indian men.

Permanently authorize the Special Diabetes Program for Indians (SDPI). To continue the progress that has been made under the SDPI with expressed directives to implement best practices learned at all IHS/tribal sites.

<u>**Increase Access to Alternate Resources**</u>

The historic and chronic under-funding of the IHS has required IHS, tribal and urban facilities to maximize the collection of third-party resources to supplement appropriated funds. Out of necessity, IHS, tribes and urban programs have become adept at accessing alternate resource coverage for their patients. It is estimated that IHS facilities rely on the collection of third-party resources for as much as 50% of their operating budgets.[6] Tribally-operated and urban programs do not report this data, but also rely on third-party collections on the same level as IHS operated facilities. It must be noted that the IHS budget authority accounts for the collection of third-party reimbursements as budgets are being developed, submitted and approved. Third-party resources are used to enhance IHS, tribal, and urban health care delivery systems. Services provided with third-party revenue include, but are not, limited to increasing staff, purchasing medical equipment/supplies, and providing patient transportation.

Proposed solutions:

Clarify authorities for third-party collections. This concept would strengthen IHS and tribal program authority to collect reimbursements from third-party insurers.

Codify payor of last resort language. This concept would codify in law the existing IHS regulation which makes IHS the payor of last resort, meaning all other available sources (e.g. Medicare, Medicaid, private insurance, other) pay for care before IHS appropriated funds are used.

Authorize expansion of Medicare, Medicaid and Children's Health Insurance Program (CHIP) collections. This concept would amend the Social Security Act to facilitate access to payments from Medicare, Medicaid, and CHIP by IHS, tribal and urban programs.

[6] Department of Health and Human Services, Budget In Brief – Fiscal Year 2010

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Authorize reimbursement for Medicaid covered services. This concept would assure services provided by mid-level practitioners (e.g. nurse practitioners, physician assistants, etc.) are covered services under Medicaid and are eligible for reimbursement.

Authorize transfer of facilities construction funds from other federal agencies to Department of Health and Human Services (HHS). This concept would allow the transfer of facilities construction funding from other federal agencies, which receive construction funding, to HHS for use in constructing IHS/tribal health care facilities.

Urban Indian Health Programs

The Urban Indian Health Program (UIHP) consists of 34 non-profit 501(c) (3) programs nationwide. The programs are funded through grants and contracts from the IHS, under Title V of the Indian Health Care Improvement Act, PL 94-437, as amended. Approximately 45% of the UIHPs receive Medicaid reimbursement as Federally Qualified Health Centers (FQHC) and others receive fees for service under Medicaid for allowable services, i.e. behavioral services, transportation, etc. Over $28.8 million are generated in other revenue sources.

The range of IHS/Urban grant and contract programs include: information, outreach and referral, dental services, comprehensive primary care services, limited primary care services, community health, substance abuse (outpatient and inpatient services), behavioral health services, immunizations, HIV activities, health promotion and disease prevention, and other health programs funded through other state, federal, and local resources, i.e. WIC, Social Services, Medicaid, Maternal Child Health, etc.[7]

While the UIHP serves over 150,000 Native Americans annually, there remains a huge unmet need in urban Indian communities. The last needs assessment for the urban Indian community was conducted in 1981, nearly 30 years ago. Based on that ancient data, the UIHP is serving approximately 22% of the entire need for the urban Indian community. Without a doubt the need for the UIHP has grown since 1981. For example, the estimated potential user population of the UIHP is almost 1 million people, and that's just in cities that already have UIHPs.[8] Eighteen additional cities have been identified as having an urban population large enough to support an UIHP.[9] Additionally, UIHPs can only receive funding for programs authorized under Title V of the Indian Health Care Improvement Act. This prohibits the UIHPs from establishing

[7] IHS Urban Indian Program Overview, http://www.ihs.gov/NonMedicalPrograms/Urban/Overview.asp
[8] Testimony of Geoffrey Roth, Executive Director. National Council of Urban Indian Health Before the House Interior Appropriations Subcommittee's Native American Witness Day, March 25th, 2009
[9] IHS Urban Indian Programs, http://www.ihs.gov/NonMedicalPrograms/Urban/UIHP.asp

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comprehensive preventive health, facilities construction and community health representative programs.

Proposed solutions:

Authorize requirement to confer. This concept would require the IHS to confer with the Urban Indian community through their duly authorized representatives regarding how the trust responsibility to urban Indians is met.[10]

Authorize expanded program authority. This concept would allow urban Indian organizations to operate mental health training; school health education; prevention of tuberculosis; and behavioral programs (if reauthorized in IHCIA bill).

Authorize facilities construction program. This concept would establish a facilities construction program and feasibility study for the creation of a loan fund for construction of urban Indian facilities.

Authorize community health representative (CHR) program. This concept would allow grants/contracts for urban Indian organizations to operate a CHR program.

Authorize access to the federal supply schedule (FSS). This concept would allow access to the FSS by urban Indian organizations.

Permanently authorize the urban demonstration projects. This would authorize the Oklahoma City Indian Clinic and Indian Health Care Resource Center of Tulsa urban Indian health programs to continue on permanent basis. These are currently demonstration projects that were recognized and supported under the 1976 enactment of the Indian Health Care Improvement Act.

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Facilities Construction

Since 1991, the Indian Health Service has used a Facilities Priority System to evaluate and develop a priority list for health care facilities construction. The recent release of the FY 2011 Planned Construction Budget for IHS health care facilities shows a backlog of at least $2.4 billion, but estimates are that the backlog for all facilities maintenance, improvement and construction likely exceeds $3 billion. Additionally, the average age of IHS facilities is 33 years as compared to 9 years for the United States. One concept is to develop a demonstration program that would maximize limited facility construction funding.

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[10] Testimony of David Rambeau, President, National Council of Urban Indian Health before the Senate Committee on Indian Affairs Addressing "Advancing Indian Health Care", February 5th, 2009

Proposed solutions:

Develop a demonstration program in which modular component facilities are used in Indian Country.

Develop a demonstration program for the use of mobile health stations.

<u>Inclusion of Indian Provisions in National Health Care Reform</u>

Indian Country strongly supports health care reform and seeks to ensure that the Indian health care delivery system is strengthened and improved so that Indian health programs benefit from reformed systems.[11]

Proposed solutions:

Assure AI/AN maximum participation in subsidies and/or newly established health coverage plans. Increase the number of Indian people enrolled in Medicaid, CHIP and other publicly-funded insurance programs, including using fast track methodologies for Medicaid enrollment and creating a portability aspect for culturally appropriate care.

Exempt Indian tribes from any employer mandate penalties and individual Indians from individual mandate penalties. In recognition of the U.S. federal government's trust responsibility to provide health care to AI/AN individuals', financial penalties should not be assessed against individual Indians failing to obtain health insurance coverage.

Culturally appropriate research and data access. Support targeted research and best practice benchmarking appropriate to AI/AN, including access to data.

<u>Miscellaneous Provisions</u>

A number of provisions that do not specifically fit into any of the identified categories are needed to update and modernize the IHCIA. These provisions are equally as important and would facilitate meaningful change to the current Indian health care delivery system.

Proposed solutions:

Authorize confidentiality of medical quality assurance records. This provision would facilitate quality assurance program reviews for IHS, tribal and urban Indian organization programs.

[11] National Indian Health Board, National Congress of American Indians, and National Council of Urban Indian Health, Health Care Reforms – Indian Country Recommendations, May 29, 2009

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Authorize an annual report on Indians served by Social Security Act Health Benefits Programs. This provision would require HHS to collect data on Indian enrollment in Medicare, Medicaid and CHIP on an on-going basis.

Authorize establishment of an Office of Direct Service Tribes. This provision would establish an Office of Direct Service Tribes within the IHS Office of the Director.

Authorize ISDEAA tribal programs to set rental rates and collect rent. This provision would allow tribal health programs established under the Indian Self-Determination and Education Assistance Act (ISDEAA) to set rental rates and collect same from health care professionals housed in federally-owned quarters.

Authorize a narrow exclusion of certain insurance products. There are some insurance products that do not provide primary coverage, but rather supplement insurance with cash benefits paid directly to the policyholder. These insurance products would be exempted from third-party reimbursements.

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