Advancing Nevada Tribal Health Care

Identifying Barriers, Priorities and Opportunities

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The Special Trust Responsibilities and Legal Obligations in Indian Health Care

Treaties between the United States and Tribal nations provide the original legal foundation of the Federal Government obligation to provide health care for American Indians and Alaskan Natives (AI/AN). Through these treaties, seizure of tribal nations' land and resources by the United States was to be compensated by the Federal Government's promise to provide payments and services, including the promise to provide health care to Tribal Citizens.

The modern authorization for the provision of health services to AI/ANs is the Indian Health Care Improvement Act, and the primary authorization to pay for federal services for the general welfare remains the Snyder Act.

Congress has also passed additional statutes directing the Indian Health Service (IHS) to provide health care to AI/ANs. Based on this body of law, the IHS describes the trust responsibility as follows:

> ***"The trust relationship establishes a responsibility for a variety of services and benefits to Indian people, including health care. This relationship has been defined in case law and statute as a political relationship . . . Treaties between the United States government and Indian Tribes frequently call for the provision of medical services, the services of physicians, or the provision of hospitals for the care of Indian people."***

Understanding the Indian Health Care Delivery System

Indian, Tribal and Urban Indian Health

The Indian Health Service (IHS), an operating division of the U.S. Department of Health and Human Services, provides culturally appropriate care to American Indians and Alaskan Natives (AI/ANs) across the Nation. The IHS provides such services a variety of ways. This varied system of delivery is commonly referred to by its initials: I/T/U (IHS, Tribal, and Urban).

As federal policy evolved toward the recognition of tribal sovereignty and encouragement of self-determination, tribal governments were given the option of assuming control over various federal programs. The Indian Self-Determination and Education Assistance Act (ISDEAA) of 1975 provided tribes with the option of managing IHS health care programs in their communities pursuant to contracts with the federal government, as well as funding to improve the tribal capacity to operate those health care programs.

I

Indian Health Service

- Tribes may choose to receive services from IHS directly, through agency-operated programs, also known as a Direct Service Unit

T

Tribal Health

- Tribes may choose to operate tribal health programs and clinics through an ISDEAA Title I Contract or Title V Self-Governance Compact Agreement, or they may combine these options based on their needs and preferences.

U

Urban Indian Health

- IHS also provides limited funding for urban Indian health programs that serve AI/ANs living outside of reservations.

NEVADA Indian Healthcare

IHS Health Facilities

- Irene Benn Health Clinic, Moapa, NV
- Southern Bands Health Center, Elko, NV

Urban Health

Nevada Urban Indians, Inc., Medical Clinic - Reno, NV

Tribal Health

- Battle Mountain Clinic
- Duckwater Health Clinic
- Fallon Tribal Health Clinic
- Fort McDermitt Wellness Center
- Las Vegas Paiute Health Station
- Newe Medical Health Clinic
- Owyhee Community Health Facility
- Pyramid Lake Tribal Health Clinic
- Reno Sparks Tribal Health Center
- Walker River Paiute Tribe Health Clinic
- Washoe Tribal Health Center
- Yerington Paiute Tribal Health Center

Health Disparities of American Indians and Alaskan Natives

Infant Mortality

- AIAN have almost twice the infant mortality rate of non-Hispanic whites (NHW)
- AIAN infants are 2.7 times more likely to die from accidental deaths than NHW
- AIAN infants are 50% more likely to die from complications related to low birthweight compared to NHW
- AIAN mothers were almost 3 times more likely to receive late or no prenatal care compared to NHW

Obesity and Diabetes

- AIAN adolescents are 30% more likely to be obese than non-Hispanic whites (NHW)
- AIAN adults are 50% more likely to be obese than NHW
- AIAN adults are almost 3 times more likely to be diagnosed with diabetes than NHW
- AIAN were 2.3 times more likely to die from diabetes than NHW
- AIAN were twice as likely to be diagnosed with end stage renal disease than NHW

Heart Disease

- AIAN were 50% more likely to be diagnosed with coronary heart disease than NHW
- AIAN were 50% more likely to be current cigarette smokers as compared to NHW
- AIAN were 10% more likely to have high blood pressure compared to NHW
- AIAN adults are more likely to be obese, have high blood pressure and more likely to be current cigarette smokers than NHW, all risk factors for heart disease

Cancer

- From 2014-2018 AIAN men were almost twice as likely to have liver and IBD cancer compared to NHW
- AIAN men are 30% more likely to have stomach cancer than NHW
- AIAN women are 2.3 times more likely to have, and 2.2 times as likely to die from liver and IBD cancer than NHW
- AIAN women are 20% more likely to have kidney/renal pelvis cancer than NHW

Chronic Liver Disease

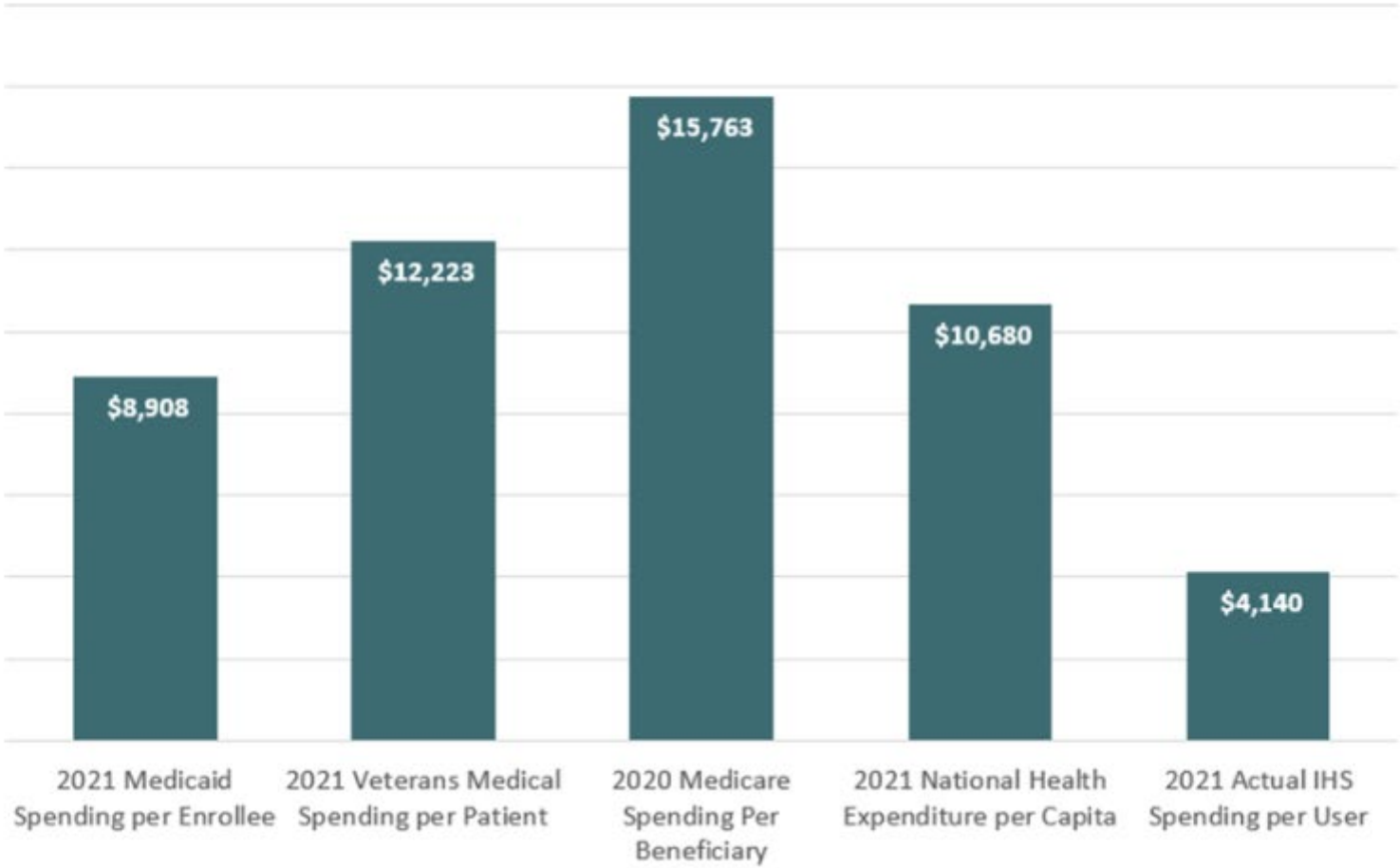
- In 2019, chronic liver disease was the 4th leading cause of death for all AIANs, and the 2nd leading cause of death for AIAN men, ages 35-44
- In 2018, AIAN were 1.6 times more likely to be diagnosed with chronic liver disease compared to non-Hispanic whites (NHW)
- The overall death rate for AIAN is almost 4 times higher than the NHW population
- AIAN women are 2.2 times as likely to be diagnosed with chronic liver disease and 4.8 times more likely to die from chronic liver disease as compared to NHW

Mental and Behavioral Health

- In 2019, suicide was the 2nd leading cause of death for AIANs between the ages of 10-34
- AIAN are 60% more likely to experience the feeling that everything is an effort, all or most of the time, as compared to NHW
- In 2019, adolescent AIAN females, aged 15-19, had a death rate that was 5 times higher than NHW females in the same age group
- In 2018, AIAN males, ages 15-24, had a death rate that was twice that of non-Hispanic white males in the same age group
- According to the CDC, in 2021 over 290 Americans died each day from drug overdose. in 2021, 1,358 AIAN died to opioid overdose, the highest rate of any racial or ethnic group across the nation.

Violent deaths, unintentional injuries, homicide, and suicide account for 75% of all mortality in the second decade of life for American Indian and Alaskan Natives

IHS per Capita Spending is 50% of the Nearest Federal Health Program Expenditure



Federal Medicaid Administrative Percentage (FMAP)

In 1976, the Indian Health Care Improvement Act amended the Social Security Act to permit reimbursement by Medicare and Medicaid for services provided to American Indians and Alaska Natives in Indian Health Service (IHS) and tribal health care facilities. In doing so, Congress recognized that many Indian people, especially those residing in very remote and rural locations, were eligible for but could not access Medicaid and Medicare services without traveling sometimes hundreds of miles to Medicaid and Medicare providers located off reservation. The Indian Health Care Improvement Act also provided states with a 100% Federal Medical Assistance Percentage (FMAP) for Medicaid services provided through an IHS or Tribal facility. The amendments to the Social Security Act created a direct relationship between CMS and the Indian Health Service delivery system that continues today.

These protections were further augmented by Section 5006 of the American Recovery and Reinvestment Act (ARRA) of 2009. The Indian Health Care Improvement Act (IHCIA), the cornerstone legal authority for the provision of health care to American Indians and Alaska Natives, was made permanent when President Obama signed the bill on March 23, 2010, as part of the Affordable Care Act. The authorization of appropriations for the IHCIA had expired in 2000, and while various versions of the bill were considered by Congress since then, the act now has no expiration date.

When Congress first authorized 100% FMAP for the Indian health system in 1976, it did so because it recognized that "Medicaid payments are a much-needed supplement to a health care program which has for too long been insufficient to provide quality health care to AI/ANs" and because "the Federal government has trust obligations to provide services to Indians, it has not been a State responsibility."

FMAP Examples of AI/AN Medicaid Encounters

IHS/Tribal Clinics

$719

100% FMAP

Billed at All Inclusive Rate (AIR)

Up to 5 Medicaid encounters per day

No cost to State budget

Non-Indian Medicaid Provider

$105

68.85% FMAP

Billed at Medicaid fee rate

Cost of Care for State

Access to Care is difficult

Non-Indian Medicaid Provider WCCA

$105

100% FMAP

Billed at Medicaid fee rate

Billing modifier for 100% FMAP

No cost of care to State

Access to care is difficult

Non-Indian Medicaid Provider WCCA

$147

100% FMAP

Billed to Tribal Clinic at negotiated rate (Medicaid rate +40%)

Billed to Medicaid at AIR rate, with modifier

Improves access to care

Beneficial to Patient, Medicaid Provider, Tribal clinics and State Budget

Health Equity

Cultural and Traditional Strengths

Recognize that our Tribes and tribal programs have the knowledge, expertise, and authority to design and deliver services in ways best suited for our tribal communities, building on cultural strengths and traditions

Understanding Tribal Sovereignty

Effective efforts for health equity in Indian country MUST approach health equity through the lens of tribal sovereignty, the Government-to-Government relationships, and the Federal Trust Responsibility

Focus on the political status and not the politics

It must conceptualize the work around an understanding of American Indians and Alaskan Natives as a group with a unique political status, not as a racial minority

Tribal Medicaid Determination

Expand the ability of Tribal Benefit Coordinators to be trained and make onsite Medicaid determinations

Expand Tribal Medicaid Reimbursement for Rx

Support a State Plan Amendment to expand Medicaid reimbursement for all prescriptions/refills covered under the Medicaid benefit plan

Tribal Medicaid Administrative Activities

Look at partnering with Tribes to develop a pathway to claim for reimbursement of Medicaid Administrative Activities

Implement Cultural Based Practices into EBP model

Work with the Tribes in allowing "Cultural based practices" to be accepted as strongly as Evidence Based Practices for prevention needs

AI/AN Status for Medicaid applications

Add a new "AI/AN status" as a marker for Medicaid and other public applications to ensure AIAN data and allowances are not being bypassed under the "race" demographics

Reinvest 100% FMAP Savings

Reinvest savings of 100% FMAP on behalf of AIANs, back into tribal programs to assist AIAN beneficiaries

Develop Tribal Set-Aside Options

Develop tribal set-aside funding to assist tribes in building capacity; an example is Prevention funding to each tribal clinic

Expand the Silver State Health Insurance Exchange Board of Directors to add a permanent Tribal Representative Seat

Tribal Sponsorship

The Affordable Care Act (ACA) provides an opportunity for Tribes and Tribal clinics to establish a Tribally-sponsored program to purchase health insurance for their uninsured members. Tribal sponsorship provides for expanded access to health care for AI/ANs.

Limited and Zero Cost Sharing

The ACA established Indian specific cost sharing protections, under which AI/ANs who are enrolled members of Federally recognized tribes pay no deductibles, coinsurance, or copayments when receiving essential health benefits. Tribal members can enroll in either a zero or limited cost-sharing plan, depending on their income level. Other AI/ANs who are eligible for services through the IHS and have a household income at or less than 250% of the federal poverty level (FPL), can obtain general (partial) cost-sharing protections if they enroll in a silver plan

Aggregate Billing,

45 CFR 156.1250 requires QHP Issuers to accept premium and cost-sharing payments for tribal members directly from Indian tribes, tribal organizations, or urban Indian organizations. By default, the monthly premiums for these enrollments are managed on an individual policy basis. CFR 155.240(b) therefore further leveraged the authority granted by 45 CFR § 155.240(b) to establish terms and conditions which will standardize the aggregated payment of premiums for tribal enrollees by Tribal Health Clinics.

Contracting and IHCIA Provisions

IIHCIA section 206, as amended by the ACA, stipulates that an IHCP can bill a QHP issuer for covered services provided to plan enrollees, regardless of whether the IHCP participates in the provider network of the plan. Specifically, IHCIA section 206 provides for a right of recovery from insurance companies and other third-party entities, including QHP issuers.

Strengthen Tribal Public Health Capacity and Infrastructure

- Expand surveillance and epidemiology capabilities and honor Tribal data sovereignty
- Invest in Tribal Health Research Capacity
- Assist in funding for tribes to complete tribal health need assessments
- Support Tribal funding for climate resilience, climate adaption, first responders training and community education

Mo Sepk'eec'a (Thank you)

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