Key Delivery Mechanisms of Indian Health Care

Fact Sheet for Professionals

Key Terms

638 Tribe: A federally recognized Indian tribe that chooses to manage and provide health care services under the Indian Self-Determination and Education Assistance Act, Public Law 93-638.

I/T/U: Indian Health Service, tribe or tribal organization, or urban Indian organization.

Self-Determination: The Indian Self-Determination and Education Assistance Act (ISDEAA), provides Indian tribes with greater autonomy and the opportunity to assume the responsibility for programs and services administered to them on behalf of the Secretary of the Interior through contractual agreements. The Act assures that Indian tribes have paramount involvement in the direction of services provided by the federal government in an attempt to target the delivery of such services to the needs and desires of local communities.

Self-Governance: The purpose of self-governance is to provide the tribal governments with control and decision-making authority over the Federal financial resources provided for the benefit of tribal members.

Title I (ISDEAA) Contracts: Federally recognized tribes or tribal organizations contract with the IHS to plan, conduct, and administer one or more individual programs, functions, services or activities (PFSAs), or portions thereof, that the IHS would otherwise provide for Indians because of their status as Indians. 25 U.S.C. § 450f

Title V (ISDEAA) Compacts: Federally recognized tribes or tribal organizations compact with the IHS to assume full funding and control over programs, services, functions or activities (PSFAs), or portions thereof, that the IHS would otherwise provide for Indians because of their status as Indians. 25 U.S.C. § 458aaa-3-4(b)

Trust responsibility: The responsibility of the federal government to honor treaties, compromises, and other bound agreements by inheriting the expectation to honor those agreements for the best interests of the tribes and its members.

Tribal sovereignty: The right of American Indians and Alaska Natives to govern themselves. The U.S. Constitution recognizes Indian tribes as distinct governments and they have, with a few exceptions, the same powers as federal and state governments to regulate their internal affairs.

Urban Indian Organization: a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a).

History & Legal Basis – Federal Trust Responsibility

Basic knowledge of historical context is critical to understanding the unique legal posture of tribes in relation to the federal government. Indian Law has always been heavily intertwined with federal Indian policy, including health policy, and over the years the law has shifted back and forth with the flow of popular and governmental attitudes toward Indians. There are, however, a few themes that have persisted and form the doctrinal basis of present law. Despite their complexity, they may be reduced to:

- The tribes are independent entities with inherent powers of self-government
- The independence of the tribes is subject to exceptionally great power of Congress to regulate and modify the status of the tribes
- The power to deal with and regulate the tribes is wholly federal; states are excluded unless Congress delegates power to them
- The federal government has a responsibility for the protection of the tribes and their properties, including protection from encroachment by the states and their citizens.

As noted by the Supreme Court in United States vs. Mitchell (1983), the '**trust responsibility**' is a legal principle that is "the undisputed existence of a general trust relationship between the United States and the Indian people." Federal Indian law emphasizes this relationship as one of its most significant and motivating concepts.

It was the Supreme Court's early interpretations of Indian treaties that recognized a federal-Indian trust relationship. Between 1787 and 1871, the U.S. entered into nearly four hundred treaties with Indian tribes. Generally, in these treaties, the U.S. acquired land and resources from the tribes. In return, the U.S. set aside other reservation lands for those tribes and guaranteed that the federal government would respect the **sovereignty** of the tribes, protect the tribes, and provide for the well-being of the tribes and their citizens. Among these legal duties, moral obligations, understanding and expectancies are the funding and delivery of health care services.[1]

The responsibility to provide quality health care to American Indian and Alaska Native (AI/AN) people is based on the Indian Commerce Clause of the U.S. Constitution, confirmed through treaties, federal law, and federal court decisions. The Indian Health Care Improvement Act (P.L. 94-437), along with the Snyder Act of 1921 (25 U.S.C. 13), form the statutory (legal) basis for the delivery of federally funded health care to AI/AN people.

The Indian Health Service (IHS), a federal health agency within the U.S. Department of Health of Human Services, is the primary system through which the U.S. government attempt to fulfil its legal responsibility to provide health services to AI/AN peoples. Since its creation in 1955, IHS has worked toward fulfilling the federal promise to provide health care to Native people.[2]

To fully understand the unique **I/T/U** (IHS, Tribal, and Urban Indian, respectively) healthcare system today, it is necessary to understand the different acts passed by Congress that have shaped the current healthcare environment in Indian Country.

Table 1: Significant Events in AI/AN Federal Health Care History[3]

Date	Significant Events
1824	Establishment of the Bureau of Indian Affairs (BIA).
1832	First federal health assistance for AI/AN people when Congress appropriated $12,000 for a health program.
1921	Passage of the Snyder Act, which authorized discretionary funded health services for AI/AN people.
1928	Published Meriam Report, which described serious morbidity among AI/AN people and insufficient health care services.
1934	Passage of the Indian Reorganization Act, which emphasized **tribal sovereignty**, economic self-sufficiency, and **federal trust responsibility**.
1954	Passage of the Transfer Act, which transferred the health care of AI/AN people from the Department of the Interior and the Bureau of Indian Affairs to the Department of Health, Education, and Welfare (now the Department of Health and Human Services) under the agency that is now the IHS.
1955	Establishment of the IHS.
1959	Passage of the Indian Sanitation Facilities Construction Act, which amended the Transfer Act and established measures for safe water and sewage disposal.
1975	Passage of the Indian Self-Determination and Education Assistance Act (ISDEAA), which authorized individual Tribes to engage in **contracts** and **compacts** to assume administration of BIA and IHS services upon request. The ISDEAA signified the U.S. government's acknowledgment of **tribal sovereignty** and the importance of tribal decision-making in tribal affairs.
1976	Passage of the Indian Health Care Improvement Act (IHCIA), which authorized funds for the IHS and Urban Indian Health programs (Title V). IHCIA included authorization to collect from Medicare, Medicaid, and other third-party insurers for services provided at IHS or tribal facilities.
1992	Amendment of the IHCIA, which made the IHS director an appointee of the president. An amendment to the ISDEAA created a Tribal Self-Governance Demonstration Project within the IHS, giving Tribes the choice of entering into self-governance compacts to gain more control over the management and delivery of their health care programs. Additionally, the IHS Office of Tribal Self-Governance was created to manage the Tribal Self-Governance Program.
2000	Congress passed the Tribal Self-Governance Amendments, which created Title V of the ISDEAA, and approved the IHS Tribal Self-Governance Program.
2010	Permanent reauthorization of the IHCIA as part of the Affordable Care Act (ACA). The ACA also included special provisions for AI/AN populations.

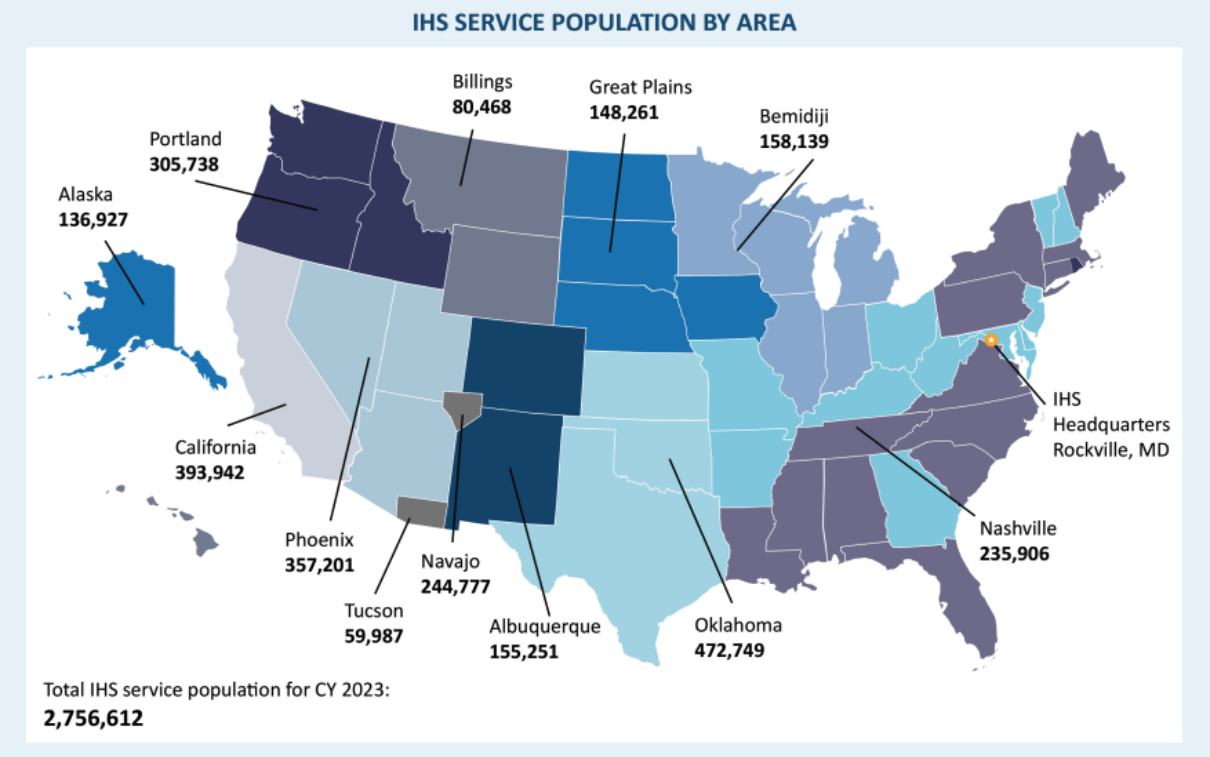
Present-Day Indian Health Care System

The federal government provides health care for Indian people as part of its **trust responsibility**. This is done through a network of tribal, federal, national, state, local, and

nonprofit programs, as well as entities composing the Indian Health System. This system has three major components, collectively referred to as the **I/T/U** (for IHS, Tribal, and Urban, respectively).[4]

Indian Health Service

The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for the administration of health care for approximately 2.7 million AI/AN people across 37 states.[5] The IHS is divided into 12 regional offices, also known as area offices. See Map 1 for the areas and population served in each area.



Map 1: IHS Service Population by Area[5]

American Indian and Alaska Native people living on reservations, or in or near Alaska villages receive the bulk of IHS funds. Additionally, Congress has also authorized funding for programs that provide some health services to urban-dwelling American Indian and Alaska Native people (see Urban Indian Health Programs on page 6).

Health care is provided within the IHS system in three ways:

1. Directly by the IHS
2. Via tribally contracted and operated programs
3. By purchasing care from private providers (see Purchased/Referred Care).

Table 2: Healthcare Facilities Operated by the IHS and by Tribes (as of December 15, 2021)[6]

Type of Facility	Operated by IHS	Operated by Tribes
Hospital	24	22
Health Center	51	319
Health Station	25	79
Alaska Village Clinic	N/A	146
School Health Center	12	8

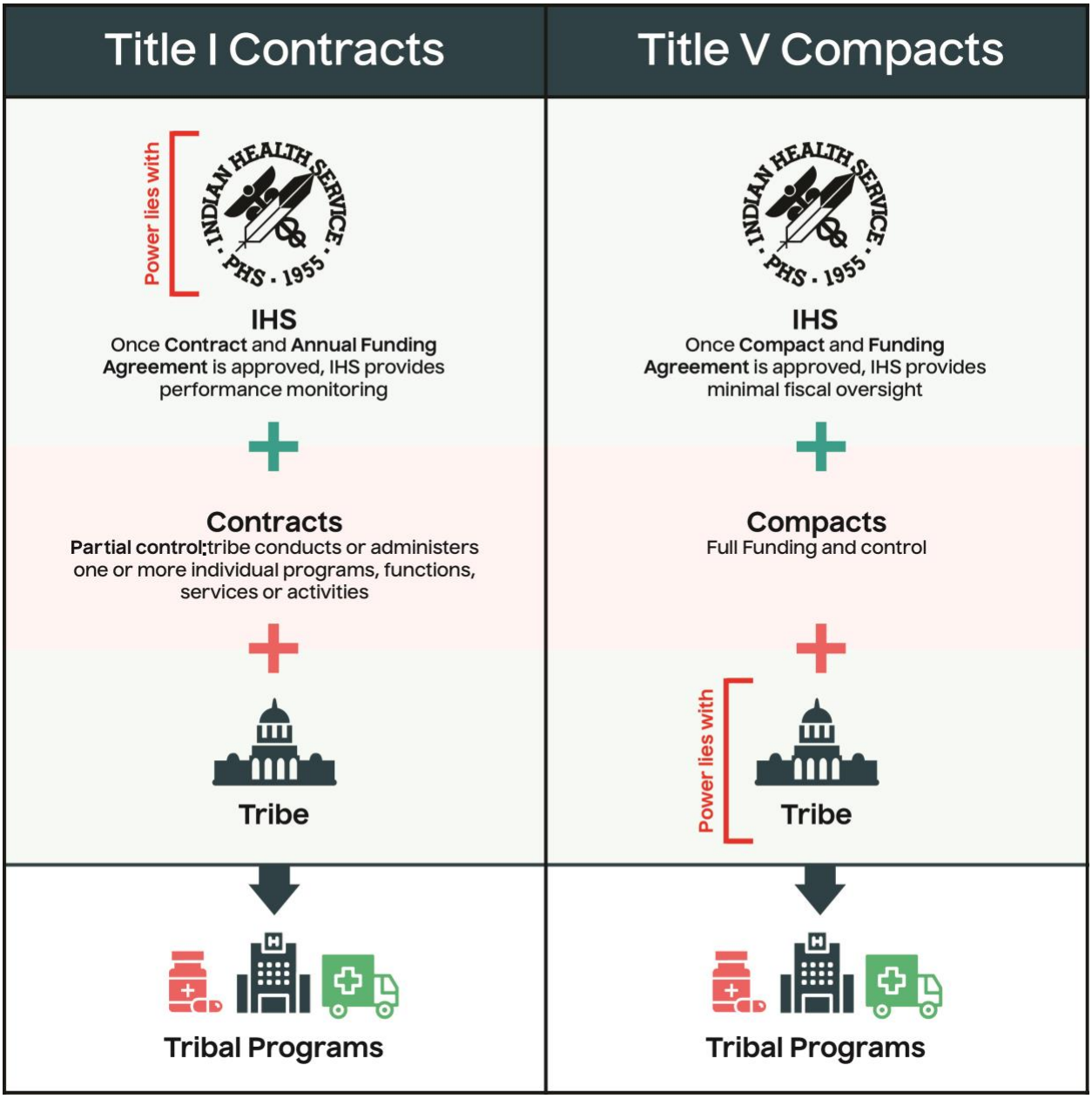
Tribally Operated Health Care Services

Federally recognized tribes are recognized by law as **sovereign** entities with the power to govern their internal affairs. The legal authority of tribal governments to determine their own health care delivery systems, whether through IHS or tribally operated programs, must be honored.

The Indian Self-Determination and Education Assistance Act (ISDEAA) of 1975 gave tribes the choice of whether to take over the administration and operation of health services from the U.S. Government or to remain with the government's direct health system.[7]

In order to meet the health care delivery challenges of their communities, tribal governments are developing innovative solutions. Tribes consider the needs and circumstances of their members when selecting from available health care options. Tribes may choose one or a combination of the following options:

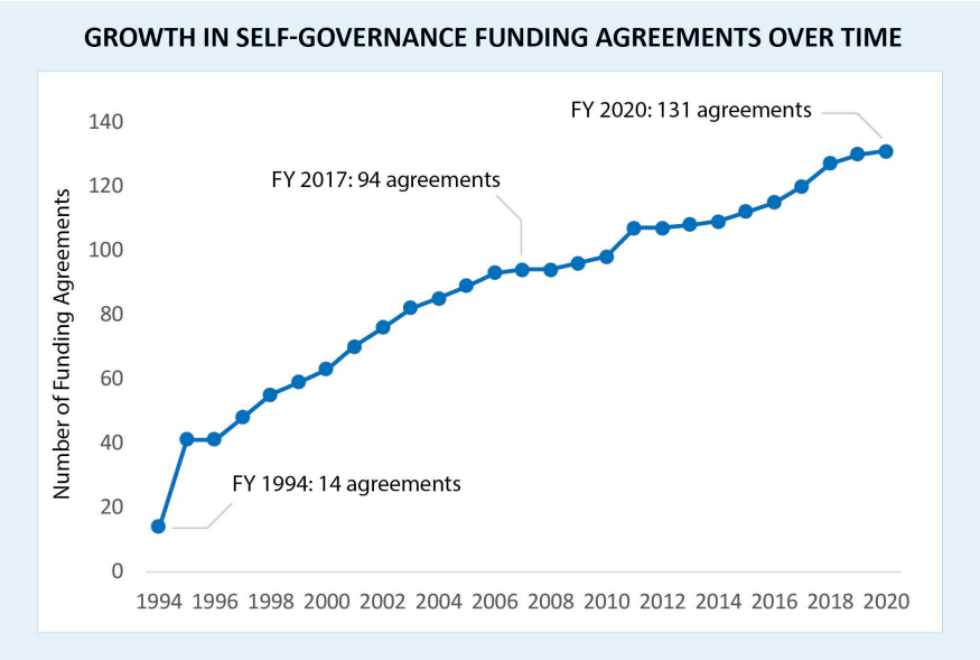
1. Continue to receive direct health care services offered by the IHS.
2. Use the authority of the Indian Self-Determination and Education Assistance Act (ISDEAA), Titles I and V, to assume responsibility, in part or in whole, for health care formerly offered by the federal government. Tribes may contract with the IHS through self-determination contracts and annual funding agreements under Title I or self-governance compacts and funding agreements under Title V. Tribes that enter contracts or compacts are also referred to as "**638 tribes**," named after Public Law (P.L.) 93-638.
3. Fund the establishment of their own programs or supplementation of ISDEAA programs.



Under ISDEAA, also known as Public Law (P.L.) 93-638, a federally recognized tribe or tribal organization may **contract** with the IHS to conduct or administer one or more individual programs, functions, services or activities.

Today, the option to enter a self-governance **compact** gives tribes the ability to tailor their healthcare services to the unique needs of their communities. This program has continued to be successful, as there is an increasing number of tribes choosing to participate (see Figure 2). As of 2020, the IHS and 135 tribes have negotiated 131 self-governance funding agreements. The Tribal Self-Governance program constitutes over 60% of the IHS budget.[8,5]

Figure 2: Growth in Title V Self-Governance Funding Agreements Over Time[5]



Urban Indian Health Programs

As stated in Section 3 of the Indian Health Care Improvement Act, P.L. 94-437, "it is the policy of the Nation, in fulfillment of its special responsibilities and legal obligations to the American Indian people, to ensure the highest possible health status for Indians and urban Indians."

Roughly 70 percent of American Indian and Alaska Native people live in urban areas. Urban Indians not only experience the same health problems as the general AI/AN population, but a lack of family and traditional cultural environments exacerbate their mental and physical health problems. Recent studies reveal that poor health status and lack of adequate health care services are serious problems for most urban Indians. This reality is reflected in the 2021 report published by The Urban Indian Health Institute, a division of the Seattle Indian Health Board, called "Community Health Profile: National Aggregate of Urban Indian Organization Service Areas." The report showed that substantial health disparities exist for urban Indians when compared with the general population.

As part of its efforts to provide better health care services for urban Indians, the IHS Office of Urban Indian Health Programs (OUIHP) was created in 1976. Health care and referral services for urban Indians throughout the U.S. are provided by the IHS through limited, competitive contracts and grants with 41 **Urban Indian Organizations** (UIOs). UIOs provide access to culturally appropriate and quality health care services. The OUIHP 4-in-1 grant program provides funding to UIOs to address four health program areas:

1. **Full Ambulatory Care**: Programs providing direct medical care for 40 or more hours per week to the population served.
2. **Limited Ambulatory Care:** Programs providing direct medical care to the population served for less than 40 hours per week.
3. **Outreach and Referral:** Programs providing case management of behavioral health counseling and education services, health promotion/ disease prevention education, and immunization counseling but not direct medical care services.
4. **Residential Treatment Center:** Programs providing residential substance abuse treatment, recovery, and prevention services.[9]

The types of services that are offered by the 41 programs vary from clinic to clinic. To learn more about specific services provided, visit: https://www.ihs.gov/urban/aboutus/

To find an Urban Indian Organization, visit https://www.ihs.gov/urban/urban-indian-organizations/.

Purchased/Referred Care

A vital component of providing comprehensive health care services to AI/AN people is the Purchased/Referred Care Program (PRC). In addition to delivering direct care services in IHS, tribal, and urban (I/T/U) health facilities, the IHS health system also offers Purchased/Referred Care services, which are rendered by non-IHS providers. The PRC is intended for I/T/U facilities to purchase services from private health care providers in the following situations:

1. There are no direct care facilities operated by the IHS or tribes;
2. There is no direct care element in place to provide emergency and/or specialty health care;
3. Direct care utilization exceeds available staffing; and
4. Supplementation of alternate resources (e.g., Medicare, Medicaid, or private insurance) is required to provide comprehensive health care to eligible AI/AN people.

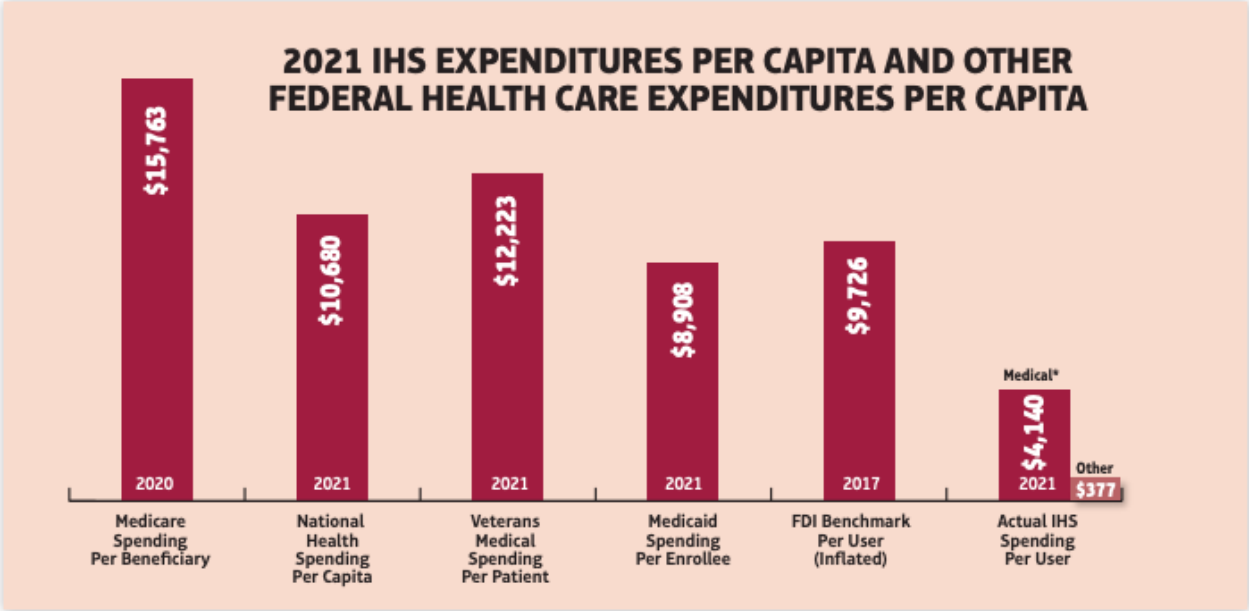
Due to growing AI/AN populations, limited funding, medical inflation, and limited pricing options, PRC guidelines must be strictly followed to ensure effective use of resources. PRC payments are made according to clearly defined guidelines and are dependent upon the availability of funds. PRC guidelines are stricter than those for IHS direct care and apply to qualifying factors such as medical priorities of care and eligibility requirements.[10]

Funding

Funding for IHS

Historically, funding for the IHS has been inadequate to meet the needs of tribal and urban Indian healthcare. There are significant funding disparities in per capita spending for the IHS compared to other federal healthcare programs (Medicaid, Medicare, and Veterans Health Administration), see Figure 3.

Figure 3: 2021 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita[11]



"A difference between the funding mechanism for IHS compared to Medicaid and Medicare is that IHS must deliver services within its available appropriation; an increasing number of people served could result in reductions in per capita spending unless funding is also increased. In contrast, Medicaid and Medicare are entitlement programs that do not have spending caps, so spending generally increases as the population served grows."
- ASPE IHS Funding Disparities Report 2022

The Tribal Budget Formulation Workgroup comprised of tribal leaders from across the country concluded that **funding for the IHS addresses only an estimated 48.6% of the health care needs for AI/AN people**.

"Funding for the IHS has historically been subject to year-by-year discretionary allocations from Congress, which creates substantial long-term uncertainty in funding levels and makes it challenging to maintain and modernize needed health care infrastructure." – ASPE IHS Funding Disparities Report 2022

Additional Information

Organizational Structure of IHS

Urban Indian Organization: National Uniform Data System Summary Report – 2019

Organizations Involved in Tribal Health (Not Part of I/T/U System):
National Council of Urban Indian Health – A national nonprofit that provides technical assistance and support to Urban Indian Organizations (UIOs).

National Indian Health Board – A national organization that advocates as the united voice of federally recognized tribes for improving AI/AN peoples healthcare.

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[1] Candy, W.C. (2009). The Special Relationship Between the Federal Government and the Tribes. In American Indian Law in a Nutshell (5th ed., pp. 35-64). West Academic Publishing.

[2] National Indian Health Board. (2014). Indian Health Care 101. https://www.nihb.org/docs/01132015/Indian%20Health%20Care%20101.pdf

[3] Kruse, G., Lopez-Carmen, V.A., Jensen, A., Hardie, L., & Sequist, T.D. (2022). The Indian Health Service and American Indian/Alaska Native Health Outcomes. Annual Public Health Reviews, 43, 559-576. https://doi.org/10.1146/annurev-publhealth-052620-103633

[4] Northwest Center for Public Health Practice. (n.d.). Health Care Overview: the I/T/U. https://www.nwcphp.org/docs/tribes-toolkit/tribal/itu.html

[5] U.S. Department of Health & Human Services. (2022). Fiscal Year 2023 Budget in Brief. https://www.hhs.gov/sites/default/files/fy-2023-budget-in-brief.pdf

[6] Office of the Assistant Secretary for Planning and Evaluation – Office of Health Policy. (2022, July 22). How Increased Funding Can Advance the Mission of the Indian Health Service to Improve Health Outcomes for American Indians and Alaska Natives. https://aspe.hhs.gov/sites/default/files/documents/1b5d32824c31e113a2df43170c45ac15/aspe-ihs-funding-disparities-report.pdf

[7] Indian Self-Determination and Education Assistance Act of 1975, Pub. L. No. 93-638, 88 Stat. 2206 (codified in scattered sections of 5 U.S.C. and 25 U.S.C.).

[8] Indian Health Service. (2022). Self-Governance Tribes. https://www.ihs.gov/selfgovernance/tribes/

[9] Indian Health Service. (2020). Urban Indian Organization: National Uniform Data System Summary Report – 2019. https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/2019_UIO_UDS_Summary_Report_Final.pdf

[10] Indian Health Service. (2016). Purchased/Referred Care (PRC) [fact sheet]. https://www.ihs.gov/newsroom/factsheets/purchasedreferredcare/

[11] IHS Tribal Budget Formulation Workgroup. (2022). The National Budget Formulation Workgroups' Recommendations on the Indian Health Service Fiscal Year 2024 Budget. https://www.nihb.org/docs/09072022/FY%202024%20Tribal%20Budget%20Formulation%20Workgroup%20Recommendations.pdf

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