INDIAN HEALTH

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On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (Act). The new law reauthorizes and makes permanent the Indian Health Care Improvement Act (IHCIA), demonstrating the federal government's commitment to honoring its trust responsibilities to Indian tribes. It also authorizes new programs and expands the accessibility of services delivered by the Indian Health Service so that it can accomplish its mission of raising the health status of American Indians and Alaska Natives to the highest level.

Numerous other Indian-specific provisions are included in the Act. This section provides an overview of some of the Act's most significant implications for Arizona's 21 federally recognized tribes and 250,000 Native Americans.[1]

KEY REFORM CHANGES

- **The Indian Health Care Improvement Act has been permanently authorized.**
- **American Indians and Alaska Natives who purchase health insurance on the individual market through an exchange do not have to pay co-pays or other cost sharing if their income does not exceed 300 percent of the poverty level.**
- **Members of American Indian and Alaska Native tribes are exempt from individual responsibility requirements such as the mandate to purchase health insurance.**
- **The value of health services/benefits from IHS-funded health programs or tribes will be excluded from an individual's gross income so that it cannot be taxed starting with benefits and coverage provided after the date of enactment.**
- **Designates the state as a contract service area.**
- **Requires the Secretary of Health and Human Services to conduct a study on the feasibility of the Navajo Nation administering its own Medicaid, CHIP and Medicare programs.**

OVERVIEW OF INDIAN HEALTH

The provision of health services to American Indian and Alaska Natives (AI/ANs) grew out of the special government-to-government relationship between the federal government and Indian tribes. This relationship was established in 1787, through Article I, Section 8 of the Constitution.[2] The federal responsibility of health care for American Indians and Alaska Natives has been reaffirmed over the last 200 years by several laws, treaties, settlements, agreements, court decisions, executive orders and legislation.

A significant advancement in Indian health care came in the form of legislation known as the Snyder Act of 1921. The Snyder Act of 1921 provided written affirmation of the federal responsibility for the health care for American Indians and Alaska Natives.[3] The Indian Health Care Improvement Act (IHCIA) was enacted by Congress in 1976 to address the deplorable health conditions in tribal communities. The IHCIA established the structure for the provision of healthcare services to American Indians and Alaska Natives. Along with the Snyder Act of 1921, the IHCIA formed the legal foundation for the delivery of health care to AI/ANs by the Indian Health Service (IHS).[4] Unfortunately, despite repeated attempts to reauthorize, the IHCIA expired in 2002.

Today, the IHS is the principal federal healthcare provider for American Indian and Alaska Natives. The IHS is an agency within the Department of Health and Human Services responsible for providing health services to federally-recognized tribal members.[5] The

goal of this health system is to raise the health status of Indian people to the highest possible level. The IHS provides healthcare services to American Indians and Alaska Natives on reservations, in rural communities and in urban areas. This healthcare system is comprised of various types of health delivery models including hospitals, clinics, and health stations. IHS services are delivered through direct (IHS) services, tribal services and contracts with non-IHS service providers.

MAJOR CHANGES FOR INDIAN HEALTH IN THE ACT

The impact of healthcare reform in Indian country is multi-fold. Although the IHS is the federal agency responsible for Indian health care, tribal members may not be able to access these services due to location and/or ineligibility. As a result, many American Indians and Alaska Natives utilize other sources of health care, such as private or employer-sponsored health insurance, Medicare, Medicaid, community health centers and the Veteran's Administration. Thus, the Affordable Care Act is applicable to American Indian and Alaska Natives because they are a part of the U.S. healthcare system.

The Act provides American Indians and Alaska Natives – and Americans – more choices and access to health care. More people will be eligible for Medicaid beginning 2014. American Indians will be able to benefit from more affordable, subsidized private insurance options through the exchange. Other provisions of the new law, including those aimed at promoting prevention and improved quality, will also benefit American Indians and Alaska Natives as members of the overall U.S. health system.

Nonetheless, there are many provisions in the Act that specifically benefit American Indian and Alaska Native individuals, tribes and Indian health facilities.

Indian Health Care Improvement Act

Healthcare reform reauthorizes and makes permanent the Indian Health Care Improvement Act (IHCIA). This is significant because it makes the provision of health care for American Indians and Alaska Natives law. In essence, it codifies existing treaty obligations to Indian tribes, legally confirming the federal government's commitment to providing health care for American Indians and Alaskan Natives.

The Act also includes many major changes and improvements to IHCIA to facilitate the delivery of healthcare services, such as:

- Enhancement of the IHS Director's authority, including responsibility to facilitate advocacy and promote consultation on matters relating to Indian health within the Department of Health and Human Services.
- Authorization for hospice, assisted living, long-term, and home- and community-based care.
- An extension of the ability to recover costs from third parties to tribally operated facilities.
- Current law updates regarding collection of reimbursements from Medicare, Medicaid, and CHIP (Children's Health Insurance Program) by Indian health facilities.
- Ability for tribes and tribal organizations to purchase health benefits coverage for IHS beneficiaries.
- Authorization for IHS to enter into arrangements with the Departments of Veterans Affairs and Defense to share medical facilities and services.[6]
- Authorization of a comprehensive behavioral health, prevention, and treatment program. This will include community-based care, detoxification, hospitalization, intensive out-patient treatment, residential treatment, transitional living. emergency shelter, case management, and diagnostic services.

Formalized support and improvements to Indian Health Service made through the Indian Health Care Improvement Act are important to ensuring healthcare access for Arizona's 250,000 American Indians. A high percentage of the American Indian population in Arizona relies on the federal government for health care.

Contract Health Service Delivery

Another important new provision in the IHCIA is the designation of the State of Arizona as a Contract Health Service Delivery Area (CHSDA). In the past, each of the three IHS service areas in the state had specific funding set aside in contract health services, which allowed the local service unit to contract out those health services that fell outside the scope of their local capacity. Currently, many Indian people who move away from their home reservations in Arizona are frequently not eligible for Contract Health Services, since they would be moving away from the CHSDA in which they have eligibility. The permanent status of the state of Arizona as a CHSDA will now allow American Indians the freedom to move about the state and still qualify to receive health care under Contract Health Services, should it be needed. Arizona tribes must now work to obtain an increase in federal dollars allocated to Contract Health Services to meet the existing need and the anticipated increased number of covered patients.

Navajo Nation Feasibility Study

The Act also includes a provision directing the Secretary of Health and Human Services to conduct a study to determine the feasibility of treating the Navajo Nation as a state for purposes of administering Medicaid, CHIP and Medicare services to American Indians living within the boundaries of the Navajo Nation. If the study eventually leads to the Navajo Nation administering its own Medicaid program, the impact on both the Navajo Nation and the State of Arizona could be profound. Arizona would no longer have to process the paperwork for Navajos living on the reservation; the government should save money because the rules could be made simpler and easier to process with Navajo rules for eligibility instead of three different state standards. The Navajo Nation, in turn, would likely be able to better serve its citizens.[7]

During the healthcare reform debate, concerns existed that Indian Health Service would be eliminated. The resulting health reform law does quite the contrary. The Act not only permanently authorizes the IHS, but it expands access to IHS services. This legislation contributes to the transformation of the healthcare system, making health care more affordable and accessible for American Indians and Alaska Natives.

KEY TAKEAWAYS:

- Permanent authorization of the Indian Health Care Improvement Act (IHCIA) makes the provision of healthcare services to American Indians and Alaska Natives through the IHS law, further cementing the federal government's commitment to provide health care for American Indians and Alaskan Natives.
- Changes to IHCIA resulting from healthcare reform will allow American Indians residing in the state of Arizona who do not reside on reservations greater access to healthcare services.
- More federal dollars and new or expanded contracts with non-Indian healthcare providers will be needed if American Indians not living on reservations are able to take advantage of their new ability to access contract health services.
- A feasibility study related to the Navajo Nation administering its own Medicaid, Medicare and CHIP programs could have a big impact on both the Navajo Nation and AHCCCS, if the findings eventually result in the Navajo Nation administering these programs.

OTHER CHANGES AFFECTING AMERICAN INDIANS

The healthcare reform legislation is organized into 10 different titles that, among other requirements, establishes a mandate for most residents of the United States to obtain health insurance. It establishes state insurance exchanges through which individuals and families can receive federal subsidies, substantially reducing the cost of purchasing health coverage. The legislation expands Medicaid eligibility considerably and reduces the growth of Medicare's payment rates for most services. The new law will also impose an excise tax on insurance plans with high premiums and make various other changes to the federal tax code, Medicare, Medicaid and other programs.

The Act also includes some American Indian-specific provisions:

Exchange

- Authorizes the Secretary of Health and Human Services to require the exchange to provide for special monthly enrollment periods for American Indians, thus giving them more time to enroll in insurance plans offered through the exchange.
- Specifies that no cost sharing will be required for American Indians with incomes at or below 300 percent of the federal poverty level enrolled in coverage through a state exchange. Cost sharing will be prohibited altogether for American Indians enrolled in any qualified health plan in the individual market through the exchange.

Individual Responsibility

- Exempts American Indians from penalties for failure to maintain minimum essential coverage that can be assessed against a member of an Indian tribe. The law exempts members of Indian tribes on the basis of the federal trust relationship.

Streamlined Insurance Eligibility

- Makes enrollment in Medicaid, Medicare and CHIP easier. Under the new law, IHS, tribes, tribal organizations and urban Indian organizations are considered "Express Lane Entities," allowing for presumptive eligibility under Medicaid, Medicare, and CHIP for American Indians seeking services from Indian providers.

Indian Hospitals and Other Healthcare Facilities

- Extends permanently creditable service definitions for Medicare, allowing Indian hospitals to bill Medicare for outpatient and doctor services.
- Allows IHS and tribal health facilities to develop new and innovative ways of addressing healthcare facility deficiencies. It also authorizes the development of new health programs providing care in alternative settings or outside regular clinic operating hours.

Maternal and Child Health Services

- Requires the Secretary of Health and Human Services to create guidelines for Indian tribes, tribal organizations, or urban Indian organizations for early childhood home visiting programs. Sets aside three percent of the annual federal funding for home visiting programs for Indian tribes, tribal organizations, or urban Indian organizations.
- Provides funding to educate adolescents on abstinence, contraception and adulthood preparation topics. Five percent of funding for Personal Responsibility Education grants is required to be dedicated to Indian tribes and tribal organizations.

Prescription Drugs

- Decreases the "donut hole" for Medicare Part D for older adult Indians, making prescription drugs more affordable. Allows all drugs dispensed by IHS, tribal or urban Indian pharmacies to be counted as "true out-of-pocket" costs incurred by individual Indians enrolled in a Part D drug program.

Prevention and Public Health

- Allows states to enter into arrangements with Indian tribes for prevention and health promotion outreach and education campaigns for Medicaid recipients.
- Allows the CDC to award grants to Indian tribes to carry out five-year pilot programs to provide public health community interventions, screenings, and clinical referrals for individuals who are between 55 and 64 years of age (Healthy Living/Aging Well grants).
- Allows epidemiology-laboratory capacity grants to tribal jurisdictions to assist public health agencies in improving surveillance for, and response to, infectious diseases.

Revenue Provisions

- Does not require health insurance or HMOs bought by tribes for members to be deemed as income by the IHS for tax purposes or for eligibility in any SSA program.
- Exempts programs established by federal law to provide care (other than through insurance policies) to members of Indian tribes from fees dedicated to the Patient-Centered Outcomes Research Trust Fund.

Federal Employees Health Benefits Program

- Allows a tribe or tribal organization carrying out a program under the Indian Self-Determination and Education Assistance Act and an urban Indian organization carrying out a program under Title V of IHCIA to purchase coverage for their employees from the Federal Employees Health Benefits Program.

Workforce

- Authorizes establishment of a Community Health Representative program for urban Indian organizations to train and employ American Indians to provide healthcare services.
- Strengthens scholarship and loan programs to attract health professionals to IHS facilities and tribal sites. Supports scholarship programs to recruit American Indian students into psychology and behavioral health professions.

State Implementation, Needed Coordination

As outlined above, there are many provisions and exemptions in the new law designed to protect American Indians and improve their access to health care. State agencies and tribal organizations will need to work together to ensure that the needs and protections offered to American Indians are addressed as part of reform implementation.

Significant efforts will be required to educate patients, individual providers, Indian hospitals, tribal organizations and other entities that interface with Indian patients on these protections and exemptions. For example, consumers and providers will need to be educated about presumptive eligibility for Medicaid for American Indians and exemption from cost sharing through the exchange for Indians with income at or below 300 percent of poverty.

IHS will play a vital role in health reform implementation. The majority of health care for American Indians and Alaska Natives in Arizona is provided directly at one of 53 IHS facilities ranging from ambulatory facilities to hospitals. Care is also delivered through 10 tribally-operated "638 Health Programs" and three urban Indian health centers in the state.[8]

New Demands on Non-Indian Health Providers

Health reform will place new demands on non-Indian health providers. American Indians living off reservations will have greater access to IHS contracted services. Expanded eligibility for Medicaid and subsidies for private health insurance offered through the exchange may mean that more Indians have health insurance – increasing demand for services at non-Indian health provider facilities.

Of course, expanded private health insurance coverage through the exchange and expanded Medicaid coverage (which will ostensibly occur as a result of the 2014 eligibility expansion and new presumptive eligibility provisions) will only become a reality if more American Indians/Alaska Natives apply for coverage. Indeed, many Americans Indians are *already* eligible for Medicaid yet remain unenrolled, even though Medicaid coverage provides them with access to some health services otherwise unavailable through IHS and improves the financial strength of IHS facilities. Concerted, cooperative outreach and enrollment efforts (as allowed by the IHCIA) may be needed by AHCCCS and tribes to make the possibility of coverage under AHCCCS a reality.[9]

Arizona must also prepare for an increase in Medicare Part B reimbursement requests from tribal entities, IHS clinics and hospitals now that they have permanent authority to receive reimbursement of some Part B services. The flow of additional reimbursement dollars into these facilities in Arizona will open the door for enhanced health services to Arizona's tribal communities.

New Grants and State Partnerships

The Act includes grants in a wide array of areas from maternal/child health, patient-centered medical homes, quality improvement, regional emergency care systems, trauma care centers, dental, and primary care residency for qualifying communities in Arizona. In many instances, it may make sense for the state to work directly with the 21 federally recognized tribes to apply for this funding, serving as either a pass-through agent or a partner. Such potential partnerships would benefit tribal communities since many of these programs are new to tribal areas. In any case, the state should be prepared to offer technical assistance on implementation.

According to the U.S. Department of Health and Human Services and IHS tribal consultation policies, consultation with tribes should occur when there is a "critical event," such as a new law or policy that may impact tribes. Clearly, the passage of the Patient Protection and Affordable Care Act, which includes the long-awaited reauthorization of the IHCIA, represents a critical event requiring tribal consultation.[10] The IHS is working closely with the U.S. Department of Health and Human Services on health reform implementation. According to IHS Director, Dr. Yvette Rubidoux, "IHS staff have reviewed each provision, and are drafting next steps, timelines, and determining which agencies we need to partner with on implementation of some key provisions."

Due to the many Indian specific provisions in the Act and the reauthorization of the IHCIA, implementation will be a complex undertaking requiring the participation of federal, state and tribal entities. Coordination and consultation will be needed to implement reform successfully.

KEY TAKEAWAYS:

- Healthcare reform implementation will be a complex undertaking requiring participation of federal, state and tribal entities.
- American Indians, government agencies, healthcare providers, and various tribal entities may need to be educated about specific provisions, exemptions and protections in the new law related to American Indians.
- Non-Indian Health Service providers may experience increased demand for services.
- Concerted, targeted outreach efforts may be needed to realize the potential of increased access to health care through AHCCCS among tribal members.
- The state may want to partner with tribes and apply for federal grants in an effort to bring new money, programs and services to Tribal communities.
- The passage of the Affordable Care Act, which included the long-awaited reauthorization of the IHCIA, represents a critical event requiring tribal consultation prior to implementation.

ABOUT THE AUTHOR

Beverly Russell has worked to improve the health of American Indian people for 15 years. She currently serves as the Tribal Liaison for First Things First. Ms. Russell is an enrolled member of the San Carlos Apache Tribe. She has a rich background in Indian Affairs and public policy, serving as the Executive Director for the National Council of Urban Indian Health, as a legislative aide for the U.S. Senate Committee on Indian Affairs, as a Kaiser Family Foundation Fellow, and as Chief of Staff to the Vice Chairman of the San Carlos Apache Tribe.

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