**Health Services on Tribal Lands**

**and for Native American and Alaska Native (NA/AN) populations**

**Judith (Judy) Williams**

**DRAFT June 7, 2021, revised August 12, 2021**

**Legal Basis**

Health care for Native Americans (nations, tribes and urban Indians) is primarily a federal affair. The US Constitution, various treaties and a body of law have defined federal responsibilities to tribes. Healthcare has been one of these treaty obligations. The Snyder Act of 1921 authorized federal funds for American Indian health care. This responsibility was reasserted and made permanent in the 2010 Patient Protection and Affordable Care Act (ACA). Other legislation covers health care facilities, alcohol and substance abuse treatment, child protection, and family violence prevention.

**How is health care funded and provided?**

The Indian Health Service (IHS) in the Department of Health and Human Services (DHHS) has the authority and responsibility to provide health services to federally recognized American Indians and Alaska Natives. This includes services to those living in tribal and urban areas. Services and facilities include hospitals and clinics. In addition, the population is eligible for all other federal, state and local services provided in the general community. The IHS also pays for services for urban Indian health programs.

In reality, the IHS has been underfunded for decades and does not provide a complete range of services. Hospitals on the reservations provide only basic services for the most part; specialty care and most surgical procedures must be obtained from community health care providers, usually off the reservation. The DHHS states that the IHS only meets half the need because of lack of funding [1].

The ACA stipulates that the Native American population must obtain health insurance through the health care exchanges or Medicaid (for the indigent). The Native population is also eligible for coverage under Medicare (for the aged and disabled). There are no charges for Medicaid or HIS services. The ACA has built-in cost-sharing for premiums and copays based on income.

An additional deficiency is that adequate consultation with tribes does not always occur. One recent example was the IHS decision, in the midst of the Coronavirus pandemic, to end emergency, inpatient hospital care, and other services at the Acoma-Canoncito-Laguna Service Unit hospital. Acoma sued the IHS for violating federal law [2]. In May 2021 the federal government settled with the tribe, committing to keep the facilities open until February 2022. Meanwhile, the Pueblo will create a plan for hospital and regional health care in partnership with the IHS.

Lack of funding is but one of the factors that has resulted in great health disparities in the native population. Others include the continued marginalization of the population, lack of employment, and inadequate education. Health disparities are differences in certain health conditions and outcomes that are worse for populations burdened by economic, social and environmental disadvantages. The Native American and Alaska Native population is at greater risk for diabetes, alcoholism, cancer [3] and other conditions.

**Budget Issues**

Since the IHS does not provide the complete package of health care needed, the AI/AN population is expected to enroll in health insurance programs via private insurance through the exchanges, Medicare, Medicaid and/or the Children’s Health Insurance Program (CHIP). Things like specialty care, ambulance services and services away from tribal lands must be paid by other sources.

The Biden administration has proposed an $8.5 billion budget for fiscal year 2022, an increase of $2.2 billion, or 36%, over fiscal year 2021. This is discretionary funding for the IHS and would be the largest increase in decades. DHHS says it will begin to address health disparities in indigenous populations. It is expected to expand access to health care services, modernize aging facilities and information technology infrastructure, and address urgent health issues, including HIV and hepatitis C, maternal mortality, and opioid use. It also includes funding to improve health care quality, enhance operational capacity, and recruit and retain health care providers [4].

The ACA also includes expanded services to address health disparities. The ACA includes a large number of items that are often overlooked in the debates and public perceptions about the legislation. Improving capacity of the safety net and overall quality of care are among the important elements of the act.

**Services**

In addition to basic hospital and clinic care, the IHS provides public health and prevention services, behavioral health services, diabetes care, and drug and alcohol prevention and treatment. However, these services are not readily available in many areas.

**The states’ role – New Mexico**

There is an Office of Tribal Liaison at the New Mexico Department of Health (NMDOH). It is responsible for communication and collaboration to “promote better health and wellness outcomes” (NMDOH Office of Tribal Liaison); leverage all DOH resources and programs; serve as information exchange; facilitate training; and provide technical assistance. The NM DOH does not provide direct services.

The State-Tribal Collaboration Act (NM SB 196, 2009) requires the state to work with tribes, pueblos and nations on a government to government basis. An intergovernmental group developed policies to promote communication and collaboration. Annual reports are required and produced [5].

**Tribal law and health care**

Tribes can make their own laws about public health emergencies, preparedness, and occupational safety and health [6]. They have the right to determine how they conduct emergency efforts, according to their own needs. This is a sovereign nation right and responsibility. (They can also regulate motor vehicle safety.)

A recent amendment to the ACA designates tribal epidemiology centers as public health authorities. It grants tribes certain rights to make their own laws in this regard. They can enter into cooperative agreements with other governmental entities to collect and analyze data. There are two such centers in New Mexico: the Navajo Nation and the Albuquerque Area Southwest.

**Counting is difficult**

Epidemiological data is considered public health data, and is critical to the identification, tracing, tracking, and measurement of disease and health outcomes. It is used in developing prevention and treatment programs and is critically important in controlling and eradicating communicable diseases. Communicable disease in individuals as well as deaths and cause of death are required to be reported to states, usually to the health departments.

In order for tribes to know what’s occurring on their lands, they must obtain this data but the tribal epidemiology centers have difficulty doing so. Some states are reluctant, or downright refuse, to share data with tribes. The often-heard reason is “HIPAA,” the law that governs confidentiality of medical records. It is widely misinterpreted as meaning data cannot be shared with anyone, ever. In fact, data can be shared for coordination of care among medical providers, and also can be de-identified and presented in aggregate form, thus protecting individual identities. [7].

A recent Searchlight New Mexico article published by *High Country News* highlights the challenges faced by tribes in counting COVID-19 related illness and deaths [8]. They report that Arizona, Utah, and New Mexico, the states in which the Navajo Nation is located, refuse to share this data. This is in spite of the collaboration requirement described above.

The IHS often does not have, or does not share, such data either (ibid.). Accurate data is hampered by misidentification of race/ethnicity and cause of death throughout the system. A common problem is the recording on death certificates of a cause of death that may be only a contributing cause, and not the immediate one. This has caused difficulties throughout the US during the COVID pandemic – instead of recording COVID as the cause of death, officials or a hospital might cite a heart attack, stroke or other accompanying condition.

# References

|  |  |
| --- | --- |
| [1] | Centers for Medicare & Medicaid Services, "10 Important Facts About Indian Health Service and Health Insurance," cms.gov, Baltimore, MD, 2016. |
| [2] | D. Walker, "Pueblo sues feds over hospital service," *Indian Country Today,* 29 January 2021. |
| [3] | S. C. Melkonian, H. K. Weir, M. A. Jim and B. Preikschat, "Incidence and trends of the leading cancers with elevated incidence among American Indian and Alaska Native populations, 2012–2016," *American Journal of Epidemiology,* vol. 190, no. 4, p. 528–538, 2021. |
| [4] | Indian Health Service, *Statement by IHS Acting Director Elizabeth Fowler on the President's Funding Request for the Indian Health Service,* Indian Health Service, 2021. |
| [5] | Trustee, State of New Mexico Office of Natural Resources, "State-Tribal Collaboration Act FY 2020 Agency Report," The New Mexico Office of Natural Resources Trustee, Albuquerque, 2020. |
| [6] | Centers for Disease Control and Prevention, "cdc.gov," [Online]. Available: https://www.cdc.gov/phlp/publications/topic/tribal.html. [Accessed 11 June 2021]. |
| [7] | Office for State, Tribal, Local and Territorial Support, "Tribal Epidemiology Centers Designated as Public Health Authorities Under the Health Insurance Portability and Accountability Act," Centers for Disease Control and Prevention, 2015. |
| [8] | S. R. Clahchischiligi, J. Bennett-Begaye and C. Trudeau, "A broken system: Why the number of American Indian and Alaska Natives who have died during the coronavirus pandemic may never be known," *Searchlight New Mexico,* 8 June 2021. |