A Legacy of Building Strong, Healthy Native Communities

Healthcare in Indian Country

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Executive Director
National Council of Urban Indian Health

National Council of Urban Indian Health

- Created in 1998 by Urban Indian Leaders to advance health care of American Indians/Alaska Natives.
- Advocates for Indian Health Care with Congress and Federal Government.

- Provides Technical support to UIHPs for implementing quality accessible health care services.
- Provides Technical Assistance support to the 42 Urban Indian Health Programs across the nation.

Our Mission

NCUIH is a national membership non-profit organization devoted to the support and development of quality, accessible, and culturally-competent healthcare services for American Indians and Alaska Natives living in urban settings.

Trust Obligation

- Between 1787 and 1871, almost 400 treaties with Indian tribes.
- The U.S. obtained tribal land in exchange for other reservation lands for those tribes and guaranteed that the federal government would respect the **sovereignty of the tribes, would protect the tribes, and would provide for the well-being of the tribes.**
- 1977 Senate report of the American Indian Policy Review Commission
  - The purpose behind the trust doctrine is and always has been to ensure the survival and welfare of Indian tribes and people. This includes an obligation to provide those services required to protect and enhance tribal lands, resources, and self-government, and also includes those economic and social programs which are necessary to raise the standard of living and social well-being of the Indian people to a level comparable to the non-Indian society.
- The **federal Indian 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*, 1942). This obligation was first discussed by Chief Justice John Marshall in *Cherokee Nation v. Georgia* (1831).

Important Indian Health Acts

- Snyder Act 1921
  - Authority for Congress to appropriate funds for the benefit, care and assistance to Indians by the Bureau of Indian Affairs
  - This Act was never superseded, authority only transferred and expanded.
- Transfer Act of 1954
  - The Indian health program became a responsibility of the Public Health Service under the Transfer Act of 1954.
- ISDEAA 1975
  - In 1992, Congress amended the ISDEAA to authorize a Tribal Self-Governance Demonstration Project within the IHS, giving federally-recognized Tribes the option of entering into self-governance compacts to gain more autonomy in the management and delivery of their health care programs.
  - By 2000, Congress permanently authorized the IHS Tribal Self-Governance Program by creating Title V of the ISDEAA through Public Law 106-260.

Important Indian Health Acts

- Indian Health Care Improvement Act of 1976
  - The act implements 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 maximum participation of Indians in such programs. This Act expanded the Snyder Act authority.
  - permit reimbursement by Medicare and Medicaid for services provided to IHS
  - 100% FMAP for AI/AN in I/T units

Important Indian Health Acts

- Indian Health Care Amendments of 1987
  - Urban Indian healthcare right:
  - The ***responsibility for the provision of health care, arising from treaties and laws*** that recognize this responsibility as an exchange for the cession of millions of acres of Indian land ***does not end at the borders of an Indian reservation***. Rather, government relocation policies which designated certain urban areas as relocation centers for Indians, have in many instances forced Indian people who did not [want] to leave their reservations to relocate in urban areas, and the responsibility for the provision of health care services follows them there.

Why are urban Indians “urban”?

- The Relocation Era took Indians off the reservations and into urban settings as a way to “Kill the Indian, Save the Man”
- Because of this, over 78% of AI/AN live off of the reservation today
- Tribal leaders and Congress decided after Relocation that the trust responsibility extends beyond the borders of the reservation

Important Indian Health Acts

- American Recovery & Reinvestment Act (ARRA) 2009
  - In 2009, the American Reinvestment and Recovery Act (ARRA) codified the TTAG/CMS relationship which strengthens the collaboration between CMS and I/T/Us.
  - Provides certain protections for Indians that preclude states from **imposing Medicaid premiums** or any other Medicaid **cost sharing** on Indian enrollees who have used the Indian health system.
  - Section 5006 also emphasizes the state-tribal relationship by formally requiring that states **consult** with the tribal community on Medicaid and CHIP policy matters.
  - States must seek advice from designees of I/U in the state when Medicaid and CHIP matters have a **direct effect** on Indians, Indian health programs or urban Indian programs.
  - States must also describe the process for seeking advice from Indian health programs and urban Indian organizations in their Medicaid and CHIP state plans.

Important Indian Health Acts

- Indian Health Care Act of 2010
  - Permanently reauthorized in the Affordable Care Act
  - Prior to permanent reauthorization, he authorization of appropriations for the IHCIA had expired in 2000
  - Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—
    - (1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;

Indian Health Service System: I/T/U

Indian Health Services (I)	Tribal (T)	Urban Indian Health Programs (U)
• Federal facilities consisting of hospitals and clinics. • Funded at 50% of need for adequate care. • 12 Regional Offices	• Compact or Contract to provide health services • Specialty care through Purchased/ Referred Care dollars for "life or limb"	• Receive approximately 1% of IHS Budget and only one line item • 3 levels of programs: Comprehensive, Limited, and Outreach and Referral

Treaty Health Services for Urban "Tribal" Members

The I/T/U System:

- **I**ndian Health Services - **T**ribal Health Programs - **U**rban Programs
- *Tribal* ***Health Programs:***
  - ***Direct Service Tribes (Tribes that get their healthcare directly to IHS)***
  - ***638 Tribe or Self-governance Tribe- Tribe has taken over their IHS facilities***
    - ***638 does NOT mean a Tribe has taken over ALL federal functions (education, etc) just health facilities***
- 42 **Urban Indian Health Programs –** ***Nationally***

History of Indian Health Policy

- Direct Service Tribes consists of 26 hospitals, 59 health centers, and 32 health stations
- Self- Governance Tribes administer 19 hospitals, 284 health centers, 79 health stations, and 163 Alaska village clinics.
- UIHPs administer 42 health centers

42 –Title V Urban Indian Health Programs

- **21 Full Ambulatory (FA)**—all weekdays access to primary care
- **6 Limited Ambulatory (LA)**—certain days/hours access to primary care
- **6 Outreach/Referral (OR)**—does not offer onsite primary care
- **2 Urban IHS Service Units (SU)**—full primary care services
- **6 NIAAA Programs-** alcohol and substance abuse services

NCUIH Membership Regions

Region I
- Baltimore, MD
- Boston, MA
- New York City, NY

Region II
- Chicago, IL
- Detroit, MI
- Milwaukee, WI (2)
- Shell Lake, WI
- Minneapolis, MN
- St. Paul, MN
- Sawyer, MN
- Kansas City, MO

Region III
- Omaha, NE
- Pierre, SD

Region IV
- Billings, MT
- Butte, MT
- Great Falls, MT
- Helena, MT
- Missoula, MT

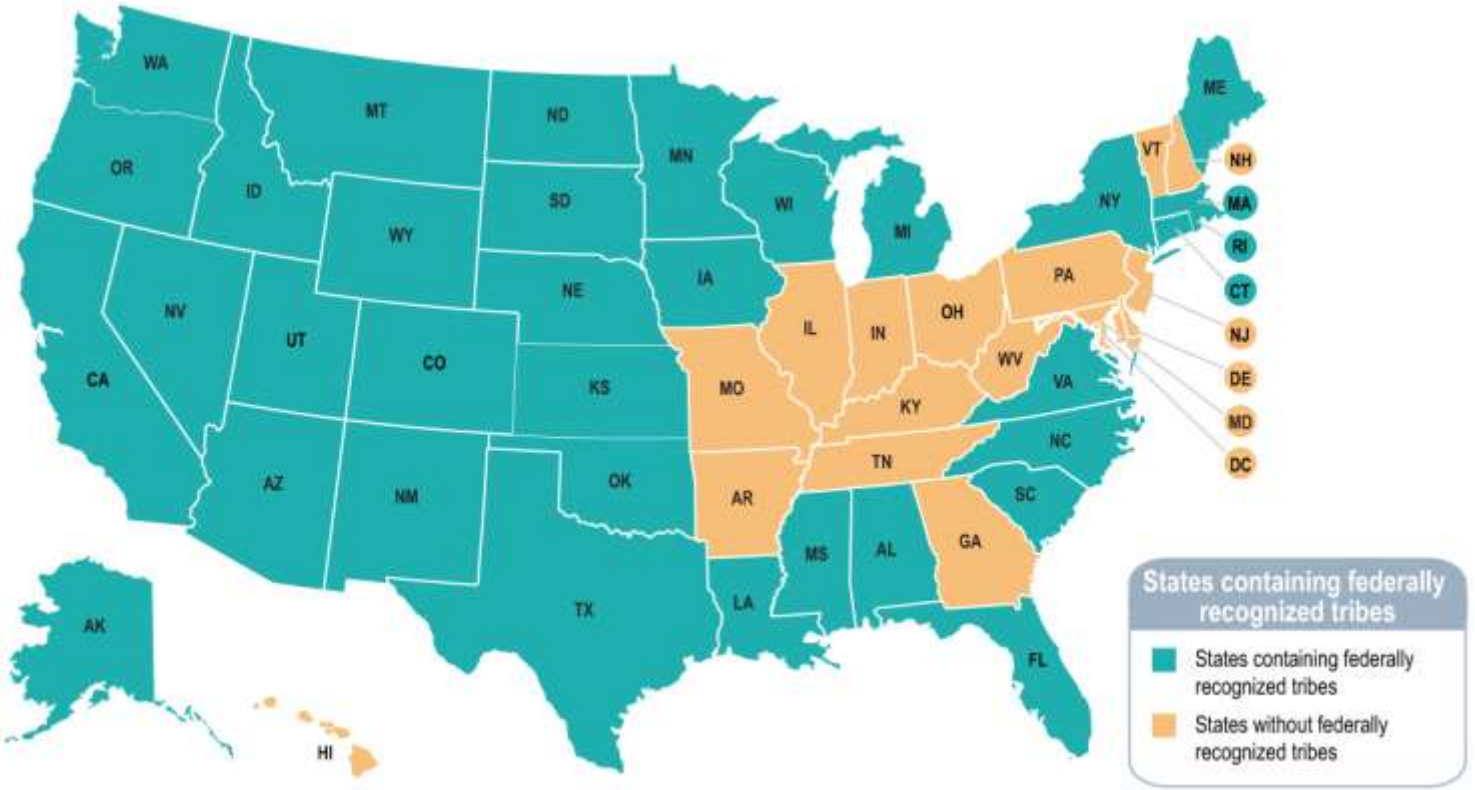
Region V
- Portland, OR
- Reno, NV
- Seattle, WA
- Spokane, WA

Region VI
- Bakersfield, CA
- Fresno, CA
- Los Angeles, CA
- Oakland, CA
- Manteca, CA
- Sacramento, CA
- San Diego, CA
- San Francisco, CA
- San Jose, CA
- Santa Barbara, CA

Region VII
- Albuquerque, NM
- Dallas, TX
- Flagstaff, AZ
- Phoenix, AZ
- Salt Lake City, UT
- Tucson, AZ
- Wichita, KA
- Tulsa, OK
- Oklahoma City, OK

Region VIII
- Denver, CO

States with Federally Recognized Tribes



The Numbers…

- In 2016, AI/ANs were **2.7X more likely to die from hepatitis C** and **2.3X as likely to die from hepatitis B** (than non Hispanic whites)
- AI/ANs have **2X the AIDS rate** (as compared to the white population)
- In 2016, AI/AN women were **3X more likely to be diagnosed with AIDS** infection (compared to the white female population)
- AI/ANs have **1.6X the infant mortality rate** (as non-Hispanic whites)
- In 2014, AI/AN mothers were **2.5X as likely to receive late or no prenatal care** (compared to non-Hispanic white mothers)
- While the overall death rate from suicide for AI/AN is comparable to the White population, **adolescent AI/AN females have death rates at almost 4X the rate** (for White females same age groups)

The Numbers – Mortality Disparity Rates

SUICIDE	1.7
UNINTENTIONAL INJURIES	2.5
DIABETES	3.2
CHRONIC LIVER DISEASE AND CIRRHOSIS	4.6
ALCOHOL INDUCED	6.6

LIFE EXPECTANCY

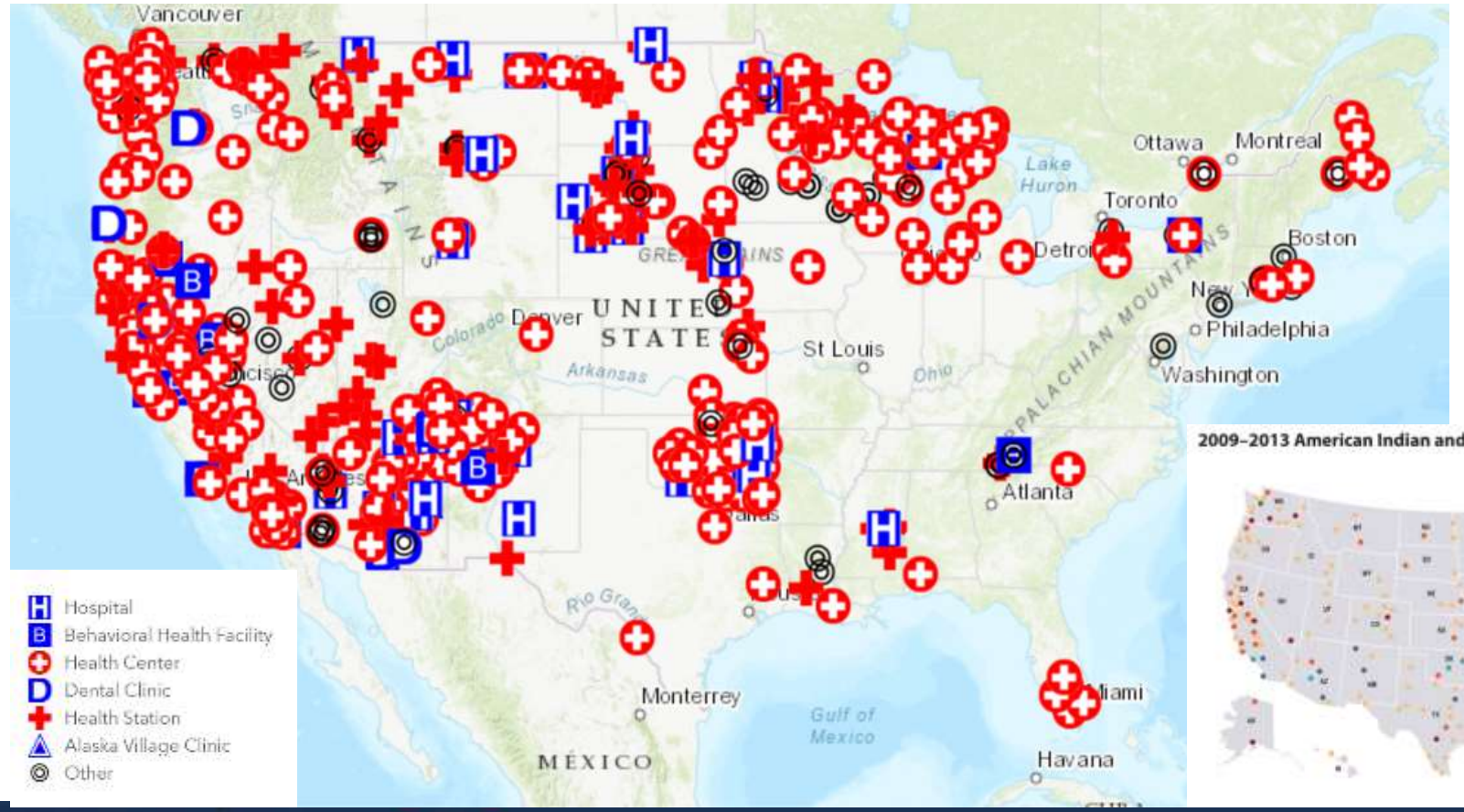
5.5

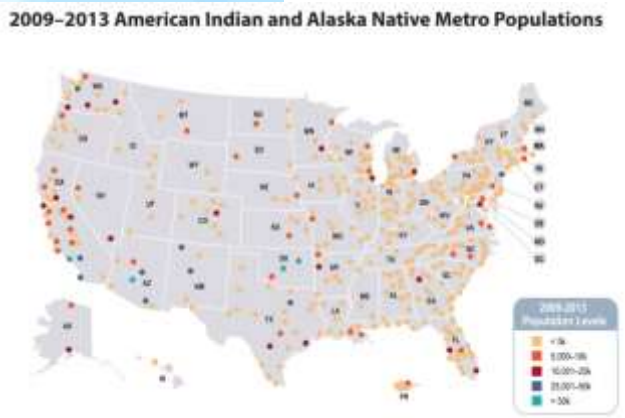
years less

The Numbers – Social Determinants of Health (SDOH)

AI/ANs		National Average
28.4%	Poverty	15.3%
$35,062	Medium Household Income	$50,046
54%	Housing Ownership	65%
17%	Post-Secondary Education	>60%

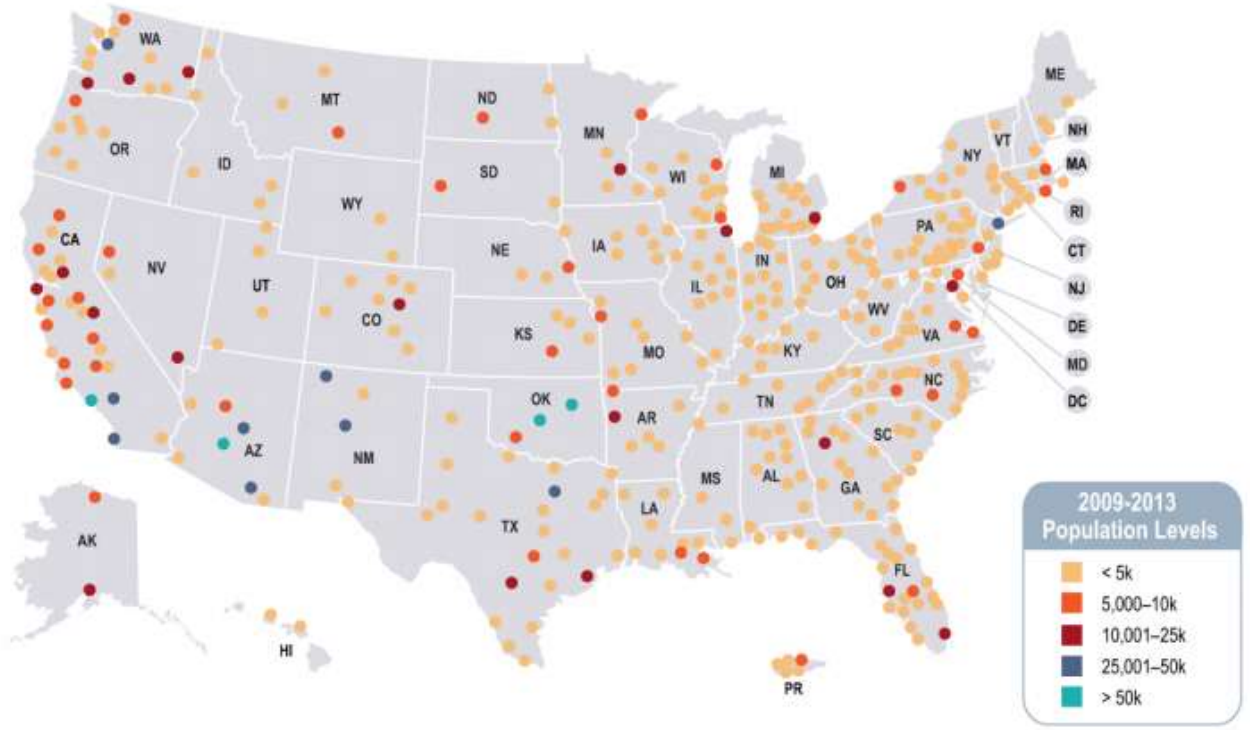
Access: IHS Facilities





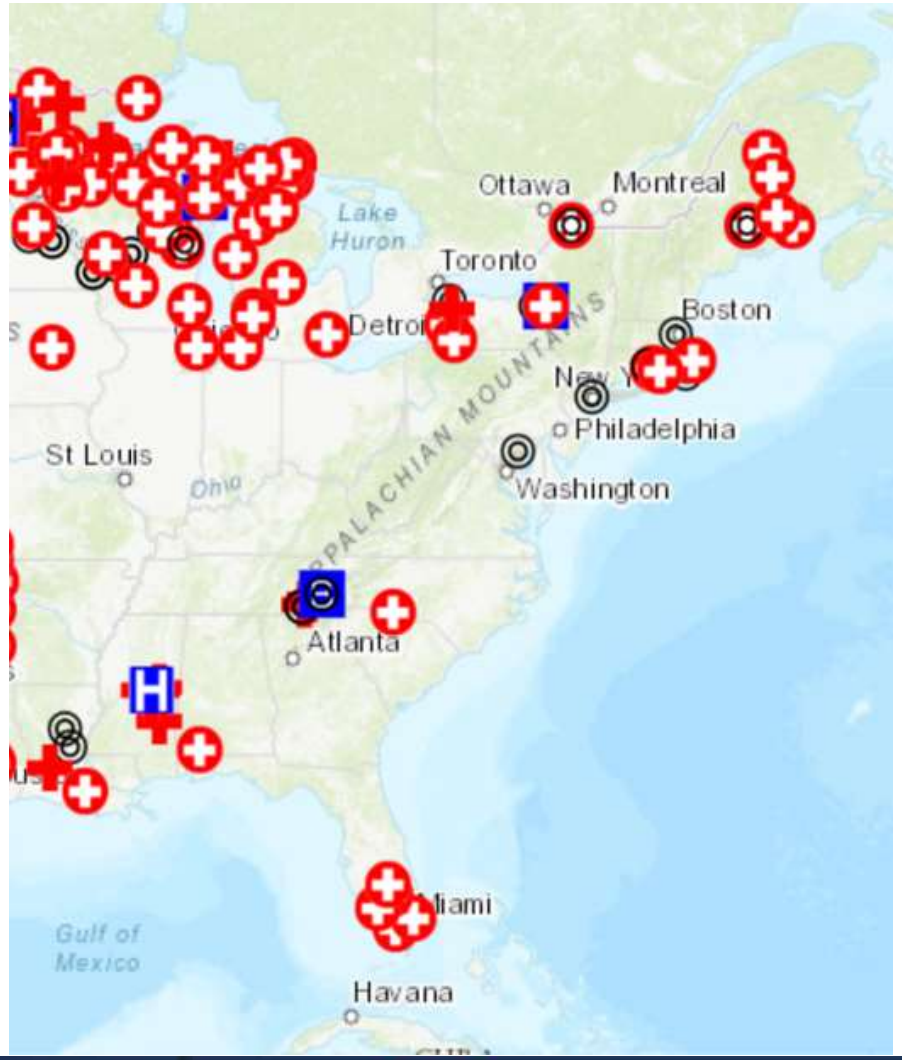
Urban Areas with AI/AN Populations

2009–2013 American Indian and Alaska Native Metro Populations



[1] US Census Bureau; American Community Survey, 2009–2013. American Community Survey 5-Year Estimates, Table BO2005 American Indian and Alaska Native alone for selected tribal groupings; generated by the Tribal Support Unit; using American FactFinder. Accessed Jun 8, 2015.

[2] Department of the Interior, Bureau of Indian Affairs. Indian entities recognized and eligible to receive services from the United States Bureau of Indian Affairs. *Federal Register* 2015;80(9):1942–8.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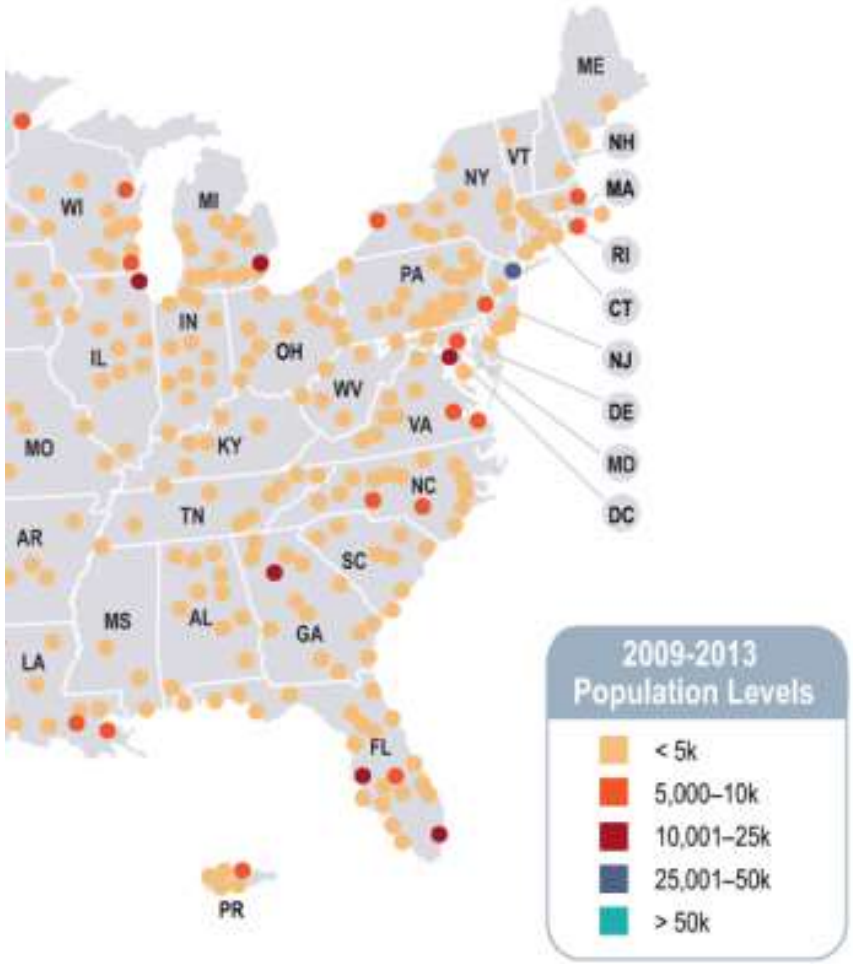
Havana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FL
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2009-2013
Population Levels
< 5k
5,000–10k
10,001–25k
25,001–50k
> 50k

National and Regional Non Profits supporting Tribal Public Health

- National Indian Health Board
- National Council of Urban Indian Health
- National Indian Council on Aging
- National Native American AIDS Prevention Center
- Seven Directions Center for Indigenous Public Health
- Area Indian Health Boards
- Tribal Epidemiology Centers

TRIBAL EPIDEMIOLOGY CENTERS

Health Disparities – Infants and Youth

- AIAN children and youth are **more than twice as likely to die in the first four years of life** as is the general population, and they are **twice as likely to die through the age of 24**.

- AIAN youth suicide rate is **twice as great among 14- to 24-year-olds and three times as great among 5- to 10-year-olds** compared to the US general population.

- The prevalence of type 2 diabetes among AIAN children is **higher than that of any other ethnic group**.

Health Disparities - Adults

- Nearly **one-fourth (23.3%) of AIAN male deaths occur by age 34**, compared with only 15.9% of American Indian and Alaska Native female deaths.

- AIAN **women are 40% more likely than white women to be obese**.

- AIAN born today have **a life expectancy that is almost six years less** than the rest of the United States population.

Mortality

American Indian and Alaska Native age-adjusted death rates are greater than for the general US population for:

- Alcoholism—740% higher
- Tuberculosis—500% higher
- Diabetes—390% higher
- Injuries—340% higher
- Suicide—190% higher
- Homicide—180% higher

Ten Leading Causes of Death

- AIAN

1. Heart disease
2. Cancer
3. Unintentional injuries
4. Diabetes
5. Chronic liver disease and cirrhosis
6. Chronic lower respiratory disease
7. Stroke
8. Suicide
9. Nephritis and nephrosis
10. Influenza and pneumonia

Whites

1. Heart disease
2. Cancer
3. Chronic lower respiratory disease
4. Stroke
5. Unintentional injuries
6. Alzheimer's disease
7. Diabetes
8. Influenza and pneumonia
9. Nephritis and Nephrosis
10. Suicide

Why are there health disparities?

- Access to health care
- Intergenerational trauma
- Loss of culture, traditions, etc.
- Research/evidence unavailable
- Statistical issues

Wait Time Standards for Primary and Urgent Care Visits in Indian Health Service Direct Care Facilities

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Indian Health Service
Rockville, Maryland 20857

Refer to: OCPS

INDIAN HEALTH SERVICE CIRCULAR NO. 17-11

Effective Date: 08/25/17

WAIT TIME STANDARDS FOR PRIMARY AND URGENT CARE VISITS
IN THE INDIAN HEALTH SERVICE DIRECT CARE FACILITIES

4. STANDARDS.

   A. Mean Appointment Wait Time for Primary Care of 28 days or less.

   B. Mean Appointment Wait Time for Urgent Care of 48 hours or less.

5. EFFECTIVE DATE.

   This IHS Circular is effective upon the date of signature.

/Michael D. Weahkee/
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Acting Director
Indian Health Service

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Joint Indian Health Policy Priorities

- IHS Advance Appropriations
- IHS exemptions from freeze
- IHS full funding
- Exemption from Medicaid work requirements

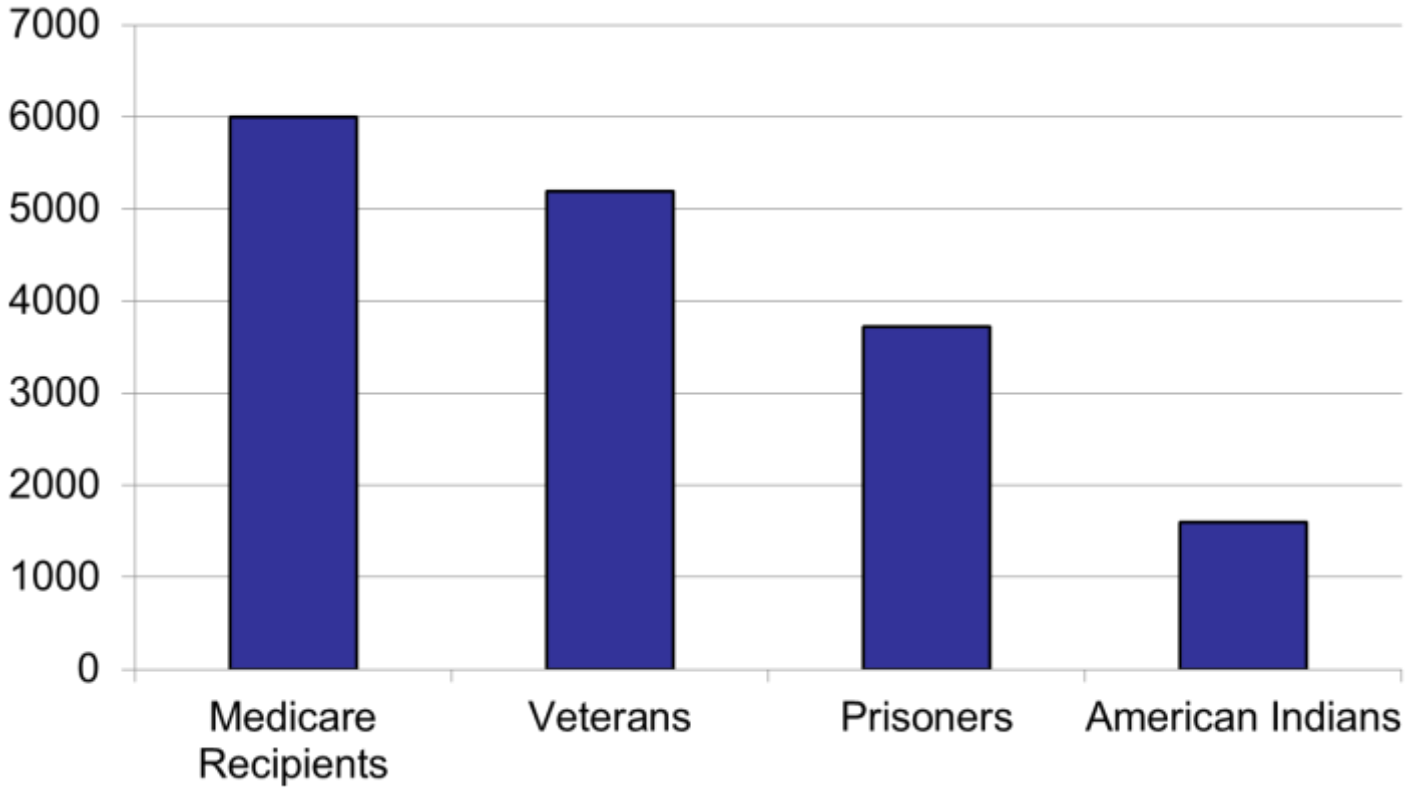
Urban Indian Legislative Priorities

- Fully Fund IHS
- 100% FMAP for UIHPs
- Federal Torts Claims Act
- HHS Urban Confer Policy
- Implementation of the VA-IHS MOU for UIHPs

Urban Indian Health Policy

- Full funding of IHS is the amount of funding which would bring health care spending for Indians on par other federal health care programs
- IHS has been traditionally underfunded (50% percent of need)
- IHS per capita health care spending in 2016 was $2,834 compared to $9,990 nationally; (UIHPS receive $721 per patient).
- IHS only spends less than 1% on the provision of health care to urban Indians

Dollars Spent Per Year on Groups in United States for Medical Care



100% FMAP for UIHPs

- IHS and Tribal facilities receive 100% FMAP
- Allows UIHPs to work with states to receive a portion of reimbursement
- Legislative
  - Bill introduced in Congress
- Work group
  - To implement care-coordination agreements and find other ways to achieve 100% FMAP under current law/regulations
- Collaboration
  - Working with other national organizations to make this a priority fix, in addition to other Medicaid legislative priorities

Federal Torts Claims Act

- Unlike providers at IHS and Tribal facilities, UIHP providers are not given protections against liability by the Federal Tort Claims Act (FTCA), so they must pay for expensive insurance—as much as $250,000 per annum.

- A bill introduced that would extend FTCA coverage to UIHPs, in the Restoring Accountability in Indian Health Service Act of 2017 (H.R. 2662, S. 1250).
  - Hopeful to get a bill introduced in next Congress

HHS Confer Policy

A Confer policy, whether through Executive Order, Agency policy, or codified through law, is necessary to fulfill the trust obligation the federal government has to American Indians and Alaska Natives.

- An agency-wide Confer policy within HHS would allow NCUIH members and UIHPs to have a seat at the table when policy that impacts their community is being discussed.
- Confer policy would benefit HHS agencies by aiding them to craft policies and procedures which at least take into account the needs and concerns of urban Indians.

Implementation of the VA-IHS MoU

- IHS and Department of Veteran's Affairs entered into a memorandum of understanding (MoU) to promote better health care for AI/AN veterans.
- However, the MoU has not been implemented for UIHPs.
- Veterans are more likely to receive the care they have earned if they have more autonomy over from whom, where, and how such care is provided.
- Many UIHPs are geographically near VA facilities, so they do not qualify under the VA Care Act.
  - Could assist with long wait times, provide culturally competent care, etc.

Medicaid Work Requirements

- Regulatory
  - Provide technical assistance to UIHPs for their engagement at the state level
  - Prepare comments to CMS on waivers with work requirement proposals
- Legislative
  - Working with other national organizations, MMPC to support legislative fixes

Any Questions?

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THANK YOU