

The Indian Health Service (IHS): An Overview

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Summary

The IHS provides an array of medical services, including inpatient, ambulatory, emergency, dental, public health nursing, and preventive health care. The IHS does not have a defined medical benefit package that includes or excludes specific health services or health conditions. The majority of IHS facilities provide outpatient care, focusing on primary and preventive care including preventive screenings and health education. IHS provides services directly when possible; when needed services are not available, IHS beneficiaries may be referred to private providers for care. This is called purchased/referred care (PRC).

IHS also provides a number of health services that target common health conditions among IHS beneficiaries. These include services for diabetes prevention and treatment, behavioral health services including suicide prevention and methamphetamine treatment, and programs aimed at the prevention of infectious diseases. In addition to health services, IHS funds a number of activities related to its unique mission. These include construction and maintenance of IHS facilities, efforts to recruit and retain a skilled health workforce who will work at IHS facilities, and support for the overhead and expenses associated with contracts and compacts that the IHS enters into with ITs and TOs.

The federal government has long-standing involvement in Indian health. The Indian Health Care Improvement Act is the major authorizing legislation for the IHS. It was preceded by several laws that included more general authorization for federal Indian programs. A number of congressional committees exercise jurisdiction over legislation affecting the IHS, including its appropriations.

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Introduction

The Indian Health Service (IHS) within the Department of Health and Human Services (HHS) is the lead federal agency charged with improving the health of American Indians and Alaska Natives. The federal government considers its provision of these health services to be based on its trust responsibility for Indian tribes, a responsibility derived from federal statutes, treaties, court decisions, executive actions, and the Constitution (which assigns authority over Indian relations to Congress).¹ Congress is seen to have a moral obligation, not a legal one, to provide Indian health care.² Congress has reaffirmed its obligation to provide care to American Indians and Alaska Natives in the reauthorization of Indian Health Care Improvement Act (IHCIA),³ which is the major legislation authorizing most of IHS's activities. IHCIA stated that "it is the policy of the Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians to ensure the highest possible health status for Indians and urban Indians and to provide all the resources necessary to effect that policy...."

IHS provides health services to approximately 2.2 million American Indians or Alaska Natives who are members of 566 federally recognized tribes.⁴ The agency provides services directly or through contracts or compacts with Indian Tribes (ITs) or Tribal Organizations (TOs) under the authority of the Indian Self Determination and Education Assistance Act (ISDEAA).⁵ IHS also provides grants to Urban Indian Organizations (UIOs), under the authority of IHCIA Title V, to operate health service programs. More than half of all federally recognized tribes operate facilities or health programs, and nearly 40% of IHS's budget appropriation is administered by tribes.⁶ IHS's FY2016 appropriation is \$4.8 billion.⁷ IHS also receives a separate direct appropriation to support special diabetes programs⁸ and supplements its appropriation with funds from collections for care provided to American Indians and Alaska Natives enrolled in insurance

¹ Section 3 of the Indian Health Care Improvement Act (P.L. 94-437, 25 U.S.C. §1602).

² See Felix S. Cohen, *Felix S. Cohen's Handbook of Federal Indian Law* (1982 edition), Rennard Strickland, editor-in-chief (Charlottesville, VA: Michie Bobbs-Merrill, 1982), p. 677; and Felix S. Cohen, *Cohen's Handbook of Federal Indian Law* (2005 edition), Nell Jessup Newton, editor-in-chief (Newark, NJ: LexisNexis [Matthew Bender & Company], 2005), §22.01(3).

³ 25 U.S.C. §§1601 et seq; permanently authorized in §102201 of P.L. 111-148, as amended; for more detailed information see CRS Report R41630, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline*.

⁴ Certain other American Indians and Alaska Natives, including urban Indians, may also be eligible for health services at IHS-funded facilities. (See report section "IHS Eligibility"). U.S. Department of Health and Human Services, Indian Health Service, "IHS Year 2015 Profile," December 2015, <https://www.ihs.gov/newsroom/factsheets/ihsyear2015profile/>.

⁵ P.L. 93-638, as amended; 25 U.S.C. §450 et seq.

⁶ U.S. Department of Health and Human Services, Indian Health Service, "Tribal Self-Governance," January 2015, <http://www.ihs.gov/newsroom/factsheets/tribalselfgovernance/>.

⁷ P.L. 114-113; see discussion in CRS Report R44040, *Indian Health Service (IHS) Funding: Fact Sheet*, by Elayne J. Heisler.

⁸ The history of this appropriation and current authorized funding are described in CRS Report R43962, *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10)*, coordinated by Jim Hahn. Funding was most recently extended through FY2017 in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10).

programs.⁹ In total, IHS's FY2016 estimated program level funding (its appropriation, plus diabetes funding, and funds from collections) is \$6.1 billion.

IHS does not offer a standard set of medical benefits or services at all its facilities; rather available services vary by facility. These services are provided free to eligible American Indians and Alaska Natives (also called *IHS beneficiaries*) regardless of their ability to pay.¹⁰ In general, IHS facilities provide health and health education services that focus on primary and preventive care. These services are available through a system of facilities operated by the IHS, an IT, a TO, or a UIO. These facilities are also referred to collectively as "I/T/U." (IHS/Tribal/Urban). They are referred to collectively as *IHS-funded facilities* in this report.

IHS services are available to members of ITs who reside on reservations and in non-reservation areas of those counties that overlap or abut reservations, and in some urban areas with a significant American Indian/Alaska Native population. Not all American Indians and Alaska Natives receive services from IHS, but more than half (59%) who are eligible do.¹¹ Those eligible for IHS may choose not to receive care at IHS-funded facilities because they are geographically inaccessible, because needed services are not available, or for other reasons.

This report provides an overview of the IHS and the population it serves. Specifically, the report describes the IHS's service population, the agency's organization, the type of facilities that IHS operates and funds, and some specific IHS programs that focus on reducing rates of common health conditions among IHS beneficiaries. The report also describes some other IHS supported activities such as those to construct new facilities, increase the IHS workforce, and support contracts with ITs and TOs entered into under ISDEAA authority. The report also describes IHS's authorizing legislation and the congressional committees that exercise jurisdiction over the agency. The report concludes with two appendices. **Appendix A** discusses how different federal agencies estimate the size of the American Indian and Alaska Native population. **Appendix B** is a timeline that provides a brief history of the federal government's provision of health services to American Indians and Alaska Natives.¹²

IHS User Population

The IHS user population differs from the self-identified American Indian and Alaska Native population because not all self-identified American Indians and Alaska Natives are eligible for or use IHS services. Specifically, more people self-identify as being American Indian/Alaska Native than are eligible for or receive services at IHS. This section discusses IHS eligibility (including the broader service population) and how this differs from the self-identified American Indian and Alaska Native population. It also discusses IHS's actual user population and how this differs from

⁹ U.S. Dept. of Health and Human Services, Indian Health Service, *Fiscal Year 2016 Indian Health Service Justification of Estimates*, <http://www.ihs.gov/BudgetFormulation/documents/FY2016BudgetJustification.pdf>; hereinafter, *FY2016 IHS Budget Justification*. See also Figure 1 in CRS Report R44040, *Indian Health Service (IHS) Funding: Fact Sheet*, by Elayne J. Heisler.

¹⁰ For information about IHS eligibility, see report section "IHS Eligibility." IHS is statutorily prohibited from charging eligible American Indians and Alaska Natives for services (see 25 U.S.C. §1681 and 25 U.S.C. §458aaa-14), but 25 U.S.C. §1680r permits tribes providing IHS-funded services through an ISDEAA compact to bill American Indians and Alaska Natives. In addition, some urban programs may charge for services.

¹¹ Mark Carroll, "Innovation in Indian Healthcare: Using Health Information Technology to Achieve Health Equity for American Indian and Alaska Native Populations," *Perspectives in Health Information Management*, Winter 2011.

¹² This report does not discuss IHS funding. This information is available in CRS reports that discuss the Interior, Environment, and Related Agencies appropriations bills, see <http://www.crs.gov/pages/subissue.aspx?cliid=2346&parentid=73&preview=False>.

the IHS eligible population. In addition, **Appendix A** includes information about how various federal agencies estimate the American Indian and Alaska Native population.

IHS Eligibility

Not all self-identified American Indians and Alaska Natives are eligible for IHS services; rather, to be eligible for IHS services, American Indians or Alaska Natives must be members of an

Indian tribe (see text box for definition) or meet certain other requirements. In general, tribal membership is determined by the tribe. Many tribes require recognized descent from a particular tribal roll for membership. In tracing descent, tribes may follow paternal or maternal bloodlines, or both. Some tribes require minimum percentages of genealogical descent, and others require only proof of descent. For a few tribes, Congress has set membership criteria in statute.¹³

IHS Definitions of “Indian” and “Indian Tribe”

IHS uses the definition in Section 4 of the Indian Health Care Improvement Act (IHCIA, 25 U.S.C. §1603) which defines “Indian(s)” as “any person who is a member of an Indian tribe.” IHCIA defines the term “Indian tribe” to mean “... any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.”

In addition to tribal membership (i.e., meeting the IHS definition of Indian), certain other individuals are also eligible for IHS services because they:

- reside within an IHS health service delivery area, defined as a county where contract health services—also called purchased/referred care—are available;
- reside on tax-exempt land or have ownership of property on land for which the federal government has a trust responsibility;
- are recognized as an Indian by the community in which they live;
- actively participate in tribal affairs; or
- meet other relevant factors in keeping with general Bureau of Indian Affairs (BIA) practices in the jurisdiction for determining eligibility.¹⁴

A non-Indian woman pregnant with an eligible Indian’s child would be eligible for care at an IHS-funded facility during the pregnancy and six weeks following birth, as long as paternity is acknowledged. The IHS also serves non-Indians in specific circumstances, such as emergencies or when an acute infectious disease is involved.¹⁵

Most IHS services are intended for members of federally recognized tribes, but UIOs may also provide services to members of terminated tribes—tribes whose federal recognition was withdrawn by statute—or to tribes that states recognize, but are not recognized by the federal government.¹⁶ Members of terminated or state-recognized tribes are not eligible for services at facilities operated by the IHS, an IT, or a TO.

¹³ For example, P.L. 95-375 recognized the Pascua Yaqui Tribe of Arizona and set certain membership criteria.

¹⁴ 42 C.F.R. §136.12(a). The Bureau of Indian Affairs (BIA) is an agency within the U.S. Department of the Interior.

¹⁵ 25 U.S.C. §1680c: Health Services for Ineligible Persons.

¹⁶ 25 U.S.C. §§1603(f), 1651-1660d.

IHS User and Service Population

The *IHS user population* is a count of individuals who received care at an IHS-funded facility (including dental services and purchased/referred care services) one or more times in the prior three years.¹⁷ IHS estimates that its FY2014 user population was about 1.6 million.¹⁸ This number is smaller than the *projected IHS service population* of 2.2 million, which represents the total number of American Indians and Alaska Natives who live within IHS service areas (i.e., American Indians and Alaska Natives who live on or near a reservation).¹⁹ The service population is an estimate of IHS's potential user population (i.e., it includes individuals who do use IHS facilities as well as individuals who live near facilities and could use IHS, but have not done so in the prior three years). IHS estimates the service population using data from the decennial census conducted by the U.S. Census Bureau.²⁰ In non-census years, it adjusts the decennial census data for population changes using birth and death data from the National Center for Health Statistics, a center within HHS's Centers for Disease Control and Prevention.²¹ Both the user and the service populations are generally smaller than the IHS eligible population because not all individuals eligible for IHS services live within the IHS service area.

IHS Organization

The IHS health care delivery system serves federal reservations, Indian communities in Oklahoma and California, and Indian, Eskimo (Inuit and Yupik), and Aleut communities in Alaska. The system is organized into area offices, which are then further subdivided into service units.

Service units may contain one or more facilities and may serve one or more tribes (see text box). In FY2016, there are 12 area offices²² and 168 local service units.²³

IHS Service Unit

IHS service units are administrative entities within a defined geographical area through which services are directly or indirectly provided to eligible Indians. A service unit may cover a number of small reservations, or, conversely, some large reservations may be covered by several service units.

As shown in **Figure 1**, the 12 area offices generally cover one or more states with the exception of the Alaska area office, which organizes services exclusively in Alaska.²⁴ In contrast, the Nashville area office is responsible for IHS-funded facilities for states on the east coast, in Louisiana, and in parts of Texas.

¹⁷ U.S. Government Accountability Office, *Indian Health Service: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program*, 12-446, June 2012, <http://www.gao.gov/assets/600/591631.pdf>.

¹⁸ FY2016 IHS Budget Justification and IHS, personal communication, March 16, 2015.

¹⁹ IHS user and service population data from IHS, personal communication, March 16, 2015.

²⁰ CRS Report R40551, *The 2010 Decennial Census: Background and Issues*.

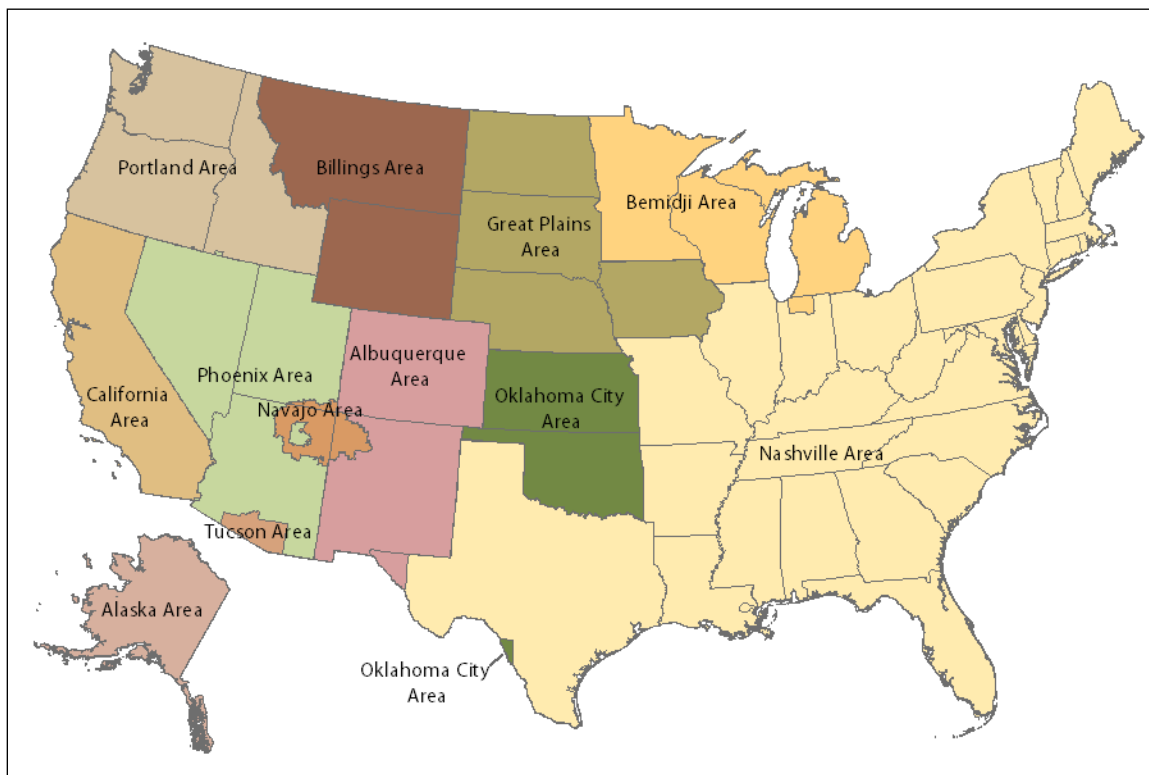
²¹ Indian Health Service (IHS) Statistical Note, "Department of Health and Human Services, Indian Health Service," press release, April 8, 1993, <http://www.ihs.gov/california/assets/File/Training/DefiningIHSPopulationEs.pdf>.

²² The 2010 IHCIA reauthorization required that IHS develop a plan to create a new Nevada area office. This office is not yet established, but should this occur, IHS would have 13 area offices. See discussion of the reauthorization of the Indian Health Care Improvement Act in CRS Report R41630, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline*.

²³ FY2016 IHS Budget Justification.

²⁴ Although the California area office covers most of California, some counties in California are covered by both the California area office and the Phoenix area office.

Figure 1. Indian Health Service Areas
(as of March 2015)



Source: CRS Analysis of IHS data from U.S. Department of Health and Human Services, Indian Health Service, “Visualizing Data” at [http://www.ihs.gov/communityhealth/gis/Provided Geographic Data](http://www.ihs.gov/communityhealth/gis/Provided%20Geographic%20Data).

Note: Hawaii, not pictured, is part of the California area.

IHS-funded health care is provided in facilities administered through area offices and service units. The 170 service units and specific health facilities may be managed either by the IHS directly, or by ITs, TOs, and consortia through self-determination contracts and self-governance compacts negotiated with the IHS under the authority of the ISDEAA.²⁵ ITs and TOs have taken over from IHS the responsibility for operating many service units and health facilities. More than half of all federally recognized tribes operate facilities or health programs and approximately 40% of IHS’s total appropriation is administered by tribes.²⁶

There are some geographic patterns in the location of tribally-operated programs, with certain areas having all or almost all facilities and programs operated by tribes. For example, the Alaska, California, and Nashville areas have few IHS-operated programs. Accordingly, these area offices are smaller because more funds have been provided to ITs or TOs to operate facilities and programs. In contrast, the Great Plains and Billings areas have more facilities operated by the IHS.²⁷ In these areas there are relatively few tribally-operated programs, and area offices are

²⁵ P.L. 93-638, act of January 4, 1975, 88 Stat. 2203, as amended; 25 U.S.C. 450 et seq.

²⁶ U.S. Department of Health and Human Services, Indian Health Service, “Tribal Self-Governance,” January 2015, <https://www.ihs.gov/newsroom/index.cfm/factsheets/tribalselfgovernance/>.

²⁷ Tribes that are served by IHS-operated facilities are sometimes referred to as “direct service tribes.”

larger than those in areas with more tribally-operated programs.²⁸ The size of the IHS user population also differs by area; more than one-third of all IHS users live in two areas: Oklahoma City (Kansas, Oklahoma, and part of Texas) and Navajo (northwestern New Mexico, southeastern Utah, and northeastern Arizona, excluding the Hopi Reservation).²⁹

IHS System: Facility Types and Services Available

The IHS system is a mostly rural outpatient system focused on primary care. The system consists primarily of five types of facilities: (1) hospitals, (2) health centers, (3) health stations, (4) Alaska village clinics, and (5) youth regional treatment centers. ITs and TOs may also operate other types of facilities or programs that exclusively focus on behavioral health concerns (such as alcohol and substance abuse). This section briefly describes these five types of facilities. As discussed above, the services available at UIOs differ from those generally available at facilities operated by the IHS, ITs, and TOs. UIOs and the services they provide are discussed separately below. (See report section “Urban Indian Health Programs.”)

IHS Facilities

IHS, ITs, and TOs primarily operate five types of facilities. Of these, only hospitals and youth regional treatment centers provide in-patient care. The five types of facilities and the services they offer are:

1. *Hospitals (46 total)*: are generally small and services available vary by hospital. Some hospitals provide surgical services and specialty care services such as ophthalmology and orthopedics. Of the 46 hospitals operated by IHS or ITs, only one has an average daily census (a measure of usage) of more than 45 patients. Nearly all of these hospitals; however, have emergency departments and eight are designated trauma centers.³⁰
2. *Youth regional treatment centers (10 total)*: are inpatient facilities that provide substance abuse and mental health treatment services to American Indian and Alaska Native youth. Congress has authorized these treatment centers in each of the 12 areas (with California counted as two areas); however, two IHS areas—Bemidji and Billings—have opted to contract with outside providers for these services.³¹ There are 10 facilities in total; 5 are operated by the IHS and the remaining 5 are operated by ITs or TOs. In addition to these facilities, a new tribally operated treatment center in California was recently built to provide services to American Indian youth in the California Area.³²
3. *Health centers (344 total)*: generally provide outpatient services and provide primary and preventive care. Some health centers will provide health education and some laboratory, pharmacy, and radiology services. Health centers operated by ITs and TOs may also receive federal health center grants authorized under

²⁸ CRS analysis of FY2016 IHS Budget Justification.

²⁹ CRS Analysis of IHS FY2014 user population data from the IHS Office of Congressional and Legislative Affairs, March 16, 2015.

³⁰ FY2016 IHS Budget Justification.

³¹ FY2016 IHS Budget Justification.

³² U.S. Department of Health and Human Services, Indian Health Service, Division of Behavioral Health, “Fact Sheet: Youth Regional Treatment Centers,” <http://www.ihs.gov/Behavioral/documents/yrtc-fact-sheet.pdf>.

Section 330 of the Public Health Service Act.³³ ITs and TOs that receive these grants are required to provide certain services to non-IHS beneficiaries using non-IHS funds.³⁴ ITs and TOs may also operate school health centers that provide services similar to those provided in health centers to children during school hours.

4. *Health stations (105 total)*: are generally smaller than health centers; these facilities provide some of the same services that health centers provide such as primary care. One distinction from health centers is that these facilities are generally open less than 40 hours per week.³⁵
5. *Alaska village clinics (150 total)*: are unique to Alaska and may provide services using paraprofessionals assisted by health professionals via telehealth technologies. For example, Alaska village clinics operate the dental health assistant program whereby routine preventive dental care and certain less complicated dental procedures are performed by paraprofessionals at village clinics. These procedures are overseen by dentists who are available remotely.

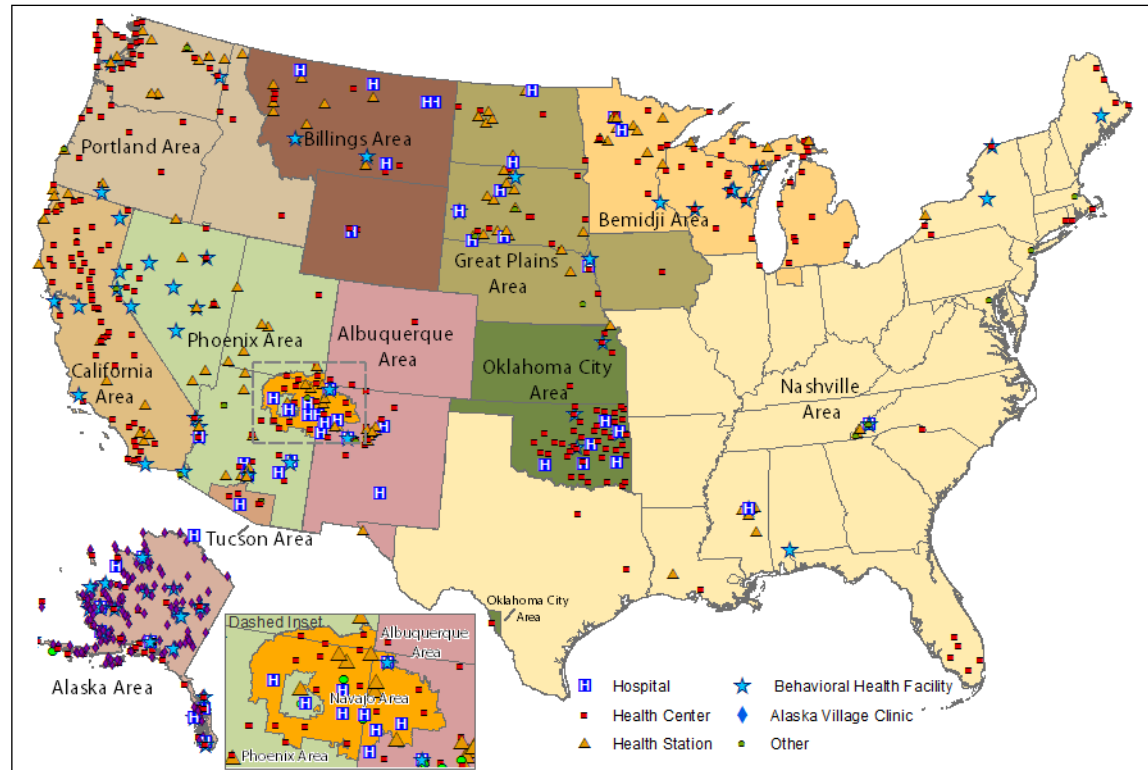
Figure 2 shows the location of the five types of facilities noted above and depicts a sixth category of “other” facilities, which includes facilities or programs that address specific concerns like emergency care, or dental care (health centers may also include dental care). Within **Figure 2**, the locations of youth regional treatment facilities are within the broader category of behavioral health facilities.

³³ 42 U.S.C. §254b.

³⁴ For more information on federal health center grants, see CRS Report R43937, *Federal Health Centers: An Overview*, by Elayne J. Heisler.

³⁵ U.S. Government Accountability Office, *Indian Health Service: Health Care Services Are Not Always Available to Native Americans*, 05-789, August 31, 2005, <http://www.gao.gov/assets/250/247558.pdf>.

Figure 2. Locations of Indian Health Service Facilities, by Area



Source: CRS analysis of IHS provided data.

Note: The figure does not include Hawaii because there are no federally recognized Indian Tribes or IHS-funded facilities in Hawaii. The category “Other” includes facilities or programs that address specific concerns like emergency care, or dental care.

Table 1 shows the total number of major IHS facilities by type of facility. It also illustrates that outpatient facilities are more likely to be administered by ITs or TOs than by IHS. The table does not include two of the categories included in **Figure 2**: “behavioral health facilities” and “other.”

Table 1. Number of Facilities Operated by IHS and Tribes
(FY2015)

Type of Facility	Total	IHS Operated	Tribally Operated
Hospitals	46	28	18
Ambulatory (out-patient) facilities	606	90	516
Health centers	344	62	282
School health centers	7	3	4
Health stations	105	25	80
Alaska village clinics	150	0	150
Health facilities, total	652	118	534

Source: U.S. Dept. of Health and Human Services, Indian Health Service, “IHS Year 2015 Profile” <https://www.ihs.gov/newsroom/factsheets/ihsyear2015profile/>.

Urban Indian Health Programs

Although most IHS facilities are located on or near reservations, IHS also funds, with approximately 1% of its budget, 35 urban Indian organizations (UIOs) that operate at 57 locations.³⁶ UIOs are supported by grants and contracts administered by IHS’s Office of Urban Indian Health Programs. Services available at UIOs vary. IHS reports that 21 of the 35 UIO grantees provide direct medical care for 40 or more hours per week; however, the services available by facility differ. There are seven UIO grantees that provide direct medical care for less than 40 hours per week, with the number of hours ranging from 4 hours to 32 hours per week. There are also five grantees that operate outreach and referral sites that do not provide direct medical care, but provide behavioral health counseling, education services, and general health education services. Each of these five facilities has relationships with local (i.e., non-IHS funded) clinics to provide health care services to the American Indians and Alaska Natives they serve. One grantee is a residential treatment facility, and the final grantee provides national education and research services for UIOs and OUIHPs.³⁷

UIOs provide care to approximately 54,000 American Indians and Alaska Natives who do not have access to facilities operated by the IHS, an IT, or a TO. In addition to IHS funds, UIOs may also receive funding from other sources, including state, private, and non-IHS federal grants and programs, reimbursements from federal programs, and from patient fees.³⁸

³⁶ Funding for urban programs is authorized under Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651-1660h), which directs the HHS Secretary to make grants to or contracts with UIOs under the authority of the Snyder Act (25 U.S.C. 13). Such grants or contracts are not ISDEAA self-determination grants or contracts. See also, FY2016 IHS Budget Justification.

³⁷ FY2016 IHS Budget Justification.

³⁸ Ibid. Under Title V of the Indian Health Care Improvement Act, UIOs are not prohibited from charging their patients.

Available Health Services

IHS health services are provided directly by IHS-funded facilities (called direct services) or are provided indirectly under contracts with outside providers (called purchased/referred care services). This section provides an overview of services provided directly by IHS-funded facilities. This section also provides an overview of IHS's authority to collect reimbursements from federal health care programs and how these reimbursements are used to increase available health services. The section concludes with a discussion of services provided indirectly under contracts to IHS beneficiaries.

Direct Services Provided by IHS Facilities

The IHS provides an array of medical services, including inpatient, ambulatory, emergency, dental, public health nursing, and preventive health care.³⁹ The IHS does not have a defined medical benefit package that includes or excludes specific conditions or types of health care.⁴⁰ As noted above, the majority of IHS facilities provide outpatient care. The focus of services is on primary and preventive care including preventive screenings and health education.

Specialty services available through IHS-funded facilities are generally limited. Although some IHS hospitals do provide specialty care, services available vary by hospital. In addition, the IHS system, which covers a wide geographic area, only has 46 hospitals, which are generally small and provide limited services.⁴¹ Some areas (e.g., California) do not have hospitals or may have only a few hospitals that may not be geographically accessible for the area's population (e.g., Bemidji and Nashville).⁴² The absence or limited geographic availability of inpatient services means that some areas must contract with outside providers (using their purchased/referred care budget) to provide inpatient care and/or specialty care.

IHS also makes use of technology to expand services available at its facilities, which are often in remote areas serving small populations, thus making it difficult to provide specialty care efficiently. For example, IHS provides some behavioral health services via telehealth (e.g., counseling). Some facilities also use telehealth technologies to consult with specialists such as dermatologists or ophthalmologists when an on-site specialist is not available. The agency also uses these technologies to disseminate best practices developed in one IHS area to other IHS areas through training and technical assistance.

IHS also uses community members as paraprofessionals to provide care at rural and remote facilities. Specifically, IHS conducts a community health representative program, which provides training to community members who, in turn, provide preventive health services, health education, and follow-up care in rural and remote areas. IHS estimates that, in FY2014, ITs or TOs employed approximately 1,600 community health representatives.⁴³ IHS also uses dental health aides, another type of paraprofessional, in Alaska to provide routine dental services in remote Alaska Native villages.⁴⁴

³⁹ See 42 C.F.R. 136.11, "Services available."

⁴⁰ In statute, IHS is prohibited from using funds from its appropriation to perform abortions (25 U.S.C. §1676).

⁴¹ FY2016 IHS Budget Justification.

⁴² See **Figure 2**.

⁴³ FY2016 IHS Budget Justification.

⁴⁴ Scott Wetterhall et al., *Evaluation of the Dental Health Aide Therapist Workforce Model in Alaska: Final Report*, RTI International, Prepared for W.K. Kellogg Foundation, Rasmussen Foundation, and Bethel Community Services

Collections

IHS facilities may supplement funding for services provided directly using reimbursements collected from Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), the Department of Veterans Affairs (VA), and from non-federal sources (e.g., private insurance).⁴⁵ IHS is unique among federal agencies in having this collection authority, and is able to retain these reimbursements to supplement the agency's annual appropriation.⁴⁶ IHS uses collections to augment funding available for clinical services. For example, reimbursements may be used to provide certain services (e.g., x-ray or other scans) that would have otherwise been purchased through the purchased/referred care program. Collections are retained by the service unit that collected them; therefore, service units have an incentive to increase collections because it enables them to expand services available at their facilities.

Health Services Purchased by IHS Facilities

IHS-funded facilities provide services directly when possible; however, when services are not available, IHS beneficiaries may be referred to private providers for care. This may occur in two ways: through the purchased/referred care (PRC) program or through the catastrophic health emergency fund (CHEF). Both programs are described below.

Purchased/Referred Care

IHS funded facilities may purchase care through contracts with private providers called purchased/referred care (PRC). These funds are limited because the program receives a discrete amount within IHS's annual appropriation.⁴⁷ The PRC eligibility criteria and requirements differ from those for direct services (i.e., services provided directly at an IHS-funded facility). The eligibility criteria differ in three specific ways:

1. To be eligible for PRC, IHS beneficiaries must live in specific geographic areas called "contract health service delivery areas" (CHSDAs).⁴⁸ CHSDAs are narrower than IHS service areas; therefore, it is possible to be eligible for IHS direct services, but not live in a CHSDA. CHSDAs are determined by each tribe, which could also mean that some tribal members may not live in the tribe's CHSDA, making them ineligible for PRC.
2. An IHS beneficiary may only receive authorization for PRC when the IHS beneficiary has exhausted all other health care resources available, such as private insurance, state health programs, and Medicaid.⁴⁹ This differs from direct

Foundation, Research Triangle Park, NC, October 2010.

⁴⁵ More information about these programs can be found in the following CRS reports: CRS Report R40425, *Medicare Primer*; CRS Report R43357, *Medicaid: An Overview*; and CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*.

⁴⁶ The ability to bill private insurance is not unique to IHS, but the ability to bill Medicare, Medicaid, CHIP, and the Department of Veterans Affairs is, as is the ability to retain reimbursements from federal sources to supplement the agency's appropriation. P.L. 94-437 at 25 U.S.C. §§1601 et seq.

⁴⁷ U.S. Department of Health and Human Services, Indian Health Service, "IHS Fact Sheet: Purchased/Referred Care (PRC)," January 2015, <http://www.ihs.gov/newsroom/factsheets/purchasedreferredcare/>. Some ITs and TOs use funds collected from Medicare, Medicaid, or other reimbursement sources to augment its PRC budget.

⁴⁸ 42 C.F.R. §136.23.

⁴⁹ 42 C.F.R. §136.61.

- services, where IHS can encourage, but not require, a beneficiary to apply for alternate resources. For PRC, such applications and proof of denials are required.⁵⁰
3. IHS uses a medical priority system to determine when a PRC referral will be authorized.⁵¹ In general, PRC is only authorized for what is termed priority one services or “life or limb” services, meaning health services that are required to prevent the immediate death or a serious impairment of the individual.⁵²

In addition to specific eligibility criteria, the PRC program has specific rules for patient and provider participants. For a patient to receive PRC services, an IHS beneficiary must be preapproved to receive the specific service. In case of emergencies, applicants must inform the PRC program within 72 hours.⁵³ For providers to participate in the PRC program, they must accept payment from IHS as full payment for services and may not bill an IHS beneficiary for authorized PRC services.⁵⁴ In the case of inpatient services, the hospital providing the service may only charge the PRC program what it would charge the Medicare program for the same service. This is called “Medicare Like Rates,”⁵⁵ but these rates do not apply to outpatient services; therefore, individual PRC programs must negotiate contracts with private providers to set rates for outpatient services.⁵⁶ In December 2014, IHS released a proposed rule that would extend Medicare Like Rates to outpatient providers; as of the date of this CRS report’s publication, the rule has not been finalized.⁵⁷

Catastrophic Health Emergency Fund

The catastrophic health emergency fund (CHEF) is a component of the purchased/referred care budget that provides funding to reimburse costs for certain high cost cases (e.g., burn victims, motor vehicle incidents, high risk obstetrics, and cardiology). Unlike the PRC program that is managed locally and can be managed by ITs and TOs, the CHEF is centrally managed at IHS Headquarters. Local PRC programs can apply to the CHEF for high cost cases that meet the CHEF criteria. IHS has reported that there are more cases that meet the CHEF criteria than available funds.⁵⁸

⁵⁰ IHS cannot require a beneficiary to enroll in an insurance program for which a beneficiary would be required to pay premiums.

⁵¹ If an IT or a TO operates a PRC program, it will also use a medical priority system to determine if a PRC referral will be authorized.

⁵² Indian Health Service, “Indian Health Medical Priority Levels,” www.ihs.gov/chs/documents/IHSMedicalPrioritiesRolesAndResponsibilities.docx. It may also be authorized to save a sense. For example, certain vision services are considered priority one because they are considered medically necessary to prevent blindness. If additional funds are available, PRC may be authorized for additional priority levels of care.

⁵³ Thirty days for disabled individuals and seniors (25 U.S.C. §1646). See 42 C.F.R. 136.24.

⁵⁴ 25 U.S.C. §1621u.

⁵⁵ This requirement was included in Section 508 of the Medicare Modernization Act (P.L. 108-173).

⁵⁶ U.S. Government Accountability Office, *Indian Health Service: Capping Payments for Nonhospital Services Could Save Millions of Dollars for Contract Health Services*, 13-272, April 11, 2013, <http://www.gao.gov/products/GAO-13-272>.

⁵⁷ Indian Health Service, “Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated with Non-Hospital-Based Care,” 79 *Federal Register* 72160-72163, December 5, 2014.

⁵⁸ FY2016 IHS Budget Justification.

Disease or Condition-Focused Services

IHS provides a number of services directly or through ITs or TOs that target common health conditions among IHS beneficiaries. IHS also operates grant programs for ITs and TOs to target common conditions. The sections below discuss some of these programs. The discussion is not comprehensive; rather, it highlights some specific programs.

Special Diabetes Program

The Special Diabetes Program for Indians (SDPI) is part of IHS's ongoing National Diabetes Program administered within IHS's Division of Diabetes Treatment and Prevention program. IHS focuses on diabetes because the American Indian and Alaska Native population have the highest age-adjusted rates of diagnosed diabetes among U.S. racial and ethnic groups, a rate that is nearly twice the rate in the general population.⁵⁹ These high rates of diabetes increase health care costs for IHS beneficiaries. IHS's diabetes division, and the SDPI specifically, aim to reduce diabetes rates and rates of diabetes-related complications among IHS beneficiaries. With SDPI grant monies, the IHS, tribal ITs, TOs, and UIOs have set up diabetes programs to create an extensive support network that provides diabetes surveillance, health promotion, research translation, and other activities. The program receives a mandatory appropriation that is separate from IHS's discretionary appropriation; this program is funded through FY2017.⁶⁰

As of January 2015, each area office had an area diabetes consultant and there were 336 community-directed diabetes program grants.⁶¹ Since the SDPI's inception, performance measures have been used to evaluate the success of the SDPI efforts to fight diabetes. These measures have found increased blood sugar control, reduced cholesterol, and improved kidney function among IHS beneficiaries with diabetes.⁶²

Behavioral Health Services

IHS beneficiaries have relatively high rates of substance abuse and mental health disorders compared to the general population; this is particularly true among younger IHS beneficiaries.⁶³ To address these issues, the agency operates special facilities to treat these conditions and administers a number of behavioral health programs, authorized in Title VII of IHCA, through its Division of Behavioral Health.⁶⁴ In general, these programs aim to create a comprehensive behavioral health care program that emphasizes collaboration among alcohol and substance abuse, social services, and mental health programs. These programs also aim to integrate behavioral health care and primary care. Although some IHS-funded facilities have psychotherapy services for individuals and groups, in general, these services are not available 24 hours a day, nor are inpatient services available. Instead, PRC funds are used to provide after

⁵⁹ U.S. Department of Health and Human Services, Indian Health Service, "Special Diabetes Program for Indians," January 2015, <http://www.ihs.gov/newsroom/factsheets/diabetes/>.

⁶⁰ See Sec. 213 of P.L. 114-10.

⁶¹ FY2016 IHS Budget Justification.

⁶² Ibid.

⁶³ Department of Health and Human Services, Indian Health Service, "IHS Factsheet: Behavioral Health" <http://www.ihs.gov/newsroom/factsheets/behavioralhealth/> and FY2016 IHS Budget Justification.

⁶⁴ See Department of Health and Human Services, Indian Health Service, "Behavioral Health," <http://www.ihs.gov/Behavioral/> and CRS Report R41630, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline*.

hours and inpatient services (except those services that can be provided at a youth regional treatment center). IHS-funded facilities also have programs that focus on suicide prevention, fetal alcohol spectrum disorder, and methamphetamine use because of high rates of these conditions among American Indian and Alaska Natives. For example, the methamphetamine and suicide prevention initiative supports 130 pilot projects focusing on innovative community-based interventions.⁶⁵

Public Health Activities

IHS undertakes selected public health activities to encourage healthy behaviors and reduce the rates of infectious diseases. IHS does so, in part, because IHS funds are limited. Public health activities that prevent illness can reduce the need for certain health services, thus enabling the agency to expand its ability to provide care to its beneficiaries. Among other public health efforts, IHS employs public health nurses to prevent and undertake surveillance efforts of communicable diseases. IHS also devotes resources to increasing immunization rates, including a targeted effort to increase immunization against hepatitis B among Alaska Natives.⁶⁶ IHS also undertakes efforts to increase access to safe water supplies, thereby reducing the rates of certain diseases, through the sanitation facility construction program.

Prevention Activities

IHS prevention activities include funding for public health nurses who provide prevention-focused nursing care interventions for IHS beneficiaries and aim to improve health by screening and disease management efforts. For example, public health nurses work with IHS beneficiaries with chronic conditions to manage their care and reduce hospitalization. They also work with IHS beneficiaries who were recently discharged from a hospital to prevent complications and reduce rates of hospital readmissions. These services are provided in conjunction with health services provided at IHS health care facilities and focus on prevention to reduce the need for more intensive health care services. With IHS funds limited, prevention and screening efforts are an important component of the agency's strategy to maximize services available to its beneficiaries.

As part of IHS's prevention activities, IHS facilities make use of community health representatives (CHRs) who are community members trained as paraprofessionals to provide lay health education services, support patient self-management efforts, and improve health at the community level. CHRs provide health education, health promotion, and disease prevention services throughout the IHS service area. CHRs, like public health nurses, aim to prevent hospital readmissions and reduce emergency department use. They provide a variety of services that include taking vital signs, providing foot care to diabetics, case management, and transportation services. They, like public health nurses, are part of IHS's efforts to expand the amount of services that the agency is able to provide.

IHS's prevention activities also include immunization efforts to reduce the rates of infectious of otherwise preventable diseases, including influenza, pneumonia, and human papillomavirus (HPV). In addition, IHS, with the Alaska Native Tribal Health Consortium,⁶⁷ undertakes efforts to increase rates of hepatitis B vaccination among Alaska Natives because the disease is more

⁶⁵ FY2016 IHS Budget Justification.

⁶⁶ Ibid.

⁶⁷ The Alaska Native Tribal Health Consortium is a TO that represents a consortium of Alaska Native villages.

common in this population. IHS also undertakes vaccination and surveillance efforts to reduce disease rates and monitor and treat individuals who have already contracted the diseases.

Sanitation Facilities

Since 1960, under the authority of the Indian Sanitation Facilities Act,⁶⁸ IHS has funded the construction of water supply and sewage facilities and solid waste disposal systems, and has provided technical assistance for the operation and maintenance of such facilities. According to IHS in 2015, about 9% of American Indian/Alaska Native homes lacked safe drinking water supplies and adequate waste disposal facilities, compared to less than 1% of all U.S. homes. IHS has found that this program has positive health benefits and is cost effective, providing a twentyfold benefit for every dollar spent.⁶⁹ Despite IHS's continued investment in sanitation facilities, there remains a backlog of approximately 3,675 sanitation facility construction projects. Fulfilling this backlog would require approximately \$3.4 billion dollars.⁷⁰

Other IHS-Supported Activities

In addition to the activities discussed above, IHS funds a number of activities related to its role as a provider of health services. These include efforts to recruit and retain a skilled health workforce and to support the overhead and expenses associated with contracts and compacts that the IHS enters into with ITs and TOs to provide services.

Facility Construction and Maintenance⁷¹

The IHS funds the construction, equipping, and maintenance of hospitals, health centers, clinics, and other health care delivery facilities, both those operated by the IHS and those operated by ITs and TOs. ITs and TOs may handle these activities under self-determination contracts or self-governance compacts. The goal of these programs is to maintain IHS-funded facilities and the equipment within them. These funds are also used to ensure that IHS-funded facilities meet applicable building codes and standards, including those needed in order to be accredited by the relevant health care accreditation body for the facility type (e.g., The Joint Commission provides accreditation for hospitals).⁷² Such accreditation may be needed to receive reimbursements from Medicare, Medicaid, CHIP, the VA, and private insurance plans. IHS also funds the construction of new facilities using a priority system that IHS developed with ITs and TOs to determine the order in which new facilities are built.

Indian Health Workforce

IHS, like other types of health care facilities located in rural areas, often has health care provider vacancies because of difficulty attracting and retaining health care professionals.⁷³ For example,

⁶⁸ P.L. 86-121, act of July 31, 1959, 73 Stat. 267; 42 U.S.C. 2004a.

⁶⁹ U.S. Department of Health and Human Services, Indian Health Service, "IHS Fact Sheets: Safe Water and Waste Disposal Facilities," January 2015, <http://www.ihs.gov/newsroom/factsheets/safewater/>.

⁷⁰ Ibid.

⁷¹ Unless otherwise noted this section is drawn from the FY2016 IHS Budget Justification.

⁷² The Joint Commission accredits and certifies health care organizations to ensure that certain standards are met. See http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx.

⁷³ For example, health centers, which are also located in rural or otherwise underserved areas also have provider

the agency's vacancy rate in 2014 was in the 20% range for physicians and nurses.⁷⁴ As one mechanism to fill these vacancies, IHS administers programs to recruit and retain providers including a scholarship program and a loan repayment program. The IHS scholarship program targets American Indians and Alaska Natives who are training in the health professions and provides academic support (including stipends) in exchange for a commitment to provide care, for a specified period of time, at an IHS-funded facility at the completion of their training.⁷⁵ Similarly, IHS provides loan repayments to health professionals (who may or may not be American Indian or Alaska Native) in exchange for a service commitment at an IHS-funded facility.⁷⁶ In addition to these programs, IHS also provides recruitment bonuses and bonus pay to make IHS salaries for health providers more competitive with the private sector. These programs are generally used to recruit for health professions with the highest vacancy rates or for health facilities that have difficulty recruiting providers (e.g., because they are in remote locations).⁷⁷

IHS also partners with the Health Resources and Services Administration (HRSA), the HHS agency that is the lead federal agency on health workforce policy, to obtain providers from the National Health Service Corps (NHSC). The NHSC is HRSA's scholarship and loan repayment program where providers receive support in exchange for a commitment to provide care in a health professions shortage area, including at an IHS-funded facility. As of December 2014, IHS reports that there were 650 IHS health facilities designated as having provider shortages, and therefore eligible to receive NHSC providers, and 381 NHSC providers were located at IHS facilities.⁷⁸

Contract Support Costs

IHS, through its annual appropriation, provides contract support costs (CSCs) to ITs and TOs to help pay the costs of administering IHS-funded programs under self-determination contracts or self-governance compacts authorized by ISDEAA.⁷⁹ CSC pays for costs that tribes incur for such items as financial management, accounting, training, and program start-up. ITs and TOs have often complained about CSC funding shortfalls and note that these shortfalls have resulted in reduced services or decreased administrative efficiency for tribes with contracts and compacts.⁸⁰ A 2012 Supreme Court decision—*Salazar v. Ramah Navajo*⁸¹—required that IHS have sufficient CSCs available to support the contracts it enters into. Specifically, the Court held that a lack of appropriations did not release the federal government from its obligations to fully reimburse CSC costs. As a result of the decision, IHS is balancing the competing priorities of ITs' and TOs' desires to administer their own programs with the amount of CSC funds available. IHS says it must ensure that adequate CSC funds are available for existing contracts and that new contracts the agency enters into do not offset funding available for direct health care services.⁸² P.L. 114-

vacancies. For discussion of these facilities, see CRS Report R43937, *Federal Health Centers: An Overview*.

⁷⁴ FY2016 IHS Budget Justification.

⁷⁵ IHCIA §104 (25 U.S.C. §1613a).

⁷⁶ IHCIA §108 (U.S.C. §1616a-1).

⁷⁷ IHCIA §116 (25 U.S.C. §1616i).

⁷⁸ FY2016 IHS Budget Justification.

⁷⁹ 25 U.S.C. §450 et seq.

⁸⁰ See U.S. General Accounting Office, *Indian Self-Determination Act: Shortfalls in Indian Contract Support Costs Need to Be Addressed*, GAO/RCED-99-150, June 1999, <http://www.gao.gov/archive/1999/rc99150.pdf>.

⁸¹ *Salazar v. Ramah Navajo*, No. 11-551, slip op. (June 18, 2012), available at <http://www.supremecourt.gov/opinions/11pdf/11-551.pdf>.

⁸² FY2016 IHS Budget Justification. The FY2016 Budget Justification contains a legislative proposal that would make contract support costs mandatory funding.

113, which provided appropriations for FY2016, included language about CSC funds specifying that funds are available indefinitely and that IHS may allocate additional funds to CSCs, but is prohibited from using funds appropriated for CSCs for other purposes.

IHS Authorization

The Indian Health Care Improvement Act (IHCIA, P.L. 94-437, as amended) is the major authorizing legislation for the IHS. It was preceded by several laws that included more general authorization for federal Indian programs. This section briefly describes several of these laws beginning from oldest to the most recent. See also **Appendix B** for a timeline of when these laws were enacted.

Snyder Act of 1921⁸³

In 1921, Congress enacted the Snyder Act, which provided broad and permanent authorization for federal Indian programs, including health-related programs. The law provided the BIA, within the Department of the Interior, explicit authorization for much of the activities that the agency was already undertaking. It also authorized the employment of physicians to serve Indian tribes. Prior to the Snyder Act, Congress had made detailed annual appropriations for these BIA activities, but funds were not always appropriated because these activities lacked an explicit authorization. The Snyder Act provided an explicit authorization for nearly any Indian program, including health care, for which Congress enacts appropriations. The Snyder Act did not require any specific programs.

Indian Health Facilities Act (Transfer Act) of 1954⁸⁴

In 1954, Congress enacted the Transfer Act of 1954, which transferred the responsibility for Indian health care from the BIA to the Public Health Service (PHS) in the then newly established Department of Health, Education and Welfare (now HHS). This transfer occurred because, among other reasons, Congress felt that the PHS could do a better job of providing health care services to Indians.⁸⁵

Indian Sanitation Facilities Act of 1959⁸⁶

In 1959, Congress enacted the Indian Sanitation Facility Act, which amended the Transfer Act and authorized the PHS to construct sanitation facilities for Indian communities and homes. IHS estimates that the construction of sanitation facilities has reduced rates of infant mortality, mortality from gastroenteritis, and environmentally related diseases by 80% since 1973.⁸⁷

⁸³ P.L. 67-85, 42 Stat. 208, as amended; 25 U.S.C. §13.

⁸⁴ P.L. 83-568, act of August 5, 1954, 68 Stat. 674, as amended; 42 U.S.C. §2001 et seq.

⁸⁵ There is some evidence that HHS was better suited to administer the agency, because after the IHS was transferred to HHS, IHS began to construct facilities on or near reservations, and the rate of deaths for a number of conditions including tuberculosis, influenza, and pneumonia declined. It is not possible to directly attribute these declines (either partially or entirely) to the transfer. *Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century*, ed. Mim Dixon and Yvette Roubideaux (Washington, DC: American Public Health Association, 2001).

⁸⁶ P.L. 86-121, act of July 31, 1959, 73 Stat. 267; 42 U.S.C. §2004a.

⁸⁷ FY2014 IHS Budget Justification.

Indian Self-Determination and Education Assistance Act (ISDEAA) of 1975⁸⁸

In 1975, Congress enacted ISDEAA, which provided for the tribal administration of federal Indian programs, especially BIA and IHS programs. The act permits tribes to assume some control over the management of their health care services by negotiating “self-determination contracts” with IHS for tribal management of specific IHS programs. Under a self-determination contract, IHS transfers to tribal control the funds it would have spent for the contracted program so the tribe might operate the program. Under ISDEAA authority, IHS has also established a tribal consultation policy giving tribes an opportunity to help formulate health priorities in the President’s annual budget request.

Indian Health Care Improvement Act (IHCIA) of 1976⁸⁹

In 1976, Congress enacted IHCIA, which authorized many specific IHS activities, sets out the national policy for health services administered to Indians, and set health condition goals for the IHS service population. Most significantly, IHCIA authorized collections from Medicare, Medicaid, and other third party insurers and established a demonstration project for ITs and TOs to directly receive reimbursements. It also gave IHS authority to grant funding to UIOs to provide health care services to urban Indians and established substance abuse treatment programs, and Indian health professions recruitment programs, among others. The IHCIA was reauthorized by the Indian Health Amendments of 1992,⁹⁰ which extended authorizations of its appropriations through FY2000. The authorizations for all IHCIA programs were later extended through FY2001.⁹¹ Although IHCIA-authorized programs continued to receive appropriations, the IHCIA was not again reauthorized until the Patient Protection and Affordable Care Act (ACA) was enacted on March 23, 2010.⁹² The ACA reauthorized IHCIA permanently and indefinitely (see “Patient Protection and Affordable Care Act of 2010”).

Indian Health Amendments of 1992⁹³

In 1992, Congress enacted the Indian Health Amendments of 1992, which reauthorized IHCIA and amended ISDEAA to permit tribal governments to consolidate IHS self-determination contracts for multiple IHS programs into a single “self-governance compact.” Self-governance compacts are similar to self-determination contracts as IHS transfers funds and operating control to a tribe, but the compacting tribe is then authorized to redesign programs and services and to reallocate funds for those programs and services. The 1992 amendment paralleled a 1988 change whereby the BIA allowed, under a demonstration, its programs to be compacted.⁹⁴ In 2000, the

⁸⁸ P.L. 93-638, act of January 4, 1975, 88 Stat. 2203, as amended; 25 U.S.C. §§450 et seq.

⁸⁹ P.L. 94-437, act of September 30, 1976, 90 Stat. 1400, as amended; 25 U.S.C. §§1601 et seq., and 42 U.S.C. §1395qq, 1396j (and amending other sections).

⁹⁰ P.L. 102-573, act of October 29, 1992, 106 Stat. 4526. Previous reauthorizations occurred in 1980 (P.L. 96-537) and 1988 (P.L. 100-713), and substantial amendments were made in 1990 (P.L. 101-630, Title V).

⁹¹ Omnibus Indian Advancement Act, P.L. 106-568, §815, act of December 27, 2000, 114 Stat. 2868, 2918.

⁹² P.L. 111-148, as amended.

⁹³ P.L. 102-573, act of October 29, 1992, 106 Stat. 4526, 4590.

⁹⁴ Title II of P.L. 100-472, act of October 5, 1988, 102 Stat. 2285, 2296.

Tribal Self-Governance Amendments⁹⁵ made the IHS self-governance program permanent by further amending ISDEAA to create Title V, which included an authorization for self-governance compacts.

Alaska Native and American Indian Direct Reimbursement Act of 2000⁹⁶

In 2000, Congress enacted the Alaska Native and American Indian Direct Reimbursement Act that made permanent the IHCIA demonstration program that allowed facilities operated by ITs and TOs to directly bill Medicare, Medicaid, and other third-party payors. The demonstration program, involving four tribally operated IHS-owned hospitals and clinics, had increased collections, reduced the turn-around time between billing and receipt of payment, eased tracking of billings and collections, and reduced administrative costs.

Patient Protection and Affordable Care Act of 2010⁹⁷

In 2010, Congress enacted the ACA, which among other things, permanently reauthorized the IHCIA. The reauthorization expanded IHS activities to include long-term care services, created a continuum of behavioral health and treatment services, and expanded the ability of ITs and TOs to receive reimbursements directly from Medicare and Medicaid.⁹⁸ The ACA also included other changes that may affect IHS, such as expansions of access to private insurance coverage that may result in more IHS beneficiaries having private insurance coverage, expanded reimbursements for certain Medicare services provided at IHS-funded facilities, and changes in the way private insurance plans offered by ITs and TOS are treated for tax purposes.⁹⁹

Congressional Committee Jurisdiction

A number of congressional committees exercise jurisdiction over legislation affecting the IHS, including its appropriations. These various committees are described in **Table 2** below. In general, legislation amending an existing statute is likely to be referred to the committees that exercised jurisdiction over the original legislation. IHCIA included authorization for participation in Medicare, Medicaid, and CHIP. As such, the committees that have oversight over these programs have been involved in the IHCIA reauthorization. In addition, these committees have oversight over legislation that affects IHS beneficiary participation in these programs and the ability of IHS-funded facilities to receive reimbursements from these programs.

Table 2. IHS Committee Jurisdiction

House	Senate

⁹⁵ P.L. 106-260, act of August 18, 2000, 114 Stat. 711; 25 U.S.C. §458aaa et seq.

⁹⁶ P.L. 106-417, act of November 1, 2000, 114 Stat.1812; 25 U.S.C §1645 and 1601 note, and 42 U.S.C. 1395qq(e), 1396j(d).

⁹⁷ §10221 of P.L. 111-148.

⁹⁸ CRS Report R41630, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline*.

⁹⁹ CRS Report R41152, *Indian Health Care: Impact of the Affordable Care Act (ACA)*.

Natural Resources (subcommittee on Indian, Insular & Alaska Native Affairs): Holds jurisdiction for Indian health care and self-governance related legislation. Energy and Commerce: Holds jurisdiction for matters related to public health, Medicaid, the State Children’s Health Insurance Program (CHIP), and shares jurisdiction for Medicare Part B with Ways and Means. Ways and Means: Shares jurisdiction for Medicare Part B with Energy and Commerce and has jurisdiction for Medicare Part A. Appropriations (subcommittee on Interior and Environment and Related Agencies): Holds jurisdiction for IHS appropriations. This differs from the appropriations of most HHS (and PHS agencies) that are under the jurisdiction of the subcommittee on Labor, Health and Human Services, Education, and Related Agencies.	Committee on Indian Affairs: Holds jurisdiction over all issues related to Indians. Health, Education, Labor, and Pensions: Holds jurisdiction over matters related to public health. Finance: Holds jurisdiction over Medicare (all parts), Medicaid, and CHIP. Appropriations (subcommittee on Interior and Environment and Related Agencies): Holds jurisdiction for IHS appropriations. This differs from the appropriations of most HHS (and PHS agencies) that are under the jurisdiction of the subcommittee on Labor, Health and Human Services, Education, and Related Agencies.
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Source: CRS Analysis of congressional Committee structure. For information on which services are included in Medicare Parts A and B, see CRS Report R40425, *Medicare Primer*.

Concluding Observations

IHS provides health care to American Indians and Alaska Natives who live on or near Indian reservations or in Alaska Native villages. Although IHS services are available free of charge to all eligible beneficiaries, not all eligible individuals choose to receive care at an IHS-funded facility. This may occur because facilities are geographically inconvenient or because needed services are unavailable. IHS focuses on primary and preventive services, so some services may not be available. Despite this, IHS has attempted to expand services by partnering with local providers, by using technology and paraprofessionals to expand the services that the agency can provide at its facilities, and by preventing disease and encouraging healthy behaviors to reduce the need for expensive health services.

Appendix A. The American Indian and Alaska Native Population

There is no uniform definition of the American Indian and Alaska Native population. Rather, federal agencies use different definitions of this population. The Indian Health Service (IHS) service population data are based on U.S. Census Bureau data, which use self-identification as American Indian/Alaska Native by race, not tribal membership.¹⁰⁰ Beginning with the 2000 Census,¹⁰¹ respondents were permitted to identify as members of more than one race or ethnic group. Consequently, some individuals who might have previously self-identified as another race, beginning in 2000, were allowed to also identify as American Indian or Alaska Natives. As such, the number of American Indians and Alaska Natives identified increased between the 1990 and 2000 Censuses beyond what would have been expected due to population growth alone. The population also increased between 2000 and 2010 Censuses. Census 2010 found that 3.7 million people identified themselves as being American Indian/Alaska Native alone and 1.5 million identified as being American Indian/Alaska Native and another race, for a total of 5.2 million people, or a 21% increase from Census 2000.¹⁰²

Tribes vary on their definitions of membership; some tribes may reserve membership for those whose parents were both members, while other tribes may trace membership to a grandparent or parent who is a member. Thus, in some cases, tribal members could be counted by the Census as American Indian or Alaska Native and a member of another race. Conversely, some individuals identifying as multiple races in the Census may not be tribal members. Given this and the fact that not all tribes are federally recognized, not all American Indian/Alaska Natives (either alone or in combination with another race) counted by the Census are eligible for IHS services. Despite the limitations of the Census data, IHS uses Census data to estimate its eligible population. In addition to imprecise estimates of the eligible population, IHS also estimates its “user population,” based on registered American Indian/Alaska Native patients who used IHS-funded services at least once in the most recent three years.¹⁰³ This figure, estimated at 1.6 million in 2014 is lower than the eligible population because not all eligible American Indian/Alaska Natives received IHS services during the reference period.¹⁰⁴

The Bureau of Indian Affairs (BIA) within the Department of the Interior also collects data on its service population, but uses a different definition than both IHS and the Census Bureau. BIA data are based on estimates received from BIA agencies and federally recognized tribes, but these estimates are not based on actual censuses and cover only persons on or near reservations.¹⁰⁵ The

¹⁰⁰ The Census allows respondents to identify their tribe, but this is still self-identification. The Census does not confirm a respondent’s enrollment (or eligibility) in a federally recognized tribe.

¹⁰¹ The Census Bureau also collects population data through the American Community Survey an ongoing survey that includes population estimates based on three-year averages. For a description of the American Community Survey see http://www.census.gov/acs/www/about_the_survey/american_community_survey/ and CRS Report R41532, *The American Community Survey: Development, Implementation, and Issues for Congress*.

¹⁰² Tina Norris, Paula L. Winves, and Elizabeth M. Hoeffel, *The American Indian and Alaska Native Population: 2010*, U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau, 2010 Census Briefs, Washington, DC, January 2012.

¹⁰³ U.S. Department of Health and Human Services, Indian Health Service, Office of Public Health, Division of Community and Environmental Health, Program Statistics Team, *Regional Differences in Indian Health, 1998-99* (Rockville, MD: IHS, 2000), p. 11.

¹⁰⁴ IHS, personal communication March 16, 2015.

¹⁰⁵ U.S. Department of the Interior, Bureau of Indian Affairs, Office of Tribal Services, *Indian Labor Force Report, 1999* (Washington: BIA, n.d.), pp. I-iii.

BIA also lists tribes' reports of their enrollment totals, but the BIA conducts no census to confirm these figures, and its publication does not show whether the enrollees enumerated live on or near reservations or inside or outside IHS service areas. In addition to these limitations, available BIA data are dated because the agency has not published data since 2013. **Table A-1** compares recent IHS, BIA, and Census population figures.

Table A-1. Differing Indian Population Figures, Selected Years, 1990-2014

Year	Indian Health Service (IHS)		Bureau of Indian Affairs (BIA) ^a		Census Bureau	
	Service Population (in IHS service areas; est.)	User Population (at IHS facilities)	Service Population (on or near reservations; est.) ^b	Tribal Enrollment (national; est.)	American Indian/Alaska Native race alone (est.) ^c	American Indian/Alaska Native Race Alone or in Combination with Other Races (est.)
1990	1,207,236	1,104,693	—	—	Decennial: 1,959,234	—
1991	1,242,745	1,134,655	1,001,606	—	2,187,000	—
1997	1,427,453	1,300,634	1,442,747	1,654,433	2,290,000	—
1999	1,489,341	—	1,397,931	1,698,483	2,397,000	—
2000	1,641,828	—	—	—	Decennial: 2,475,956	Decennial: 4,119,301
2001	1,670,454	1,345,242	1,524,025	1,816,504	2,725,594	4,319,387
2003	1,744,792	1,383,664	1,587,519	1,923,650	2,821,438	4,464,402
2005	1,805,122	—	1,731,178	1,978,099	2,924,141	4,620,280
2006	1,829,792	1,461,639	— ^a	— ^a	2,978,564	4,702,396
2007	1,868,643	1,463,661	— ^a	— ^a	3,307,691	4,790,858
2008	1,911,986	1,483,423	— ^a	— ^a	3,095,246	4,876,973
2009	1,945,531	1,500,044	— ^a	— ^a	3,151,284	4,960,643
2010	1,981,213	1,524,346	579,981 ^d	1,969,167 ^d	Decennial: 3,739,507	Decennial: 5,220,579
2011	2,016,143	1,542,164	— ^d	— ^d	3,814,772	—
2012	2,051,718	1,561,075	— ^d	— ^d	—	—
2013	2,087,943	1,576,629	— ^d	— ^d	2,548,921	5,208,962
2014	2,124,823	1,598,385	— ^d	— ^d	2,565,520	5,602,861

Sources: IHS user and service population data—IHS, *Trends in Indian Health and Regional Differences in Indian Health* both authored by U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, Office of Planning, Evaluation, and Legislation, Division of Program Statistics, and published in Rockville, MD, and IHS, personal communication, August 13, 2013, and March 16, 2015. BIA service population—1991: *Indian Service Population and Labor Force Estimates* (1991), Table 1 (recalculated by CRS). BIA service population and tribal enrollment, 1997: *Indian Labor Force Report: Portrait 1997*, “National Totals” table. BIA service population and tribal enrollment, 1999: *Indian Labor Force Report, 1999*, “National Totals” table. BIA service population and tribal enrollment, 2001: *Indian Labor Force Report, 2001*, “National Totals” table. BIA service population and tribal enrollment, 2003: *Indian Labor Force Report, 2003*, “National Totals” table. BIA service population and tribal enrollment, 2005: *Indian Labor Force Report, 2005*, “National Totals” table; BIA service population and tribal enrollment, 2010, 2013 *American Indian Population and Labor Force Report*, “Population Indicators by State, for

Federally Recognized Tribes, 2010.” All BIA publications are authored by U.S. Department of the Interior, Bureau of Indian Affairs, and published in Washington, DC *Census Bureau*—U.S. Bureau of the Census, (July 1): *Population Estimates*, <http://www.census.gov/popest/data/historical/index.html>. For 2000 and 2010 data: Tina Norris, Paula L. Winves, and Elizabeth M. Hoeffel, *The American Indian and Alaska Native Population: 2010*, U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau, 2010 Census Briefs, Washington, DC, January 2012; U.S. Census Bureau, ACS Demographic and Housing Estimates, 2011-2013 American Community Survey, 3-Year Estimates, http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_3YR_DP05&prodType=table; and U.S. Census Bureau, ACS Demographic and Housing Estimates, “2014 American Community Survey 1-Year Estimates,” <http://factfinder.census.gov/>.

- a. The BIA did not release an Indian Labor Force Report between 2005 and 2013. The BIA attempted to survey the tribes in 2010 about their service population and labor force estimates, but due to methodological concerns, these data were never released. See Letter from Donald E. Laverdure, Acting Assistant Secretary of Indian Affairs, to Tribal Leader, July 2, 2012, <http://www.bia.gov/cs/groups/public/documents/text/idc-019173.pdf>.
- b. The Bureau of Indian Affairs defines “near reservation” as areas or communities either contiguous or adjacent to a reservation that are so designated by the Department’s Interior’s Assistant Secretary of the Interior for Indians Affairs. These areas are so designated, in consultation with the relevant Indian Tribe or Alaska Native village governing body, based on criteria such as the number of American Indians or Alaska Natives residing in the area, whether these residents have close affiliation with the Indian Tribe or reservation, the proximity of the area to the reservation, and whether BIA will be able to provide services to this area.
- c. Census data are estimates except in decennial Census years (2000 and 2010). The Census Bureau only began collecting data on American Indians alone or in combination with another race in the 2000 Census.
- d. The BIA’s 2013 report included data for 2010. No subsequent report has been released.

Measuring the Urban Indian Population

Determining the *urban* Indian population eligible for Urban Indian Health Program services is equally inexact. Urban Indian Organizations (UIOs) serve a wider range of eligible persons, including members of terminated or state-recognized tribes and their children and grandchildren (see report section “Urban Indian Health Programs”). They are not, however, authorized to serve anyone who merely identifies themselves as racially American Indian or Alaska Native.¹⁰⁶ BIA figures for service population and tribal enrollment do not help determine the urban UIO population, because the BIA data are not broken down by urban or metropolitan residence, nor do they cover terminated or state-recognized tribes. Nor is an answer provided by Census Bureau data on American Indians/Alaska Natives, since, although the data are broken down by urban, metropolitan, city, and other types of residence, they are still, as noted above, based on self-identification by race, not on tribal membership, whether in federal, state, or terminated tribes. IHS figures for urban Indian populations are based on these Census data.

While IHS, Census, and BIA figures for Indians, whether resident in urban areas or not, may not be definitive for the IHS-eligible population, they provide useful approximations of the population that IHS serves. Census data suggest that most American Indians/Alaska Natives live outside reservations and other census-identified Indian areas, that the movement out of these areas is many decades old, and that a majority of census-identified Indians live in census-identified urban areas.¹⁰⁷ Many urban areas are within IHS service delivery areas, so further analysis may be needed to determine what proportion of census-identified urban Indians are eligible for general IHS services.

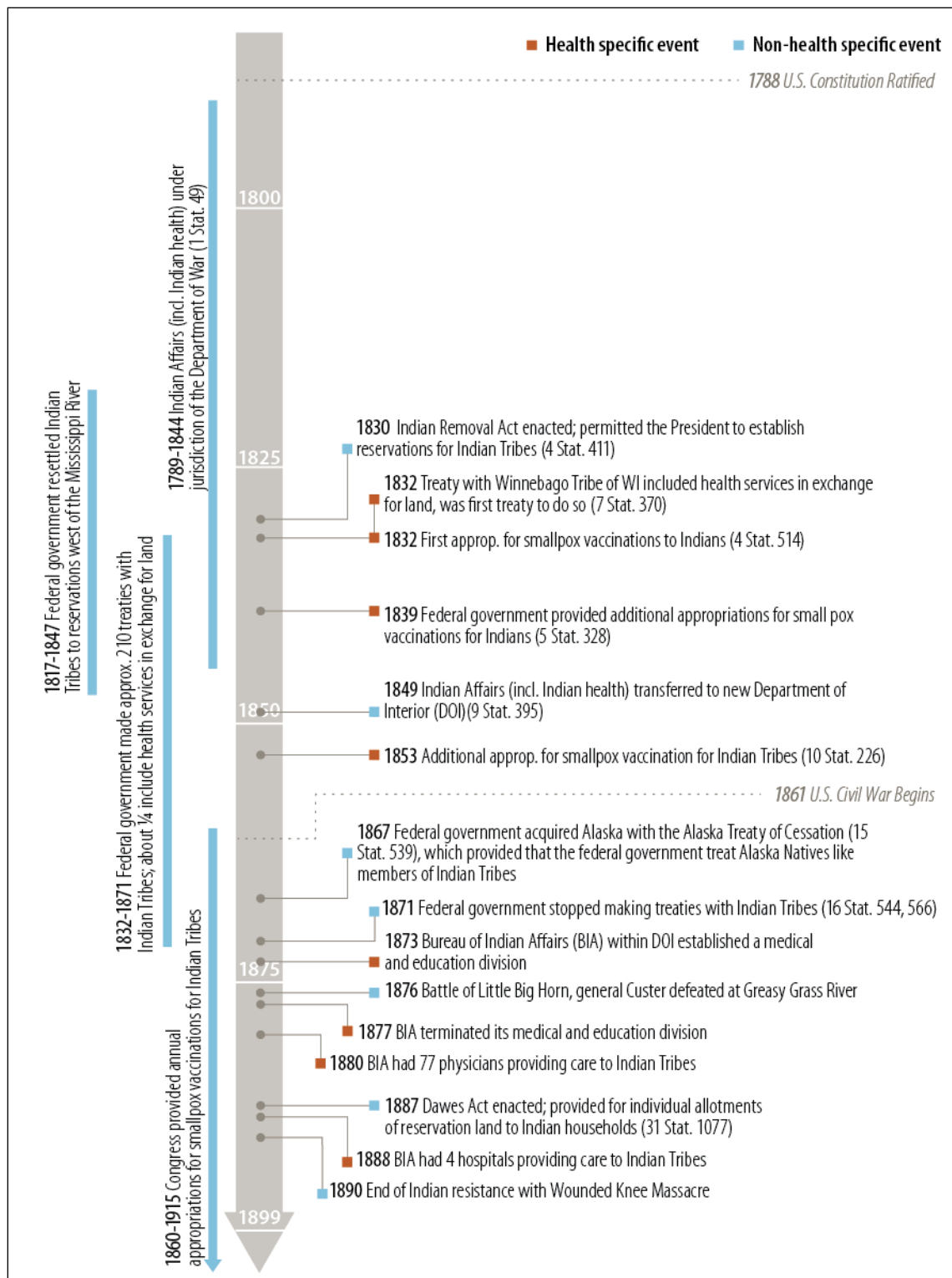
¹⁰⁶ See 25 U.S.C. 1603(f), 1651 *et seq.*

¹⁰⁷ Ralph Forquera, *Urban Indian Health*, The Henry J. Kaiser Family Foundation, Issue Brief, Washington, DC, November 2001, p. 1 and Appendix 1, <http://kaiserfamilyfoundation.files.wordpress.com/2001/10/6326urbanindianhealth.pdf>; and Marlita A. Reddy ed., *Statistical Record of Native North Americans* (Detroit: Gale Research, 1993), p. 420.

Appendix B. Brief History of Federal Involvement in Indian Health

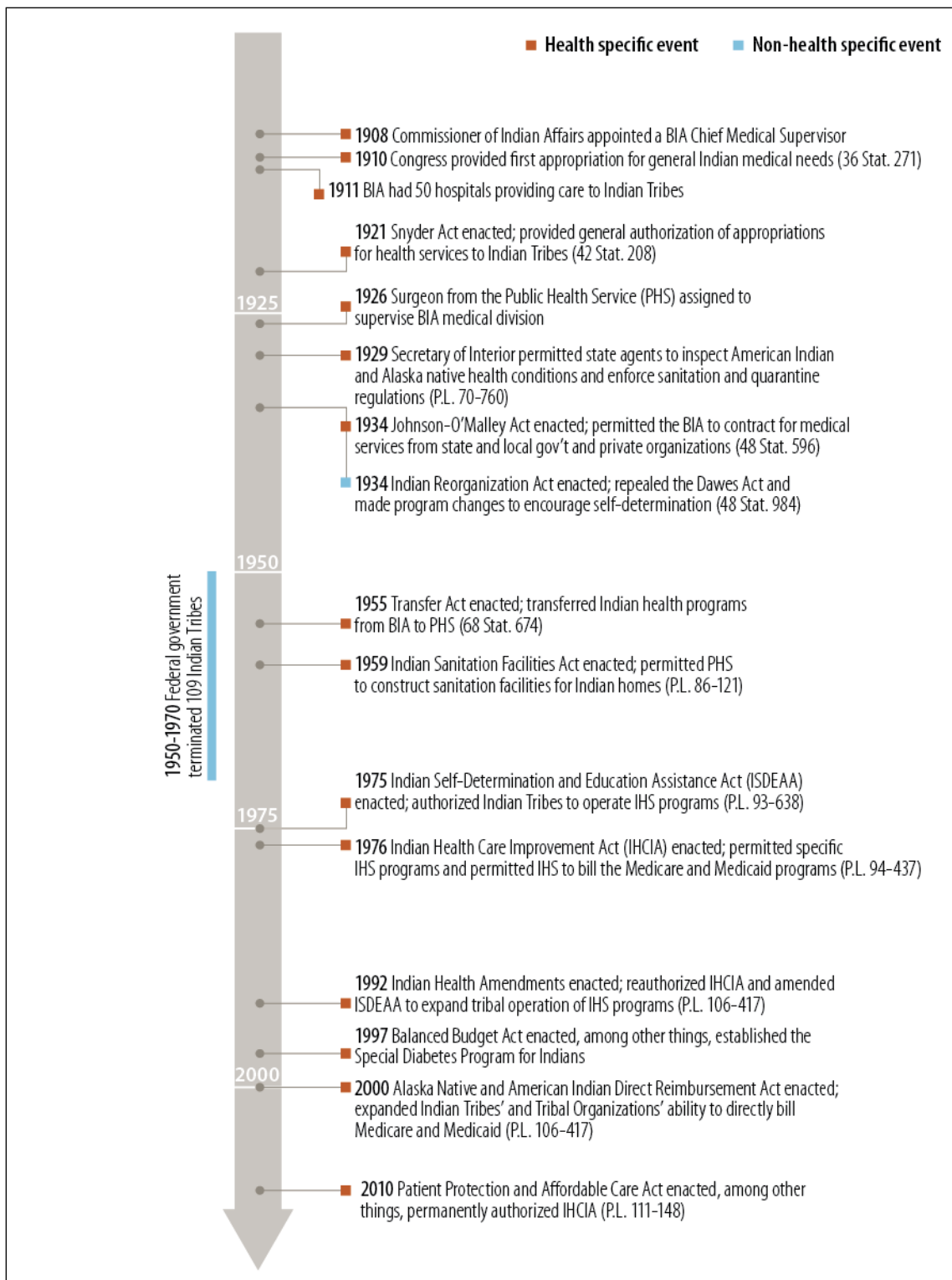
The following timeline (see **Figure B-1** and **Figure B-2**) presents a brief overview of federal involvement in Indian health. Federal involvement began as infectious disease control (e.g., smallpox vaccines), but grew over time to encompass more services and eventually evolved into the modern day IHS. Federal involvement in Indian health is rooted in treaties between Indian Tribes and the federal government. Over time, federal involvement has been formalized in legislation. The timeline below presents some selected events both Indian health specific and some related historical events to provide context. The timeline is followed by a more detailed list of sources.

Figure B-1. Brief Timeline of Federal Involvement in Indian Health (Part I)



Sources: See "Timeline Sources" section below. Some information in this timeline was adapted from an archived CRS report authored by Roger Walke, former CRS Specialist in American Indian Policy.

Figure B-2. Brief Timeline of Federal Involvement in Indian Health (Part 2)



Sources: See "Timeline Sources" section below. Some information in this timeline was adapted from an archived CRS report authored by Roger Walke, former CRS Specialist in American Indian Policy.

Timeline Sources

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