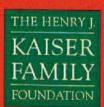# A Forum on the Implications of Changes in the Health Care Environment for Native American Health Care

The Henry J. Kaiser Family Foundation

The Henry J. Kaiser Family Foundation in Menlo Park, California is one of the nation's largest private foundations devoted exclusively to health. Established in 1948 by industrialist Henry J. Kaiser and his wife Bess, the Foundation now has assets of approximately $440 million. It is not associated with Kaiser hospitals or the Kaiser Permanente Medical Care Program.

The Foundation makes more than $30 million in philanthropic expenditures each year. The four main areas in which the Foundation is involved are health policy, reproductive health, HIV, and health and development in South Africa. A further interest is in health policy and innovation in the Foundation's home state of California.

Grants support a range of health care related activities, including policy analysis, applied research to define and measure public health problems, demonstration and pilot projects, and communications activities.

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Introduction

Over the past year, the Kaiser Family Foundation has conducted a broad-range investigation of the impact of changes in the national health system on Native-American health and health care. This process has included extensive consultation with individuals and organizations important in Native-American health, as well as scholars, advocates and other experts on Native-American health care.

With the assistance of the First Nations Development Institute, the Foundation convened a distinguished advisory group to help identify priorities. The Foundation subsequently commissioned several studies of critical issues in Native-American health care. These studies examined the trends shaping the future of Native-American health care, the existing health systems and planning capacity in the Native-American health care system, the changes occurring in the IHS, the role of Medicaid in Native-American health care, the attitudes and preferences of Native American health care consumers, and the factors shaping the decisions being made by tribal leaders. The findings from these studies were presented at a Kaiser Forum held in Washington D.C. on the *Implications of Changes in the Health Care Environment for Native-American Health Care* in November 1996. The studies and a synthesis of the Forum discussion are published in this report.

Although many people have made invaluable contributions to this process, the Foundation would like to particularly acknowledge the assistance of Rebecca Adamson and Sherry Salway-Black of the First Nations Development Institute, and Yvette Joseph-Fox, Executive Director of the National Indian Health Board.

This study is one of many analyses that have been supported by the Foundation to provide information to policymakers, the media, and the public about health care reform issues. The conclusions reached in this report are those of the authors.

1.
SUMMARY OF FORUM PROCEEDINGS

Prepared by
Steve Sternberg

Poverty and Health Coverage

1.1 IMPLICATIONS OF CHANGES IN THE HEALTH CARE ENVIRONMENT FOR NATIVE AMERICAN HEALTH CARE

In America, as in no other industrial nation, health and wealth are inextricably linked; access to health care is limited to those who have the means to pay for it. The extent of the poverty among the nation's 2.3 million Indian people is unmatched among any other population in the United States. Indeed, studies have shown that Native Americans are three times more likely to live in poverty than people of all other races. In 1989, the U.S. Census determined that the median income of reservation-based Indian households was just $19,897 per year, compared with a median income of $30,056 for other Americans.

Not surprisingly, in light of this income disparity, Native Americans are less likely to have private health insurance than other Americans. A study by the Agency for Health Care Policy and Research (AHCPR) in 1987, the "Survey of American Indians and Alaska Natives," found that fewer than one of three Native Americans reported having private health insurance, compared with 80 percent of whites, 52 percent of blacks and 50 percent of Hispanics. This places Native Americans on the lowest rung of the insurance ladder in a nation with greater gaps in the health care safety net than all other industrial nations.

Publicly subsidized programs offer some access to care that might otherwise be denied by private-sector health organizations. The AHCPR survey, for instance, found that 11.4 percent of Native Americans, about 100,000 in all, enroll in Medicaid. Many more Native Americans might qualify if more applied; however, many Indians are unaware of the program, are not able to navigate the enrollment process or regard Medicaid as welfare and shun the program out of pride. Others cherish the federal government's trust relationship with the Indian people — along with its guarantee of lifetime health benefits. They want to hold the federal government accountable for its commitments

and fear that if Indians are assimilated into the Medicaid program, in which eligibility is based on income, the government will declare them ineligible for services.

Another 6.3 percent of Indians — about 56,000 — obtain coverage through Medicare. Estimates based on the 1987 AHCPR survey indicated that two thirds of elderly Native Americans were covered by Medicare, a proportion of the elderly that ranks far below that of the total U.S. population, in which virtually all elderly are covered. One possible reason few Indians participate in Medicare is that many lack an employment history, which is required by Medicare for enrollment. Another is that traditional elders reject Medicare for the same reason they will not apply for Medicaid — they believe they are entitled to their own health-care system because of their unique relationship with the U.S. government.

The Indian Health Service (IHS) narrows this gap making health services available to 1.41 million American Indians and Alaska Natives. While IHS programs are designed to serve tribes, an estimated 56.2 percent of American Indians live in urban areas. Urban Indians are served through IHS grants and contracts with 34 programs that provide services to 41 metropolitan Indian communities. Programs funded by IHS provide a range of health delivery systems, including hospitals, outreach programs, referral stations and comprehensive outpatient health clinics.

IHS has calculated that use of outpatient services both on reservations and in urban areas has grown considerably over the past two decades. In 1993, the agency logged some 6 million outpatient visits to IHS, tribal and contract facilities, an increase of 234 percent since 1970. Most outpatients have sought care at IHS facilities. Tribal facilities reported 1.7 million visits in 1993.

As outpatient visits have risen, hospitalizations have decreased by more than half since 1970, falling to 92,000 admissions in 1993 or 1,133 patients per day. Nearly two-thirds of all IHS hospitals are small, rural facilities with fewer than 50 beds. In some cases, smaller hospitals have been closed or turned into outpatient clinics. And although IHS provides a comprehensive range of services, not all of them are available at all facilities or to all IHS beneficiaries. Many Indians living in remote rural villages or large urban areas cannot easily obtain IHS medical care. IHS distributes resources based on population density, accessibility and other factors. Some Native Americans object that this amounts to "rationing" throughout the IHS system.

They may be the lucky ones. Some 700,000 Native Americans are not eligible for the agency's services, according to IHS statistics. These people fall outside the eligibility regulations as set out in 42 C.F.R.36.1, section 36.12:

Persons to whom services will be provided:

(1) Services will be made available as medically indicated to persons of Indian descent belonging to the Indian community served by the local facilities and program...

(2)...an individual may be regarded as within the scope of the Indian health and medical service program if he is regarded as an Indian by the community in which he lives as evidenced by such factors as tribal membership, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors.....

Even excluding those who are not deemed eligible for IHS services because they cannot demonstrate membership in one of the 554 federally recognized Indian tribes — or because they are members of tribes that have not been federally recognized — IHS is essentially the sole health care provider and payer for more than half of the Indian families nationwide. These people represent a grave responsibility for an agency confronting its own daunting uncertainties, including partial dismemberment, in an era of federal "downsizing."

A Brief History of Government Involvement in Health Care And the Birth of IHS

The federal government first stepped in to provide health services to Indians in 1832. The government acted less out of beneficence — it has been well documented that the government's stance toward the Indians fluctuated wildly between "extermination" and "assimilation" until the late 19th Century — than to treat people who contracted smallpox, measles, diphtheria, malaria and other diseases that were common among soldiers and settlers living near military outposts.

By the early 1900's, the U.S. Bureau of Indian Affairs employed 160 doctors who were scattered throughout Indian country providing basic health services. In 1921, the Snyder Act authorized Congress to appropriate funds for the "relief of distress and conservation of health and for the employment of physicians" for Indians nationwide.

Health services available to Indians expanded almost from the moment an ailing President Woodrow Wilson signed the Snyder Act into law. The government, through the Bureau of Indian Affairs (BIA), quickly set up a health infrastructure throughout Indian country. In 1954, the responsibility for providing these services was transferred from the BIA to the U.S. Public Health Service, which in 1955 established the IHS to administer Indian health care programs.

In its first 30 years, IHS established 30 hospitals and 90 health centers across the U.S. Today, IHS funds 49 hospitals and 461 outpatient health centers throughout U.S., many of which are operated by Indian tribes. Among these are 171 tribally operated village clinics in Alaska.

Access to basic medical care has changed the state of Indian health in important ways. Between 1955 and 1982, the maternal death rate among Indian women hovered at a tragic level of 82.6 deaths for every 100,000 live births, nearly three times that for other women. By 1991, the rate had diminished to 8.9 deaths per 100,000 live births, which was still slightly higher than the average among non-Indian women. Infant mortality has also declined, from 22.2 deaths for every 1,000 live births to 9.4 deaths for every 1,000 live births.

Yet this average remains significantly higher than the 8.9 per 1,000 infant mortality rate for the nation as a whole. And when studies control for underreporting among some states that are unable to accurately verify the race of some deceased Indian infants, the Native American Indian infant mortality rate is 26 percent higher than the national average, matching the unacceptably high rates in many developing nations.

In this and many other ways, poverty — compounded by inadequate access to health care, difficult living conditions; a lack of adequate transportation; and substance abuse — exacts a terrible toll on Indian health. A 1995 IHS report found that Native Americans suffer dramatically higher death rates from a variety of ills than other Americans. In some IHS areas, the age adjusted mortality rate of Native Americans is double that of the total U.S. population.

According to the IHS, 447 percent more Indians die of alcohol-related causes; 340 percent more Indians die of tuberculosis; 168 percent more Indians die in accidents; 154 percent more Indians die of diabetes; 47 percent more Indians die of pneumonia and flu; 42 percent more Indians die of suicide; and 34 percent more Indians die of homicide. Whether Native American health will continue to improve and these chronic problems diminish in an era of managed care remains to be seen.

Context of Government's Historical, Legal, and Political Relationship with Native Americans

To understand the complexities facing the provision of health care to Native Americans it is useful to understand the historical context governing the growth of health services throughout Indian country and the Indians' unique legal relationship with the federal government.

In Pre-Colombian North America, Indians governed themselves and their territories. The arrival of Europeans began a long struggle between these settlers, who sought to acquire Indian lands and assert their dominance over the native inhabitants, and Indians, who fought to retain their ancestral lands and their autonomy. This struggle was a long and bloody one, marked by the pioneers' philosophical and political claim to "Manifest Destiny" — the right to settle and govern all of North America. As European settlers encroached upon this land, and as government assumed ever-growing responsibility for lands once dominated by Native Americans, the Indians' remaining territories became known as "Indian Country." Contrary to popular belief, Indian country extends beyond the boundaries of the current reservations. In 1948, the federal government adopted a three-part definition of Indian Country, which included reservation lands, dependent Indian communities, and Indian allotments, which are lands that were parceled out to individual Indians by the government. But the picture is even more complex than this. Some tribes own their lands outright through Spanish land grants preceding U.S. acquisition of the territory; others were given land through settlement acts adopted by Congress. The definition of what constitutes a "dependent Indian community" remains a tenuous one, including scattered Pueblos and the off-reservation community of Ramah in New Mexico.

The designation is critical in certain matters. It governs whether a tribe may impose taxes on individuals and businesses operating within the tribe's territory; whether the tribe may assert jurisdiction over child welfare; whether the tribe may punish offenders who commit misdemeanors on tribal land; where tribes may conduct gaming operations; and whether the tribe or state may enact zoning or health ordinances. The evolution of the current system encompasses some of the bloodiest chapters in American history.

THE TREATY-MAKING ERA

From 1776 to 1871, the political and legal relations between Native Americans and their adversaries were embodied in treaties negotiated by tribal and government leaders (today some 800 treaties set out the terms of these relationships). Some treaties specifically provided for health care services. Article 2 of the 1854 Treaty with the Rogue River Indians, for instance, established that the United States would provide the tribe with "a hospital, medicines, and a physician." But as the settlers pushed Westward, the growing population and resources of the United States forced the Indians to give up more and more land.

Many of these people were compelled to resettle in remote and often less desirable locations. In return, they were promised federal protection from land-hungry settlers and the jurisdictional ambitions of expanding state and local governments. Even so-called Friends of the Indians supported "removal" to reservations and separation from white men. The Indians' self-styled protectors advocated this course to save the Indians' lives and preserve them from the perceived evil influences of white men,

which were regarded as contributing to the Indian's difficulties and degeneracy. Such removals continued throughout the 19th Century, although some members of the tribes refused to move and remained behind in small enclaves.

ALLOTMENTS

From 1871 to 1928, the era of treaty-making came to an end, crushed by land-hungry expansionists who did not want lands set aside for Indians and sought to open federally protected Indian lands to white settlement. Christian reformers intent on "civilizing" the Indians argued forcefully that the Indians should be forced to give up their communal, nomadic ways and become farmers on individually owned plots of land. Subsequent passage of "allotment" laws forced a dramatic redistribution of lands from Indians to other owners. In 1887, Indians held 138 million acres of land. By 1934, their acreage had shrunk to 55 million.

In keeping with this assimilationist movement, Native American children were forced into boarding schools and state public schools, where many children were compelled to wear uniforms and participate in military-style drills. "[The officers] were thoughtful towards you. They were also mean. They would make you drill for hours. We learned from watching the boys marching. Girls also marched. It was beautiful to see us in our little pleated skirts, marching and going back and forth and doing all these maneuvers...like an army going back and forth on campus," a Navajo woman recalled. ("One House, One Voice, One Heart, Native American Education at the Santa Fe Indian School," by Sally Hyer, 1990, Museum of New Mexico Press.)

Paradoxically, these efforts to assimilate Indians into the now dominant culture brought many white people into close contact with Indians for the first time, and awakened them to the Indians' shockingly poor health. Numerous reports documented rampant tuberculosis, smallpox, trachoma and other illnesses that were fast declining outside Indian Country.

These revelations helped pave the way for the passage of the Snyder Act, under which the government assumed responsibility for Indian health care, in 1921.

A new turning point in U.S.-tribal relations came with the publication of the Meriam Report in 1928, which detailed the failures of the government's allotment program, the inadequacy of educational initiatives and the dismal health status of the American Indian. This report, and a subsequent conference convened by Indian Affairs Commissioner John Collier, led Congress to pass a bill called the Indian Reorganization Act (IRA).

This act, signed by President Roosevelt, went into effect on June 18, 1934. It repealed the allotment laws and returned control of Indian affairs to the tribes themselves. Some tribes objected that the IRA substituted a white man's form of government for traditional tribal ways. Tribal traditions in this era were mostly oral. Some tribes today, including the Navajo, still have no written constitution. Most tribes have since adopted a written constitution or charter, although these vary considerably.

TERMINATION

A backlash against the IRA led to a further loss of Indian lands, termination of federal recognition of 109 bands and tribes — which affected 13, 263 of approximately 400,000 surviving Indians — and an end to the special federal-tribal relationship. Federal responsibility for the tribes was transferred to the states. This era also saw the transfer of responsibility for health services from the Bureau of Indian Affairs to the federal Department of Health Education and Welfare, a shift that led to the establishment of the IHS in 1955.

SELF-DETERMINATION

The so-called termination era ended in 1970, when President Nixon laid the foundation for the current Indian policy of self-determination. Congress passed numerous tribal restoration

bills. A flurry of reports — and a Supreme Court decision ruling that lawsuits against a tribe under the Indian Civil Rights Act must be brought in tribal court — buttressed this approach. And in 1975, the Indian Self-Determination and Education Assistance Act provided the opportunity for Indian tribes, not federal agencies, to deliver federally sponsored services to Native Americans.

The Indian Health Care and Improvement Act of 1976 specifically addressed the continuing lag of Indian health status behind that of the general population. The Act provided for increases in appropriations to the Indian Health Service; grants and scholarships to recruit Indians into the IHS; funds to expand the Indians' health care infrastructure; lifted the prohibition against Medicare and Medicaid reimbursement for health services provided by IHS or the tribes; and established limited funding for Indian health care in urban areas.

IHS in an Era of Reform

The IHS has struggled ever since to keep pace with the larger health care industry in the U.S. A report issued by the Department of Health and Human Services in May 1996 found that per capita expenditures for IHS beneficiaries began to decline in 1975, from 75 percent of the amount spent per capita on other Americans, to less than 69 percent by 1986.

When President Bill Clinton proposed the Health Security Act in 1993 as a means to enact universal health coverage for all Americans, it appeared that an opportunity to achieve parity in Indian health care might be at hand. Indeed, many Native Americans still speak admiringly of this effort despite its resounding political defeat. Although the Clinton bill was eventually withdrawn, it prompted a reassessment of health services provided to Native Americans.

Because the IHS is not technically an entitlement program — rather it is a rationed health system dependent on annual appropriations — IHS beneficiaries bear the burden of inadequate funding. Shortfalls limit access to health services and restrict the types of health services they may obtain. The IHS has also been required to reduce its staff as part of the "downsizing" initiative proposed by President Clinton and expanded by Congress. By 1999, IHS must restructure its operations and reduce its workforce of 15,000 full-time equivalents by a total of 1,357 positions. Any savings from this reorganization are to be channeled into patient care.

IHS also faces other changes in the way it parcels out resources. Through a congressionally approved contracting process, a growing number of Indian tribes are obtaining IHS dollars and offering their own health services. Currently, 35 percent of the IHS budget is contracted out to tribes, and the percentage will grow under a new provision allowing tribes to obtain funds once used for administrative purposes by IHS headquarters and area offices. Kaiser Forum participants noted that these contracts and compacts may ultimately limit IHS's powers to protect beneficiaries. For instance, some tribes empowered by compacts have chosen to provide health services only to members of those tribes. This has left some Indian descendants of other tribes who live in the tribe's catchment area without access to health care services which they might otherwise receive. However, many of the tribal programs have succeeded in improving the quality of the health care they offer to their members, by instituting more efficient billing practices and increasing the amount of money available to fund health care programs. The tribes have used this revenue to recruit health care providers and expand the services available to their members.

Yet IHS still bears much of the burden of providing services to Native Americans. As a result, the agency must grapple with the consolidation of the nation's private health care industry, the shift of federal programs to the states, the push to enroll Medicaid beneficiaries and IHS beneficiaries in managed-care plans, and welfare reform. Such sweeping changes will inevitably have a profound impact on Native American health care.

I/T/U: THREE FACES OF IHS THREE REFORM CHALLENGES

The Indian Health Service presides over 12 area offices, which govern 143 local service units throughout the United States. Seventy three of these service units are operated by tribes. These services are referred to by the acronym I/T/U, which stands for IHS, Tribal and Urban programs:

- Under the IHS system, the agency directly operates 40 hospitals, 64 health centers, five school health centers and 50 health stations. IHS also offers a "Contract Health Services" program. Under this program, IHS pays for health services supplied by non-IHS providers — but only when the ser-

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vices are pre-approved by IHS; only while annual funding is still available; and only when the IHS beneficiaries are eligible for care under the contract and reside in a designated catchment area.

- Under the Tribal system, IHS contracts or enters into other relationships (known as compacts) with tribes to run several hospitals, 116 outpatient health centers, 171 Alaskan village clinics, 56 health stations, and five school health centers. In some cases, tribes have adopted eligibility criteria that exceed IHS standards, such as limiting certain services to members of the tribe. In other cases, tribes seeking additional revenue have made health services available to non-Indians.

- Under the Urban system, IHS supplies grants to, and administers contracts with, 34 urban Indian programs in 41 communities, ranging from outreach and referral stations to comprehensive outpatient clinics. These grassroots organizations have no funds for inpatient care and must establish ties with public and other charitable hospitals. Urban IHS programs aggressively seek outside funding, matching every IHS dollar with a dollar from other sources.

A "Health Services Inventory" conducted by IHS in 1996 found, however, that IHS, Tribal and Urban health programs meet just 58 percent of the demonstrated need in the agency's 12 service areas. Some areas performed better than others. On average, Aberdeen and Tucson met about 70 percent of the needs of its beneficiaries, while California was able to meet the needs of fewer than one third of the state's beneficiaries.

Adapting to the demands of the new health marketplace may overwhelm these already overstressed programs. And no one model will solve all of the problems of these three very different health care systems.

Honoring the Guarantee

Many researchers assert that scores of individuals outside Indian Country will inevitably fall through growing gaps in the health care safety net as the national transformation to managed care proceeds. Yet Native Americans, unlike other populations in the United States, have been promised health care and other services by the federal government.

Some policy analysts believe the shift to managed care systems, with their overriding imperative to contain health-care costs, could jeopardize this guarantee. Dr. Emory Johnson, a former director of IHS who helped craft President Nixon's policy of self-determination, contends: "The Indian people in this country have already bought a prepaid health care plan. They paid for it with good land. I think Red Cloud said, 'The white man made a lot of promises, but he kept only one — to take our land'. We should not allow the [federal] Office of Management and Budget and other folks to cash out on our commitment."

Johnson, speaking at the Kaiser Forum, was referring to the tendency among some in government to regard Native Americans as merely one more minority group whose profound need exceeds the resources that can be obtained to provide them with services — ignoring or downplaying the government's legal obligation to care for them. These politicians and some appointed government administrators view the Indian Health Service much as they see other federal agencies — as a bloated, cumbersome, inefficient bureaucracy that gobbles up funds that might otherwise be applied to services. They seek to relieve taxpayers of some of the expense of providing health care to Indians by proposing to contract these services to highly efficient private-sector companies experienced at cutting costs to maximize profits.

Johnson contends that there is nothing intrinsically wrong with private sector companies providing care for Native Americans. He pointed out that, while the federal Transfer Act holds the government legally responsible for

covering the cost of care provided to Indians, "it didn't say the federal government must *provide* medical care."

Myra Munson, a former Commissioner for Health and Social Services in Alaska and an attorney who specializes in Native American law, observes that some critics believe that removing the delivery of health services from IHS will fundamentally change the quality of healthy services available to Native Americans — "for the worse." IHS-sponsored health facilities are the only health centers that exist in many remote corners of Indian Country, Munson says.

As a result, the IHS is likely to retain its leading role as a provider of health services to Native Americans. And any new system must also sustain an array of services — including environmental health programs, sanitation systems, health professions training, inpatient substance abuse treatment, remote or satellite health clinics, emergency response units and outreach workers — that ordinarily fall outside the realm of managed care. For these and other reasons, Munson told the forum that any new system must preserve and protect IHS.

ADAPT OR ELSE

Market forces and political decisions have already wrought dramatic changes in IHS. Once an agency that simply took its annual appropriation from Congress and used it to set up and administer health services, IHS now must function, to some degree, like a private health plan. Amendments to the Indian Health Care Improvement Act made IHS eligible to receive payment from Medicare, Medicaid and private insurers. In 1994, IHS earned $154.2 million from Medicare and Medicaid. The same year it collected $22.7 million from insurers.

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Americans who have such coverage without pursuing third-party payment actively enough.

Some individual tribes that govern their own health care are "much more aggressive about encouraging their members to enroll in Medicaid" because Medicaid patients supply up to one-third of their revenues, Munson said. Other tribes resist the temptation to become dependent on Medicaid, because they fear they will sacrifice their trust relationship with the government — and because qualifying for Medicaid forces individuals to acknowledge poverty, a stigma that repels many Americans no matter what their status in society.

Sara Rosenbaum, of the Center for Health Policy Research at Georgetown University, noted that Medicaid regulations represent a barrier that prevents members of many tribes from qualifying for the programs. For instance, she said, many tribes own land and reap revenues from tribal enterprises. These assets are taken into account by Medicaid officials, who may use them as grounds to deny members of a given tribe access to Medicaid coverage. IHS and its Native American beneficiaries, however, have much to gain from overcoming these barriers, because the increased revenue could be translated into additional services.

The controversial welfare reform measure recently signed into law by President Clinton, may create additional barriers to Medicaid enrollment. Under the new welfare regulations, tribes themselves may apply to become welfare agencies, which would theoretically give the tribes the power to make Medicaid eligibility decisions. However, no funding is provided to the tribes to cover the administration of these services.

Moreover, the federal government and the states dispute this interpretation, asserting that states will continue to make decisions regarding Medicaid eligibility. Federal officials have notified tribes that while they may administer cash welfare programs, they may not administer Medicaid eligibility determinations and enrollment processes. If this formulation holds, tribes may find their role restricted to merely providing tribal members with informal assistance as they fill out forms. The tribes may then relay the forms to state Medicaid authorities.

While this shift of responsibility will not directly affect the number of Native Americans who are eligible for Medicaid, welfare reform may have a profound indirect impact on the size of Medicaid enrollment among Native Americans by shrinking welfare rolls. If many Native Americans lose their welfare benefits, they may inadvertently lose their Medicaid benefits, since applications for welfare, Medicaid, and food stamps are often included in a single document.

In addition, tribes that take on the responsibility of managing welfare programs will shoulder much of the administrative workload once performed by state offices that jointly managed local welfare, Medicaid and food-stamp programs. This may prompt states to close underused offices near Native American population centers, making it that much more difficult for Native Americans to apply for Medicaid.

Munson said many Native Americans are likely to respond to these changes by saying: "If I'm not getting cash, and since I'm eligible for IHS, why should I travel a long distance to stand in a Medicaid line and answer intrusive questions?"

Indian Health Meets Managed Care

The managed-care revolution is certain to envelop thousands of Native Americans. Those covered by Medicaid will be affected first, as states contract with managed-care organizations to provide services to Medicaid recipients. Native Americans will encounter managed-care in less direct ways as well. Increasingly, IHS, tribal, and urban health services will face competition from managed-care organizations seeking to expand their business. Conversely, managed-care organizations that contract to provide services to Native Americans will face the challenge of providing culturally sensitive care to people from vastly different cultures who often live far from the nearest available hospital, clinic or referral center. (Assistant Secretary of Health, Phillip R. Lee, drawing on a truism to emphasize the remarkable diversity among Native American tribes, told Forum participants: "If you've seen one tribe — you've seen one tribe.")

To compete with these entrepreneurial managed-care providers, the IHS, tribal, and urban providers will have to shift from a system in which care is rationed under a defined budget to one that is governed by captitated fees or discounted payments. Ironically, many IHS tribal and urban programs that were accustomed to functioning under severe budgetary constraints have in recent years broken free of this fiscal yoke to some degree by expanding their revenues from Medicaid and private insurance. Competition from managed-care plans will again impose sharp budget constraints on these programs. Yet, because they have long experience with inadequate health care budgets, Native American health programs may find this aspect of the transition to managed-care easier than it has been for many health care providers outside Indian Country.

This does not mean it will be easy. IHS, tribal and urban health programs will have to dramatically upgrade their facilities, training programs, malpractice coverage, patient education and data collection and analysis. Ralph Forquera, of the Seattle Indian Health Board, asserted at the Kaiser Forum that establishing effective information systems is "critical" to the success of any managed-care effort. "Finding the right system, and training staff to input the data is critical because the information must be consistent — otherwise it's impossible to interpret. You wind up with reams of information that you can't use," he said.

Relatively few IHS-sponsored programs now have adequate data on costs, on their patient populations, and on the demand for their services. "Most programs are absolutely unprepared to negotiate partially or wholly capitated rates, because they don't know what a procedure will cost and they don't know how many patients will need that service," Munson said. "In a budget-driven system you hire as many doctors, nurses and technicians as you can afford. If you don't have enough people to meet the demand for care, patients just wait in line, or their procedures are delayed. That won't be acceptable in a managed-care plan."

A number of legal issues will also confront IHS, Tribal and Urban health programs as they negotiate the shift to managed-care programs. Waivers granted to states by the Health Care Financing Administration, which governs Medicaid and Medicare, enable the states to avoid regulations that would ordinarily govern the types of patients served; the extent of enrollment, and the current standard of cost-based reimbursement for care.

This presents special challenges to the many IHS, Tribal and Urban programs that recently won automatic designation as Federally Qualified Health Centers (FQHCs). This designation enables these health programs to bill Medicare and Medicaid for the actual costs of service rather than a fixed fee, set by capitation or negotiation, which the shift to managed-care has enshrined nationwide as the reimbursement mechanism of choice.

In addition, the federal Anti-Deficiency Act — which prohibits federal employees from

placing the government at financial risk — could represent a serious obstacle for IHS-sponsored facilities that seek to convert to managed-care plans. Theoretically, this would place the facility, and thus the government, at risk for the cost of any services provided that exceed limits outlined in the managed-care contract. IHS has recently ruled, however, that such arrangements would not violate the Anti-Deficiency Act, because the agency would use third-party payments to fund the managed-care services it provides.

Terry Batliner, director of the Rocky Mountain Health Network of the Veterans' Health Administration in Glendale, Co., said that the tendency of Native Americans to live in small population groups scattered over vast tracts of land complicates matters for tribal health authorities by making the costs of health care more difficult to anticipate. "When you have a large population, you have a pre-dictable cost of care. In a small population, the cost is unpredictable," he said. "To assume risk, you need a large population."

Batliner observes, however, that Indian health programs that adapt to managed-care have an opportunity to greatly increase their revenues. Programs that have large patient populations — what one Kaiser participant termed "locked-in lives" — that represent a dependable revenue stream for any managed-care plan that succeeds in winning a contract to care for the program's beneficiaries. These programs may use the size of their patient populations as a bargaining chip to wrest favorable contracts from managed-care plans.

IHS's IDENTITY CRISIS

IHS's history of lax collections from Medicaid and other third-party payers results, in part, from the agency's traditional role as a provider of last resort to people without other resources. IHS also finds it difficult to persuade Native Americans — who view the agency as responsible for their care — to enroll in Medicaid. When the agency does make this effort, many Native Americans assume that IHS is simply trying to evade its long-standing obligation to provide for their care.

Another factor plays a role as well. The demands upon IHS are becoming increasingly complex, forcing the agency to serve simultaneously as a health care provider, a third-party payer, and a health plan. Paul Benson, of the New Mexico Human Services Department's Medical Assistance Division, calls this IHS's "identity crisis."

"IHS plays three different and sometimes conflicting roles," he said. "As provider IHS renders health services and is reimbursed on the basis of services for which it bills. As a payer, it is obligated to pay for services rendered by others. As a plan, IHS designs benefit plans and tries to make sure it gets the biggest bang for its buck."

These competing roles place IHS in an uncomfortable bind, forcing it to accomplish exceedingly different administrative tasks, even as its administrative budget shrinks. As a health care provider, the agency must provide a cost-effective array of services that meet the needs of its beneficiaries and maximize third-party payment. But it must also respect the limits of a shrinking budget and carefully monitor its payments to other service providers.

The case of a hospital run by the Mescalero Apache in New Mexico illustrates the nature of the difficult decisions the agency must make. Although the hospital is unprofitable, the hospital's administrator has fought to keep the hospital open, both because it provides the Mescalero people with needed health care and because it provides them with jobs. IHS, as a provider of last resort, also wants to keep the hospital open. Yet, as a health plan working within the confines of a chronically tight budget, IHS also must keep its overall costs down. Such conflicts are not easily reconciled, and have obvious political ramifications.

Not surprisingly, IHS administrators are acutely uncomfortable with the uncertainties that lie ahead. "The system we've known for 40 years is disappearing," mused James Floyd, director of the Portland area IHS program.

"What we don't know is what's going to replace it."

Factors Affecting Choice of Health Care Delivery Systems by Tribes

IHS is undergoing a rapid transformation from an agency that provides Indian health services to one that pays for services provided by tribes themselves, participants at the Kaiser Forum agreed. This shift presents tribes with the opportunity to make complex health care choices that will inevitably affect the breadth and quality of the services available to their members. Yet the pronounced cultural differences between the tribes, and the dearth of prior research on how tribes make crucial decisions, combine to complicate any effort to integrate information and understand how to assist tribes in making these crucial decisions.

The Foundation sponsored a study to provide answers to these important questions. The research involved 27 interviews with leaders and health directors of nine tribes and with IHS directors and planning staff in four of the agency's area headquarters. To provide background for the development of the interview guides and to assist in analysis of this information, the researchers also conducted a literature review on the legal, political, and historical basis underpinning tribal decision-making, the substance of which was outlined earlier in this summary.

The complexity of developing a coherent picture of how tribes make crucial health care decisions is compounded by the fact that the 554 federally recognized tribes have many different types of tribal governments. In many tribes, the Tribal Council serves as both the executive and legislative branches of government. Elected tribal leaders may also be spiritual leaders. In some tribes, the Tribal or Community Council encompasses the entire membership of the tribe.

In addition, roles and responsibilities of the tribal leaders and the various branches of government are rarely defined with the clarity and rigidity that other Americans have come to expect from their governments. And, because tribes are often relatively small groups of individuals who are interrelated by birth, clan, or marriage, most tribal decision-making is complicated by relationships that, in other contexts, would be considered conflicts of interest. Most tribes reach decisions by arriving at a consensus of what the tribe's proper course of action should be.

All of the tribes in the study have health directors who are responsible for the management of health programs operated by the tribe. Policy questions requiring tribal rulings usually originate with the health director, who gathers background information on the issue to be discussed. In these tribes, the information is then placed before health committees, which screen the information so that the tribal council can reflect on broad issues of policy rather than operational details. These health committees also hear patient complaints and set tribal health priorities.

Still, the task of making major policy decisions is reserved for the tribal council, whose members may simultaneously represent tribal members as consumer advocates and the tribal management that provides health care services to the members of the tribe. The tribal council also may serve as purchasers of health care — both as employers and as managers of IHS-funded contract health services.

The tribal leaders interviewed for this survey expressed broad agreement that the following values underlie all of their health care decision-making:

- Every tribal leader and every tribal health director said it is important for the Indian people to have a separate health care delivery system from other Americans
- Tribal leaders want quality health care.
- Tribal leaders understand the importance of long-term decision-making.

- Tribal leaders want holistic solutions to health care problems.
- Tribal leaders understand the importance of information and communications.
- Tribal leaders have a duty to continuously educate and remind Congress of the federal trust responsibility.

Nearly all tribes in the United States are choosing health care providers from the same list of options. The first choice reflects whether primary health services will be provided directly by IHS, managed by the tribes themselves, or contracted out to private health care providers. The second key choice is whether the tribe will manage IHS-funded health services under a contract with the federal government or under a compact, which gives the tribes more freedom and flexibility. Almost all tribes and urban Indian programs also must decide how to organize their health care systems to obtain Medicaid financing, a decision that has taken on increasing importance as states shift their Medicaid programs to managed care. Tribes also seize local opportunities — based on the breadth of the services available in their area — to shape their health care organizations.

These choices may be limited by geographic and economic circumstances. For instance, some tribes cannot contract with private-sector health providers simply because no such provider is available to the tribe. And if IHS has not established any health care facilities in close proximity to the tribe, the tribe may not be able to depend on IHS for direct provision of health services.

SOME ISSUES CONSIDERED BY TRIBES

Although all of the tribal leaders and health directors expressed confidence that they would be competitive in a managed-care environment, the IHS area directors and planning personnel expressed their concern that the tribes needed a greater understanding of the health care industry and the current trends that are shaping it; better business management skills; more marketing and public relations skills; and finan-

cial support during the transition to managed-care, as a period during which many Indian patients may choose other options before they return to Indian health care providers. Moreover, as tribal leaders and health directors evaluate specific health care decisions they consider a range of issues that may or may not be directly related to health care; among these are, the quality of care provided; the employment of trial members, financial management; and community and tribal development.

PLANNING

The study found that most tribes lack the staff and expertise needed to draw up quantitative plans for the provision of health services. Many lack the capability to gather information about the availability of health services; the staffing and space needed to provide services; the costs of different services; and sources of funding. Only about a third of the tribes studied have dedicated planning staffs and only a third have developed long-range plans. This is due in large part to a lack of resources for planning purposes. IHS remains the main source of funding for tribal planning.

None of the IHS programs, however, provide the financial resources necessary for tribes to carry out long-term or strategic planning. Tribal management grant programs do not provide funding for urban programs, the collection of demographic information, or the hiring of actuarial or legal consultants. They also fail to provide funds for tribal health directors or other staff members to attend national meetings. Funding from some source outside IHS is necessary for tribal health personnel to get the training they will need to design and establish health departments.

NEGOTIATING

Tribes regard negotiations as part of the decision-making process. Only when negotiations are completed do tribes make a final decision on whether or not to go forward with

their plans. Tribal members rarely viewed planning, negotiating, and decision-making as separate functions with distinct beginnings, processes, and end-points. Although tribes have much experience in negotiating with IHS, they are less experienced in negotiating with the private sector. When tribal representatives come to the bargaining table, they face individuals who most likely have formal training in negotiating skills who have probably prepared for the negotiations by gathering a great deal of information. IHS apparently has never provided training for tribes in negotiating and has not provided funding for tribes to recruit consultants to assist in this process.

RECOMMENDATIONS

How tribes make health care decisions is directly related to their access to information on perceived outcomes, planning and negotiating. Improvements in the quality of this information is the most immediate way to buttress tribes' abilities to make crucial decisions. Perhaps the best way to provide information on outcomes, is through demonstration projects that can supply a wealth of practical information on the value of different approaches and the outcomes that result from adopting each one. One such project might involve assisting a tribe to set up a managed-care plan under a state Medicaid program. No tribe has attempted this; as a result, tribes fear that they could not manage the risk. A successful demonstration project might change this perception.

Tribes could also reap valuable information on the options open to them when they are exposed to situations outside their immediate experience. This might include exchanges between tribes, internships in the private sector, and attending national meetings. The tribes

desire the ability to exchange information over the Internet, but many lack the resources (computers and funding for Internet access) and training to engage in communications via computers.

Tribes would also benefit from grants that would enable them to develop long-range health strategies; to hire dedicated, experienced planning staff; and to retain consultants. These consultants could help tribes develop planning strategies; determine the health status of their members; develop demographic data bases and analyze the information; design and analyze consumer surveys; draw up facility and staffing plans; estimate costs; and identify alternatives for financing these efforts. If this approach is selected, tribes should also receive training and assistance that would help them define their consulting needs; select the right consultant for the job; and manage consulting contracts.

Tribes in this study did not recognize a need for training or assistance in negotiating, so it is possible that assistance offered in this area might not be taken. The first step may be to raise awareness that negotiating is often viewed as a formal process encompassing sophisticated strategies that require information and preparation. This may involve exchanges between tribes, internships in the private sector, and attending national meetings. Another way to approach this issue would be to develop a negotiation-training curriculum using examples that are relevant to tribes.

Those interviewed for this study were nearly unanimous in their desire to use existing tribal organizations and to deliver health services from facilities located as close to the tribes as possible. To achieve this, it is necessary to build capacity with area and national tribal organizations. Tribes should be viewed, and used, as important resources for providing technical assistance to other tribes.

Factors Affecting Choice of Health-Care Delivery Systems by Consumers

Native Americans, like other consumers, base their health care choices on the availability of needed services, on convenience, and on whether they have sufficient resources to pay for private-sector care. Among those who can afford some level of private care are the 350,000 American Indians and Alaska Natives who are covered by Medicaid. Employer-purchased health insurance is rare, because relatively few Native Americans are employed by non-governmental enterprises, which are typically the largest employers in tribal areas.

Out of necessity, urban Indian health programs rely more than rural programs on non-governmental sources of funding. Limited IHS funding has forced the programs to actively seek patients with some form of insurance coverage. Urban programs are thus acutely sensitive to competitive forces that may spirit away their patients and revenue. But other IHS-funded programs also are likely to become somewhat more dependent on third-party payments as IHS funding shrinks.

Consequently, even IHS-funded services now must develop effective marketing plans to help them attract and retain patients. Two factors contribute to this imperative: IHS and tribally operated programs must accept virtually all Indian people, without regard to whether they have alternate sources of payment. This means that if a Native American Medicaid patient enrolls in a managed-care plan, he or she may go outside the plan and obtain care at IHS-funded facilities without penalty. If the facility the patient visits is not a member of the patient's plan, however, it will not recoup the cost of providing that care. Most states will not reimburse an IHS facility for out-of-plan care.

To qualify for this revenue, then, IHS facilities must persuade Native American Medicaid patients to enroll in plans for which they are providers. If they can accomplish this while the patients are still at a healthy stage of life, they can bolster their income by increasing their fee base while providing less expensive services.

Some state Medicaid managed-care plans intend to phase out essential community providers, including FQHCs, figuring that as long as the Native American Medicaid beneficiaries can get access to care, it doesn't matter what system they choose. Yet such a shift could deprive Native Americans of culturally sensitive care, an argument that many of these threatened programs use to justify their continued existence. Until now, little data existed on what factors govern Indian consumers' choices.

A survey of 409 tribal employees and 20 face-to-face interviews with Medicaid recipients during September 1996, however, has provided some answers.

The study found that community services vary widely, and studies in one community will not yield broadly applicable approaches to providing health care. In addition, what people desire in a health care provider is not always available in their community; people ultimately measure the quality of their health care against the range of services available in the community and an idealized conception of the services they would like to receive.

In rural areas, people who used private sector services seemed happier with their health care than those who used IHS-funded services. In urban areas, the opposite was true. When tribal employees were asked to rank which type of institutional provider they prefer for each of 13 services, however, two thirds responded that they prefer IHS facilities. These groups did not differ in age, gender or self-reported health status. Those who preferred IHS were twice as likely to speak their native language; those who favored the private sector tended to be slightly better educated and were 5 times more likely to have had a bad experience using IHS.

Most telling though, for health plans seeking to retain patients, is that only about 35 percent of the people interviewed receive all their services from the same provider organization. Twenty percent of this group obtains medical care solely at IHS facilities. Most of those interviewed shifted between IHS and either private sector or county services. Some chose to visit IHS facilities for minor problems, and private or county facilities for major problems.

In contrast to tribal employees, Medicaid beneficiaries valued appointments over access to walk-in care. This is probably because Medicaid consumers have been enrolled in managed care plans and have been assigned to a primary care doctor. The survey found that 85 percent of Medicaid beneficiaries reported that they have a primary care provider, compared to 54 percent of tribal employees. Nevertheless, a majority of Medicaid recipients reported that they did not know how managed care works, even though they were enrolled in managed care plans. The study indicates that the three most important sources of information about Medicaid and managed care are pamphlets, state and county social workers and the individual's private physician.

In rural areas, only half of the Medicaid recipients recognized that Medicaid pays for services provided in IHS-funded facilities. About 70 percent were negative about relying on Medicaid funds to pay for care provided in IHS facilities, and none favored this.

Although both groups regarded the doctor's training and experience as the overriding consideration when choosing a health service, they weighed other priorities differently. Those who preferred the private sector — 15 percent reported only using private or county health services — tended to attach greater importance to seeing the same physician regularly. IHS proponents valued having culturally sensitive doctors; a range of services provided in a central location; access to care on evenings and weekends; lower cost, the availability of a consumer advocate and traditional healers. Although the authors note that their study only scratched the surface of what consumers seek in "culturally competent care," some important elements appeared to be a sense of belonging, an understanding of tribal culture, friendliness, acceptance and respect.

Overall, the study indicates that tribes must engage in long-term planning that will enable them to assess the nature and availability of local services. The tribes would benefit from training and technical assistance in developing marketing plans to reach consumers who can go elsewhere for care. An important effort must be undertaken to design pamphlets, establish hotlines and train social workers to educate Native American consumers to assist them in choosing plans. This educational program should also focus on the basics of how reimbursement works.

Management Development Needs in Native American Health Care

Health care administrators charged with leading their agencies through this period of accelerating change face formidable challenges. The success of Native American health programs — and, in some cases, their survival — depends in large measure on astute decision-making under the pressure of tightly constrained budgets; rising competition; the freedom of their patients to choose where they obtain health care; state and federal controls; and the requirements set by local tribes and their governing bodies.

A comprehensive analysis of current national management challenges in Native American health care was carried out by the Indian Health Design Team (IHDT), a group of health professionals formed to draft an outline for the establishment of a new Indian health system. The team's preliminary report, issued in August 1995, focuses mainly on IHS. Nevertheless, it reflects many of the challenges that face Native American health organizations in urban and rural areas. The IHDT recommendations, slated for adoption by 1998, place control of Indian health care at the local level. The report urged that local agencies be charged with their own reorganization, and the role of IHS shift from controlling these agencies to supporting their efforts. It also advised that IHS headquarters and area offices be consolidated to centralize this support, and that the proceeds of federal downsizing be redirected to "local, clinical services." The report emphasizes the value of increased tribal influence at the local level, a stance consistent with the current conversion of some IHS programs to full tribal operation.

For this transformation to succeed, local managers must be fully prepared to meet their growing responsibilities. Few researchers, if any, have attempted to determine how much training managers will need to conquer the immense challenges that lie ahead. A survey of 85 managers at 33 sites throughout the United States attempted to address these questions. The sites selected for the survey are distributed in four geographic regions (Midwest, Plains, Northwest, and Southwest.) The clinical sites varied greatly in size, with budgets ranging from $427,000 to $44.8 million. The sizes of their staffs differed as well, ranging from 11 to 750. The average caseload ranged from 2,000 to 215,000.

The researchers reported that it proved exceedingly difficult to assess the kinds of management training programs already available to clinical program staff. The programs varied significantly between regions and tribes. Training depended on the availability of, and access to, local educational resources and other factors, including the staffs' personal interests and goals. All of those interviewed were asked to list the management training programs, workshops, and skills development sessions that they had attended during the past year; the topic that was covered; the length of the program; the organization providing the training; the relevance of the topic to their work; and the quality of the educational experience. The respondents were asked to rate the relevance and quality of the session on a five point scale.

The respondents reported attending 31 programs, 10 of which were offered by IHS. The topics addressed included training in JCAHO accreditation; advanced managed-care strategies; budget appropriations; legal issues in medical care; and risk management and leadership. Each of the respondents said they had attended an average of 4.6 days in management training each year and rated the relevance and quality of programs offered by JCAHO and IHS as extremely high. Some programs offered locally, mainly by private firms, earned exceedingly low ratings.

The tribal health directors, chief medical officers, nursing supervisors and other

administrative staffers who were interviewed were shown a list of 48 management topics and asked to select which topics or skills would benefit them most. They were also asked to narrow the list by ranking their 10 top choices.

Interestingly, the survey revealed "impressive agreement" among the top ranked priorities, the researchers report. Eight of the top ten ranked training priorities were the same for at least three of the four categories of administrators. Fourteen of the top fifteen ranked training priorities were the same for at least three of the four types of administrators.

All of the administrators ranked "continuous quality improvement" and "total quality management" at the top of their lists. They rated as equally important "creating customer orientation in services delivery and assessing customer satisfaction." In addition, all of the managers felt that training in managed care trends — particularly contract health services — and management of conflict among staff were crucial to the performance of their duties. This high level of agreement indicates that it would be feasible to train leadership teams as a unified group, with break-out sessions for the different disciplinary specialties.

There were also glaring disagreements, according to the study. CEO's, medical directors, and other administrators gave a high priority to board and manager education for effective, collaborative relationships with tribal health boards, tribal councils and other tribal governance bodies. They also rated as important training in contract negotiation for clinical services, including HMO contracts and discounts for referral services. These priorities were rated far down the list by nursing directors, probably because they would rarely employ these skills in their day to day activities.

Not surprisingly, medical directors and nursing supervisors favored training in use of information services for clinical care, a priority that was ranked far lower by CEOs and other administrators.

When asked to list the three most significant problems or concerns local organizations have in dealing with IHS headquarters and area offices, the respondents cited inadequate funding, an inaccessible and slow bureaucracy, communications problems and a lack of trust in the organization.

The researchers also assessed training approaches through a series of questions on the types of management education and training that were most appropriate to the managers' personal needs. Managers also were asked how much time they could commit to training without neglecting their other duties; in what setting this training should take place; and how the training periods could be most effectively organized.

Respondents replied that they preferred training off-site for one or two day periods. Although the educational experience would not be as comprehensive in such a short period, longer educational retreats are much more difficult to schedule. In addition, they felt person-to-person contact with faculty and colleagues would be more valuable than educational programs conducted from a distance, through mail, video or other means. Educational sessions should be designed differently for senior and mid-level managers, to meet the specific needs of each group.

The researchers recommended that health management training programs should be designed to train entire teams of five or six senior managers in each health care organization. These training programs should include a few week-long retreats — away from the health care setting — every year. The program also should offer one to two day retreats, outside the health care setting but in a location near the facility. Mid-level managers (department chairs, for instance) should receive training on site.

Faculty should include members with university level academic expertise and those with extensive experience in Indian health care settings. The curriculum should be carefully planned and topics presented in a structured, sequential order. Finally, the program should be continually evaluated by an advisory group comprising experienced American Indian Health Care Leaders.

Off to a Good Start

Some IHS and tribal organizations have already begun to adapt to the daunting new world of managed care. Some examples follow:

- In Wisconsin, the 11 members of the Greater Lakes Inter-Tribal Council began to provide their own health services with support from IHS from the agency's inception in the 1970's. The state now is in the process of shifting from fee-for-service financing to contracting for care through HMOs. The state has encouraged tribal health clinics to negotiate their own contracts with HMOs and has provided clinic directors with the state's 40-point Medicaid-HMO contract to assist the directors to negotiate favorable terms. Also, because many Indians have established relationships with their tribal clinic, many may continue to seek services at that clinic even though the clinic is not a provider for the Medicaid HMO in the individual's catchment area. The state has arranged to pay for this care directly, and plans to include a provision covering this circumstance in its next Medicaid HMO contract.

- In Seattle, Wash., the Indian Health Board runs an urban health facility that provides medical, dental, mental health, substance abuse, case management and outreach services to 7,200 individuals — 67 percent of whom are American Indians and Alaskan Natives — living in the greater Seattle area. Through the Thunderbird Treatment Center, the agency also provided residential substance abuse care to 400 people, more than 70 percent of whom are Native Americans. As these percentages indicate, nearly 30 percent of the agency's clients are not Native American. The agency's funding also reflects this — its $8 million budget includes revenues from more than 40 different sources, including public and private grants and contracts. IHS and other federal funds account for just under half of the agency's funding, which is a measure of the center's success at sustaining an independent revenue flow in a competitive marketplace.

- In Alaska, the state's tribes run 171 clinics and 10 hospitals that are funded partly by IHS and partly through Medicaid and third-party sources. This network of clinics is linked to physicians in subregional hospitals and the Alaska Native Medical Center, a secondary- and tertiary- level facility in Anchorage. The clinic in Fairbanks was established in leased space in a private hospital. In Bethel, a consortium of 58 tribes created the Yukon-Kuskokwim Health Corp. set on Arctic tundra in one of the state's poorest regions. The consortium runs a hospital and three clinics, one of which was built using revenues from patient care rather than IHS funding. Many of those residing the consortium's catchment area are subsistence hunters and fishers, and Medicaid funding accounts for much of the non-IHS revenue, although private insurance also supplies a share. The consortium has sued managed-care plans to force them to provide the same level of coverage to Native Americans in IHS programs as they supply to beneficiaries in non-IHS regions.

2.
RESEARCH STUDIES

2.1

Overview: Current and Evolving Realities of Health Care to Reservation and Urban American Indians

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Understanding the Unique Relationship Between American Indian Tribes and the Federal Government

Most Americans do not understand the unique relationship which exists between Indian tribes and the Federal Government. Many perceive issues related to American Indian affairs as concerns of one minority group within a plural society. While American Indians have certainly become a minority within their own country, the status of American Indian affairs and the laws pertaining to those affairs are far more specific and complex. American Indian people are different from any other racial group in the United States. As the indigenous peoples of this country, our ancestors negotiated nation-to-nation treaties with the United States government and with foreign governments prior to the establishment of the U.S. In negotiating as nations, a government-to-government relationship was established and a doctrine of Indian law constructed and affirmed over the centuries. These government-to-government agreements involved the relinquishment of over 50 million acres of land in exchange for certain guarantees, provision of services and reserved rights.[1]

The U.S. Supreme Court affirmed the government-to-government relationship in 1831, when it ruled that the Cherokee Nation and other Indians were "domestic dependent nations". The Supreme Court ruled again in 1832 that the Cherokee Nation had a right to "self-govern-ment" and moved to nullify actions by the State of Georgia legislature designed to dispossess the tribe of lands and resources.[2] American Indian people reserved within this relationship a dual citizen status, that as citizens of the United States as of 1924, and as citizens of their tribal nations. President Nixon further underscored the government-to-government relationship when he signed the Indian Self-Determination Act in 1975, which provided tribes with the means to administer federal programs for themselves. This unique relationship differs from any other in American history, and is fundamental to understanding the basis of Indian affairs.

The United States maintains a legal and moral obligation to provide health care to American Indians and Alaska Natives based on treaties signed between the U.S. and various Indian tribes, and a long history of federal law, executive orders and court cases related to the provision of services and protection of Indian health.[3] The underlying authority for federal health services for American Indian people is found in the Snyder Act of 1921, which provided *"such sums as Congress may from time to time appropriate for the benefit, care and assistance of Indians"*. The delivery of federal health services to Indian people has resulted in major health status improvements over time.

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1   Cohen, F. (1982). *Handbook of Federal Indian Law*. Charlottesville, VA: Mitchie.

2   Samuel A. Worcester v. the State of Georgia. (1832). *U.S. Supreme Court Reports*, 6 Peters 559-561

3   Cohen, F. (1982). *Handbook of Federal Indian Law*. Charlottesville, VA: Nlitchie

A Brief History of Health Services to American Indian People

It has been estimated that there were nearly 10 million American Indians living in what was to become the continental United States at the time of first European contact.[4] By the twentieth century, that number had diminished to just over 200,000.[5] The devastation of diseases for which American Indian people had no immunity or treatment eliminated whole nations and severely reduced others.

The term "decimate" is often used when referring to the history of American Indian people upon European contact. It means to eliminate or wipe-out one in ten people. For American Indians the result was much worse than decimation. Based upon these estimates, closer to 95 percent of the total American Indian pre-columbian population had been eliminated by the 1900's.

There is a perception that European contact helped to "civilize" American Indian people. It must be noted that there existed highly developed societies in precolumbian America which included extensive knowledge of diseases, medicines, surgery, health promotion activities and related rituals.[6] In fact, Native American medicinal knowledge contributed substantially to western pharmacology and treatment of diseases which had plagued the old world for centuries.[7] The Native American notion of health is inseparable from and interdependent with the balance and harmony of mental, physical, spiritual and community well-being. The loss of medicinal practitioners, medicines,

rituals, native foods, and the societal structure which supported balance and harmony compounded the hardships faced by American Indians exposed to new diseases, forced relocations and cultural upheaval.

The devastation visited upon Indian cultures is hard to comprehend. In addition to the shear numbers of lost lives, and forced relocations, many basic practices and remedies which supported good health in Indian cultures were lost or were forced underground through the persecution of traditional healers and practitioners.

As early as 1832 the Federal Government became involved in delivering health care services to American Indians when the U.S. Army first attempted to protect soldiers and non-Indian neighbors from smallpox, measles, diphtheria, malaria and other diseases that were pummeling Indian villages and camps near the posts.[8] By the early 1900's the U.S. Bureau of Indian Affairs (BIA) employed 160 physicians who were scattered through-out Indian country providing basic health services.[9] The policies of the Federal Government with regard to the "assimilation" or "extermination" of Indian people fluctuated over the years, until at the turn of the century an effort to salvage the socio-economic potential of Indian tribes began in earnest.[10] Facing an uphill battle, Indian health began a slow turn around through the 20th century.

4   Vogel, V. (1970). *American Indian Medicine*. Norman, OK: University of Oklahoma Press.

5   Ibid

6   Weatherford, J. *Indian Givers: How the Indians of the Americas transformed the world*. Crown Publishers. New York, NY. 1988.

7   ibid.

8   Cohen, F., (1982) *Handbook of Federal Indian Law*. Charlottesville, VA: Mitchie.

9   Stearns, C. & Wilson, C., (1993). *Indian Health Care Reform, the Delivery of Indian Health Care: The Legal and Policy Foundation*. Unpublished manuscript.

10 Spicer, E.H., *A Short History of the Indians of the United States*. Van Nostrand Reinhold Co., NY, NY, 1969.

In some cases, treaties specifically required the provision of health care, such as the following.

"Three hundred dollars per anum for vaccine, matter, medicines, and the services of physicians,..." (**1836 Treaty with the Ottawas and Chippewas**)

"And the United States shall further agree to employ a physician to reside at the said central agency, who shall furnish medicine and advice to the sick, and shall vaccinate them; the expenses of the said school, shops, persons employed, and medical attendance to be defrayed by the United States, and not deducted from the annuities." (**1855, 1856, Treaty with the Quinault and Quileute**)

In addition to U.S. Treaties, the Federal obligation to provide health care to Indians was further articulated throughout the 20th century via specific federal laws.

The Snyder Act, Act of November 2, 1921 (25 U.S.C.13)

The Snyder Act authorizes Congress to appropriate funds for the "relief of distress and conservation of health and for the employment of physicians" for Indians through-out the United States. It represented the first time Congress enacted permanent authorization for funding of health care for Indian people, and has been the foundation for the IHS and other Indian programs.

The Johnson O'Malley Act, Act of April 16, 1934, amended June 4, 1936 (25 U.S.C.452)

The JOM Act authorized the Secretary of Interior to enter into contract with states and other local governments to provide for the education, medical attention, agricultural assistance and social welfare of Indian people in situations where the allotment process and other hardships resulted in Indians living off the reservations.

The Transfer Act, Act of August 5, 1954, amended by Health Maintenance Organization Act of 1973, Section 69(a) (42 U.S.C. 2001 et seq.)

This Act transferred the responsibility for health care for Indians from the Department of Interior to the Department of Health Education and Welfare as a means to improve the quality of care provided by the IHS under the Public Health Service.

The Indian Health Facilities Act of 1957 (42 U.S.C. 2005)

This Act provided the IHS with authority to contribute toward the construction of community hospitals when tribal patients would substantially benefit from the facility.

The Indian Sanitation Facilities and Services Act of 1959, (42 U.S.C. 2004).

This Act substantially expanded the role of IHS to ensure safe public health environments for Indians and Indian communities, including safe water supplies and systems, drainage facilities, sanitary waste and sewer systems and access of these services to Indian homes.

Public Law 91-224, (16 U.S.C. 459, 33 U.S.C. 446, 31 U.S.C. 529, 41 U.S.C. 5) of 1970

This Act provided authority for the Secretaries of the Interior and the Health, Education and Welfare departments to demonstrate methods for central community systems for safe drinking water in Alaska Native villages.

The Indian Self-Determination and Education Assistance Act of 1975, as amended in 1988 and 1994 (25 U.S.C. 450 et seq)

This landmark Act provided Indian tribal governments with the authority to take over the operation of Federally run programs of the IHS and BIA through tribal contracts or compacts. This authority which was expanded by amendments in 1988, and 1994, opened the door to tribally operated health care systems, and the division or allocation of the entire IHS system into tribal shares which could be contracted by each tribe, with only a few exceptions reserved for "residual", non-tribal specific, obligations of the agency.

Indian Health Care Improvement Act of September 30, 1976, as amended in 1980, 1988, 1990 and 1992 (25 U.S.C. 1601 et seq)

This Act provided a clear Federal policy "to elevate the health status of Indians and Alaska Natives to the highest possible level" and began to articulate specific components of the national strategy to accomplish its stated goal. This Act also established the role of IHS in the assistance and provision of services to Indians living off-reservation in urban areas.

Public Law 96-139, (93State. 1056-1049) of 1979

This Act provided for employees of the BIA and the IHS who are not Indian and not entitled to Indian employment preference to receive early retirement benefits under certain conditions. The Indian preference application was also modified to apply to "RIF" situations.

The Indian Alcohol and Substance Abuse Prevention and Treatment Act, (Subtitle C of the Omnibus Drug Act of 1986: P.L. 99-570, amended by P.L. 100-690 in 1988, 1990 and P.L.102-537 in 1992)

This Act was passed to address the growing alcohol and drug problems in the U.S., and included "Subtitle C" specifically targeting alcohol and substance abuse prevention and

treatment needs of American Indian and Alaska Native communities. It provided for the development of "tribal action plans", substance abuse counselors, prevention activities and the establishment of inpatient youth Regional Treatment Centers in each of the 12 IHS areas.

The establishment of the U.S. Indian Health Service in 1955 under the Public Health Service represented the single most significant move toward formalizing and vastly improving the effort of Indian health care. The IHS developed into a model in rural health care delivery, with a system of outpatient service units, rural hospitals, public health nurses, sanitation initiatives and a team of contract providers. The comprehensive approach to improved health addressed not just medical treatment, but encompassed public health initiatives, sanitary drinking water and sewer systems, environmental safety, and a strong emphasis on cultural acceptability of care. Immediate attention was placed on halting the spread of communicable diseases such as tuberculosis and on improving maternal mortality rates. These health problems have today been overshadowed by other health problems such as unintentional injuries, cardiovascular disease, alcoholism, diabetes and mental health.[11] Since, 1955 major health care improvements have been achieved.

TABLE 1			
RATES FOR SELECTED LEADING CAUSES OF DEATH AMONG INDIANS IN 1955 AND 1992 (DEATHS PER 100,000 POPULATION)			
Cause	1955	1992	% Change
Injuries	184.0	83.2	-55%
Heart Disease	134.1	163.2	+22%
Pneumonia and Influenza	91.9	19.7	-79%
Certain Conditions in Perinatal Period	73.6	N/A	
Malignant Neoplasms	62.0	96.1	+55%
Tuberculosis	58.0	2.2	-96%
Homicide/Suicide	25.5	16.2/14.6	-36%
Chronic Liver Disease/Cirrhosis	15.8	13.5	-15%
Diabetes Mellitus	14.3	30.0	+143%

Indian Health Service, Program Statistics Branch (Bridging the Gap, 1986; Trends 1995)

11. U.S. Department of Health and Human Services, *Public Health Service, Bridging the Gap: Report on the Task Force on Parity of Indian Health Services*, May 1986.

The IHS has helped to establish an infrastructure of health care facilities throughout Indian country, building 30 hospitals and 90 health centers in the first thirty years.[12] Having access to these facilities has had a major impact on Indian health. For example, between 1955 and 1982, the Indian gastrointestinal death rate decreased by 93 percent in reservation states.[13] In 1958 the maternal death rate for Indian women was 82.6 per 100,000 live births, as compared to the U.S. All Races rate of 37.6 deaths. In 1991, that rate had dropped to just 8.9 deaths per 100,000 live births (3 deaths over a two year reporting period), as compared to the 1991 U.S. All Races rate of 7.9 deaths. Indian infant mortality has also experienced a major improvement, dropping from 22.2 deaths per 1,000 live births in 1974 to 9.4 deaths per 1,000 live births in 1992. This compares with a U.S. All Races infant mortality rate of 8.9 deaths per 1,000 live births. There are still many areas in the U.S. with troubling high Indian infant mortality rates, such as in North and South Dakota and in urban Indian communities.

The development of basic health services on Indian reservations and Alaska villages helped to address many health problems. The growing number of Indian people, combined with the increased costs associated with providing health services outpaced the appropriations provided for the IHS. By the 1980's the IHS restricted the funds it used to pay outside providers and hospitals for care of IHS beneficiaries to situations of life or limb saving measures only. This component of the IHS, known as "Contract Health Services" has remained on priority one status since.

The second most significant event in the evolution of Indian health systems was the enactment of two pieces of legislation in the 1970's. The passage of the Indian Self-Determination Act in 1975 and the Indian Health Care Improvement Act in 1976 provided a much needed transfusion into the Indian health system and opened the door for Indian community leadership. Throughout the 1950's

and 1960's American Indian families moved in large numbers relocating to some of the largest cities in the United States. This was due in large part to a program operated by the BIA, known as the "Relocation Program" which promised job training and employment opportunity to relocatees. This social experiment ended with little to show, other than the creation of large urban Indian enclaves struggling for basic survival in unfamiliar and sometimes hostile city environments. The Indian Health Care Improvement Act recognized the health needs of the hundreds of thousands of American Indian and Alaska Native people living in urban areas. Title V of this Act provided funding for urban Indian health programs. Today, 34 urban programs serve 41 cities under Title V. The Indian Health Care Improvement Act also advanced the delivery and billing systems of IHS and increased the number of Indians in the health professions.

The Indian Self-Determination Act of 1975 authorized a process for tribes to take over IHS programs serving their communities. This Act opened up new opportunities for tribal participation in the delivery of health services and the direction of their community development. Tribes began to contract for IHS services, expanding the delivery systems and bringing in new dollars from alternate resources. Today, tribal contractors represent approximately 35 percent of the overall IHS budget for health care:

TABLE 2 FACILITIES OPERATED BY IHS AND TRIBES		
Type of Facility	**IHS**	**Tribal**
Hospitals	41	8
Outpatient Facilities	114	347
Health Centers	66	110
School Health Centers	4	4
Health Stations	44	62
Alaska Village Clinics	—	171

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12 U.S. Department of Health and Human Services. *Bridging the Gap: Report on the Task Force on Parity of Indian Health services.* Flay 1986.

13 Ibid

Demographics and Epidemiology of American Indians

The 1990 U.S. Census reported a total American Indian/Alaska Native population of 2.015 million, and estimated the 1995 Indian population to be 2.3 million. The birth rate for Indian people is 67 percent greater than for U.S. All Races birth rate. The population is much younger than other groups. The median age for the Indian population is 24.2 years as compared to 32.9 years for the U.S. All Races. Indian people are three times more likely to live in poverty than all other races. In 1989, the census reports that the median income of reservation based Indian households to be $19,897 per year, as compared to the annual household income of $30,056 for U.S. All Races population. The impact of poverty and the hardships associated with poverty, cannot be ignored in examining Indian health problems today.

The health status of Indians and Alaska Natives remains poor relative to the rest of the United States population. Inadequate access to basic health care, poor living conditions, poverty, remote rural roads and alcohol and substance abuse contribute to an annoying health care picture which continues to undercut progress made in health delivery systems. The underlying problem to addressing major causes of death among Indian people today, is the fact that the majority of these problems are lifestyle related and entirely preventable. This presents new challenges to the IHS.

The IHS Health Trends Report for 1995 shows that Indian people continue to die from the following causes at rates far exceeding the U.S. All Races population:

TABLE 3	
Cause of Death	Percent Exceeding U.S. Rate
Alcoholism	447 percent greater
Tuberculosis	340 percent greater
Accidents	168 percent greater
Diabetes mellitus	154 percent greater
Pneumonia and Influenza	47 percent greater
Suicide	42 percent greater
Homicide	34 percent greater

(Indian Health Service 1995)

Of all deaths among Indian people from 1990 to 1992, the IHS reports that 31 percent were to those younger than 45 years, as compared to only 11 percent for U.S. All Races, including 22 percent for Black decedents and only 9 percent for White decedents.[14] Alcoholism continues to be a major health and social problem for many Indian communities. Although alcohol death rates among Indians declined steadily, the rates have begun to increase in 1986 and continue to increase in 1992. Increasing trends in death rates for Indians can also be seen in tuberculosis and diabetes.

From region to region, stark differences are apparent in the overall health status of Indians. While IHS has achieved national infant mortality rates which approach the national average, some regions, such as the Aberdeen, Tucson, Alaska, Nashville, Phoenix and Billings Area, and many urban Indian communities, face infant mortality rates up to twice the national rate. It is important to note that some state "underreport" Indian deaths, having particular difficulty in correctly identifying the race of Indian infants who die. When these trouble states are removed from the data, the Indian

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14 U.S. Department of Health and Human Services, Public Health Service. *Trends in Indian Health* - 1995.

TABLE 4
MORTALITY RATES FOR LEADING CAUSES - INDIAN MALES/FEMALES 1990-92
AND U.S. ALL RACES PER 100,000 POPULATION

Cause of Death	Males	Females	U.S All
All Causes	620.0	427.2	513.7
Diseases of Heart	138.5	90.6	143.2
Accidents	118.8	40.1	31.0
Malignant Neoplasms	79.5	76.8	134.5
Suicide	26.7		11.4
Homicide	22.0		10.9
Chronic liver disease/Cirrhosis	25.7	20.3	8.3
Diabetes Mellitus	21.3	27.6	11.8
Pneumonia/Influenza	22.5	17.2	13.4
Cerebrovascular diseases	21.3	24.7	26.8

IHS Trends Report 1995

infant mortality rate exceeds the U.S. All Races rate by 26 percent.

Environmental health remains a serious problem in remote reservations and Alaska, with 50 percent of the Alaska Native villages lacking sanitary water and sewer systems. To make a healthier and safer environment for Indian families to truly achieve improved health status, will require public health resources which are beyond the scope of standard health coverage systems. Comprehensive, community based, preventive and culturally sensitive systems which empower individuals and communities to overcome health problems is necessary. IHS, tribal and urban delivery systems provide a framework for Indian communities to assume the leadership in culturally relevant health promotion and disease prevention efforts.

TABLE 5
INDIAN INFANT MORTALITY RATES (CY 1990-92) BY IHS AREA

Population	Infant Rate	Neonatal	Postneonatal
U.S. All Races	8.9	5.6	3.3
California	4.6	1.5	3.1
Oklahoma	4.9	2.6	2.3
Albuquerque	7.1	3.5	3.5*
Navajo	9.4*	4.6	4.8*
Portland	9.7*	4.2	5.5*
Bemidji	10.2*	3.1	7.0*
Phoenix	10.8*	5.5	5.2*
Nashville	10.8*	6.2*	4.7*
Alaska	12.6*	5.1	7.5*
Billings	12.8*	6.0*	6.8*
Tucson	13.4*	5.8*	7.6*
Aberdeen	15.8*	6.9*	8.9*

*Exceeds U.S. All Races Rate

IHS Regional Differences in Indian Health 1995

The Indian Health Delivery System Today

The U.S. Indian Health Service was established when the Transfer Act of 1954 removed the responsibility for health services to American Indian and Alaska Native people out from under the U.S. Bureau of Indian Affairs and placed it under the U.S. Public Health Service. What has evolved is a complex system of health care delivery and contract systems serving a large percentage of Indians and Alaska Natives throughout the United States.

According to the most recent IHS Trends Report in 1995, the Indian Health Service administered 11 regional Area Offices, which includes 143 local Service Units nationally, 73 of which are operated by tribes. The IHS, tribal and urban Indian health programs have been identified as the "I/T/U" system. The three basic components to the Indian delivery system are:

IHS Direct System

IHS directly administers 40 hospitals, 64 health centers, 5 school health centers, and 50 smaller health stations. These facilities provide direct services to IHS beneficiaries who meet the IHS eligibility criteria. The IHS also maintains twelve Area Offices and two Headquarters offices to oversee the operations of the agency. IHS employs approximately 14,000 full time equivalent staff through this system. IHS also operates a Contract Health Services (CHS) program to reimburse non-IHS hospitals and other providers for pre-approved care to IHS beneficiaries. The CHS system is vital in most IHS areas where inpatients or specialty care services are not directly provided the IHS. Unfortunately, the CHS budget is not adjusted to keep pace with medical inflation, and the services purchased under CHS have been limited to priority services only since 1982.

Tribal System

The Indian Self-Determination Act (P.L. 93-638), provides for IHS contracts to Indian tribes to administer components of the IHS system.

Currently tribes operate 9 hospitals, 116 outpatient health centers, 5 school health centers, 56 smaller health stations and 171 Alaska village clinics. Recent amendments to this Act allow for the transfer of proportionate shares of pooled funds at the Area Office and Headquarters levels to tribes. The total number of Indian tribes which opt to administer their own system is increasing. This is having an impact on the balance of the IHS system. The amount of contracting or "compacting" engaged by tribes varies from area to area. In some cases, tribes have instituted eligibility requirements which exceed IHS standards, limiting certain services to tribal members only, particularly as resources for health care become more limited. In other cases, tribes have opened up their health systems and marketed services to surrounding non-Indian populations generating needed revenues.

Urban System

IHS established an Urban Health Branch under authority of the Indian Health Care Improvement Act (P.L. 94-437 as amended). This branch administers grants and contracts with 34 urban Indian programs which serve 41 communities. The purpose of the urban program is to provide health delivery systems which range from outreach and referral stations to comprehensive outpatient health clinics. Eligibility requirements for patients of urban Indian health programs is far more flexible than the IHS direct service system. Urban programs have been aggressive in seeking other funding sources, matching every IHS dollar with a dollar from state, local or private sources. These grassroots organizations have no resources for inpatient care, except to link with urban public hospitals and other charitable resources for care. Less than 1 percent of the total IHS budget is allocated to the Title V Urban Health Program.

The Indian Health Service estimates its patient population to be 1.41 million Indians and Alaska Natives in 1996. This represents approximately 57 percent of the total number of Indians and Alaska Natives identified in all areas in the United States Census of 1990. The IHS estimates that approximately 700,000 American Indians do not receive any health care from the IHS or tribal delivery systems.[15] Health status data on Indians not residing within established IHS service areas is limited. The system developed by IHS is targeted at those Indians within identified service areas or which fall under the existing delivery system of I/T/U providers. Substantial infrastructure is in place within the IHS delivery system. IHS owns and operates 2,600 buildings and other structures with a replacement value of $1.4 billion. This does not include the many facilities dedicated for health care delivery owned and operated by tribes and urban providers.

Over 98 percent of all the IHS/tribal health care systems have earned accreditation from the Joint Commission for the Accreditation of Health Care Organizations. The focus of the IHS delivery system is on preventive, curative, rehabilitative and environmental health services, including sanitation oversight for water and sewer systems. The care provided through the IHS/tribal/urban systems strive to be culturally sensitive to the service population and accessible despite numerous geographic, economic and facility barriers. As a culturally based, comprehensive model for health care, more than just clinical services are provided. Community Health Representatives (CHR) and Community Health Aids (CHA) have extended health services out into the community setting and provided a vital link between clinical and home-based care. In addition to inpatient and outpatient medical care, the IHS has established services in dental care, mental health, alcohol/substance abuse treatment and prevention, public health nursing, community health, nutrition and dietetics, injury prevention and control and environmental health.

The IHS reports that Ambulatory Visits to all IHS, Tribal and Contract facilities increased by 234 percent from 1970 to 1993, with a total number of 6 million outpatient visits in 1993. IHS facilities still represent the majority of these visits, with tribes reporting 1.7 million of those outpatient visits that year. In contrast, hospitalizations have decreased. Most IHS hospitals are small rural facilities, with 76 percent holding fewer than 50 beds. In some cases smaller hospitals have been closed or converted to other outpatient purposes. The average daily hospital patient load in IHS hospitals decreased by 52 percent since 1970. In 1993, the average daily patient load for IHS inpatient facilities was 1,133 patients system-wide, with a total of 92,000 admissions that year.[16]

Unfortunately, while the model is comprehensive on the face, not all services are available to all IHS beneficiaries all the time. Many IHS services are available to those IHS eligible patients residing near large facilities, such as the Phoenix Indian Medical Center. But for IHS eligible patients located in remote rural villages or large urban centers, those same IHS services are not realistically available. The IHS budget also plays a major role in the way services are made available or restricted. The word "rationing" has been used to define the manner in which services are apportioned and/or withdrawn throughout Indian country, depending upon coverage, funding and accessibility.

COVERAGE ISSUES

When President Clinton proposed the Health Security Act in 1993 as a means to ensure universal health coverage for all Americans, it appeared that an opportunity to achieve parity in the Indian health system might finally be at hand. Unfortunately, these dreams were short lived, but it provided an opportunity for tribal, urban health and IHS leaders to address the future of Indian health in the context of our changing environment. The health coverage of

15 *US. Department of Health and Human Services, Indian Health Service, Design for a New IHS. Recommendations of the Indian Health Design Team, Final Report.* November 1995.

16 Department of Health and Human Services, *Trends in Indian Health* 1995, Rockville, MD.

all Indian people across the United States needed to be determined. Several excellent studies produced new information.

Private Insurance, Public Coverage and Uninsured

The most reliable examination of health coverage of American Indians and Alaska Natives is the "Survey of American Indians and Alaska Natives" by the Agency for Health Care Policy and Research (AHCPR) of the U.S. Public Health Service in 1987. An oversampling of Indian households was conducted from the 1987 National Medical Expenditure Survey to determine the private and public health insurance coverage of American Indian and Alaska Native households which were also eligible for services under the Indian Health Service. The sample focused on individuals living on or near Indian reservations, and therefore may not reflect a true picture nation-wide, particularly in urban Indian communities. But the data does reveal the significant disparity in healthcare coverage for Indian working adults as compared to the U.S. population.[17]

TABLE 6 TYPES OF HEALTH CARE COVERAGE OF AMERICAN INDIAN AND ALASKA NATIVES IN THE SAIAN, U.S. 1987		
Type of Coverage	SAIAN Population (In thousands)	Percent
Total	885	100%
IHS only	486	54.9%
Private Insurance		
Work related	226	25.5%
Other	23	2.6%
Public Coverage		
Medicaid	101	11.4%
Medicare	56	6.3%
Other	29	3.3%

AHCPR, PHS, 1987

When compared to other U.S. populations, American Indians were much less likely to have private insurance coverage. This held true, even when compared to other minority groups with reportedly low rates of private insurance coverage. For example, only 28.2 percent of the Indian sample reported private insurance. This compares to 74.5 percent for U.S. All Races, 80.8 percent for Whites, 52. percent for Blacks, and 50.1 percent for Hispanic Americans. A slightly higher ratio is revealed for Indian individuals with public coverage for health care as shown on the next page.

This data revealed that Indian people are less likely to have private insurance coverage, even when they are employed and health coverage is an option. Many rely solely upon the Indian Health Service for health services and opt not to purchase private insurance. For all working Indian families only 36.2 percent had private insurance compared to 75.4 percent for the U.S. working families. The survey also revealed that Indian people 65 years and older were less likely to have public coverage, such as Medicare, than the total U.S. population, where virtually all elderly are covered. This might be due to the lack of employment history for many of Indian elderly which is required to qualify for Medicare benefits.

The 54.9 percent of American Indian families who are uninsured or reliant solely upon the IHS represents the seriousness of the challenge for the IHS system, in light of planned "downsizing" of the federal system. These figures do not include the estimated 700,000 American indian and Alaska Native people who are not eligible beneficiaries of the IHS system. When applied to the estimated 2.3 million Indians in 1995, this data suggests an uninsured Indian population of 1.26 million people.

IHS Eligibility

Current regulations governing eligibility for services from the U.S. Indian Health Service (42 C.F.R. 36.1) describe a rationed health delivery system, wherein the IHS does not provide the

17 Cunningham, P., and C. Shur. (1991, July). *Health Care Coverage: Findings from Survey of American Indians and Alaska Natives.* (AHCPR Pub. No. 91-0027). National Medical Expenditure Survey Research Findings 8, Agency for Health Care Policy and Research, Rockville, MD: PHS.

Population	Private Insurance	Public Coverage	Uninsured or IHS only
SAIAN Sample	28.2%	16.9%	54.9%
U.S.	74.5%	10.0%	15.5%
White	80.8%	6.8%	12.4%
Black	52.9%	25.1%	22.0%
Hispanic	50.1%	18.3%	31.5%

(AHCPR, 1987)

same level or type of services in every area served. Generally, the services provided directly by IHS providers and contractors fall under the following eligibility requirement:

> *36.12 Persons to whom services will be provided:*
> *(1) Services will be made available as medically indicated to persons of Indian descent belonging to the Indian community served by the local facilities and program....*
> *(2) ... an individual may be regarded as within the scope of the Indian health and medical service program if he is regarded as an Indian by the community in which he lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors...*

There are also provisions for the care and treatment of non-Indian family members, non-Indian women pregnant with an Indian child, and anyone in need of emergency medical treatment who is otherwise not IHS eligible or for whom eligibility has not yet been determined. For people of Indian decent living near an IHS direct service clinic, they are eligible to receive care under the above conditions.

In the matter of "Contract Health Services," however, the eligibility criteria are much more strict. The CHS program of the IHS pays for health services provided by non-IHS hospitals or other non-IHS providers. These services are paid only for cases which have been pre-approved by the IHS and only for IHS patients who meet the CHS eligibility criteria. The first requirement for CHS is to reside within an established "Contract Health Service Delivery Area" (CHSDA). The IHS designated the states of Alaska, Nevada and Oklahoma to be CHSDA's, and other specific areas described in the regulations. For all remaining reservation areas the regulations state the CHSDA "....*shall consist of a county which includes all or part of a reservation, and any county or counties which have a common boundary with the reservation...*" (42 CFR 36.22). The regulations provide for the amendment of these CHSDA boundaries based upon a formal administrative application of the affected tribe or tribes. If, for example, reduced funds justified reducing the CHSDA boundaries to the reservation boundaries only, the CHSDA could be changed.

CHS services are provided, "to the extent that resources permit", to IHS eligible patients who meet the following criteria:

> *"(1) Reside within the United States on a reservation located within a contract health service delivery area; or*
> *(2) Do not reside on a reservation but reside within a contract health service delivery area and; (i) Are members of the tribe or tribes located on that reservation or of the tribe or tribes for which the reservation was established or, (ii) maintain close economic and social ties with that tribe or tribes"* (42 CFR 36.23).

37

The governing body of the affected tribe defines what constitutes "close economic and social ties" for individuals seeking CHS coverage. Additional provisions include CHS coverage for eligible persons who are students or transient at the time of medical need; eligible foster children placed outside the CHSDA; and eligible persons who leave the CHSDA for up to 180 days. Within these criteria, priorities for the use of CHS dollars will be determined on the "basis of medical need".

Obviously, CHS eligibility is a major concern for Indian people who depend upon the IHS system for care, because it is most likely to be needed for cases of medical emergency, inpatient care, specialist referrals or catastrophic health coverage. In light of IHS data which shows a 56 percent reduction in IHS direct hospital care since 1970, CHS is a critical component to the overall health service package, even if this resource is limited to priority, emergent care only.

These eligibility criteria could change if a tribe were to contract for IHS services under a Self-Governance Compact. For example, if a self-governance tribe took over the IHS direct services programs in a particular CHSDA and restricted all services, including outpatient direct care to enrolled tribal members only, there could emerge a large number of formerly IHS eligible patients, such as descendant of other tribes, who no longer have health coverage. Anecdotal reports confirm that this appears to be the case in a few sites. Whether this becomes a trend of national concern remains to be studied.

The 34 Urban Indian Health programs which are funded under Title V of the Indian Health Care Improvement Act maintain a separate and unique eligibility requirement. Historically, the original intent of the Urban Program was to assist those Indian patients who for reasons of geography and residence found themselves ineligible for IHS direct or contract services. Urban Indian health programs receive funding from a variety of non-IHS sources as well, and

have adjusted their programs to meet a variety of eligibility criteria. In some cases, urban programs receive Community Health Centers funding under Section 330 of the Public Health Services Act, and cannot discriminate on the basis of race, but offer services on a sliding-fee scale. In these situations, the IHS has allowed for a percentage of non-Indian patients, as long as the percentage does not exceed the ratio of non-IHS funding to IHS funding. The IHS Policy Manual Chapter 19 "Urban Indians" defines the following criteria for Title V services:

(1) "Is a member of a tribe, band, or other organization of American Indians and Alaska Natives, or is a descendent in the first or second degree of any such member. This includes membership in tribes, bands, or groups terminated since 1970, as well as those recognized now, or in the future, by the State in which they reside. The individual does not have to live on or near a reservation.
(3) Is an Eskimo or Aleut or other Alaska Native.
(a) Is considered by the Secretary of the Interior to be an American Indian and Alaska Native for any purpose.
(4) Is determined to be American Indian or Alaska Natives promulgated by the Secretary of Health and Human Services."

Patients who rely upon urban Indian health programs for health care are for the most part uninsured. A 1988 report by the DHHS Inspector General found that a large percentage of Indian users of the urban health program lacked Medicaid or other forms of health coverage, and issued the following statement:

"INDIANS FACE BARRIERS TO HEALTH CARE: Urban Indians who are indigent or who lack health insurance face barriers in attempting to gain access to health care. Barriers to mainstream care include complex and restrictive eligibility requirements for State and local assistance programs, lack of outreach or targeted services from other community providers and, on occasion, direct prejudice. These are

similar to barriers faced by other indigent, but include some cultural factors unique to Indians."[18]

Urban Indian health providers have reported some increase in new patients seeking care due to reduction in services from other providers, including former patients of IHS services. The concern about an influx in new patients was expressed by urban programs when examining the impact of tribal contracting of IHS direct services, reductions in state Medicaid programs, and reductions in other local government health programs.[19]

ACCESSIBILITY ISSUES

Accessibility is a key factor to understanding the limitations of the Indian health system. As was mentioned earlier, a large number of Indian people who can prove Indian "decent" are eligible to receive health services from IHS direct service systems, hospitals and clinics for example. The primary barrier to their health services is one of "access". They can only utilize these services if they can physically enter the health care facility, regardless of their place of residence. For all practical purposes these "direct services" are realistically accessible only

to those persons located on or near reservations, since this has been the focus of the IHS delivery system historically.

The geographic catchment areas which the IHS has established to determine its service population for "contract" services is the Contract Health Service Delivery Area (CHSDA). As previously described, these geographic areas describe required areas of "residence". Additional requirements for contract services related to tribal enrollment also apply.

It is often assumed that IHS programs are all located in isolated, rural, reservation settings and urban programs in urban/non-IHS areas. While there certainly are a large number of rural, remote reservations and villages, not all reservations and their related "catchment areas" are in rural areas. Occasionally, there are over-laps between reservation based delivery areas and urban Indian health programs, although no formal catchment area definition has been promulgated for urban programs. Again, urban Indian health programs are only realistically a resource to those Indian people who are located near the facility. The IHS recently reported on Indian populations and their accessibility to IHS and urban programs, based upon the U.S. Census definition for rural or urban areas.[20]

TABLE 8
TOTAL U.S. AMERICAN INDIAN AND ALASKA NATIVE POPULATION AND PERCENT BY U.S. CENSUS GEOGRAPHIC AREAS, 1990

Population Category	1990 Census Population	Percent of Total U.S. Indians
Total U.S. Indians	1,959,234	100.0
Indians in "Urban" Areas	1,100,534	56.2
Indians in "Rural" Areas	858,700	43.8
Indians in IHS Service Areas	1,161,629	59.3
Indians outside IHS Areas	797,605	40.7
Indians in Urban Project Areas	362,087	18.5
Indians outside Urban Projects	1,597,147	81.5

D'Angelo A. IHS/OPEL 1995

18 Kusserow, R.P., Department of Health and Human Services, Inspector General, *The Urban Indian Health Program: A Bridge to Mainstream Health Care Delivery.* July 1988
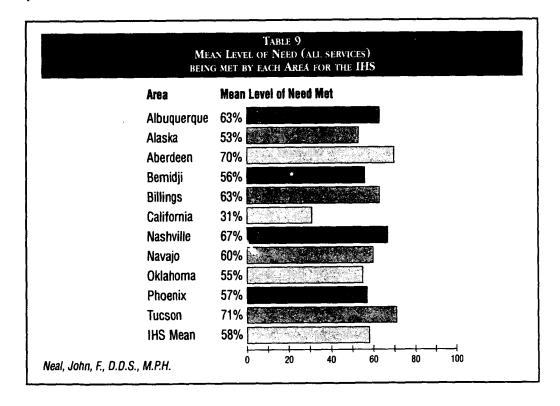
19 American Indian Health Care Association, 1996. *Toward Equal Partnership: Urban Indian Health Redesign Recommendations,* Denver, CO.

20 D Angelo, A. *American Indians and Alaska Natives: Defining Where They Reside.,* The IHS Primary Care Provider, 1993.

Even when Indian families are fortunate enough to be located near an IHS, tribal or urban health care facility, the scope of services vary greatly from area to area and program to program. The resources available in Phoenix, Arizona are not the same as those available in Portland, Oregon or Omaha, Nebraska. The comprehensive outpatient urban programs in Seattle and Minneapolis bear no resemblance to the outreach and referral urban programs in Boston or Lincoln.

In an effort to quantify the scope, level and method of services delivered in each of the 12 IHS areas a "Health Services Inventory" was conducted in 1993. This survey of I/T/U programs found that overall, the I/T/U systems were meeting only 58 percent of their needs.[21] This same survey found that some areas met 100 percent of their need in one service category, while another area met 0 percent for that same category. Generally, the survey found that Areas with a number of IHS hospitals show a higher percentage of their services provided directly, and Areas without IHS hospitals revealed a greater dependence upon CHS providers.

In addition to questions of geographic barriers, earlier cited studies revealed cultural and historical barriers to certain health services. For example, the SAIAN survey of 1987 found that fewer Indian elderly over the age of 65 were on Medicare as compared to the total U.S. elderly over 65. The study suggests that the high unemployment of American Indian people historically has resulted in a lesser number of Indian elderly who qualify for the benefits. With regard to alternate resources provided through the states and local government, such as Medicaid, the report on urban health by the Inspector General in 1988, cited cultural barriers and discrimination against urban Indian people as real barriers.

TABLE 9
MEAN LEVEL OF NEED (ALL SERVICES) BEING MET BY EACH AREA FOR THE IHS

Area	Mean Level of Need Met
Albuquerque	63%
Alaska	53%
Aberdeen	70%
Bemidji	56%
Billings	63%
California	31%
Nashville	67%
Navajo	60%
Oklahoma	55%
Phoenix	57%
Tucson	71%
IHS Mean	58%

Neal, John, F., D.D.S., M.P.H.

21 Neale, John F., DDS, MPH, *Health Services Inventory of the Indian Health Service*, (unpublished paper of the IHS)

The Dynamic Environment of Indian Health

IMPACT OF FEDERAL BUDGET CUTS

The U.S. Indian Health Service has struggled to keep pace with the larger health care industry in the United States, but continues to lag far behind. A major report by the Department of Health and Human Services, issued in May, 1986, entitled *"Bridging the Gap: Report on the Task Force on Parity of Indian Health Services"* found that costs per capita spent by IHS on IHS beneficiaries began to decline in 1975, from 75 percent of the national per capita expenditure level to less than 69 percent by 1986. Because the IHS is not an entitlement program, but a rationed health system dependent upon annual appropriations, IHS beneficiaries bear the burden of inadequate funding by restrictions and limitations on their health services. The larger health industry has traditionally been consumer controlled and is just recently moving more toward managed care systems designed to slow health costs and restrict choices.

While there are numerous treaties with tribes which stipulate the provision of health services, including physicians and inpatient facilities, the underlying authority for the U.S. Indian Health Services is the Snyder Act of 1921, which states that *"such monies as Congress may from time to time appropriate, for the benefit, care, and assistance of Indians"*. The argument can certainly be made that treaty provisions establish an entitlement to health services, but in fact the IHS, pursuant to the Snyder Act, is treated as a discretionary program in the federal budget process. As a discretionary program, the IHS is vulnerable to the annual budget process.

In addition to the annual budget process, the IHS has been required to join other federal agencies in the overall "downsizing" of federal employees, an initiative proposed by President Clinton and expanded upon by Congress. The initiative provides that the IHS workforce will be reduced from 15,000 full time equivalent (FTE) employees to 14,000 FTEs, a reduction of 1,000 FTEs by 1998, and 1,357 by 1999. This reduction has already began through a hiring freeze of non-critical positions, and a reduction in force (RIF) of IHS staff.[22]

The historic budget agreement signed by the President to balance the federal budget by the year 2002 poses serious problems for the IHS and its beneficiaries as we examine how existing federal programs will be reduced to meet that goal. Even before the impact of the balanced budget agreement, we can see that appropriations for the IHS have not kept pace with the rising cost of health care. The IHS has requested between 5 percent and 6 percent increases in order to keep pace with medical inflation. Unfortunately, the appropriated levels fall short and are resulting in a net loss in the overall purchasing power of the I/T/U system.

In addition to appropriated funds, the IHS has expanded its revenues from third party payers. Title IV of the Indian Health Care Improvement Act establishes the IHS as eligible to receive payments for services provided to eligible American Indians under the Medicare and Medicaid programs. In Fiscal Year 1994, the IHS generated $154.2 million through Medicare and Medicaid collections. The Fiscal Year 1997 Appropriation Act estimates $176 million will be collected by the end of the year. In addition to these programs, the IHS is also authorized to bill private insurers for services provided to their beneficiaries. In Fiscal Year 1994 the IHS collected $22.7 million from private insurers.[23]

22 Department of Health and Human Services, *Design for a New IHS: Recommendations of the Indian Health Design Team-Final Report*. November 1995.

23 Department of Health and Human Services, Public Health Service, *Indian Health Service: fiscal Year 1996 Volume XIII Justification of Estimates for Appropriations Committees*.

TABLE 10
INDIAN HEALTH SERVICE APPROPRIATIONS (FY94-FY96)

(dollars in thousands)

Program	FY 94	FY95	FY 96	FY 97*
Hosp/Clinics	799,574	823,866	852,435	883,691
Dental Services	53,151	57,518	59,680	62,285
Mental Health	35,272	36,448	37,561	38,640
Alcohol/Sub.Ab.	87,617	91,352	91,666	92,538
Contract Health Serv.	349,848	362,564	365,099	371,569
Public Health Nursing	22,187	23,505	24,311	26,552
Health Education	7,919	8,244	8,421	8,633
Community Health Reps	43,010	43,955	43,958	44,857
AK Immunizations	1,348	1,328	1,328	1,339
Urban Health	22,834	23,349	23,360	24,580
Health Professions	27,406	28,044	26,271	28,545
Tribal Management	5,285	5,348	2,348	2,368
Direct Operations	49,471	49,709	49,260	50,297
Self-Governance	4,980	9,090	9,104	9,184
Contract Support Costs	136,186	145,460	153,040	161,191
Total Services	1.646,088	1,709,780	1,747,842	1,806,269
Total Facilities	296.980	253,282	238.958	247.731
Total Appropriations	1,943,070	1,963,062	1,986,800	2,054,000
Percent Change		1.02%+	1.2%+	3.4%+

(*FY 97 Dollars based on Conference Report figures)

TRIBAL CONTRACTING

The enactment of the Indian Self-Determination Act in 1975 (P.L. 93-638), put wheels on the concept of tribal self government, when it provided for the contracting and self-administration of federal functions benefiting Indians. Tribes could take over and administer their own health care delivery systems by assuming the responsibility from the IHS for the delivery of services and administration of funds under what became known as "638 contracts". These 638 contracts became an attractive vehicle for many tribes seeking to expand and develop their health delivery systems. The IHS reported 35 percent of its budget contracted under P.L. 93-638 by FY 1995. In Fiscal Year 1992, the Indian Health Service became involved in planning with tribal governments for the implementation of a tribal Self-Governance Demonstration Project as authorized by P.L. 100-472, P.L.102-537, P.L. 102-184 and amendments to P.L. 93-638. In FY 1993, a Self-Governance compacting process began, which provided for the identification of "tribal shares" of the overall IHS system, and a compact between a tribe and IHS for tribal administration of the tribal shares. In FY 1994, the IHS negotiated and signed 14 compacts and funding agreements, for a total of $51 million. In FY 1995, 29 Self-Governance Compacts and 41 Annual Funding Agreements were in place, totalling $262.7 million.

For those tribes exercising their governmental authority under either the Self-Determination or Self-Governance process significant challenges and opportunities have emerged. Many tribes, such as the Couer d'Alene in Idaho or the Salish-Kootenai in Montana have discovered

vast improvements in the health options for their tribal members by administering their own programs. In Alaska, the entire IHS Area Office is under consideration for take-over by a consortium of Alaska Area tribes and villages. The direct and indirect impacts are yet to be measured. One major impact these and future Self-Governance Compacts are having on the IHS, is the proportionate reduction of the IHS system, as each tribe extracts its tribal share of service dollars, and administrative dollars from Area and Headquarters functions. The IHS requests shortfall funds from Congress to be used in cases when the transfer of IHS funds to a Self-Governance Compact will have an adverse effect on other tribes not participating in compacts. The IHS has discovered, however, that the overall impact of increased contracting and compacting (combined with FTE reductions) is forcing an inevitable redesign of the total IHS agency to remain functional and to protect the interests of those tribes not involved in contracting or compacting for services. The balance of these divergent objectives is a critical concern for the future of Indian health.

IHS RESTRUCTURING

One of the most immediate challenges facing the IHS today is the current and increasing shift of IHS resources away from the agency. Three major factors are influencing this reduction. First, the authority for tribal governments to contract their proportionate share of the IHS functions which serve them was significantly expanded when P.L. 93-638 (The Indian Self Determination Act) was amended to include contracting for "tribal shares" of the overall IHS system, including Area and Headquarters functions. As tribes contract for more shares of the IHS, the agency must make adjustments throughout.

The second major factor is the rapid changes in the overall health care industry. Health care inflation has accelerated at a rate higher than the overall Consumer Price Index. The cost of new technologies, pharmaceutical, equipment, personnel, hospitalization, and related costs

have far outpaced increases provided to the IHS through the federal and Congressional budget process. Health delivery systems are changing to adjust to increased costs resulting in mergers of systems, movement toward managed care systems for Medicaid beneficiaries and a shift of many federal programs to states.

Finally, the third major factor is the current federal downsizing initiative to meet overall reduction of personnel targets and the impending budget reductions necessary to balance the federal budget by the year 2002. This collision of events has placed the IHS at a critical crossroads.

The IHS enlisted the assistance and consultation of Indian tribes and urban Indian representatives to review the challenges, seek input from grassroots communities and develop a series of recommendations for the future. Described as *"... the first attempt in 40 years to change the overall structure of the IHS ..."*, a partnership was formed called the "Indian Health Design Team" (IHDT) in January 1995. By November 1995, the IHDT issued its Final Report. This report was mailed to over 1,000 tribal and urban organizations, and provided to 12,000 IHS employees for comment. A series of public forums were held throughout 1996 to secure feedback on the recommendations proposed by the IHDT. The deliberations of the IHDT were based upon the following **"Guiding Principles"**:

Patient Care Comes First
Be Customer-Centered
Focus on Health
Sovereignty
Cultural Sensitivity
Trust Responsibility
Empowerment/Adaptability
Accountability
Treat Employees Fairly
Excellence
System-wide Simplification
Full Disclosure and Consultation

The recommendations were proposed in two "Phases". Phase I centered upon a restructuring and downsizing of the Headquarters function of the IHS into three basic offices. These included the (1) Office of the Director; (2) Office of Health Support; and (3) Office of Administrative

Support. This change suggests a major downsizing of the headquarters staff, and a fundamental shift in the focus of the agency, from one of "directing and controlling" to one of "supporting" tribal and urban programs. A subsequent report from the IHDT issued in September 1996, states that the IHS has already begun to implement these changes and has reduced headquarters staff to 500 workers, transferring many functions to the Area and field office levels. IHS Headquarters is working with the IHDT to identify additional functions and dollars which can be transferred to the local I/T/U level.

Phase II of the recommendations center on restructuring steps at the Area Office level of the IHS. Hearings were held throughout Indian country to solicit feedback on IHDT recommendations. Little support was received for the concept of reducing the total number of Area Offices or consolidating Areas. There was support for other aspects of the IHDT plan, however, including the establishment of a "center of excellence" function within each or several Areas which would specialize in certain aspects of health management and offer that assistance to the I/T/U's. Any savings which result from restructuring and downsizing should be passed along to patient care under the I/T/U system. These deliberations are continuing and it is expected that the authorizing committees of the U.S. Congress will likely become involved through oversight hearings on the restructuring of the IHS in the future.

TRENDS ACROSS THE INDUSTRY AND IMPACTS ON INDIAN HEALTH

Managed Care Systems

In order to compete with larger managed care systems for Medicaid dollars, the I/T/U systems must transition from a system of rationed care under a defined budget, to a system of managed care under capitated pay-

ments. The benefits and risks of such a transition have been assessed and evaluated at various levels. There have been a few examples of tribally based managed care efforts, such as the Pasqua Yaqui in Arizona and the Pawnee Hospital in Oklahoma. Other tribal and urban Indian clinics have ventured as partners with larger HMO's in an effort to maintain Medicaid patients tracked to managed care systems, such as the Minneapolis Indian Health Board, an urban program. Other I/T/U programs have worked closely with their states to ensure that for Indian Medicaid patients tracked into a managed care system, existing Indian providers are integrated into the managed care system and cultural acceptability of the services is protected.

The impact of managed care systems on the I/T/U system has been sporadic and focused in states undergoing health care reform. The concern about managed care, however, is significant. Studies, roundtable discussions and training sessions have been offered by the Indian Health Service, the National Indian Health Board and the American Indian Health Care Association to better understand and prepare for a managed care transition if necessary.

A recent report by *George Washington University* on an IHS Managed Care Roundtable, cites five major issues facing Indian health programs if Indian health were to move into a managed care model. These are[24]:

Mission: The historical and legally based mission and role of the U.S. Indian Health Service must be preserved under a managed care system. The unique trust relationship which exists between the federal government and Indian people must be a fundamental component of a new system. As such, the door opens to an array of health related services and functions not normally associated with a managed care system, such as environmental health, sanitation systems, health professions training, inpatient alcohol/drug treatment, remote or satellite stations, emergency response units and

24 Rosenbaum, Sara, J.D., Zuvakas, Ann, D. P.A., 1996 *Integrating Indian Health Programs into Medicaid Managed Care Systems; A Roundtable sponsored by the Indian Health Service.* Center for Health Policy Research of the George Washington University Medical Center, Washington, DC

culturally acceptable providers and outreach personnel. In addition to ensuring these wrap-around services are included in an Indian managed care system, there are the initial start-up costs for the I/T/U system to become a competitive managed care system. Assuming I/T/U systems must compete for patients to enroll the needed number of participants to provide services, the existing infrastructure of the I/T/U system will require upgrades in facilities, data information systems, personnel training, malpractice coverage and patient education.

Populations, Eligibility and Enrollment: The current push toward managed care enrollment is focused on state Medicaid patients. For I/T/U programs to fully embrace a managed care approach it must quantify the number of Medicaid patients within the I/T/U system, and the number eligible but not necessarily on Medicaid.

There are many barriers which prevent eligible Indian patients from enrolling on Medicaid. These barriers include language and cultural differences between Indian people and the state enrollment officials, lack of outreach to Indian communities, philosophical positions that Indian health is a right and enrollment on Medicaid not needed, fluctuating economic status of Indian families may move Indians on and then off Medicaid.

The enrollment process has been difficult for many Indian patients caught in a managed care experiment. While some states have allowed for a voluntary enrollment, others have mandated enrollment into managed care systems. In these cases, I/T/U systems must integrate into the system or lose patients and patient revenues. The geographic isolation of many IHS and tribal programs suggest additional problems. The small populations in these isolated areas make it almost impossible to capitalize the delivery of services on a capitated basis unless there is a larger partner willing to share the financial risks.

Remote IHS and tribal programs may need to assess the benefits of opening the doors to non-

Indians in this situation to expand the patient base. Finally, the Indian population is not the normal HMO patient pool. Indian populations are more mobile, less stable, experience earlier onset of chronic diseases, higher rates of expensive accidental injuries, higher rates of poverty, and other psychosocial complications and ultimately more costly. The Indian population profile is in direct conflict with the preferred patient profile sought by managed care systems.

Barriers to Participation: The I/T/U system is moving away from economies of scale (as described in the earlier sections on IHS restructuring and tribal contracting) and toward decentralized administration and local control. The larger health industry is moving in the opposite direction, consolidating, building mergers, and creating the economies of scale necessary to financially support managed care systems. The largest barrier for I/T/U systems to participate is identifying the linkage into a larger system of shared resources and shared risks. Other barriers include the lack of capital to develop the needed data systems, facilities, equipment, experienced staff, and to cover the degree of risk which is assumed to cover the health services of the plan. When the IHS considered its options under the Health Security Act, an actuarial study was conducted which estimated that only 80 percent of the existing IHS patient load would opt to enroll in an IHS managed care plan if given the flexibility and portability to do so.[25]

Legal Issues: There are a variety of legal issues which must be sorted out upon entering into the managed care network. For example, the Health Care Financing Administration (HCFA) has provided waivers to states implementing health care reform (section 115 waivers and section 1915 waivers). These waivers have made it easier for states to avoid various regulations under Medicaid regarding the types of patients served, mandated enrollment, and elimination of cost-based reimbursement for care. This is particularly troubling for many I/T/U s which only recently received automatic designation as a Federally Qualified Health

25. Department of Health and Human Services, *I.H.S. Health Care Reform Actuarial Study Preliminary Report - Implementation Analysis.* February 25, 1994. Contract No. 282-91-0052.

Center (FQHC) to bill Medicaid and Medicare for actual costs as opposed to a fixed fee. The Anti-Deficiency Act which prohibits federal employees from placing the federal government at financial risk could be a legal consideration and well depending upon the type of managed care system. Conflicts between tribal sovereignty and state authority to license managed care systems must be resolved. Finally, the issue of required malpractice coverage for managed care systems and the acceptability of IHS and tribal program coverage under the Federal Tort Claims Act is unclear.

Assistance and Training: While it can be said that the IHS has operated a large managed care system for decades, the contemporary and competitive managed care environment poses new challenges. Training and technical assistance will be needed for all I/T/U participants in managed care systems to better understand the insurance component of managed care; negotiation strategies and pitfalls for I/T/U linkages with larger systems; marketing strategies; and federal, state and tribal collaboration.

Welfare Reform

When Congress enacted and the President signed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193), there was much concern about the elimination of entitlements and transfer of authority from the Federal government to the states. For Indian people, the transfer of federal responsibilities to state levels is always disconcerting given the historical conflicts between tribes and state governments. While P.L. 104-193 did contain a few provisions for direct block grants to tribal governments for child welfare purposes, the impact the welfare reform effort will ultimately have on I/T/U health care systems is still unknown. The new welfare reform act provides for sweeping overhaul of the nation's welfare system including the following programs: (a) Assistance to Needy Families; (b) Supplemental Security Income Benefits; (c)

Child Support Enforcement; (d) Welfare and Public Benefits for Aliens; (e) Child Protection; (f) Child Care; (g) Child Nutrition; and (f) Food Stamps and Commodity Food Distribution.

An analysis of the new welfare reform law by the George Washington University, discusses the potential impact of welfare reform on the Medicaid system that exists today.[26] These concerns are of interest to I/T/U systems as well. Of principle concern to health providers is the historical linkage between welfare enrollment and automatic Medicaid eligibility which is now separate under welfare reform. The act repeals the Aid to Families with Dependent Children program which provided certain benefits to anyone meeting the criteria, and replaces it with the Temporary Aid to Needy Families (TANF) program, which is no longer an entitlement. States will receive the TANF block grant and develop their own criteria and procedures. The GWU report cites 60 percent of the individuals who received Medicaid in FY 93 also received cash assistance under welfare. When individuals lose their cash assistance under welfare reform they could potentially lose their Medicaid eligibility as well.

Individuals may not follow-up on Medicaid eligibility even if eligible, once cash assistance has been severed, through the loss of AFDC or SSI benefits. The GWU report underscores the disproportionate risk faced by children, because their health needs are primarily preventive in nature and thus there is less likelihood that Medicaid enrollment will be sought out for them. The tremendous reductions in welfare enrollment throughout the United States anticipated under this Act could produce a migration of Indian families between reservation and city environments, depending upon job opportunities, medical crises, tribal resources and welfare benefit options by state. These fluctuations in the Indian population will be a factor for all components in the I/T/U system which must be monitored.

26. Rosenbaum, Sara, J.D., Darnell, Julie, M.H.S.A., *An Analysis of the Medicaid and Health-related Provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996*, George Washington University Center for Health Policy Research, August 1996.

Quality, Accountability and Consumer Choice

Health care in America has largely been a physician controlled system, a network of patient/doctor relationships supported by hospitals and payment systems. Physician prosperity in the last 40 years has been incomparable for many specialties. But the realization of physician surplus, managed care networks, consumer choice, quality and accountability have quickly emerged to change the environment.[27] Doctors are now facing the financial implications of specialty surplus, quality of care report cards and managed care mergers.

The IHS system recognized its unique relationship with the patient base early on, and has instituted quality control and accountability systems locally and nationally, perhaps ahead of the curve. The accreditation process for health care organizations, such as those in the I/T/U system have recognized the integral requirement for quality assurance systems and consumer feedback. The IHS launched a major initiative to seek accreditation for all I/T/U facilities through the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) and has for all practical purposes succeeded. In the early 1970s the IHS implemented a series of Indian Advisory Boards at the local, Area and national levels which remain active and effective today.

The larger health care industry is likewise instituting these systems as the resources for health care diminish and competition for consumers increase. For example, the National Commission on Quality Assurance (NCQA) which oversees the quality of care for managed care organizations, is providing prospective subscribers with report cards on health plans. Employers and others shopping for Health Maintenance Organizations to enroll members can look to a report card on the Internet called the Health Plan Employer Data and Information Set (HEDIS) to select their plan. As consumers of health care become more proactive, and quality of care data more accessible, the I/T/U systems will benefit by pursuing both historical and newly instituted means to hold programs accountable to set standards and increase consumer involvement.

Cultural Acceptance of Health Services

The I/T/U health care delivery system is probably one of the finest studies in culturally acceptable health services available. It has proven over the history of the IHS that health services are far more effective with the Indian population when provided in the context of Indian cultures, in the Indian environment, with indigenous outreach staff, using culturally sensitive and Indian providers trained in the unique health problems facing that population.

The importance of cultural acceptance of health services is being recognized by managed care systems as these plans reach out to diverse Medicaid populations, and face criticism about effectiveness with poor and elderly enrollees. The efforts by I/T/U providers in California and Oregon to convince those states to integrate the Indian programs into the managed care network for Indian patients has proven effective. Initially, in California Indian Medicaid patients were mandated to other systems. While their funds went to the managed care system, the Indian patients continued to seek services from the Indian programs in California. The preference for culturally sensitive health care outweighed the attractions of larger plans, for many of the anecdotal examples in California.

State Initiatives

The states have taken the lead on health care reform. When the Health Security Act failed to move through Congress in 1993, many thought health care reform would be delayed or worse. On the contrary, states have moved aggressively to implement various incremental reforms which are having an impact on the I/T/U system. As discussed earlier, the push by many states to enroll Medicaid patients into managed care systems as a means to control costs caught most I/T/U providers by surprise. The GWU/IHS Roundtable on Medicaid and man-

27 The Advisory Board Company, Washington, DC. *To the Greater Good: Recovering the American Physician Enterprise., 1995.*

aged care found interesting situations in several states. In Oregon, Indian Medicaid patients have the option of enrolling in the states managed care plan or remaining with their existing approved provider on a fee-for-service basis. Oklahoma provided a similar situation where both patients and I/T/U providers could opt to participate in the managed care system to continue the fee-for-service arrangement. In Oklahoma, the I/T/U provider could also seek payment for out-of-plan services. On the other hand, Minnesota took a harder line. With the exception of reservation based Indians, the Minnesota demonstration was not optional for Medicaid recipients. Minnesota Indian programs were forced to negotiate with an HMO for financial survival, but the HMO had no requirement to integrate the I/T/U program. In California, more options are available. Indian patients and Indian providers have the option to participate and there are several incentives to cover services outside the plan.[28] The states will continue to play a major role in the future of health care reform. These state initiatives will have an impact on the I/T/U system.

The reduction in federal budgets is impacting government policy at both the federal and local levels. State Block Grants have been one approach to shift a reduced level of some federal resources and policy to the states. For IHS, American Indian tribes and urban providers, this shift will require renewed efforts to build bridges and opportunities at the state level. While the unique relationship which exists between tribes and the federal government must be protected, there are also opportunities for improved services through improved coordination with states. States have also taken the lead in health care reform by shifting Medicaid dollars to certain providers, such as approved managed care organizations. Services to Medicaid eligible patients have generated significant resources for IHS, tribal and urban providers, the loss of these patient revenues could threaten the ongoing viability for many of these services.

TRADITIONAL NATIVE HEALING

Native American cultures historically maintained traditional teachings and practices which promoted health, prevented diseases and provided curative care to individuals and families. Much of these teachings and knowledge survived centuries of hostility, persecution, acculturation and are practiced today in varying degrees by both tribally based and urban Indian populations. Federal government policy related to traditional healing practices among Native Americans has shifted over the course of U.S. history from one of prohibition to one of acceptance. As modern medicine begins to understand and appreciate the healing power of traditional Native ceremony, ritual, faith and herbal remedies there has developed a growing interest in its preservation and integration into health systems. It is significant to see the IHS and other agencies such as the National Institutes of Health, reach out to link traditional healing and modern medicine, however, there is also concern voiced by tribal and spiritual leadership regarding the need to prevent the exploitation of Native practices.

Lifestyle factors which impact on Native American mortality and morbidity are not always effectively addressed through the clinical approaches of modern medicine, and a vast potential exists for the improvement of Indian health through the integration of traditional healing, culture and spirituality with the health care system. For years, the IHS has examined the feasibility of merging the alcoholism and mental health components of its service delivery system to more holistically respond to the complex behavioral health needs in American Indian communities. These considerations have met with both support and opposition at professional and grassroots levels. There are other tribal and urban Indian health settings which have successfully merged these fields into a behavioral health model.

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28 Rosenbaum, Sara, J.D., Zuveka, Ann, D.P.A., *Integrating Indian Health Programs into Medicaid Managed Care Systems: A Roundtable* sponsored by the Indian Health Service, Center for Health Policy Research of the George Washington University Medical Center, 1996.

The Indian Health Service established the Traditional Medicine Program in 1992, to provide national focus on the use of traditional practices and beliefs within the IHS system. This program was renamed the Traditional Cultural Advocacy Program and is located within Headquarters of IHS. The mission of this program is to promote the integration of culturally sensitive values, beliefs, and practices into the local health care system at the I/T/U level.[29]

It is interesting to note the shift of federal policy over the years from one of prohibition (as described in the 1923 BIA memo) to one of integration as proposed by the IHS Traditional Cultural Advocacy Program in 1993. The efforts within the IHS vary from Area to Area with regard to traditional Indian healing. Most Areas reported that they did not have a formal policy on traditional Indian healing, but indicated several informal policies, like the following:

- liberal leave policies for staff requesting time to participate in; traditional tribal treatment
- a tribal 638 program which offers traditional healing services;

TO ALL INDIANS:

Not long ago I held a meeting of Superintendents, Missionaries and Indians, at which the feeling of those present was strong against Indian dances, as they are usually given, and against so much time as is often spent by the Indians in a display of their old customs at public gatherings... From the views of this meeting and from other information I feel that something must be done to stop the neglect of stock, crops, gardens and home interests caused by these dances or by celebrations, powwows, and gatherings of any kind that take the time of the Indians for many days...

Now, what I want you to think about very seriously is that you must first of all try to make your own living, which you cannot do unless you work faithfully and take care of what comes from your labor....I do not want to deprive you of decent amusements or occasional feast days, but you should not do evil or foolish things or take so much time for these occasions. No good comes from your giveaway custom at dances and it should be stopped. It is not right to torture your bodies or to handle poisonous snakes in your ceremonies. All such extreme things are wrong and should be put aside and forgotten. You do yourselves and your families great injustice when at dances you giveaway money or other property . . .

I could issue an order against these useless and harmful performances, but I would much rather have you give them up of your own free will and therefore, I ask you now in this letter to do so. I urge you to come to an understanding and an agreement with your Superintendent to hold no gatherings in the months when the seedtime, cultivation and the harvest need your attention . . . If at the end of one year the reports which I receive show that you are doing as requested, I shall be very glad for I will know that you are making progress in other and more important ways, but if the reports show that you reject this plea, then some other course will have to be taken.

With best wishes for your happiness and success, I am,

Sincerely yours,
CHARLES H. BURKE,
Commissioner, BIA

Commissioner Parke, U.S. National Archives, File: 10429-22-063 (1923)

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29 Department of Health and Human Services, A roundtable conference on traditional cultural advocacy program final report, November 16, 17, 1993, Tucson, Arizona

- incorporation of sweat lodges in alcohol/drug treatment;
- ceremonial room set aside for traditional healers in hospitals at Navajo, and allowed to conduct bedside ceremonies as needed;
- general requirements that traditional healers, cultural beliefs and spirituality will be respected by providers.

It is important to note the impact traditional belief systems have had on the current wellness movement in Indian country. Professional and grassroots workers in the field of alcoholism and substance abuse treatment and prevention have long incorporated the traditional teachings and ceremonies of Indian culture as a key and fundamental path to wellness of Indian people. Since the early 1970s Indian alcohol programs have incorporated the Indian Medicine Wheel to emphasize balance between the physical, mental, spiritual and emotional realms for recovery. The Red Road to Recovery is often referenced when describing the tremendous positive impact traditional teachings, ceremonies and lifestyle offers for those in recovery. Violent deaths and injuries represent a significant proportion of the health problems facing American Indian and Alaska Native populations. Suicide and homicide rates are 30 percent to 40 percent greater. The impact of poverty, negative behaviors, alcoholism and self-destructive acts cannot be ignored.

In 1995 the National Association for Native American Children of Alcoholics (NANACOA) sponsored a national summit to end Indian alcoholism and drug abuse. This gathering was co-sponsored by the National Indian Health Board, the National Congress of American Indians and the American Indian Health Care Association. The gathering produced the Healing Journey Accord which makes specific commitments from each national Indian organization to achieve an end to Indian deaths from alcoholism or alcohol abuse by the year 2005. Much of this process was achieved through the integration of traditional Native American teachings and the involvement of individual healers from several Nations. Clearly, the lifestyle related health problems which plague Indian populations today are those most likely to be addressed by the spiritual revival, cultural survival and reintegration of traditional Indian teachings and belief systems. The healing practices indigenous to America are the single most important tools available to improve the health status of Indian people today and in the future.

Alternative Delivery Options

Tribal health programs and urban Indian health providers are facing a new competitive environment. Tribes and urban providers will be seeking financing alternatives and opportunities for joint ventures in the development of health services. A driving force behind the need for alternative financing options, will be anticipated changes in the way health care for the poor and indigent is ultimately financed. The federal responsibility to provide health care to Indian people is based on treaty obligation, the ceding of millions of acres and has been described by former IHS Director, Emery Johnson, as this nation's oldest pre-paid health plan. Yet, unless the federal government funds the IHS enough to truly meet 100 percent of the health needs, tribes and urban programs must assess alternative financing options. The IHS has a responsibility to assist tribes and urban programs to develop alternatives and provide the technical assistance and training to compete in the larger health industry. There are several experiments throughout the United States which should be assessed and policy considerations provided for national replication. The National Indian Health Board is currently examining several of these alternative delivery options. Those are:

Chief Andrew Issac Health Center

In Fairbanks Alaska, a Self-Governance compact is administering a managed care system which based itself on working with patients first to better understand managed care.

Pascua Yaqui Health Plan

Located in Tucson, Arizona, this plan was the first effort by the Indian Health Service to purchase health services for its beneficiary population through a managed care plan utilizing Contract Health Service funds.

Indian Health Board of Minneapolis

An urban Indian health program funded under Title V of the Indian Health Care Improvement Act, this program is a provider with several managed care plans in Minnesota under the states health care reform efforts and targeted Medicaid spending.

Critical Decisions for the Future

The future health status of American Indians and Alaska Natives is faced with a critical crossroad. The major causes of disproportionate death and disease among Indian people can be prevented, and appear to be related to, or impacted by, psychosocial factors such as poverty, self-destructive behaviors and social environment. The movement in the IHS to embrace traditional Indian belief systems, healers, practices and knowledge in the contex of health care could be the pivotal step to begin to address these contemporary killers of young Indian people. On the other side, Indian people are living longer, and are experiencing the health problems associated with aging. The I/T/U systems providing care to our population must ensure access to the appropriate level of services, specialty care, advanced technology and quality facilities.

The current turbulence in the health care industry is not necessarily a negative feature in the environment, but one which must be monitored and actively engaged by Indian health leadership. Much more study, training and technical assistance in the area of managed care is needed at the IHS, tribal and urban health levels. The fact that I/T/U systems are currently in a downsizing mode while the rest of the health care industry is in a merger mode should be faced and addressed at the I/T/U system. The question of economies of scale is one which will inevitably be addressed, either now or at the point when I/T/U systems face the challenge of managed care with limited resources. Will the dismemberment of the IHS system reach a point of diminished returns for Indian health? Will the autonomy of I/T/U systems at the local level increase the linkages for better services for Indian people?

The I/T/U system has lead the way in the development of population focused health care services, consumer involvement, quality assurance, cultural acceptability, meeting geographic challenges and health promotion initiatives. The same enthusiasm which went into establishing smoke-free facilities throughout the I/T/U system is needed today as we reshape our health care efforts to be both responsive to the cultural and health needs of our clients, but also to be competitive partners in new networks of health systems.

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Factors Affecting Tribal Choice of Health Care Organizations

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Introduction

Within the limitations of funding, all Tribes in the United States of America are making decisions about how their Tribal members will receive health care services funded through the Indian Health Service (IHS). Two types of basic choices are presented to all Tribes. The first type of choice is whether primary health care services will be provided directly by the IHS, or managed by Tribes, or contracted with private sector medical providers. The second basic choice is whether the Tribe will manage IHS-funded health services under a contract with the Federal government or by using the more flexible "compact." Almost all Tribes and urban Indian programs that manage health services are also faced with choices about how to organize their health care systems to maximize Medicaid income, particularly in an environment in which many States are changing their Medicaid programs to managed care. In addition to these choices which are common to all Tribes, there are many Tribal-specific decisions which help to shape the health care organizations that serve Native Americans.

While most health care in America is based on economic principles of free enterprise and health care providers as privately-owned businesses, within Indian health care the concepts are more representative of a national health care program. This is not only because the primary provider is the Federal government through the Indian Health Service, but also because the Tribes serve as governments which make collective decisions on behalf of Tribal members. The purpose of this paper is to define the role and authority of Tribes and how their decision-making must take into account factors which are different from other sectors of American society.

The model used in this paper is that the factors that affect decision-making are a combination of the legal, historical and political context in which Tribes operate; the political process of Tribal decision-making; underlying values; perceptions of likely outcomes; and specific information related to a particular decision. This paper also considers the current sources and unmet needs for information, technical assistance and training in planning and negotiating. Some recommendations are made to improve the quality of information that Tribes have to make decisions more effectively.

Methods

This study involved nine Tribes in four Areas of the Indian Health Service. One of the IHS Areas included in the study delivers most primary care health services directly through the IHS; two Areas rely on Tribes to manage primary health care delivery services, and one Area has a mixture of the two approaches.

The nine Tribes in this study represent a cross-section of the 175 Tribes recognized by the Federal government in all the States except Alaska and California.[1]

The Tribes range in enrollment from 215 to 13,000, with the median[2] having a Tribal enrollment of 4,000. Federal recognition of the Tribes in this study spans a time period from a Tribe with a treaty in 1855 to one that was recognized in 1981. Two of the Tribes in this study have no reservations, while the other seven have reservations ranging in size from 15 acres to 2.3 million acres. Eight of the nine Tribes conduct gaming operations. Four of the Tribes have compacts and five have contracts with the IHS under P.L. 93-638. Four of the Tribes have most of their health services delivered directly by IHS; three of the Tribes operate their own health care delivery systems; and two of the Tribes purchase most of their services from the private sector. For the Tribes in this study, the Tribal health departments range in size from 6 to 150 employees.

Among the Tribes in this study, unemployment ranges from less than 10 percent to more than 70 percent of Tribal members, with a median unemployment rate of 30 percent. When asked to list the top three health status problems within their Tribes, the first problem listed by 7 of the 8 Tribal Health Directors was diabetes. Heart disease ranked second along with alcohol and substance abuse. Other leading problems cited were hypertension, tobacco use, cancer, and the combination of stress, mental health and suicide.

To understand the factors affecting Tribal choice of health care delivery organizations, 12 elected Tribal officials were interviewed, including 8 Tribal Chairpersons and 4 Tribal Council members. The Tribal Chairpersons who participated in this study have been in office from 3 months to 20 years, with a median of 3 years. The time they spend on health issues ranges from less than 5 percent to about 40 percent with a median of 20 percent. The interviews were conducted in September 1996 at the Tribal offices and lasted approximately one hour. An interview guide was used with 31 questions.

In addition to elected Tribal officials, the highest ranking manager of health programs was also interviewed for 8 of the 9 Tribes. Six Tribal Health Directors and one Executive Director were interviewed. For one Tribe, the health director position was vacant, so the assistant director and the person who supervises the health director were interviewed. The Tribal Health Directors had been at their present jobs from 1 month to 22 years. The interviews lasted about 1.5 hours using an interview guide with 36 questions.

The IHS Area Directors for each of the four Areas were interviewed, as well as the individuals in the Area Office with responsibility for planning functions. These interviews were conducted in their offices, except for one telephone interview with an Area Planning Office director. Separate interview guides were developed for each of these categories of interviews and they lasted approximately one hour. The purpose of the Area Office interviews was to place the Tribes in the study in a broader context and to learn about the planning and technical assistance available through the IHS. In addition, one telephone interview was conducted with IHS headquarters staff responsible for Tribal planning programs.

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1 There are also 226 recognized Tribes in Alaska and 150 in California.

2 Median is the midpoint with half being larger and half being smaller.

Altogether, this study included 27 interviews which were analyzed for content. To provide background for the development of the interview guides and for analysis of the information, a literature review was conducted and a background paper was written on the legal, political and historical basis of Tribes. Further information about the organization of the Indian Health Service is presented in a separate paper and is not duplicated here.

Model

In analyzing the content of the interviews, a model emerged which provides a way to integrate information and to understand how assistance could be provided to Tribes to improve decision-making. This model is illustrated as a pyramid in Figure 1.

The bottom layers of the pyramid represent fundamental factors which are unlikely to change from decision to decision. The top of the pyramid represents factors which affect specific decisions.

Most fundamental to Tribal decision-making is the legal, historical and political context in which Tribes exist. Most Tribes actively consider the effects of their decisions on preserving their sovereignty and their government-to-government relationship with the Federal government. Most Tribes are concerned about the repetition of history when the Federal government actively terminated Indian rights and programs, and they make decisions with that concern in mind. Many Tribes are willing to forgo short term gains in order to preserve legal and political precedents.
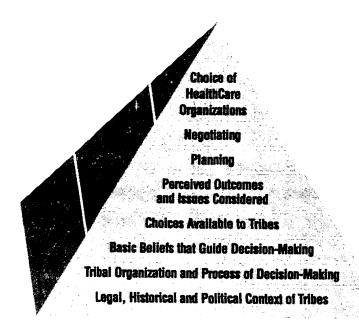
Another fundamental factor in Tribal decision-making is the internal political process which Tribal governments use to make decisions. The political process includes an understanding of how Tribes are organized, where the authority to make decisions is located, and the needs and demands of specific constituencies to whom the political process must be responsive. Tribal organizations are not the same as profit-making businesses which provide or purchase health care.

A third factor which remains fairly constant regardless of the decision under consideration is the underlying values of the Tribe and its leadership. Underlying values are those basic beliefs, derived from cultural patterns and historical experience, which influence all decisions. The most consistent expression of underlying values in this study was that it is important for Native American people to have a separate health care delivery system.

Decisions are made considering both the fundamental factors and factors related specifically to those decisions. Four groups of factors

FIGURE 1
MODEL USED TO ANALYZE AND SYNTHESIZE
FACTORS AFFECTING TRIBAL CHOICE OF HEALTH CARE ORGANIZATIONS

Choice of HealthCare Organizations

Negotiating

Planning

Perceived Outcomes and Issues Considered

Choices Available to Tribes

Basic Beliefs that Guide Decision-Making

Tribal Organization and Process of Decision-Making

Legal, Historical and Political Context of Tribes

are related to specific decisions. These include the choices available to the Tribe, perceptions of likely outcomes, information gathered in the planning process, and the identification of more specific information in the negotiating process.

The choices available to the Tribe may be limited by geographic and economic circumstances. For example, if there is no private sector health care near the Tribe, there may not be a choice to contract with the private sector. If the IHS has not built any health care facilities in the area, a Tribe may not have a choice of IHS direct care.

Perceptions of likely outcomes are expressed in this study as perceived advantages and disadvantages of choices. For choices which are common to all Tribes, such as contracting versus compacting, there are fairly consistent perceptions of advantages and disadvantages. These are expressed in rather broad terms, such as "more flexibility." Tribal leaders may have a range of knowledge about the details of regulations, but they all have a summary knowledge which influences their decisions.

Specific information related to a particular decision comes from planning and negotiating. Ideally, the planning process involves gathering information about the availability of services, the demand for services, staffing and space needed to provide services, the cost of different alternatives and sources of funding. While planning leads a Tribe to a preliminary decision on a course of action, it is the negotiating process that determines whether or not Tribal intentions can be implemented as envisioned. For example, the planning process may provide cost estimates, but it is the negotiating process that determines the actual cost. For both planning and negotiating, the Tribe gathers and analyzes specific information often using experts, which may be either in-house staff or consultants. For some people, negotiating is seen as part of implementing a decision; however, in this model it is regarded as part of decision-making because when a Tribe has the results of the negotiation they have another chance to decide whether or not to go forward with their plans.

The distinctions between planning, negotiating and decision-making are an artificial tool of analysis in this study. Among the Tribal representatives interviewed for this study, there was rarely an awareness of these processes as having distinct beginnings, processes and endpoints. Tribal leaders and health directors communicate about these activities in a more broad and holistic way, as a part of politics and life.

Legal, Historical and Political Context of Tribes

WHAT IS A TRIBE?

There is no universal legal definition of Tribe. Originally the term was used to identify various political entities for treaty-making purposes. Later the term was used in Federal legislation regulating Indian affairs and identifying groups eligible for Federal benefits and services. Generally, a recognized Indian Tribe is a group of Native Americans whose existence pre-dates European contact and which has continued to remain a separate and distinct group of people.

A determination that a group is an Indian Tribe is usually made by Congress or, through delegation from Congress, by the Secretary of the Interior pursuant to the Indian Commerce Clause of the Constitution. Occasionally a determination of recognized Tribal status is made by the courts. The Federally Recognized Indian Tribe List Act was enacted in 1994 requiring the Secretary of the Interior to annually update and publish in the Federal Register a list of all Federally recognized Tribes. Additional Tribes have petitioned for Federal recognition. Some Tribes that are not Federally-recognized have been recognized by the States in which they are located. Congress has stated that all Federally-recognized Tribes are to be treated the same regardless of how or when they became Federally recognized and that only Congress has the authority to remove a Tribe from the list.

While the term "Indian" has been used to describe people with a particular cultural heritage, for most legal purposes it refers to persons who are identified by a Tribe as members of the Tribe. Thus, it is a political rather than a racial determination. Further, the government-to-government relationship between Tribes and the Federal government is based on political principles, not race or status as a minority.

However, in determining eligibility for health care provided by or funded by the Indian Health Service, the Federal regulations are based on a three approaches: 1) Tribal membership; 2) certification of Degree of Indian Blood (CDIB); or 3) proof of descent from a Tribal member.

Tribes govern both their members and their land. In 1948, Congress adopted a three-part definition of Indian country including: reservation lands, dependent Indian communities, and Indian allotments. Courts have ruled that many diverse types of settlements fit the dependent Indian community definition of Indian country, including pueblos in New Mexico owning their lands in communal fee simple, off-reservation communities, and a housing project within a disestablished reservation. Even when a Tribe has no land base, it may enroll its members, adopt a constitution or other form of government and select or elect leaders to govern its internal affairs. However, a jurisdictional land base allows Tribes to exercise other authorities, including imposing taxes, punishing misdemeanor criminal offenders, conducting gaming operations and enacting and enforcing zoning and health ordinances.

FEDERAL-TRIBAL RELATIONSHIP

Prior to European discovery of North America, Indians governed themselves and their territories. Following European colonizing efforts, this sovereignty was recognized in the treaties which opened Indian lands for non-Indian settlement in return for promises of respect for reduced Indian territories and other promises of material goods and services, including health care. Over the past two centuries a complex body of Federal Indian law has developed defining the unique relationship between the Federal government and Indian

Tribes. Three enduring principles have emerged as the foundation of this evolving Federal-Tribal relationship: inherent sovereignty of Tribes, Congressional authority over Indian affairs, and the Federal trust responsibility.

The inherent sovereignty of Tribal governments is a recognition that the Tribes have powers of self-government within their territories, commonly called "Indian country," including a right to be ruled by their own laws, to determine their own membership and to be free of State control and regulation unless Congress declares otherwise. Because Tribes are considered sovereign, there is a government-to-government relationship between a Tribe and the Federal government. The concept of Tribal sovereignty is the underpinning of current policies of self-determination and self-governance. The policies are further defined in the Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638) and its amendments which give the Tribes the right to contract with the Federal government to provide any services to Tribal members that the Federal government would otherwise provide.

The 1988 Amendments to the Indian Self-Determination Act created self-governance demonstration projects in which participating Tribes enter into annual funding agreements, or "compacts," with the Federal government in which they receive a block of funds under Tribal control and administration with minimal Federal oversight. In the first three years following implementation of the 1988 Amendments, self-governance efforts were concentrated on the Bureau of Indian Affairs. Through the Indian Health Care Improvement Act Amendments of October 29, 1992, the Tribal Self-Governance Demonstration Project was extended to the Department of Health and Human Services, allowing up to 30 tribes to enter into annual funding agreements with the IHS to delivery health services. In Alaska, 221 village council governments cooperated for a single compact.

The Federal trust responsibility originally applied to protection of Indian lands and resources, but the term has been extended to cover the Federal government's obligation to provide social and health services and benefits to Indians and Tribes. The first Congressional appropriation specifically to fund Indian health care occurred in 1911 with the funds going to the Bureau of Indian Affairs (BIA). The Snyder Act of 1921 was the first time that Congress codified the Federal government's obligation to provide health care to Native Americans and provided for regular appropriations. In 1928, the Meriam Report strongly urged that an effective public health program be instituted to replace the existing system which was aimed mainly at relief of the sick, not prevention and eradication of disease. The Transfer Act of 19ᵕᵕ transferred the health services from the BIA in the Department of the Interior to the U.S. Public Health Service (PHS) in the Department of Health, Education and Welfare. At that time, the Indian Health Service was created in the PHS. The Indian Health Care Improvement Act of 1976 is one of the more recent laws in which Congress declared that the Federal government has a legal responsibility to provide health care to American Indians and Alaska Natives.

Federal Indian policy has gone from one extreme to another from the beginning of the history of the United States until today. Historians often identify distinct periods of Federal Indian policy: the Treaty Making Era (1776-1871), which included removal of Indians from their homelands to designated Indian Territory; the Assimilation and Allotment Era (1871-1928), which opened Federally- protected Indian lands to white settlement; the Reform and Indian Reorganization Era (1928-1945), which began with the Meriam Report and culminated in passage of the Indian Reorganization Act of 1934; the Termination Era (1945-1961) in which Congress terminated the Federal relationship with 109 Tribes and began a policy of relocating Indians to urban areas; and the Indian Self Determination Era (1961 - present).

The lack of consistency in Federal policy makes Tribes distrustful. When Representative Harold Froehlich of Wisconsin introduced the

Menominee Restoration Act of 1973 to repeal the termination act of 1954, he stated:

> Whatever its motivation and objective, this Termination Act has proved in the ensuing years to be a misconceived and tragic experiment. It was an involuntary experiment that has produced cultural shock and severe economic hardship for the Menominee people. It has led to disorientation, disunity, and despair in the Tribe. And it has written a sad and regrettable chapter in American social history.[3]

While many of the Tribes that were terminated subsequently had their relationship with the Federal government restored, Tribal leaders and members remember termination and they suspect new government policies and approaches of containing the seeds of a new termination era. This is particularly true at the present time when the Federal government is intent on balancing the budget by cutting programs.

TRIBAL-STATE RELATIONSHIPS

Tensions between Tribes and States have existed since the formation of the United States. While some States have begun to work more cooperatively with Tribes and recognize their Tribal sovereignty, most of the 34 States with Tribes have attempted at one time or another to extend their jurisdiction over Indians and Indian country. Tribes have relied on all three branches of the Federal government to help protect their special status and autonomy. For example, in 1995 after almost ten years of litigation by two Tribes in Alaska, the State ceased challenging their Tribal status, although these Tribes had been on the Secretary of the Interior's list of recognized Tribes for many years and had approved IRA constitutions dating from the 1940's. Federal courts have often been asked to resolve conflicts between Tribes and States over such matters as Tribal status, extent of Indian country, hunting and fishing rights, water rights, zoning, land management, child welfare jurisdiction, and gaming.

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3 Congressional Record, 119:14052.

Process of Tribal Decision-Making

Courts have consistently held that the form or organization of Tribal government is a Tribal decision. There are many types of Tribal federally recognized governments.[4] In the 12 years following passage of the Indian Reorganization Act of 1934 (IRA), 161 Tribes reorganized their governments under constitutions which were approved by Tribal members and the Secretary of Interior. However, many Tribes retained their traditional form of government. Today, some Tribes, like the Navajo, have no written constitution, although most have adopted some form of charter. The IRA constitutions adopted in the 1930's and 1940's have embodied governmental forms similar to those in other political jurisdictions within the United States, except that they do not usually provide for separation of powers or the prohibition against the establishment of religion.

In many Tribes, the Tribal Council is often both the executive and legislative branch of government. For the smallest Tribe that participated in this study, the Tribal Chairman is also the Executive Director of the Tribe. Elected Tribal leaders may also be spiritual leaders. In some instances, the Tribal Council or Community Council is composed of the entire Tribal membership. Roles and responsibilities are rarely defined with the clarity and rigidity that other Americans have come to expect from their governments. With Tribes being relatively small groups of individuals who are interrelated by birth, clan or marriage, most Tribal decision-making has an element of what would be considered conflict-of-interest in another context. Consensus is the usual process for Tribal decision-making.

All of the Tribes in this study have Health Directors who are responsible for the management of health programs operated by the Tribe. Policy decisions usually originate with the Health Director who provides the background information on the issue. Major policy decisions are usually made by the Tribal Council. Two of the Tribes in this study have General Councils which include all Tribal members over the age of 18. General Councils usually only meet annually and during the interim there is an elected Business Committee which acts on Tribal matters. The other Tribes in the study have Tribal Councils which are elected by Tribal members.

Most Tribal Councils deal with many issues, such as land management, fish and game policy, economic development, gaming, and law enforcement. They create advisory committees to study specific types of issues more closely and make recommendations. Thus, all of the Tribes in the study had a body called a Health Commission, a Health Committee, a Human Services Board, a Health Board or a Health Advisory Board. In some cases these health committees are appointed by the Tribal Council and in some cases they are elected by the members. The health committees among the Tribes in this study had 5 to 8 members. For some Tribes, the health committee serves as a "clearing house," sifting through lots of information and providing guidance to the health care delivery system. Health committees screen information so that too many details do not go to the Council. Health committees also hear patient complaints and set Tribal health priorities. In some Tribes, the Tribal Council "rubber stamps" all health committee recommendations. In other Tribes, there is duplication at every level, with no clear delineation of roles and responsibilities. One Tribal Health Director explained that "probably the Council has not developed trust in delegating decision-making authority to the health director."

Where IHS is providing most of the health services directly, the Tribal Council is asked to advise on program and policy changes. For

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4 There are presently 554 federally recognized tribes. This includes newly-recognized Tribes not yet included on the list published in the Federal Register by the Department of Interior.

Tribes that are operating health care programs, Tribal Councils make the final decisions on budgets, changes in rules for eligibility for services, adding or deleting types of services, compacting and contracting, major purchases and facilities constrction. Where gaming enterprises have become profitable, Tribal Councils are often asked to use gaming revenues to supplement health budgets, to finance new health programs or to construct new health facilities. Tribal Councils also consider positions on national and State legislation, and adopt Tribal codes and ordinances. Most Tribal Councils hire the top management for Tribal programs. Some Tribal Councils in this study approve all personnel actions, approve contracts requiring the chairperson's signature, and even approve travel to conferences.

The Tribal Chairperson, sometimes called Chief or Governor, usually serves as the presiding member of the Tribal Council during Council meetings. Between meetings, the Chairperson is usually responsible for management of the Tribal operations. As the highest elected official, the Tribal Chairperson usually has a fair amount of influence in Tribal decision making.

Tribal leaders interviewed for this study were able to identify several constituencies which could have conflicting needs. These include elders and youth, people living on the reservation and Tribal members off the reservation. They also acknowledged that health service decisions have to take into account users who are members of other Tribes. Tribal

leaders are aware of people with special needs, such as dialysis patients. They also feel concerned about meeting the needs of people who live in communities furthest from services. Another constituent group mentioned by Tribal leaders was Tribal members eligible for Medicaid.

When asked what methods they used to resolve conflicts between the needs of different constituent groups, some of the Tribal leaders distanced themselves from the larger political issues and regarded these as individual complaints which would either be resolved through patient complaint procedures, or referred to the IHS. In some situations conflicts between the needs of competing constituent groups are accepted as a fact of life, a consequence of the lack of funding which makes it impossible to meet all needs. Other Tribal leaders, however, took a systems approach. They stated that the competing needs of different constituencies can be handled by developing long term goals and plans, public education and seeking expert opinions.

When a Tribal Council meets to decide health issues, they can be wearing several hats simultaneously. They are representing their Tribal members as consumers of health care. They can also be representing Tribal management as providers of health care. And they can be in a role as purchasers of health care, both as employers and as managers of IHS-funded Contract Health Services.

Basic Beliefs That Guide Decision-making

At the end of each interview, Tribal leaders were asked what advice they would offer to other Tribal leaders. In this part of the interview, they expressed some fundamental guiding principles. These basic beliefs seem to be a foundation for all decision-making.

Every Tribal leader and every Tribal Health Director interviewed for this study said that it is important for Indian people to have a separate health care delivery system from other people. One reason they all cited was cultural issues. "From time immemorial, Tribes have taken care of their members' health - it is a traditional function for a Tribe to fill," said one Tribal Chairman. Another leader cited "Tribal feelings of concern for all members' well-being." A Tribal Chair reported that while the members of his Tribe are bilingual, 90 percent speak the Tribal language first and they need interpreters for English. Other cultural issues included the availability of traditional healers and feeling more comfortable in a program that is designed for them. "Understanding by providers that Indian people have different attitudes and beliefs" is important, explained one Tribal Chairperson, because it "means people are more likely to seek medical care if they believe providers understand them."

Another reason frequently cited for a separate health care delivery system was that the Federal government needed to uphold treaty rights and the Federal trust responsibility to provide health care. One way of looking at this is that Native Americans have a pre-paid health plan with the Federal government — it was paid with lands taken by the Federal government.

Tribal leaders also said that a separate system creates more employment opportunities for Tribal members. Federal law and regulations allow for Indian preference in hiring for jobs in both the IHS and Tribes. However, the Indian hiring preference does not apply in the private sector and fewer jobs in the private sector go to Native Americans. Discrimination against Indians in other health care systems was also listed as a reason for a separate system, both as it relates to employment and in the delivery of services. American Indian and Alaska Native employment preference means economic and community development, as well as assuring that Tribal members are served by people who understand them. Employment goes hand-in-hand with other reasons expressed, including ownership, empowerment, sovereignty, and Tribal identity.

Many of the Tribal leaders said that the current system has a needed focus on community health. A separate system is more responsive to the needs of Indian people, including their unique health problems and genetic make-up. "We still have high infant mortality and people die younger," said one Tribal leader who concluded, "These unique health problems need special care and services by understanding people."

Tribal leaders believe management of health care system decisions involves risks that affect human lives. They believe that the human risks must be weighed along with financial risks. "Figure out whether you want to be a service or a business," said one Tribal leader. "Without good health, everything else is in jeopardy," stated another. The Tribal leaders take seriously their responsibility for other Tribal members.

Tribal leaders want quality health care. They see the need to have good facilities and to select good staff. "The bottom line is to provide quality services," said one Tribal chair, "so you have to constantly watch all the changing conditions." Another expressed it this way: "Always focus on providing quality health care that is effective for your Tribal members and

cost efficient. Quality health care should be provided for the entire Tribe."

Tribal leaders are looking for holistic solutions. With unemployment rates as high as 70 percent, Tribal leaders must look at the connections between health decisions, employment and health: "More employment adds to well-being and empowerment and this, in turn, helps break the cycle of dependency and paternalism of the Federal government." Another Tribal chairperson expressed the relationship between employment and health education: "Part of public health is education. If Indians provide this education, it is better received and there is more willingness to allow providers into a person's home."

Tribal leaders understand long term decision-making. "Once you decide what way to go, be patient, pace your growth. . . keep focused and don't throw up your arms and accept failure," offered a Tribal leader as advice to others. Tribal leaders know the importance of stable, long term relationships. They see the need for good, long term relationships with Congress, IHS officials and State officials. One Tribal leader said, "Stability of Tribal government and finances is important in making long term decisions."

Tribal leaders understand the importance of information and communications. "Understand that the health care industry is very complex and you need people to explain it in simple terms," advised one Tribal chairperson. Another said, "Study and plan - know all sides of the issue before you make decisions. Make decisions based on being fully informed." Another Tribal leader said that they needed financial people to "spell out costs and help the Tribe understand what forecasts look like."

Tribal leaders have a duty to continuously educate and remind Congress of the Federal trust responsibility. Tribal leaders know that they need to keep their issues in front of Congress through ongoing communications. One Tribal leader acknowledged that Congress has appropriated funding for Indian Health Service to meet only 50 percent of the need, and added that Tribal leaders must "put the documented need in front of Congress continuously." Tribal leaders interviewed for this study regard legislators as generally open and willing to listen and learn. But it takes time, effort and money to keep a presence in Washington, D.C. This is considered a priority. Tribes recognize their individual responsibility to communicate with Congress, but they also want IHS to be a powerful voice advocating for budget and policy issues within the Federal bureaucracy. Several Tribal representatives interviewed for this study spoke of the importance of the the National Indian Health Board (NIHB) in representing all Tribes in the formation of Federal policy and funding priorities.

Choices Available to Tribes

Nearly all Tribes in the United States are choosing health care organizations from the same basic "menu." The first type of choice is whether primary health care services will be provided directly by the IHS, or managed by Tribes, or contracted with private sector medical providers. The second basic choice is whether the Tribe will manage IHS-funded health services under a contract with the Federal government or using the more flexible "compact." Almost all Tribes and urban Indian programs that manage health services are also faced with choices about how to organize their health care systems to maximize Medicaid income, particularly in an environment in which many States are changing their Medicaid programs to managed care. In addition to this "basic menu," Tribes can respond to local opportunities to shape their health care organizations. This section of the report gives a brief summary of the kinds of choices that are available to Tribes and some of the limitations in alternatives.

PROVIDER ORGANIZATIONS: IHS, TRIBE, PRIVATE

Historically, the IHS operated a health care delivery system that included hospitals, outpatient services, and community health services. With the Indian Self-Determination Act, Tribes were given an opportunity to operate any portion of this health care system that they choose to operate. Most every Tribe in the country manages some portion of the health care system, such as community health representatives (CHRs) which provide outreach services and transportation to increase accessibility of services. Tribes in this study were considering taking on the management of additional services, such as mental health, alcohol and substance abuse, pharmacy, and ambulatory care.

In places where Tribes were Federally-recognized relatively recently and no IHS infrastructure was in place, such as Wisconsin and California, Tribes have not had the option of IHS direct services. In places where the IHS direct health care services have been well-integrated into local communities and a very high percentage of IHS employees are members of local Tribes, few Tribes have seriously explored the alternatives of Tribal management of health programs.

For both IHS direct services and Tribally operated services, there are some types of health care that must be purchased from the private sector, such as specialty medical care. Even in Areas where IHS operates tertiary care centers, such as the Alaska Native Medical Center (ANMC) in Anchorage and the Phoenix Indian Medical Center (PMIC), some subspecialty services must be purchased from the private sector. The IHS program for purchasing private health care is called Contract Health Services (CHS). CHS has some special Federal regulations, including that it is the payer of last resort and alternate resources must be used first. Management of CHS programs has given Tribes experience in negotiating contracts, purchasing services from the private sector, and accessing alternate resources. Tribes can shift funding between CHS and direct care, deciding which kinds of services to purchase and which to provide. Some of the smaller Tribes, including two in this study, purchase all of their medical services from the private sector.

Geographic and economic realities affect Tribal choices. Some reservations and Alaska Native communities are located in remote areas. Small population size, low density of people in a geographic area, isolation, and few non-Indian residents with health insurance make it unprofitable for private health care to operate in those locations. Where private health care is less accessible, it becomes a more limited alternative for a Tribe. For example, a small Alaska Native village in a remote area may

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choose to use CHS to purchase speciality medical care in a geographically distant city for the few people with extraordinary needs, but they also need local services for primary health care for which there are no private vendors. In another geographic setting, a small Indian community located near a large city may find that there are economies of scale in purchasing services from the private sector and that their limited health dollars can serve more people with this arrangement.

TRIBAL DELIVERY: CONTRACTING, COMPACTING

When Tribes decide to manage a portion of the Indian health system, they have some choice about whether to enter into a contract or a compact with the Federal government. Contracts have more Federal supervision and oversight. Only Tribes which have successfully managed programs under contracts for 5 years are eligible to enter into compacts. Compacting is still a demonstration project and the IHS has limited the number of Tribes which will receive compacts, or annual funding agreements. Five Tribes in this study had completed or started planning studies for compacting.

STRATEGIES FOR MAXIMIZING MEDICAID INCOME

All but one of the Tribal leaders and health directors interviewed for this study said that Medicaid income was very important to them. Many States are reforming their Medicaid programs to become managed care programs. Some States allow Tribes to opt out of participation in health plans and to receive fee-for-service or flat rate reimbursement for treating Medicaid patients. However, Tribes recognize that managed care is the way of the future. In analyzing how to maximize their Medicaid revenues, Tribes must choose whether to become providers under Medicaid managed care plans. This choice in turn shapes the type of organization they must become.

Tribal leaders are dealing with State Medicaid reforms on two levels. The first is the proactive level. Four of the Tribal leaders interviewed said that they had personally been involved with the State in advising on Medicaid reforms or negotiating Medicaid rates and conditions for their Tribe. Tribes in this study were located in five different States. Three of the States were perceived by Tribal leaders in mostly positive terms. Tribal leaders from one State described the attitudes of State officials as very poor. And the fifth State got mixed reviews. When asked if managed care is a topic they feel comfortable discussing with State officials, about half of the Tribal leaders interviews said "yes" and half said "no." Two of the Tribal leaders had never been personally involved in any discussions about managed care. The responses from Tribal Health Directors to the same questions were similar to Tribal leaders.

The second level on which Tribal leaders and Tribal Health Directors are dealing with managed care is in the management of health facilities. As they try to maximize Medicaid income, they must decide whether to enter into contracts with Medicaid managed care plans. Further, they must consider whether they will loose their current patients who have Medicaid coverage to other providers and thereby lose their present income from Medicaid.

TRIBAL-SPECIFIC DECISIONS

When asked to list the most important health care decisions their Tribes had made in the past five years, Tribal leaders and health directors cited most frequently compacting and contracting. The next most frequent type of decision was related to facilities. Four Tribes considered financing and building a new clinic. One Tribe was involved in opposition to an IHS proposal to close the local hospital. And another Tribe had to consider whether to accept an IHS recommendation to replace a hospital with an ambulatory care center. One Tribe decided to purchase a home for a physician to aid in recruitment and retention.

The decision to build or lease a new facility has many limitations related to financing. Congress appropriates money for new facility construction and construction of replacement facilities in a capital budget which is based on formulas that assign priority status to different projects. Capital budgets have never been sufficient to meet the needs. Many proposed facilities have been on the waiting list for a decade or longer. The rules for the Federal government to lease space are as complex as new construction and create the same barriers. A Tribe may be willing to construct a facility and lease it to the Federal government; however, private financing is nearly impossible without a long-term lease. Some Tribes with income from gaming or other sources have been able and willing to finance health care facilities construction. While Medicaid and other third party reimbursement can include facility depreciation and that money can be set aside for future building projects, the IHS has never done business that way (and really cannot because any unspent money at the end of the fiscal year must be returned to the general treasury) and many Tribes are not familiar with this approach.

Another common type of Tribal specific decision is whether to assume additional programs from the IHS under contract or compact, or to start new programs without IHS funding. One Tribe in this study decided to start a dialysis center. Several Tribes considered adding specific programs or expanding programs, sometimes financed with income from gaming. Other types of decisions included considering the feasibility of serving non-Indians, pursuing JCAHO accreditation, and changing the Tribal constitution and bylaws to require elected officials to be alcohol and drug free. A list of decisions cited by Tribal representatives in the interviews is given in Figure 2.

FIGURE 2
TYPES OF TRIBAL CHOICES IDENTIFIED BY LEADERS(*) AND HEALTH DIRECTORS

*Compacting and Self-Governance (5)

Facilities
* Build a new clinic (4)
* Hospital versus ambulatory care facility as replacement facility for old hospital (1)
* Opposition to closing hospital (1)
  Purchase home for MD (1)

Adding or Expanding Tribally-operated Programs
* Tribal contracting for alcohol and substance abuse services (2)
* Increase EMS services (2)
* Expanding programs like pharmacy, CHS, WIC and nutrition (2)
* Tribal contracting for mental health services (1)
* Tribal contracting for primary health services (1)
* Starting a dialysis center (1)
* Adding programs for AIDS, FAS, diabetes (1)
  Using casino income to start or expand health programs, like home health care (1)

Policies
* Participation in State health care reform (1)
  Change Tribal constitution and bylaws to require elected officials to be alcohol and drug free (1)
* Consider feasibility of serving non-Indians (1)

Other
* Adopting a new health plan (1)
  Considering pursuing JCAHO Accreditation (1)

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Perceived Outcomes and Issues Considered in Decision-making

Because Tribes communicate with each other and the IHS, there is a general understanding of the outcomes inherent in each item in the "menu of basic choices." This study looks at these outcomes as advantages and disadvantages. There is a common realization that any choice involves tradeoffs. Different Tribes will weigh the importance of the advantages and disadvantages differently.

PERCEIVED OUTCOMES OF CHOOSING PROVIDER ORGANIZATIONS

All of the people interviewed for this study were asked about the advantages and disadvantages of each choice of health care organizations. On the whole, Tribal leaders were well versed in the advantages and disadvantages of IHS direct services and Tribally operated services, but they were less able to discuss purchasing care from the private sector. For example, over half (5) of the Tribal leaders in this study could cite 5 advantages to Tribally operated programs, but only one Tribal leader in the study could cite more than one advantage to purchasing services from the private sector. In general, Tribal leaders could cite more advantages for the type of health care delivery organization that their Tribe had chosen than for other options. Figures 3, 4, and 5 list advantages and disadvantages cited by Tribal leaders. These have been divided into categories, including quality of care, financial and management, community development, other and none. These perceived outcomes are some of the factors Tribal Leaders consider when making choices of health care delivery systems.

ADVANTAGES AND DISADVANTAGES OF CONTRACTING, COMPACTING

With the negotiated rule making for the Indian Self-Determination Act reducing the differences between contracting and compacting, the choice tends to be more philosophical than based on specific criteria. Those who are already compacting see it as a natural progression in self-determination and self-governance. Those who are not compacting are more concerned about the effect of compacting on the delivery of direct IHS services, particularly those provided to their Tribe. However, they also express concern about reduced Federal budgets and newly recognized Tribes resulting in "a larger number of Tribes splitting a smaller pie." Leaders of non-compacting Tribes view self-governance as an experiment which could lead to termination. They say "the U.S. government is getting off the hook" on its trust responsibilities and that other Tribes are engaged in "a money grabbing scheme." However, even the leaders of non-compacting Tribes acknowledge the advantages of flexibility and a higher degree of integration of services from the annual funding agreement approach. The leader of a compacting Tribe said that contracting means the Tribe is "stuck with programs IHS has decided are needed."

ADVANTAGES

Quality of Care
IHS offers ancillary services, such as pharmacy, Public Health Nursing. (3)
IHS facilities are generally accessible to Tribal members. (1)
There is continuity of care within the IHS system. (1)
It is the best health care provider. (1)

Financial and Management
No financial responsibility for Tribes. (1)
Tribal members do not have any financial cost for health care, such as co-pays. (1)
IHS has more resources than the Tribes. (1)
No paperwork for Tribes. (1)

Community Development
Tribal employment opportunities. (2)

Other
IHS takes full responsibility for services, exercises treaty and trust responsibilities. (1)

None. (2)

DISADVANTAGES

Quality of Care
Quality of services is not always the best. (3)
Too many people for the services provided. (3)
Long distances to IHS referral hospitals. (2)
Long waiting times. (1)
Facilities are not up-to-date. (1)
Does not use a holistic approach. (1)

Financial and Management
Not enough resources. (1)
Inconsistent administration. (1)

Community Development
No Tribal input in decisions. (2)

None (3)

STRATEGIES FOR MAXIMIZING MEDICAID INCOME

One question in the interviews was, "If your Tribe is put in the position of competing with the private sector for patients, how do you think your Tribe would do?" Virtually every Tribal leader interviewed expressed confidence that they would retain their existing patients. They supported this view by saying the their existing patients have a history of consistent use of the clinic and that they are more comfortable in the Tribal setting. One Tribal Health Director offered this observation about expanding services to include non-members:

"Tribal members would be upset if doors were opened to non-members - they want this to be 'their clinic.' Most non-members would not use Indian services because there is lots of discrimination and race-based harassment in [this] county."

The interview did not explore what would happen if Medicaid patients enrolled in other

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ADVANTAGES

Quality of Care
Better meeting people's and community's needs. (6)
More consumer satisfaction. (2)
Better quality. (1)
Reduced waiting time. (1)
More services, including specialty services. (1)
More prevention. (1)
More culturally aware, including interpreters. (1)

Financial and Management
Tighter controls and more efficient use of resources. (3)
More flexibility. (2)
Better planning. (1)
Better able to solve problems. (1)
Easier and faster to upgrade facilities. (1)

Community Development
More community involvement, feeling of ownership. (3)
Local employment. (3)
Less Federal involvement. (1)

DISADVANTAGES

Financial and Management
Not enough funding. (6)
More financial risk. (3)
Further burden on the Council. (1)
Recruitment and retention of physicians. (1)

Other
More risk for health outcomes. (1)
Users may be more critical. (1)
Federal treaty and trust responsibilities are not met. (1)

None. (1)

plans but continued to use IHS-funded facilities without those services being compensated.

Tribal leaders were asked what they need to be more competitive in the managed care market. Five of the nine Tribes said that they needed better facilities with more capacity. Three said that they needed to improve staff quality, and one other said that they needed more training. Two cited the need for more technology and better computer systems. Two said that they needed more staff and expanded services. Only one Tribe said that more finan-cial backing was needed, although that was implied in all the other answers to the question. One Tribe said that they needed a partnership with a private sector health plan.

Area Directors and Area planning personnel identified other factors limiting the competitiveness of Tribes in a managed care market. To be more competitive, they said Tribes needed greater understanding of the health care industry and trends, better business management skills, more marketing and public relations, and compensation during the transition period

ADVANTAGES

Quality of Care
More specialty care available. (2)
Better doctors, better health care. (1)
Less waiting time for access to physician. (1)
Meets the needs of individual patients. (1)

Financial and Management
Good vendors, good relations. (1)

Other
More freedom of choice. (1)

None. (2)

DISADVANTAGES

Quality of Care
Not culturally appropriate, language barriers. (2)
Sometimes quality is a problem. (1)
Discontinuity of care. (1)
Distance from rural residents. (1)

Financial and Management
Costly. (4)
Hard to negotiate costs. (1)

None. (3)

when Indian patients choose other options before they return to Indian health providers. One Area Director said, "They need to see examples at their level" and "a managed care technical center to draw help and information from." Another suggested that Tribes pool resources on a regional basis, such as CHS funding.

ISSUES AFFECTING TRIBAL-SPECIFIC DECISIONS

As Tribal leaders and health directors evaluate Tribal specific decisions, a number of issues come into play that include quality of care, financial management, community and Tribal development and other concerns. Figure 6 shows a list of factors Tribal leaders said they consider as they make decisions about health care delivery systems

The factor cited most frequently was employment. Since most of the Tribes in this study are gaming Tribes, the Tribal leaders and health directors were asked whether gaming or other economic development decreased the need for Tribal members to find employment in health care services. The most commonly expressed views were that gaming had, in fact, reduced unemployment. In one Tribe, unemployment went from 90 percent to 70 percent, while another Tribe had a decline from 95 percent unemployment in 1971 to 30 percent today due to both gaming and other new employers, including new educational institutions, government offices and a factory. The chairperson of a Tribe with 40 percent unemployment said, "We still need employment in all areas - we haven't met members' employment needs yet." Another Tribe without an unemployment problem said that gaming has increased unemployment because more people were coming back

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Quality of Care

Standards of care and quality of staff.
Accessibility and transportation.
Health risk for members.

Financial and Management

Cost to Tribe and financial risk. (4)
Income to Tribe.
Income source, if gaming stops.
Space availability.
Is staff available to do it?
Cost efficiency.

Community and Tribal Development

Employment . (7)
Community development. (3)
Opportunity to increase Tribal expertise and capability.

Other

Is service needed?
Serving IHS eligibles who are not Tribal members.
Understanding of Federal, State and local resources.

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to Tribal lands looking for jobs. Several leaders and health directors said that increased employment had increased the local population which increased the demand for health care.

Tribal leaders tend to weigh the opportunity for employment and community development against financial risk. Cost to the Tribe and financial risk is the factor cited second most frequently by Tribal leaders in their decision-making. Cost to the Tribe implies a source of income. One Tribal leader expressed the long range concern about the source of income if gaming stops. Unlike the private sector, a profit motive was not cited by any of the Tribal leaders interviewed.

Planning

While the interviews tried to elicit information about the level of effort, funding, technical assistance and time Tribes typically apply to planning processes prior to decision-making, it was difficult to obtain this information. For the most part, Tribal leaders and health directors did not seem to see planning as a distinct step in the decision process, except where they received designated planning funding. This was generally limited to planning for contracting or compacting, facilities planning and long range health planning. Few of the Tribes in this study have current long range plans, and most tend to plan for specific decisions using available in-house staff.

LONG RANGE PLANNING

Only three of the nine Tribes in this study reported that they had developed long range health plans. One Tribal Health Director explained that the Tribe did not have a long range plan because they do not have the expertise.

The Health Director of another Tribe reported that they had completed a 5-year plan in 8 months with no outside funding and no consultants. "We just did it ourselves," she said.

One of the Tribes in the study had completed a 7 year plan with 160 objectives to be achieved by the year 2000, and they were actively tracking the implementation process. They anticipate starting in 1998 on a plan for the year 2010. They expect the planning process to take two years, cost a minimum of $30,000 of funding from the Tribe and use primarily in-house staff. Their staff of approximately 42 includes a full-time health planner with an MA in Health Administration and 20 years experience, although they anticipate hiring temporary help for the plan. This Tribe would like to have an epidemiologist as a consultant.

The Executive Director of a small Tribe with only 10 employees in the health department reported that the staff could not do the planning needed because their time is needed to run their programs. He also said that staff could not provide the objective approach of a consultant from the "outside looking in." This Tribe did undertake a planning effort to look at the feasibility of providing direct care. An IHS Tribal Management Grant enabled them to hire a consultant to help with data collection and they were assisted by IHS employees. While they felt that the grant provided expertise they needed, the resulting plan was very limited in scope and did not provide broad long term direction.

STAFFING WITHIN TRIBES

For most of the Tribes in this study, the health director is also the planner. Some health directors interviewed had extensive planning experience, while others are more limited. One third of the Tribes in this study reported that they had designated health planning staff. One had a policy analyst on a two year contract; another had a full time health planner with an MA in health care administration and 20 years experience; and the third Tribe had a full-time health planner with a Ph.D., but the health director for that Tribe said they could use another person half time.

CONSULTANTS

Use of consultants seems limited to large scale projects with budgets funded by external grants. One Tribe considering compacting their Contract Health Services program hired a health planning consultant, an actuary and an information system program development consultant to assist in the planning process. Another Tribe

used casino revenues to pay a health consultant $10,000 to help them decide whether to support an ambulatory care center as a replacement for an IHS hospital. Tribes report that they hire engineering consultants to help design new or remodeled facilities.

Tribal Health Directors identify the unmet need for consultants in a number of areas including grant writing, lobbying, computer systems, statistics, epidemiology, developing data bases, and legal assistance with matters related to the Federal Tort Claims Act. A Tribe which would like to expand their clinic to serve the non-Indian community recognizes that they need the assistance of consultants for an actuarial study and a marketing survey, but they do not have the resources to hire this expertise.

Barriers to obtaining consultants identified by Tribal Health Directors are lack of funding and not knowing where to turn to find the expertise they need. Area planning directors identified additional barriers, including that there are not a lot of good, unbiased consultants available. Many are former IHS employees with "axes to grind." Tribes are often located in remote places without access to colleges or consultants. There is a high turnover rate in Tribal management and many do not have the education to know what expertise they could be using. One Area Planning Director said, "Tribes are unfamiliar with how to work with consultants and want to treat them like employees."

FUNDING FOR PLANNING AND CONSULTATION

IHS is the main source of funding for Tribal planning. There are three programs in the IHS headquarters that provide planning grants to Tribes: the Office of Tribal Activities, the Office of Self-Governance and the Office of Environmental Health. Each of these programs has grants that allow Tribes to plan to access the activities of the programs. For example, the grants from the Office of Self-Governance allow Tribes to prepare to enter into compact negoti-

ations. Similarly, the grants from the Office of Environmental Health allow Tribes to prepare the documents to justify new facility construction. The largest and most flexible of these IHS programs is the Tribal Management Grants administered by the Office of Tribal Activities.

Funding for the Tribal Management Grant Programs is currently $2.2 million. The nationally competitive program attracts about 120 applications from Tribes each year. There is only one funding cycle per year. The announcement is usually made in November and training is provided shortly thereafter. Grants are usually awarded by August 1. Post-award grantee training is provided to explain the PHS regulations for grants management. The grants are expected to take about 12 months to be completed, but in some circumstances continuing funding could be obtained. There is no dollar limit on the grants. This year 23 new grants are expected to be awarded.

Some Tribes have never applied for Tribal Management Planning Grants. In the Albuquerque, Aberdeen and Phoenix areas there is a higher rate of Tribes not applying for Tribal Management Planning Grants. The reason that Tribes in these areas are reluctant to explore their options is not clear.

The purpose of the Tribal Management Grants Program is to assist Tribes in planning for the assumption of services under P.L. 93-638 contracting. The program prefers that funding be used to build capacity within Tribes rather than contracting with consultants to perform the work. Priority is given to Tribes in the following order from highest priority: 1) Tribes that are newly-recognized by the Federal government, 2) first time applicants, 3) other Tribes considering initiating or expanding P.L. 93-638 contract operations. Six types of grants are available:

1. Feasibility Study (collecting data to consider taking over program)
2. Planning Grant
3. Development of Health Management Structure (including policies and procedures, billing systems, records management)

4. Evaluation
5. Federal Programs Analysis (added as a result of the 1988 Amendments to P.L. 93-638)
6. Technical Assistance

From 1989 to 1994, over 300 Tribes received Tribal Management Grants. During this time, each of the nine Tribes in this study received at least one grant and altogether they received a total of $1,348,185 in planning funding. This ranged from a Tribe that received only one grant of $10,850 to a Tribe that was funded for six consecutive years for a total $355,665. The largest grant in a single year was $98,803. The average total amount per Tribe in this study over the seven year period was $149,798.

In addition to the planning funds offered to Tribes by IHS headquarters programs, one of the Areas included in this study reported that they provide $25,000 annually to each Tribe in their area for planning purposes. Tribes also can receive funding for alcohol and substance abuse prevention and treatment planning from the Center for Substance Abuse Prevention (CSAP) and the Center for Substance Abuse Treatment (CSAT).

UNMET NEEDS

None of the IHS programs provide funding for long range or strategic planning by Tribes. The Tribal Management Grant Programs do not provide funding for urban programs, the collection of demographic data, or hiring actuarial or legal consultants. These grants do not cover the implementation of plans, such as assisting in negotiating contracts. They do not provide funds for Tribal Health Directors or other employees to attend national meetings, such as the Group Health/Association of Health Plans meeting. There is a need for funding outside the IHS to provide training on designing and setting up health departments.

Negotiating

Negotiating is often seen as the first step in implementing plans. However, in this model, negotiating is regarded as the final step before a decision is made. This is because the results of negotiating give information that is not available in the planning process. The negotiations determine the actual costs, income and scope of services which prior to the negotiations were somewhat hypothetical. Throughout the negotiating process, until a contract or agreement is actually signed by both parties, Tribes can walk away from an offer. This means they can still decide to take it or leave it. For this reason, the model for this paper considers negotiating as the middle stage between planning and decision-making. While the planning process helps a Tribe determine what they want, they won't know whether they can get what they want until after they entered into negotiations. Negotiations identify the "bottom line" which then becomes the reality for decision-making.

Like planning, negotiating was not a process that Tribal leaders and health directors were able to explain clearly in the interviews. Most people interviewed regarded negotiations as meetings with the IHS to decide programs and budgets for contracting or compacting. The only preparations for negotiations alluded to in the interviews was consulting with lawyers. One Tribe uses their attorney "behind the scenes," but not in the actual negotiating meetings. The other Tribes had lawyers on staff with whom they consulted.

TYPES OF NEGOTIATIONS

Tribes are involved in negotiations with the IHS, States and the private sector. Typically, negotiations with IHS cover the scope of services and the amount of funding for Tribes to assume management of health care under contracts or compacts.

With States, negotiations involve policy, legislation and regulations regarding Medicaid programs, especially during this time in which many States are engaging in reforms to change Medicaid from fee-for-service to managed care. Tribes may also be involved in negotiations with States over licensing, certificates of need for new facilities, access to funding from Federal block grants to States, rates of compensation, and contracts to assume management of State administered programs.

Negotiations with the private sector could take a number of forms, including subcontracting with health plans under State Medicaid programs, dealing with insurance companies to obtain third party reimbursement, purchasing services under the Contract Health Services program, purchasing supplies and equipment and other types of contracts.

NEGOTIATING TEAMS

When Tribal leaders speak of negotiating health care contracts, their frame of reference is generally negotiating P.L. 93-638 contracts and compacts with the IHS. This is where Tribes seem to have the most experience. Virtually all Tribes use negotiating teams, but the composition of those teams varies. In all but two cases, the teams were comprised of in-house staff and elected Tribal officials.

The negotiating teams of the Tribes in this study included the Tribal Health Director 75 percent of the time. A member of the Tribal Council, Business Committee or Health Committee was included by 62 percent of the Tribes. The Tribal Chairman or Second Chief was included 50 percent of the Tribes. Two Tribes reported that their Executive Director was part of the negotiating team. Other members of negotiating teams cited only once by Tribes were a Tribal accountant, financial analyst, Tribal planner, self-governance coordinator, contracting officer and attorney.

The two Tribes that used consultants, used lawyers and a health planner with whom they had had long relationships. The Tribes that used consultants "learned about them by word of mouth." When the other Tribes were asked why they do not use consultants for negotiations, they said that they did not need consultants, did not have the money for them, and that consultants were not available.

UNMET NEEDS

The Tribal leaders and health directors interviewed for this study were unable to identify any unmet needs for assistance in negotiating. However, the Area Directors interviewed for this study expressed concern about the negotiating skills of the Tribes in their area. In general, they ranked the Tribes highest in negotiating with the IHS, average in negotiating with the State, and lowest in negotiating with the private sector. One Area Director for an Area in which most Tribes are managing health care systems said all the Tribes in that Area need help in negotiating with the private sector. The Area Directors for the two Areas in which IHS provides most health care said that the Tribes in those Areas had not yet begun to negotiate with the private sector. One Tribal Health Director identified the need for a consultant who would act as a liaison between the private sector and the IHS.

Information, Technical Assistance and Training Needs

CURRENT SOURCES OF INFORMATION, TECHNICAL ASSISTANCE AND TRAINING

In the interviews, Tribal leaders were asked about their sources of information about managed care. Because managed care is a current topic which requires an on-going effort to stay informed of new developments, it was considered a bell-weather topic which could help to identify how people obtain information more generally.

Three Tribal leaders said that they relied on the Tribal health staff, such as the Health Director, Executive Director or other staff. Five said that they got information from reading literature. The sources of literature they identified were information provided by State government, IHS newsletters, and Tribal newspapers. One Tribal leader had received information from a regional health board and another had used a consultant as a source of information. None of the Tribal leaders interviewed said they had attended national meetings or training sessions as a source of information.

For Tribal Health Directors, about half derived their information from sources that included the private sector. Only two Tribal Health Directors said that they had attended conferences or workshops on the subject. One Tribal Health Director reported that she attended a couple of conferences in which managed care was a topic, but she said that the information presented was "geared to a different world." At one conference she learned that "players assume the risk," and that is when she "really understood managed care." One Tribal Health Director had worked in a managed care setting and another obtained information from people in the private sector.

About half the Tribal Health Directors derived their information from contacts with the IHS, Indian health boards or forums directed at Tribal leaders. One Tribal Health Director for a Tribe for which most services are provided directly by the IHS said that the IHS is her model for managed care: "This is what we've been doing for years." While she said she would like more information about what the State is thinking and doing regarding managed care, she added, "We could teach them a lot."

Other sources of information about managed care cited by Tribal Health Directors were a State network and a health planning consultant. Only one Tribal Health Director stated that literature was a source of information. Most Tribal Health Directors said that they would welcome more training and information about managed care. They know that this is going to be an important area and they want to know more.

The need for training does not stop with the Tribal Health Directors. One Tribal Health Director said that "it would be good to require Tribal employees to get training to do their jobs better," but they need to have access to such training and it must be affordable. Another Tribal Health Director said, "We are always recruiting non-Indians. We need training dollars to bring Indians up to par in skills. The motivation is there, but the money and skills are lacking."

The IHS defines its role as supporting Tribes by providing information, technical assistance and training. However, the reality of budget cuts, reorganization and removal of Tribal shares has left the IHS Area Offices limited in their capacity to assist Tribes. Two of the four Areas included in this study had converted their planning staff to serving as self-governance coordinators. The annual planning budget for

each of the IHS Area Offices in this study ranged from $100,000 to $200,000. The number of professional staff with planning experience ranged from 1 to 3, excluding project officers. Area Office functions in support of Tribal planning vary from Area to Area, but may include: self-governance and contracting planning; computer systems, including RPMS; health data; coordinated purchasing; accreditation assistance; facility planning; and financial data. One Area provides management assistance to help Tribes bridge the gap when there is turnover in their Health Directors and Tribal Councils. One Area provides $25,000 planning grants to each Tribe in the Area on an annual basis.

Some IHS Area Offices have delegated their information, technical assistance and training functions to Area Health Boards. Half of the Areas in this study had Area Health Boards with offices and staff. Area staff regard the role of the Area Health Boards as communicating policy issues to Tribes, following legislation, coordinating Tribal responses to Congress, and operating grants for area-wide programs. Most see the potential for an expanded role for Area Health Boards.

While the National Indian Health Board (NIHB) is another source of information, it is generally funneled through the Area Health Boards to the Tribes. The NIHB also holds an annual Consumer Conference where workshops provide training for Tribal leaders and Health Directors. While the NIHB has long range plans of providing technical assistance and training directly to Tribes, funding and staffing have been inadequate to engage in these activities.

CAPACITY BUILDING VERSUS EXTERNAL EXPERTISE

Capacity building is regarded as increasing the skills of existing Tribal staff and hiring new staff with expertise not already available within the Tribe. Several people interviewed for this study stated that they would prefer to build capacity within Tribes and Tribal organizations

than to hire consultants. Some Tribal leaders believe that the Tribe is not using all the expertise that they currently have, such as the elders who can offer their wisdom and experience. A Tribal leader said they always tried to minimize the use of "outsiders" since those consultants "learn at Tribal expense." Consultants are regarded by many Tribal leaders and Health Directors as too expensive.

The Executive Director of one Tribe cited a model for capacity building used by the Environmental Protection Agency (EPA) several years ago. In this model, the Federal agency provides a planning format and support for Tribes to do planning in-house. The leader of another Tribe said, "When the need arises, we will bring in an expert and we want them to train a [Tribal] member to be able to do the job."

COMPUTER NETWORKING

Every Tribal leader and every Tribal Health Director interviewed said that they wanted to be connected to other Tribes through the Internet. Only three of the Tribes in this study reported that they currently have Internet and E-mail capability. Only one Tribal leader and one Tribal Health Director interviewed personally use E-mail. None of the Tribes in this study are connected to the IHS system, "Banyan Vines." The Area Offices reported only one Tribe in the four Areas being connected to the IHS system. The IHS is currently trying to get the Federal Service Units connected to the IHS system. The Area Health Boards with offices can access the IHS system.

The NIHB has just received a grant from the Administration for Native Americans (ANA) to purchase a new computer system, to develop a home page and to assist Area Health Boards in accessing the NIHB computers. Within a year, there should be computer communications between the IHS, the Area Health Boards and the NIHB. However, the weakest link appears to be with the Tribes.

TRIBAL NETWORKING AND MUTUAL ASSISTANCE

Tribal networking was identified by many of the people interviewed as a good idea that is growing. In addition to the more formal network provided by Area Health Boards, Tribal leaders and Tribal Health Directors cited other examples of Tribal networking that they found productive. In some Areas which do not have Area health boards, regional organizations have been effective in delivering support services. Since 1990, six compacting Tribes[5] have formed and managed a consortium to provide training and services to Tribes that request it. In one State in this study, an American Indian Health Commission had been formed. While it needs staff and funds to do analysis of "big issues," it provides a forum for Tribes to share information and training specific to State policy and Medicaid reforms and to deal collectively with the State.

Four Tribes said that when they need help, they turn to other Tribes. Three of the larger Tribes said that they did not need training and technical assistance, but they were aware that other smaller Tribes did. "We are willing to help them," said one Tribal leader, "and this can be done through existing organizations." The Health Director of a Tribe in this study had been asked by Tribes in another Area to share information and ideas about Tribal-State relationships.

Tribal networking results in benefits to both the Tribes that are providing the consulting services and those that are receiving services. According to one Tribe in this study, providing consulting services to other Tribes and helping to organize Federal and State health conferences and workgroups gives Tribes a leadership role in health policy and provides opportunities (including funding) for those Tribes.

The Area Health Board in one of the Areas included in this study was regarded by Tribes as playing a very important role in helping Tribes with planning and analysis of issues. Weekly mailouts of information on State and national issues were regarded as valuable. An expanded role for Area Health Boards was generally seen as a good idea. Recruiting services were seen as a fruitful area for future Area Health Board expansion. Tribal Health Directors thought the proposed Epidemiology Centers would enhance Tribal planning in the areas where the centers would be located. One Tribal Health Director suggested developing a regional clearinghouse for types of assistance available and which Tribes are experienced in various topics.

NATIONAL TRAINING CENTER

The concept of a national training center for contracting and compacting Tribes was discussed with Tribal leaders and Tribal Health Directors. While only 30 percent of the Tribal leaders interviewed saw a need for this, over 60 percent of the Tribal Health Directors thought there was a need. This difference probably reflects the different levels of detailed information required by Health Directors compared to Tribal leaders. Less experienced Tribes seemed to support the concept of a national training center more than the Tribes with greater compacting experience. The Tribes with more experience were aware of national and regional organizations already providing this support.

Among those who thought a national training center was needed, 75 percent thought it should be a collaboration between both contracting and compacting, rather than separate services. "It is not wise to exclude anyone," said the Executive Director of one Tribe. "When people talk together, they get other viewpoints. Sometimes people get locked in -

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5 All the Tribes in this consortium were part of the first two self-governance demonstration projects. They include the Lummi , Quinault, Hoopah Valley, Sac and Fox, Mille Lacs Band of Ojibway Chippewa and Jamestown S'kallam. Staff for this program is mainly housed at the Lummi Nation.

they need to look at the reality of what is going on." Another Tribal leader thought it was important to know the pros and cons of both contracting and compacting. Those who were opposed to a collaborative approach either were anti-compacting or felt that compacting issues were so different from contracting issues that collaboration would waste people's time.

Tribal leaders and health directors were also asked about the need for compacting Tribes to have a national association to meet and share concerns and training. Several people interviewed pointed out that such organizations already exist. Compacting Tribes have regularly scheduled meetings with the IHS. Since 1990, six compacting Tribes[6] have formed and managed a consortium to provide training and services to Tribes that request it. And the National Indian Health Board (NIHB) provides an opportunity for all Tribes to be represented in the development of national policy. "Not another new organization!" said one Tribal leader. A separate organization would make for "unnecessary schisms," said another Tribal leader.

Tribes were unanimous in the position that a national training center should be run by the Tribes and not by IHS. One Tribal leader said that the Area Office of IHS tries to influence them against compacting and that training by IHS would not be objective. However, one Tribal chairman said that a national association of compacting Tribes should be done within IHS since this is the organization that collects health data and is recognized nationally by all Tribes. One Tribal leader said that they could support a regional coordinating effort, but a national effort would be too broad.

One of the people interviewed for this study predicted that there would be a need for a national organizations for Tribal health departments similar to the Association of State and Territorial Health Departments.

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6 All the Tribes in this consortium were part of the first two self-governance demonstration projects. They include the Lummi, Quinault, Hoopah Valley, Sac and Fox, Mille Lacs Band of Ojibway Chippewa and Jamestown S'kallam. Staff for this program is mainly housed at the Lummi Nation.

Suggestions for Additional Planning Support and Technical Assistance to Tribes

People interviewed for this study suggested a variety of models for delivering additional planning support and technical assistance to Tribes:

1. Provide greater funding to statewide, regional and IHS Area Tribal organizations to increase their staffing to provide more technical assistance and training to Tribes. Use these organizations to increase inter-Tribal cooperation and assistance. Develop regional clearinghouses for types of assistance available from Tribes and others. Training should include basic education on managed care and management training.

2. Identify a pool of consultants who can help Tribes develop management systems, data systems, facilities planning, services planning, financial analysis and negotiating skills. Some of the types of consultants that might be included in this pool are actuaries, statisticians, computer programmers, billing systems specialists, people with experience in managed care, and epidemiologists. Assist Tribes in accessing these consultants by teaching them how to use consultants most effectively and providing funding for travel, equipment and other costs of working with consultants. The cost of hiring the consultants could be underwritten by a national organization or Tribes could be given funding to purchase these services.

3. Develop a national training center under the direction of Tribes, through the NIHB. Provide a catalog of courses and technical assistance offerings. A priority is a National Managed Care Program for Tribes to provide training and technical assistance. Offer mentor relationships to develop experts in managed care in Tribal settings. Create more opportunities for Tribes to interact with the private sector so that they can learn to use more entrepreneurial "capitalistic" approaches. Develop applications or models of real life experience and share with other Tribes.

4. Pilot a managed care demonstration project with a Tribe assuming risk (with a stop loss and/or reinsurance plan that protects the Tribe) that could serve as a model from which other Tribes could learn.

5. Assist the Tribes with the least experience and expertise in developing long range health plans.

6. Use community colleges and Tribal colleges to develop continuing education programs in health professions for Tribal employees to increase capacity and reduce the need to hire contractual and consulting personnel from the private sector. Priorities should include health systems management, business management, planning, and negotiating.

Some of these ideas can be combined in different ways. For example, the consultant pool could be available at either the national or the regional level. The managed care demonstration project could be incorporated in the National Managed Care Program. Mentoring relationships could be included in a program which increases interaction between Tribes and the private sector.

Validation of Acceptability of Suggested Models

Some of the ideas listed above were suggested by a single individual. Others reflect themes from several interviews. These ideas should be submitted to a different group of Tribal leaders and Tribal Health Directors to assess their acceptability. This process was not included in the research design or funding for this study; however, it would provide the needed information to make the transition from ideas to recommendations.

Conclusions and Recommendations

This study provides insights from a representative cross-section of Tribal leaders and Tribal health directors. It describes the factors affecting Tribal choice of health care organizations using two categories. The first category includes factors which remain relatively constant, including the legal, historical and political context of Tribes, the process of decision-making within Tribes, and basic beliefs that guide decision-making. These factors provide the foundation for all types of decisions made by Tribes. The second category includes factors that are specific to particular decisions: choices available to Tribes, perceived outcomes and issues considered by Tribes, and information gathered through planning and negotiating.

The model used in this paper is illustrated as a pyramid (see Figure 1). The factors lying closer to the foundation of the pyramid constitute the very identity of Native Americans. This foundation could be strengthened by Congressional actions providing more legal protections for Tribes and better funding for services. Tribes may choose to develop their governmental structures and processes to respond to changing needs and conditions. Correspondingly, their basic beliefs could undergo change. However, it is difficult and dangerous to change the fundamental factors and this is not a recommendation of this report.

As one moves up the pyramid, it is easier to make interventions to improve Tribal decision-making. Choices available to Tribes are dependent on the complex interaction of geography, economics, the free market, and government policy. This is probably the most complicated factor to influence of all the factors that are specific to particular decisions. How Tribes select from the choices available to them is directly related to information from perceived outcomes, planning and negotiating. Improvements in the quality of this information can make the most immediate impact on the quality of decisions. Therefore, the recommendations from this study are focused on these three areas.

PERCEIVED OUTCOMES

If one wants to change perceptions of outcomes, demonstration projects can open minds to different approaches with different outcomes. For example, at the present time no Tribe has become a managed care plan under a State Medicaid program. Because it has not happened in the past, there is a perception that Tribes could not manage the risk. However, a successful demonstration project might change this perception. Another way to change people's perceptions of outcomes is to provide more information about existing programs, such as the "Case Studies of Managed Care in Indian Health" that the National Indian Health Board is currently conducting with funding from the Henry J. Kaiser Family Foundation. Similarly, Tribes will see more possibilities when they are exposed to situations outside of their immediate experience. This might include exchanges between Tribes, internships in the private sector, and attending national meetings. Exchange of information via the Internet is highly desired by Tribes, but many lack the resources (computers and funding for Internet access) and training to engage in this type of communications. Increasing communications between Tribes may change perceived outcomes.

PLANNING

There are a number of organizations in Indian country offering their services as facilitators in the planning process. The techniques they offer usually start the process by identifying organizational strengths and weaknesses, core values and goals. However, most Tribes

lack the staff and expertise to do the more intensive and quantitative work of planning such as gathering information about the availability of services, the demand for services, staffing and space needed to provide services, the cost of different alternatives, and sources of funding. Only about a third of the Tribes in this study have dedicated planning staffs and only about a third have developed long range plans. Three ways to improve Tribal health planning are: 1) Grants for long range health plans; 2) Increase Tribal capacity by providing funding to hire dedicated planning staff; or 3) Improve the quality of planning products by making consultants available to work with Tribes on the development of planning product workplans, health status and demographic data collection and analysis, designing and analyzing consumer surveys, facilities and staffing plans, estimating costs, and identifying alternatives for financing. If the consultant approach is used, Tribes should also receive training and assistance in how to identify their need for consultants, how to find the right consultant for the job and how to manage consultant contracts.

NEGOTIATING

While Tribes have a great deal of experience negotiating with the IHS, they are less experienced in negotiations with the private sector. When Tribal representatives come to the negotiating table, the people they meet there have probably received formal training in negotiating skills and have probably prepared for the negotiations by gathering a great deal of information. Apparently the IHS has never provided training for Tribes in negotiating and has not provided funding for consultants to assist in the negotiating process. Tribes in this study did not see a need for training or consultants in negotiating, so it is possible that assistance offered in this area may not be taken. The first step may be to raise awareness that negotiating is often viewed as a formal process with sophisticated strategies that require information and preparation. This might include exchanges between Tribes, internships in the private sector, and attending national meetings. Another way to approach this need is to develop a negotiating training curriculum that uses examples which are relevant to Tribes.

ORGANIZATIONS FOR DELIVERING INFORMATION, TRAINING AND TECHNICAL ASSISTANCE

Any initiatives to improve Tribal decision-making by offering demonstration projects, information, training and technical assistance must be coordinated and managed by an organization which is accessible to Tribes. The nearly unanimous recommendations from those interviewed for this study are to use existing Tribal organizations and to deliver services as close to the Tribes as feasible. This would suggest that services could be delivered by Area or regional health boards, with backup and coordination by the National Indian Health Board. To make this possible, it is necessary to build capacity within these Area and national Tribal organizations. Tribes should be recognized and reinforced as resources for technical assistance to other Tribes.

Sources

BOOKS, TREATIES AND REPORTS

Bush, J.K. *Historical, Legal and Political Context in Which Indian Tribes Make Health Care Decisions,* prepared for the National Indian Health Board's project **Factors Affecting Tribal Choice of Health Care Organizations** (October 1996).

Cohen, F. **Felix Cohen's Handbook of Federal Indian Law** (Charlottesville: Michie: Bobbs-Merrill, 1982).

Comments: Tribal Self-Government and the Indian Reorganization Act of 1934, 70 **Michigan Law Review** 955 (1972).

Deloria, V., Jr. and C.M. Lytle. **American Indians, American Justice** (Austin: Univ. of Texas Press, 1983).

Getches, D.H., D.M. Rosenfelt and C.F. Wilkenson, **Cases and Materials on Mederal Indian Law** (St. Paul: West Publishing Co., 1979).

Lobsenz, J.E., *"Dependent Indian Communities": A Search For a Twentieth Century Definition,* 24 **Arizona Law Review** 1 (1982).

Institute for Government Research, The Problem of Indian Administration (Meriam Report) (Baltimore: John Hopkins Press, 1928).

Prucha F. **American Indian Treaties, The History of a Political Anomaly** (Berkeley: Univ. of California Press, 1994).

Prucha, F., **The Great Father: The United States Government and the American Indians,** **Vols. I and II** (Lincoln: Univ. Of Nebraska Press, 1984).

Wilkenson, C.F. and E.R. Biggs, *The Evolution of the Termination Policy,* 5 **American Indian Law Review** 139 (1977).

FEDERAL STATUTES, REGULATIONS, AND OTHER SOURCES

Federal Statutes:

U.S. Const. Art. I, § 8, cl. 3 (Indian Commerce Clause).

The Snyder Act of 1921, 42 Stat. 208, codified as amended at 25 U.S.C. § 13.

Indian Reorganization Act of 1934, 48 Stat. 984, codified as amended at 25 U.S.C. § 461 *et seq.*

Indian Country Definition of 1948, 62 Stat. 758, codified at 18 U.S.C. § 1151.

Indian Health Facilities and Hospitals Act of 1954 (the Transfer Act), 68 Stat. 674, codified as amended at 42 U.S.C. § 2001 *et seq.*

Menominee Restoration Act of 1973, P.L. 93-197, codified at 25 U.S.C. § 903-903f.

Indian Self-Determination and Education Assistance Act of 1975, P.L. 93-638, codified as amended at 25 U.S.C. §§ 450 *et seq.*

Indian Health Care Improvement Act of 1976, P.L. 94-437, codified as amended, in part, at 25 U.S.C. §§ 1601 *et seq.*

Federally Recognized Indian Tribe List Act of 1994, P.L. 103-454, codified at 25 U.S.C. §§ 1212-1214.

Federal Regulations:

Indian Health Service (IHS) Eligibility Regulations, 42 C.F.R. § 36.12.

Other Sources:

Federally Recognized Indian Tribe List of February 16, 1995, 60 Fed. Reg. 9250-55.

Congressional Record, 119:14052.

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FACTORS AFFECTING NATIVE AMERICAN CONSUMER CHOICE OF HEALTH CARE PROVIDER ORGANIZATIONS

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Introduction

Ignatious is a 66 year old full-blood Indian who was born at home in a small town with a majority Indian population. He had only one year of school and cannot read or write. He never married and has no children. He lives alone and speaks his Tribal language. He does not own a car. He has minor health problems and sees a doctor about 4 times a year. For his entire life he used the IHS hospital which is less than 2 miles from his home, until 1 1/2 years ago when he became eligible for Medicaid. Now he uses the private sector because there is less waiting time and he thinks the quality of care is better. He has a primary care physician with whom he is very satisfied. His niece takes him to the doctor and serves as his translator. He uses traditional healers for colds and minor illnesses. He says it is not important that traditional medicine be part of the regular health care delivery system because he "knows how to use a medicine man and where to get in touch with them."

Jerry is a a 23 year old man who lives with his wife and two young children. Last year he became a quadriplegic. The social worker at the hospital helped him to apply for Medicaid and explained how the State's managed care program works. He has never seen any advertisements or pamphlets explaining Medicaid or managed care. He thinks that Medicaid will not pay for his care at an IHS-funded facility. He needs daily physical rehabilitation at home and frequent medical attention, for which he prefers walk-in care. Having used IHS for most of his life, Jerry still continues to get most of his care at the IHS hospital, where he has a regular doctor whom he thinks is "nice but young." He considers the care at the IHS facility to be excellent and wants to use it because it is only about 10 minutes from where he lives. For specialty care, he uses private health facilities that are about an hour and 15 minutes from his home. Transportation is not a problem since he has a van with a lift and his father takes him for medical care.

Josephine is a 23 year old single woman who has been on Medicaid since she was 18 years old. She has one child and is pregnant. She speaks a little of her Tribal language and she is working on getting her GED. She has spent most of her life in an urban area and she has used many different types of health care providers, including the private sector, county health department, the university hospital and clinics, and the urban Indian clinic. Her information about Medicaid and managed care comes from pamphlets provided by the State social worker and health care providers. She has seen some advertisements for HMOs on television, but she has not paid attention to them. She is currently using a private health care provider because that is where she wants to deliver her baby and Medicaid provides transportation to these appointments. She prefers getting her health care from the urban Indian clinic that is about a 10 minute walk from where she lives. In talking about the urban Indian clinic, she says, "I like it because its my own people. I know almost everyone, I'm more comfortable here and the staff are friendly." By comparison, she says that the private facility should improve their attitudes toward patients: "They act kind of snotty." When choosing a health care provider, she says she wants to go somewhere that she "doesn't have to feel ashamed."

Sarah is a 50 year old woman who grew up on a reservation, lived in California for 25 years and moved to a city in another state about 3 years ago. She is raising 5 of her grandchildren. As she took on responsibility for each grandchild, the State social worker helped her secure Medicaid for them and explained managed care, although most of her attitudes about managed care were developed from her experiences in California. "When I hear the word 'HMO', I feel fear like the words 'bogeyman' or 'Hitler,'" she says. She says she would go back to the IHS services on her reservation before she would go to an HMO. She doesn't listen to

advertising for HMOs on the televisions because "they tell lies." She says with HMO's "people can die waiting around the table for the crumbs." With her 5 grandchildren, she often needs to use walk-in services for urgent matters, but she prefers appointments. She is very pleased with the urban Indian clinic and other IHS-funded services. "It feels like home, like family," she says. "I feel free to ask questions of the doctors and nurses, and they call me with the results." She adds, "The people here have heart. They make you feel it." She says that the most important factor in choosing a provider is "the way I am treated as an individual worthy of respect."

Ignatious, Jerry, Josephine and Sarah are the faces of this report. Their names have been changed, but their stories give life to the facts and figures presented on the following pages. They are among the estimated 350,000 American Indians and Alaska Natives receiving Medicaid throughout the country. These Medicaid recipients have a choice of health care providers because they live in areas where there are both private sector health care and services funded by the Indian Health Service (IHS), which could be provided directly by the IHS, Tribally-operated facilities or urban Indian programs (taken together these are called "I/T/U"). Where Native Americans have access to more than one health care delivery system, some choose the I/T/U, some choose the private sector, and some choose to use both options. This paper considers factors that affect their decisions.

Historically, most American Indian and Alaska Native people have lived in isolated areas where there is no choice of health care delivery systems. Various demographic and economic factors are changing the accessibility of private sector health care to Indian people. These include a growing number of people who have health care benefits from employment in Indian gaming and other economic development on reservations, and a growing number who are eligible for Medicaid.[1] However, this varies from place to place and the numbers are not known. A large percentage of those who are eligible for the IHS live in urban areas and near towns with private health care systems.

The IHS traditionally regarded itself as serving those without other resources and therefore the IHS has been slow to develop effective billing systems to capture alternate resources. As Tribes have taken on the management of IHS-funded health care programs, there has been a greater emphasis on billing insurance companies and Medicaid. Because urban Indian programs have had only a very small portion of their budget provided by the IHS, they have had to rely on third party collections and they have probably become the most sophisticated part of the I/T/U in billing practices.

The more effective an organization is in third party billing, the more their budget becomes dependent upon these collections. Therefore, the organizations that are most effective in billing are most sensitive to the impact of losing paying patients. In the current period of Congressional budget cutting, the I/T/Us are increasingly dependent on third party income, including Medicaid. Losing patients with alternate resources means losing income. In the IHS facilities which collect very little third party income, there is a feeling of being overworked and understaffed; so if patients want to seek health care somewhere else, it is a relief to the overburdened IHS system. The concept of marketing to patients is virtually unknown in the I/T/U.

The current trend toward Medicaid managed care programs is changing this institutional perspective. Two factors are contributing to this change. The first is the fact that Indian people who seek services at IHS-funded facilities virtually cannot be turned away, regardless of their alternate resources. This means that if Medicaid patients enroll in a managed care plan, they can go outside of that plan to seek care at IHS-funded facilities. However, in most situations the State will pay the managed care plan and that plan will not pay the I/T/U unless

they are a provider under the plan. Thus, the I/T/U can deliver services without receiving compensation for Medicaid patients. To protect itself from this situation, the I/T/U must convince the Medicaid patient to enroll in a plan for which they are a provider. The process of convincing the Medicaid patient to do this has to involve marketing.

Second, there is an opportunity for managed care providers to make money on their patients. Why else would profit-making corporations go into this business? If the I/T/U can structure their contracts with health plans and manage their health care delivery systems to make money, then there will be more resources to serve all Native American people, including those who have no alternate resources and for whom Congress has provided inadequate funding. The way that I/T/Us can increase their Medicaid income under managed care is to enroll Medicaid-eligible people while they are healthy so that the capitation rate is received when services are not being provided. Again, this requires marketing.

In order to market their services, I/T/Us must know how their consumers perceive them, particularly compared to the competition. They must build on their strengths and correct their weaknesses. The only way to know what consumers think is to listen to them and to observe their behaviors. Because the IHS financing is through global budgets that are insufficient to serve the defined pool of eligible patients, there has not been the emphasis on marketing and competition for patients that is found in the private sector. Therefore, consumer behavior has not been studied and consumers have not been asked for advice. The survey and interviews in this study are intended as a preliminary look at that consumer perspective.

In some State Medicaid managed care plans, there is intent to phase out essential community providers (ECPs) including Federally Qualified Health Centers (FQHCs) which encompass the Tribal and urban Indian health programs. The State plans assume that as long as there is access to health care for Medicaid-qualified Indian people, it is not relevant what health care system they use. Indian health providers have presented the concept of "culturally competent care" to explain the need for their continued existence even if Indian consumers have access to other health care delivery systems. This study attempts to explore some aspects of culturally competent care from a consumer perspective.

The consumer perspective will not always be the same as the institutional perspective. The institution may know that their providers are competent and that the care they provide is comprehensive. When a consumer does not have a choice, they may assume that what is being offered to them is inferior to what they could obtain within a context of marketplace competition. Consumers who do not have choices may devalue what they have simply because they feel powerless to decide on another course of action. Those who are limited to using the IHS-funded programs may assume that the private sector offers better care, without having the experience to substantiate this belief. The sample for this study is important because it consists of people who do have a choice.

Methods

Two groups of consumers who live in areas with both private sector health care and Indian health care were included in this study: those with health insurance and those with Medicaid. These two groups may have different values, life circumstances and needs which affect their decision-making. To look at decision factors, this study attempted to learn about the attitudes and behaviors of both people who used private sector health care and those who choose Indian health care. Two approaches were used. A written survey was conducted with 409 Tribal employees, and 20 face-to-face, in-depth interviews were conducted with Medicaid recipients.

Background research included analysis of existing data to obtain a better understanding of who is insured, who is not and the role of Medicaid funding. Information on employment and unemployment rates were used as limiting factors for employment-related insurance. One of the sources of background information used was information from a data base on 25 Tribes which had used the services of Tribal Data Resources, a planning and consulting firm in California which serves Indian Tribes by developing population surveys that are considered more accurate than Census data for American Indian populations. To protect confidentiality, the Tribes were not identified.

TRIBAL EMPLOYEE SURVEYS

Given the time limitation of approximately 2 months, it was important to select an approach which could yield some preliminary data. To obtain information on those with health insurance, the most efficient way was to survey employees of Tribes that offer health insurance benefits, because there is likely to be a large percentage of Tribal employees who are eligible for IHS. Existing data from the 1995 Regional Meeting[2] briefing books was used to identify Tribes with offices near communities which are likely to have both IHS and private facilities. A list of 10 possible sites was developed and Tribal personnel directors were called by telephone interview to determine how many employees they have, what percentage are Native American, and whether they offered health benefits to their employees. Based on the initial interviews with Tribal personnel directors and follow-up letters and calls to Tribal leaders, two survey sites were selected. One Tribe had 1,600 employees with an estimated 1,450 eligible for both IHS-funded services and Tribal employee health insurance. The other Tribe has 400 employees of whom an estimated 360 are eligible for both IHS-funded services and Tribal employee health insurance.

A one-page, two-sided survey instrument was designed to be easily tabulated and to explore some of the factors identified through previous experience. Tribes participating in this study agreed to place a cover letter, survey form and postage paid addressed envelope in the regular pay envelopes for their employees. Approximately 2,000 survey forms were distributed in September 1996. However, it is estimated that only 1,810 people were eligible to participate.

A total of 459 questionnaires were returned, of which 50 were eliminated from further analysis because the individual either did not have health insurance benefits or was not eligible for IHS-funded services. The sample used for this study was 409, which represents approximately 22.5 percent of those eligible to participate from the two Tribes. The sample from the larger Tribe was 308 or 21 percent;

while the sample from the smaller Tribe was 101 or 28 percent.

MEDICAID RECIPIENT INTERVIEWS

Two sites were selected for Medicaid recipient interviews. One was the same as the larger Tribe used for the Tribal employee survey. The other was an urban center which has an urban Indian clinic, as well as private sector health care, county services and university hospitals and clinics. All of the non-IHS alternatives are called "private" in this study. Finding a sample of Medicaid recipients that includes both those who use I/T/U facilities and those who use private sector health care required people to volunteer for the study. A variety of methods were used to get people to volunteer including offering compensation ($20 per interview) and distributing flyers in locations such as WIC offices, private doctors' offices, Senior housing and other places.

Two people who were familiar with both I/T/U health care and Medicaid were trained to schedule and conduct the interviews. They also participated in developing the interview guides, which consisted of 36 questions and took approximately one hour. A written consent form was also developed, which included a record of receipt of payment for the interview.

Given the time frame, only 20 interviews were conducted with Medicaid recipients. Of the 10 interviews at each location, 5 were people using I/T/U facilities and 5 were people using private sector facilities. Included in each set of 5 interviews were a minimum of one person for each of the following categories: pregnant women, parents or guardians of young children, elderly, and disabled. Stratifying the sample in this way was intended to elicit factors that affect people in different circumstances.

Both Medicaid interview sites were located in States in which Medicaid was a managed care program. For this reason, the interview guide included several questions about managed care, which was not a subject in the Tribal Employee Surveys.

Estimate of Alternate Resources in Native American Populations

This study looks at the factors that affect consumer choices of health care providers. The extent of choice in the Native American population is dependent on the availability of private sector medical services near Native American communities and the level of alternate resources in the Native American population to pay for private health care. Unless both of these factors are present (an accessible private sector and alternate resources to pay for those services), there is little need for IHS and Tribal providers to concern themselves about competition with the private sector or maximizing income from third parties.

For most people, the main sources of alternate resources are health insurance provided by employers, Medicare, Medicaid, military and veterans benefits. Research is needed to quantify the extent to which Native Americans have access to each of these types of alternate resources. IHS registration records are a poor source for this information because many consumers will not disclose their alternate resources and because eligibility for these alternate resources changes frequently. The one part of IHS which is most effective at identifying alternate resources is the Contract Health Services (CHS) program. Because Federal regulations require that CHS is the payer of last resort and that alternate resources must be used first, many CHS programs are staffed with Alternate Resource Specialists to identify possible resources and assist patients in applying for them. CHS usually only is used to purchase specialty medical care which is not available within the I/T/U. Residency rules and limited funding for CHS mean that it is not used on a regular basis by most Indian health consumers.

Anecdotal information suggests that most elderly Native Americans who have access to IHS-funding facilities do not have Medicare Part B because they are unwilling and/or unable to pay the premiums and they do not know about the Qualified Medicare Beneficiary (QMB) or the Specified Low-Income Medicare Beneficiary (SLMB) programs for Medicaid to pay the Part B premiums. IHS funding cannot be used to pay the Medicare Part B premiums or to purchase health insurance.

While it has been reported that American Indians have a greater percentage of veterans than any other ethnic group in the United States, it is not clear to what extent Native Americans take advantage of veterans health benefits. Native Americans who live on reservations and predominantly Indian communities are usually geographically distant from Veterans Administration (VA) health care.

The extent of employer-purchased health care benefits is also unknown. To receive those types of health care benefits people usually must be employed fulltime by an organization which has a substantial number of employees. Historically, reservations and predominantly Native American communities have not had many employers. Tribes and government agencies tend to be the largest employers in these areas. If rates of unemployment, seasonal employment and part-time employment could be established, this would provide some limiting factors for the rate of employment with health benefits.

The rates of unemployment are often misleading. The U.S. Department of Labor calculates unemployment rates based on a person's efforts to seek employment. In rural areas where employment opportunities are limited, people often quit seeking employment. Thus an unemployment rate of 16 percent, may simply reflect that 16 percent of the people are currently actively looking for jobs. It does not mean that 84 percent of the people are employed.

One of the sources of background information used for this study was provided by Tribal

Data Resources, a private consulting firm in California which conducts household surveys for Tribes. They provided information on 25 Tribes in their data base which suggests significantly higher unemployment rates than the figures provided by the Federal government. While it cannot be determined how representative the Tribes are in this data base and the methods for collecting and analyzing the data are not clearly delineated, the results suggest that over half the Tribes have unemployment rates of over 30 percent, and 40 percent of the

Tribes have unemployment rates over 40 percent. This is much higher than government estimates of unemployment which range from 11 percent to 25.6 percent. These figures are presented in Table 1.

While higher rates of employment may indicate higher rates of employer purchased health benefits, lower rates of employment may indicate higher rates of Medicaid coverage. There is a high correlation between unemployment and poverty. Poverty rates in Indian communities tend to be higher than the national

TABLE 1 ESTIMATES OF NATIVE AMERICAN UNEMPLOYMENT				
Source	**Date**	**Information**		
U.S. Census	1990	Reservation and Trust Lands		25.6%
		Alaska Native Villages		24.5%
		Tribal Jurisdictions		12.4%
		Tribal Designated Stat. Areas		11.0%
IHS-"Trends in Indian Health"	1995	AI/AN		US Population
		Males 16.2%		6.4%
		Females 13.4%		6.2%
Tribal Data Resources- Survey of 25 Tribes	1996	Number of Tribes with Unemployment Rates:		
		Below 20%	1	4%
		20-29%	7	28%
		30-39%	7	28%
		40-49%	9	36%
		50% or above	1	4%
		Parttime Employment Rates:		
		Below 10%	17	68%
		10% to 19%	8	32%
		Seasonal Employment Rates:		
		Below 2 %	14	56%
		2% to 4.9%	8	32%
		5% to 9%	2	8%
		10% or above	1	4%
		AFDC Households:		
		Below 10%	15	60%
		10% or above	10	40%

Note: The information from Tribal Data Resources was based on household surveys of 25 Tribes. The distribution of these Tribes by State was 18 from California, 3 from Wisconsin, and 1 each from Alabama, Nevada, New Mexico and Oregon. The 25 Tribes included 13 gaming Tribes and 12 non-gaming Tribes. The information was in an existing data base for current and previous clients. Tribes included in this summary were selected randomly by Tribal Data Resources from their data base and NIHB was not provided the names of the Tribes or the size of Tribal enrollment.

average, so that more people qualify for Medicaid. However, figures suggest that not all people who qualify for Medicaid actually enroll in Medicaid and receive the benefits. In isolated areas where American Indian and Alaska Native people have access to IHS-funded programs but there is not private sector health care, there may be little incentive to enroll in Medicaid. Historically, Medicaid has been tied to categorical assistance programs which primarily serve pregnant women, single parents with young children and the disabled. In the past Medicaid has been linked to public assistance programs, such as Aid for Families with Dependent Children (AFDC), but the current welfare reform may change some of these patterns of use.

A somewhat puzzling fact is that States pay less for the health care of American Indian and Alaska Native Medicaid recipients than they do for other Medicaid recipients. These figures and a discussion are presented in Appendix I. Many States which have expanded their Medicaid programs to serve people at slightly higher incomes levels require those recipients to make co-pays for health services. Anecdotal information, including that gathered from the Regional Meetings in 1995, suggests that most IHS-eligible people are not willing to make those co-pays so that the IHS-funded facilities cannot take advantage of those expanded Medicaid programs. In addition, State governments often operate under the assumption that Federal IHS funding provides for 100 percent of an individual Indian patient's health care, when in fact the level of need funded on reservations is estimated at 49 percent.[3]

3 Source: Fy1994 Indian Health Service Budget Justification.

Tribal Employee Survey Results

DESCRIPTION OF THE SAMPLE

The average of demographic characteristics suggests a composite of the average person who completed the survey. She is a 40 year old woman employed full time by the Tribe for which she is a member. She grew up in a predominantly Native American community, graduated from high school and has some college or vocational training. She owns a vehicle and lives about 20 minutes from either the IHS-funded facility or private health care. She reports that her health status is excellent or she only has minor problems. She saw a doctor fewer than 5 times last year and she also helps her family seek health care. A more specific description of the sample is provided in Table 2.

EXPERIENCE WITH IHS-FUNDED SERVICES

All but 3 percent the people in the survey had had some experience with IHS-funded services. Most found the services acceptable. About 18 percent thought the services were excellent and 10 percent thought the services were bad. These percentages were consistent for both of the Tribes in the study. Table 3 summarizes the findings and compares them with experiences in the private sector. Those who prefer to use the IHS-funded facilities find them more acceptable than those who choose to use the private sector. Preference for IHS-funded services or private sector services was determined by the the majority of responses to question 2 which lists 13 types of services and asks respondents to indicate which health care delivery system they would most likely use for each service.

EXPERIENCE WITH PRIVATE HEALTH CARE

About 86 percent of the people in the survey had had some experience with the private sector. Nearly half of the entire sample rated their experiences with the private as excellent, which is almost triple the amount that found IHS-funded services to be excellent. Among those who prefer to use the private sector, 74 percent found the services to be excellent and none reported bad experiences. Only 1 percent of the total study respondents reported bad experiences with the private sector, which is about one-tenth of the number who had bad experiences with IHS-funded care.Importance of Factors in Selecting Health Care Provider. A list of 19 factors was presented in question 5 and respondents were asked to indicate whether each factor was "very important," "somewhat important," or a "minor consideration" in choosing a health care provider. Based on the average response, these factors were ranked and presented in Table 4. The five highest ranking factors are:

> Doctor's training and skills
> Confidentiality
> Doctor takes time to listen to me
> Attitudes of support staff (receptionist, billing, etc.)
> Modern facility and equipment

While "how much I have to pay," "waiting time in the clinic or office" and "waiting time to get an appointment" were ranked 8, 9 and 10 respectively, they were the most common reasons cited for actually using one type of provider or another. Confidentiality is significant issue for these Native Americans because they live in small communities and know most of the people working in IHS-funded facilities.

TABLE 2 TRIBAL EMPLOYEE SURVEY: DESCRIPTION OF THE SAMPLE	
(n = 409)	
Age	
Minimum	19
Maximum	69
Mean	39.7
Standard deviation	10.8
Gender	
Female	77 %
Male	23 %
Tribal Membership	
Same Tribe as employer	79 %
Different Tribe from employer	21 %
Community of Residence as a Child	
Reservation or small town with majority Indian population	57%
Urban area or place where Indians were a minority	41%
Both	1%
Highest Level of Education	
Vocational training or college	65 %
GED or high school graduate	18 %
Advanced professional degree	15 %
Some school	2 %
Transportation	
Has vehicle for daily transportation	95 %
Does not have a vehicle	5 %
Often helps others in family to seek health care?	
Yes	85 %
No	15 %
Self-Reported Health Status	
Excellent health	42 %
Minor problems	53 %
Chronic Disease	11 %
Current Serious Illness	<1 %

TABLE 3
TRIBAL EMPLOYEE SURVEY:
GENERAL ASSESSMENT OF PREVIOUS EXPERIENCE WITH EACH HEALTH CARE SYSTEM

By All Survey Respondents
(n = 409)

	IHS-funded Health Care	Private Health Care
Excellent	18 %	49 %
Acceptable	66 %	41 %
Bad	10 %	1 %
No Experience	3 %	7 %

By Those Who Prefer IHS-funded Services*
(n = 295)

	IHS-funded Health Care	Private Health Care
Excellent	21 %	38 %
Acceptable	70 %	44 %
Bad	5 %	2 %

By Those Who Prefer Private Sector Services*
(n = 101)

	IHS-funded Health Care	Private Health Care
Excellent	10 %	74 %
Acceptable	52 %	23 %
Bad	24 %	0 %

*Preference for IHS-funded services or private sector services was determined by the the majority of responses to question 2 which lists 13 types of services and asks respondents to indicate which health care delivery system they would most likely use for each service.

CULTURAL ISSUES IN SELECTING HEALTH CARE PROVIDERS

Of the 19 factors listed above, four were intended to elicit responses on the importance of culturally-specific needs in selecting a health care provider. While these did not receive the highest rankings, they were considered "very important" by a significant group of respondents:

Doctor's experience with Indians	52 %
Consumer advocate available	30 %
Tribal language spoken	20 %
Traditional Indian healers available	19 %

People who ranked one of these factors "very important" were more likely to rank the other culturally-related factors very important. Among those who said that having the Tribal language spoken was very important, the ranking of very important for doctor's experience with Indians was 91 percent, consumer advocate was 65 percent and availability of traditional Indian healers was 63 percent

People for whom cultural factors were most important did not differ significantly from the survey sample as a whole in age, gender or education. Those for whom the cultural factors are most important are more likely to have grown up where Indians were a majority and to speak their Tribal language. For example, among those who think it is very important for

the health care provider organization to have the Tribal language spoken, 59 percent speak their Tribal language compared to 17 percent survey respondents who did not think this was very important. About 65 percent of this sub- group grew up on a reservation or in a small town where a majority of the population was Indian, compared to 45 percent of those who did not think it was very important to have the Tribal language spoken.

	TABLE 4 TRIBAL EMPLOYEE SURVEY: RANK ORDER OF FACTORS IN DECISION TO CHOOSE A HEALTH CARE PROVIDER	
Rank	**Factor**	**Mean***
1	Doctor's training and skills	2.959
2	Confidentiality	2.948
3	Doctor takes time to listen to me	2.935
4	Attitudes of support staff (receptionist, billing, etc.)	2.826
5	Modern facility and equipment	2.825
6	Can see same doctor most of the time	2.800
7	Choice of providers (doctors, specialists, etc.)	2.774
8	How much I have to pay	2.615
9	Waiting time in the clinic or office	2.596
10	Waiting time to get appointment	2.577
11	Evening and weekend hours for care	2.511
12	Billing practices and paperwork	2.509
13	All services in one location	2.391
14	Doctor's experience with Indians	2.336
15	Convenient for transportation	2.296
16	Recommendation from family member or friend	2.088
17	Consumer advocate available	2.064
18	Tribal language spoken	1.749
19	Traditional Indian healers available	1.678

*Scoring: 3 = very important   2 = somewhat important   1 = minor consideration

WHAT ATTRACTS CONSUMERS TO IHS-FUNDED FACILITIES

Survey respondents were asked the open-ended question, "What makes you want to use IHS-funded facilities?" The answers were categorized and tabulated. Only 5 categories were cited by greater than 5 percent of the respondents. These are:

Affordable	47 %
Access, convenience	20 %
Good care	15 %
Government commitment and trust responsibility	9 %
Family history of use, habit, familiar, always used	7 %

While the leading factors cited for using IHS-funded facilities was cost and convenience, these factors were ranked 8 and 15 on question 5. This suggests that while people value certain

factors in the abstract, other factors may actually play a greater role in their decisions.

It is clear from this survey that cost plays the most important factor in deciding to use IHS-funded facilities. The health benefits for one of the Tribes included in this study has a $250 deductible and the other has a $200 deductible per individual or $400 per family. Both require a 20 percent co-pay. Apparently this level of cost to the consumer is sufficient to encourage 47 percent of the sample to use IHS-funded services as a regular source of care. The survey did not ask about marital status. Presumably some of the respondents have spouses with insurance and the coordination of benefits means that costs to the consumer are less of a factor in choosing a health care provider.

WHAT ATTRACTS INDIAN CONSUMERS TO PRIVATE HEALTH CARE

There were many more responses to the open-ended questions, "What makes you want to use privately-operated facilities?" These responses were more easily classified according to the categories listed in question 5 which asked people how important 19 factors were in

their decision to choose a health care provider. However, only 10 factors were cited by more than 5 percent of respondents, and the frequency of responses to the open-ended question suggests a different rank order. A comparison of the responses to the two questions is given in Table 5.

Survey responses from the two Tribes in this study differed significantly on the top four reasons cited for wanting to use private health care:

	Tribe 1	Tribe 2	Total
Less waiting time	38%	17%	32%
Quality of care	15%	20%	16%
Medical specialists, specialized care	13%	20%	15%
Confidentiality	8%	25%	12%

These differences between the Tribes likely reflect differing local conditions. Based on comments on the survey, waiting time in the clinic is a bigger problem at Tribe 1 than at Tribe 2. One respondent from Tribe 1 wrote:

Most of us use IHS because of financial reasons. . . we can't afford private care. However, if you have a job, sometimes it is cheaper to go to private care because it takes too long for a simple appointment

TABLE 5
TRIBAL EMPLOYEE SURVEY:
WHAT MAKES PEOPLE WANT TO USE PRIVATELY OPERATED FACILITIES
(RANK ORDER OF FACTORS IN DECISION TO CHOOSE A HEALTH CARE PROVIDER COMPARING OPEN-ENDED QUESTION 3 TO STRUCTURED QUESTION 5)

Question 3 (Open-ended) Rank/Percent		Question 5 (Structured) Rank	Factor
1	32%	9	Waiting time in clinic or office
2	16%	*	Quality of Care
3	15%	*	Medical specialists, specialized care
4	12%	2	Confidentiality, anonymous
5	10%	3	Doctor takes time to listen to me, explains
6	9%	*	Personalized care
7	8%	1	Doctor's training and skills, knowledge
8	8%	4	Attitudes of support staff, considerate, know staff
9	6%	6	Can see same doctor most of the time
10	5%	15	Convenient for transportation, accessible

Question 3 (Open-ended) Rank/Percent		Question 5 (Structured) Rank	Factor
1	39%	9	Waiting time in clinic or office, patient flow
2	21%	4	Attitudes of staff, compassion, respect
3	10%	1	Doctor training and skills; competency
4	10%	10	More doctors (waiting time to get appointment)
5	9%	3	Doctor takes time to listen to me
6	8%	*	More medical specialists
7	6%	13	More services available (all services in one location)
8	6%	*	Quality of care, quality assurance, better care
9	5%	7	Can see same doctor most of the time

* Item was not specifically stated in list of 19 factors in question 5.

at the IHS facility. A one hour appointment takes 3 hours.

Thus the shorter waiting time in the private sector is cited more than twice as often by respondents from Tribe 1 than Tribe 2. Confidentiality is cited three times more frequently by respondents from Tribe 2 than Tribe 1. This is likely because Tribe 2 is smaller and Tribal employees are more likely to know people working at the IHS-funded facility. For Tribe 2, there are few types of medical specialists at the IHS-funded facility so people must go to the private sector for specialty care; hence, the greater rate of response that this is a reason to use the private sector.

For most of the rest of the survey, respondents from the two Tribes were remarkably similar in responses. This is one of the few places where the patterns are so different that it seems necessary to consider local conditions. However, even with those differences, the findings of the top ten reasons for using private sector health care were essentially the same for both Tribes.

AREAS FOR IMPROVEMENT IN INDIAN HEALTH CARE

Survey respondents were asked the open-ended question: "What are the most important things that should be improved in IHS-funded health care?" Responses were coded by category and tabulated. Nine categories of responses were cited by more than 5 percent of respondents and these are listed in Table 6. As might be expected, the list of items that should be improved in IHS-funded care is the mirror image of what makes people want to use privately-operated facilities. Reducing waiting time in the clinic was the most frequent improvement cited.[4] Perhaps surprisingly, the second most frequently cited area for improvement, listed by more than 20 percent of the respondents, was the attitudes of staff, compassion and respect. A possible explanation is that understaffing and overcrowding contribute to compassion fatigue by providers, high turnover among staff which interrupts the development of provider-patient relationships, and pressure

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4 Again there was a significant difference between the Tribes. While 43 percent of respondents from Tribe 1 cited less waiting time as a needed improvement, this was only cited by 24 percent of respondents from Tribe 2.

to move patients through the system more quickly so that there is less time to listen to them.

While confidentiality or remaining anonymous was given as an important reason for seeking care in the private sector, it did not emerge as an area for improvement in IHS-funded health care. This suggests that people accept the fact that in the I/T/U patients are going to have friends and relatives working in clinics where they have access to personal information about consumers.

Over half of the items suggested for improvement related specifically to doctors, including doctor training and skills, the need for more doctors, the desire for doctors to take more time to listen to patients, the need for more medical specialists, and the desire to see the same doctor most of the time.

Within the I/T/U there has been a frequent complaint that facilities are substandard and that this is a major limiting factor in the ability of the I/T/U to compete with the private sector for patients. This did not emerge as an issue in this survey. Perhaps that is because the Tribes in this study have more modern facilities than much of the rest of the IHS system. It should be noted that 82 percent of respondents did rank this as very important in question 5.

AREAS FOR IMPROVEMENT IN PRIVATE HEALTH CARE

When asked to list the most important things that should be improved in private health care, only 3 items were listed by more than 5 percent of the respondents. These are:

Cost	59%
Less waiting time	9%
Billing and paperwork	6%

About 20 percent of those in Tribe 2 thought waiting time was a problem in the private sector, compared to 6 percent in Tribe 1. Again this likely reflects local conditions in which waiting time is excessive in the IHS-funded

facility for Tribe 1 and therefore the private sector compares favorably.

PREFERRED HEALTH CARE SYSTEM FOR SPECIFIC NEEDS

Among those in the survey, 79 percent preferred appointments, 17 percent preferred walk-in care and 4 percent expressed no preference.

While 80 percent of all respondents said that having the same doctor most of the time was very important, only 55 percent reported that they had a regular primary care provider. Among those, 60 percent had their regular primary care provider in an IHS-funded program, 36 percent were in the private sector, and 4 percent reported having regular primary care providers in both places. For people who preferred walk-in care, only 39 percent reported having a regular primary care doctor and 73 percent of those were at the IHS-funded facility.

Question 2 listed 13 types of health care services and asked respondents to indicate the health care system that would most likely use for each type of service. The results are given in Table 7. A clear pattern emerges: people are more likely to use IHS-funded services for routine health needs; however, for more serious problems and problems which often have social stigmas and therefore require greater confidentiality (such as HIV and STD testing, mental health, and substance abuse treatment) there is a greater likelihood that people will use the private sector.

The two Tribes in this study were remarkably consistent in their reported patterns of use of the two health care delivery systems. There were only two types of services in which there divergence between the Tribes. The first was emergency room care. Respondents from Tribe 1 reported that they would use IHS 61 percent of the time and the private sector 32 percent of the time. For Tribe 2, there was a lower use of IHS (44 percent) and a higher use of the private sector (51 percent). The differences between the Tribes can be explained by differing local conditions in the availability of emergency room services. The largest community for Tribe

Health Care Service	IHS-funded	Private
Walk-in care for minor illness	82 %	16 %
Appointment for minor illness	81 %	18 %
Health education	78 %	20 %
Prescription medicine	76 %	19 %
Annual physical exam	72 %	26 %
Pregnancy and childbirth	65 %	32 %
Over-the-counter medicine	60 %	38 %
Emergency room	57 %	36 %
Mental health or substance abuse treatment	51 %	46 %
HIV or STD testing	51 %	47 %
Medical specialist	43 %	53 %
Surgery or treatment of a serious problem	35 %	59 %
Dental care	55 %	36 %

2 has only a private sector emergency room, so there really is no choice.

The other area of divergence between the Tribes was dental care. Tribe 1 had 49 percent use of IHS and 43 percent use of the private sector, while Tribe 2 had 75 percent use of IHS and 19 percent use of the private sector. Tribe 2 has a new dental clinic which offers a wide variety of services including orthodontia.

On the basis of the majority of their choices of health care providers for the 13 services in question 2, the respondents were divided into two groups: those who prefer IHS-funded services (72 percent of sample) and those who prefer private services (25 percent of sample). These two groups did not differ in age, gender, or self-reported health status. Those who prefer the private sector tend to be slightly better educated and are 5 times more likely to have had a bad experience with the IHS. Those who prefer IHS-funded health services are twice as likely to speak their Tribal language. While both groups say that doctor's training and skills are the most important factor in their decision to choose a health care provider, they differ on other factors. Those who prefer the private sector attach greater importance to having the same doctor most of the time. Those who prefer the IHS-funded care attach more importance to the doctor's experience with Indians, all services in one location, evening and weekend hours, how much they have to pay, the availability of a consumer advocate, Tribal language spoken and the availability of Traditional healers. These differences are given in greater detail in Table 8.

	Percentage ranking factor as "Very Important"		
Decision Factors with >5% Difference between groups	**Prefer IHS**	**Prefer Private**	**Difference**
Can see same doctor most of the time	77 %	91 %	14 %
How much I have to pay	71 %	52 %	19 %
Doctor's experience with Indians	60 %	32 %	28 %
Evening and weekend hours for care	61 %	50 %	11 %
Waiting time to get appointment	59 %	65 %	6 %
All services in one location	53 %	40 %	13 %
Consumer advocate available	36 %	17 %	19 %
Recommendation from family member or friend	36 %	23 %	13 %
Tribal language spoken	24 %	8 %	16 %
Traditional Indian healers available	23 %	8 %	15 %

TABLE 8 •
TRIBAL EMPLOYEE SURVEY: DIFFERENCES IN DECISION FACTORS
BETWEEN THOSE WHO PREFER IHS-FUNDED FACILITIES
AND THOSE WHO PREFER PRIVATE SECTOR HEALTH CARE

Medicaid Consumer Interview Results

edicaid consumers differed from Tribal employees in several factors that affect choices of health care providers. While the Tribal employees had health care insurance, they still were required to pay a deductible and co-pays to access alternatives to the IHS-funded care. The Medicaid consumers had no financial barriers. Even when they were not on Medicaid, there was little financial difference in their choices. While health care is free in IHS and Tribally-operated facilities, urban Indian clinics charge fees on a sliding scale similar to community health centers. The Tribal employees had health benefits that were like conventional health insurance, while the Medicaid recipients had to choose from managed care plans.

The 20 interviews with Medicaid recipients were conducted at two different locations. One was a rural setting in which the IHS-funded health care was provided predominantly by IHS directly and by the Tribe. The other was an urban setting in which the IHS-funded health care was provided by an urban Indian clinic. The choices for these two groups of consumers differed significantly.

In the rural setting, the only primary care alternative to the IHS-funded care was the private sector. In the urban setting, there were additional choices including county hospitals, university hospitals and clinics, and community health centers. Perhaps for continuity of care or other reasons, very few of the Medicaid recipients in the urban setting chose to use private sector providers. If they did not use the urban Indian clinic, they were most likely to use county hospitals. The county hospitals in this urban area were underfunded, overcrowded and had waiting time problems similar to the IHS hospital in the rural setting. It should be noted that the urban Indian clinic was a subcontracted provider under the Medicaid managed care plan that included county hospitals. Where the differences between the rural and urban settings have

produced different types of response, interview results are reported separately for each group.

DESCRIPTION OF THE SAMPLE

The sample for interviews was stratified to include a variety of types of people who represented different categories of Medicaid recipients. Included in the sample were 8 people who were raising young children, 6 pregnant women, 4 disabled people, and 2 elderly people. There were 16 women and 4 men. They ranged in age from 19 to 70 years old. Only one person interviewed was currently married and living with their spouse. A more detailed description of the sample is given in Table 9. No analysis was done using these categories because the numbers are too small.

Using the median figures, a composite of the typical person interviewed for this part of the study would be a 35 year old woman who is divorced and living with her children. She is a high school graduate who grew up on a reservation or a small town where there was a majority Indian population. She has relatively good health and saw the doctor 4 to 12 times in the past year.

The sample of Medicaid consumers in the urban area does not reflect the transient migration patterns that are often associated with urban Indians. Perhaps those who move back and forth between reservations and the city tend to get their medical care on the reservations. The urban people in this sample have resided in their present community for an average of 12.2 years, with a range of 1 to 27 years. Still, their length of residence on average is about half that of the rural Medicaid consumers. Both groups have lived in their present community long enough to be familiar with the range services and providers that are available. Table 10 further describes this sample in terms of health status and health seeking behaviors.

TABLE 9
MEDICAID CONSUMER INTERVIEWS: DESCRIPTION OF THE SAMPLE

Age

19 - 29 years old	40 %
30 - 39 years old	20 %
40 - 49 years old	10 %
50 - 59 years old	20 %
60 - 70 years old	10 %

Gender

Female	80 %
Male	20 %

Marital Status

Never married	40 %
Divorced/separated	45 %
Widow/widower	10 %
Married	5 %

Highest Level of Education

GED or high school graduate	40 %
Some college or vocational education	35 %
Less than 12 years	25 %

Community of Residence as a Child

Small town with majority Indian population	40 %
Reservation	35 %
Urban area or place where Indians were minority	25 %

Length of Residence in Present Community

	Rural	Urban
Range	1 yr - 52 yrs	1 yr - 27 yrs
Average	25.8 yrs	12.2 yrs
Median	23 yrs	10 yrs

Household Composition

Self and children	55 %
Lives alone	20 %
Lives in shelter	10 %
Other	15 %

The Medicaid consumers differ from the Tribal employees surveyed in several ways. As might be expected from Medicaid consumers who are likely to be unemployed and to have lower income levels than Tribal employees, only 40 percent own vehicles compared to 95 percent of the Tribal employee sample. This is largely a factor of the urban sample of Medicaid consumers in which only 10 percent own vehicles. Medicaid consumers are more likely to go the the doctor by riding with relatives, walking, or using transportation services provided by the Tribe or the provider. None of the Medicaid consumer reported using public buses. While 20 percent of the Medicaid consumers said that transportation was a factor in selecting a health care provider, 80 percent said that this was not a consideration.

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The Medicaid consumers reported a greater preference for appointments rather than walk-in care, compared to the Tribal employees surveyed. This is probably because Medicaid consumers are enrolled in managed care plans and have assigned primary care providers. While 79 percent of the Tribal employees indicated that they preferred appointments, 85 percent of the Medicaid consumers interviewed said they preferred appointments. Only 10 percent of the Medicaid recipients said that they preferred walk-in care, compared to 17 percent of the Tribal employees surveyed.

TABLE 10
MEDICAID CONSUMER INTERVIEWS:
HEALTH STATUS AND HEALTH SEEKING BEHAVIORS

Self-reported Health Status

Excellent	35 %
Minor Problems	30 %
Chronic disease	30 %
Disability or current serious illness	10 %

"How often did you see a physician or midlevel practitioner for yourself in the past year?"

Less than 4 times	20 %
4 to 12 times	45 %
More than 12 times	35 %

Preference for Appointment or Walk-in Care

Appointments	85 %
Walk-in Care	10 %
No preference	5 %

Health Care Provider Experience in This Community

	Rural	Urban	Total
IHS-funded	90 %	80 %	85 %
State, County, City	50 %	80 %	65 %
Private Providers	70 %	40 %	55 %
University	0	10 %	5 %

"How much does transportation determine where you get your health care?"

Not at all	80 %
Somewhat important	20 %

Do you have a vehicle for daily transportation?

	Rural	Urban	Total
Yes	70 %	10 %	40 %
No	30 %	90 %	60 %

Primary Source of Transportatin for Health Care

Ride with relative	45 %
Own vehicle	25 %
Walk	20 %
Outreach worker/ CHR	15 %
Provider provides transportation	15 %
Taxi	5 %

EXPERIENCE WITH IHS-FUNDED SERVICES AND ALTERNATIVES

Medicaid consumers in this study had experience with IHS-funded health care in their current communities of residence. However, 70 percent of those in rural areas had sought care from private providers, compared to only 40 percent in urban areas. Conversely, in the urban areas the Medicaid consumers had more experience with state, county and city services (80 percent compared to 50 percent in rural areas) and university-based health care (10 percent in urban areas, but none from rural areas).

Table 11 summarizes how the Medicaid recipients report their previous experience with IHS-funded services and the alternatives. While those in rural and urban areas have fairly similar assessments of the IHS-funded services, they differ considerably on their assessments of the alternatives. This is because the predominant alternative for the rural area is private sector health care (which is ranked relatively high), while the predominant alternative in the urban area is county health care (which is ranked lower).

Medicaid Experience and Sources of Information. The people interviewed for this study ranged from one month to 25 years of experience with Medicaid. The woman who had been receiving Medicaid for 25 years said that she had been placed on Medicaid when she was born and got her own card when she turned 18 years old. It appears that many people initially received Medicaid benefits when they qualified for public assistance and that they learned about Medicaid from the county or State social worker who was their caseworker. It is interesting to note that IHS-funded facilities were not identified as a source of encouragement or assistance in the application process, or as a source of information about Medicaid. While 75 percent said that they thought they could choose their provider, the other 25 percent believed that they did not have a range of choices. This information is summarized in Table 12.

In the rural areas, only half the Medicaid recipients interviewed thought that Medicaid would pay for services provided in IHS-funded facilities. About 70 percent of the rural people interviewed were very negative about the use of Medicaid in IHS-funded facilities and none of them expressed a positive attitude about this.

TABLE 11
MEDICAID CONSUMER INTERVIEWS: GENERAL ASSESSMENT OF PREVIOUS EXPERIENCE WITH EACH HEALTH CARE SYSTEM

Previous Experience with IHS-funded Services

	Rural	Urban	Total
Excellent	30 %	40 %	35 %
Acceptable	60 %	60 %	60 %
Bad	10 %	0	5 %

Previous Experience with Private Sector and City, State or County Services

	Rural	Urban	Total
Excellent	50 %	10 %	30 %
Acceptable	50 %	60 %	55 %
Bad	0	10 %	5 %
No experience	0	20 %	10 %

Typically, rural people said "I don't think it is right, because Indians deserve to be treated for free," and "We shouldn't have to show our [Medicaid] card - the Indian card should be enough," and "They are getting paid double." Only one rural Medicaid recipient interviewed expressed the understanding that Medicaid billing would provide more resources to help more people receive health care in the IHS-funded facilities.

In the urban area, there was a different attitude. Among those interviewed, 80 percent knew that Medicaid would pay for services in the urban Indian clinic. They expressed gratitude for this, because they would otherwise have to pay a fee for services. There were no negative comments about the urban Indian clinic billing Medicaid.

Medicaid consumers were asked where they thought the money comes from to operate IHS, Tribal and urban Indian clinics. Virtually all who answered the question knew that money came from the Federal government. However, no one cited third party payment, insurance, Medicaid or Medicare as sources of funding. Also, no one suggested that money came from gaming or other Tribal activities. (It should be noted, however, that these interviews were not done in gaming areas.) About 25 percent thought that the State provided money to operate I/T/U health care.

MANAGED CARE EXPERIENCE AND SOURCES OF INFORMATION

For both the rural and the urban samples in this study of Medicaid recipients, the Medicaid program is a managed care program. For consumers, the most basic aspects of managed care are enrolling in a health plan and selecting a primary care provider (PCP) to serve as a case manager or gatekeeper for specialty services. Theoretically, everybody interviewed should have had a PCP who served as a case manager. Of the 20 people interviewed, 17 reported that they had a regular PCP and 16 of those could

give the name of that provider. By design, half the people interviewed had their PCP located in an IHS-funded facility. While the other half were intended to have a PCP in the private sector or county health care, only 6 of those 10 could name their PCP. Among the 16 with named PCPs, the length of time the individual had served as PCP ranged from 6 months to 10 years. The 16 people were satisfied or very satisfied with the PCP. These experiences with PCPs are summarized in Table 13.

Even though they are currently using Medicaid managed care, a majority of those interviewed said that they did not understand how managed care works. Information about consumer sources of information about managed care is presented in Table 14. Most people said that their sources of information about managed care came from a pamphlet they received in the mail or from the State or county social worker. Only one person cited advertisements as a source of information. If they had questions about managed care, most people would call their State or county social worker. The second most frequent resource cited for answering questions was the person's primary care physician. Several people mentioned that they would call the "1-800" telephone number listed in the pamphlet they received from the State or county. IHS-funded facilities and HMOs were given as a source of information by only one person interviewed.

IMPORTANCE OF FACTORS IN SELECTING HEALTH CARE PROVIDER

Medicaid consumers were asked an open-ended question about what factors they consider in choosing a health care provider or organization. Their answers were similar to the list of factors provided to Tribal employees, except that Medicaid consumers used the term "quality of care" and nobody cited confidentiality, billing practices and paperwork, evening and weekend hours for care, choice of providers, Tribal language spoken, or

TABLE 12
MEDICAID EXPERIENCE AND INFORMATION

Self-reported Length of Time on Medicaid for Those in Study

Range	1 month to 25 years
< 1 year	20 %
1 to 3 years	25 %
4 to 6 years	20 %
20 to 25 years	10 %
No information	25 %

"Did anyone help you or encouraged you to apply for Medicaid? Who?"

No one	30 %
Family Member	25 %
County or State Social Worker	25 %
Hospital Social Worker	5 %
Doctor	5 %
Lawyer	5 %
On Medicaid since birth	5 %

"Did anyone explain to you how Medicaid works? Who?"

State or County Social Worker	50 %
HMO or Private Provider	20 %
No one	20 %
Hospital Social Worker	5 %
Social Security Office	5 %

"When you started on Medicaid, did you think that you could choose the clinic or doctor you wanted for health care?"

Yes	75 %
No	25 %

"Does Medicaid pay for services you receive in IHS, Tribal or urban Indian clinics?"

	Rural	Urban	Total
Yes	50 %	80 %	75 %
No	40 %	0	20 %
Don't know	10 %	20 %	15 %

Traditional Indian healers.[5] Factors cited by 25 percent or more of those interviewed are given in Table 15.

The information in Table 15 illustrates the significance of local conditions in determining what factors are important. For example, quality of care and waiting time in the clinic are much more important to rural people than to urban people in this study. This is because the IHS-funded facility in the rural area is perceived to have problems with quality of care and waiting times in the clinic, as indicated by both the Tribal employee survey and the Medicaid consumer interviews. In the urban area, it is much more important to the consumers interviewed that the providers listen to patients and

5 The Tribal language and traditional Indian healers were discussed in another part of the interview and were considered important by more than 20 percent of those interviewed.

TABLE 13
MEDICAID CONSUMER INTERVIEWS:
PRIMARY CARE CASE MANAGEMENT

Medicaid Consumers Able to Identify A Regular Primary Care Provider who Serves as a Case Manager or Gatekeeper?" (n=20)

Yes	85 %
No	15 %

Location of Primary Care Provider (n=17)

IHS-funded facility	59 %
Private or County Facility	41%

Length of Time This Individual has been Respondent's Care Provider (n=16)

Range 6 months to 10 years

< 1 year	6 %
1 to 3 years	50 %
4 years or more	44 %

Primary Care Provider is Available to See Medicaid Consumer upon Request (n=17)

Yes	76 %
No	24 %

Waiting time to get an appointment with Primary Care Provider (n=14)

	Percent of Responses	Cumulative Percentage
Regular appointments scheduled	21 %	21 %
< 1 day	14 %	35 %
2 to 3 days	7 %	42 %
1 week	14 %	56 %
2 weeks	14 %	70 %
1 month	7 %	77 %
3 months	21 %	98 %

Level of Satisfaction with Primary Care Provider (n=17)

Very satisfied	41 %
Satisfied	53 %
Not satisfied	7 %

have experience with Indians. This is because the private sector and county health programs are perceived as being less respectful and responsive to Indian people than the urban Indian clinic is.

The absence of confidentiality from the list in Table 15 is interesting because confidentiality ranked second among the factors cited in the Tribal employee survey. It is possible that confidentiality is not an issue for Medicaid recipients because they are not seeking health care from co-workers in the I/T/U. In the urban area, people already feel anonymous and seem to be seeking health care where they know other people.

TABLE 14
MEDICAID CONSUMER INTERVIEWS:
SOURCES OF MANAGED CARE INFORMATION

Reported Understanding of How Managed Care/HMO works

No	75 %
Yes	25 %

Sources of Initial Information about Managed Care

Pamphlet	55 %
State or county social worker	35 %
Direct mail	15 %
Family and friends	15 %
Hospital or doctor's office	10 %
Work-related insurance	5 %
Posters	5 %
Advertisements	5 %
Received no information	10 %

Where Consumers Would Go for Answers to Questions about Managed Care

State or county social worker	60 %
Call my own doctor	20 %
Call 1-800 telephone hot line	15 %
Pamphlet	15 %
Relative	10 %
IHS-funded facility	5 %
HMO	5 %
Don't know	10 %

TABLE 15
MEDICAID CONSUMER INTERVIEWS:
FACTORS CITED BY 25 PERCENT OR MORE
IN CHOOSING HEALTH CARE PROVIDERS AND ORGANIZATIONS

	Rural	Urban	Total
Quality of care	90 %	10 %	50 %
Attitudes of support staff	40 %	50 %	45 %
Provider takes time	20 %	50 %	35 %
Provider listens to me	10 %	50 %	30 %
Waiting time to get an appointment	30 %	20 %	25 %
Waiting time in the clinic	40 %	10 %	25 %
Provider experience with Indians	10 %	40 %	25 %

Cultural Issues in Selecting Health Care Providers

The interviews with Medicaid consumers were helpful in exploring broader aspects of cultural issues than could be covered in the Tribal employee survey instrument. Medicaid consumers were asked if there was anything about being Indian which affected their choice of health care providers. While 45 percent initially said they couldn't think of anything that made them different in their choices, with later prompting they did speak about the importance of provider experience with Indians, having the Tribal language spoken in the clinic and having a consumer advocate available. About 25 percent of the Medicaid recipients interviewed spoke about prejudice against Indians being a factor in their choices and their desire to find health care providers and organizations which would treat them with respect. Two people answered the question by talking about the importance of finding a health care provider organization in which other people there are Indians.

Among the Medicaid consumers interviewed, 35 percent spoke their Tribal language as compared to 25 percent in the Tribal employee survey sample. In the Medicaid consumer interviews, 75 percent of the people reported that they used traditional medicine, or Indian medicine, such as medicine men, traditional healers, herbs and other types of healing which Indians used before there was Western medicine. There was little consensus about the kinds of problems best treated by traditional healers.[6] This question was not asked in the Tribal employee survey.

Despite the fact that 75 percent of the Medicaid consumers interviewed reported using medicine men, only 35 percent thought it was somewhat important or very important to have them available in their health care clinic. One person said that medicine men work separately in his Tribe and he would not expect to find them in a Western health care setting. Similarly, a majority thought it was not very important to have their Tribal language spoken in the clinic. In the urban setting, there are people from so many different Tribes that they may realistically not expect to hear their Tribal language in a health care setting. There was a greater expectation for consumer advocates, with 70 percent saying it was very important or somewhat important.

While people do not generally expect to find traditional healers or their Tribal language spoken, they do want to be treated by providers who understand and accept their culture. Among the Medicaid consumers interviewed, 85 percent said that it was very important or somewhat important to have doctors who have experience with Indians. One person said it was especially difficult to see foreign doctors because of the barriers to communication and understanding. Cultural factors were also expressed in a more subtle way when people discussed what made them want to use IHS-funded facilities.

What Attracts Consumers to IHS-funded Facilities

About half the rural consumers interviewed said they used IHS-funded facilities because it was free and they had the right to health care services as part of the Federal trust responsibility. This is similar to the Tribal employee survey in which 47 percent said that the wanted to use IHS-funded facilities because they were affordable. Only 10 percent of both rural and urban consumers cited quality of care, doctors or convenience as reasons to use IHS-funded services, which is somewhat less than the Tribal employee survey. Most people talked about wanting to use IHS-funded facilities for social and cultural reasons. These included knowing the staff, seeing friends and socializing, feeling

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6 People interviewed said the the following kinds of health problems are best treated with traditional healers: All kinds of problems (4), don't know (4), colds (2), cancer (2), gall bladder (2), minor illness (1), serious illness (1), teeth (1), stomach ache (1), menstruation (1), arthritis (1), diabetes (1), asthma (1), coughs and lung problems (1), high blood pressure (1), strep throat (1), removing warts (1), and grief (1).

more comfortable, and liking the more relaxed atmosphere. Some said that they went to IHS-funded facilities because their family did and it was a "habit."

WHAT ATTRACTS INDIAN CONSUMERS TO PRIVATE HEALTH CARE

The reasons consumers cited for using private health care were closely related to the deficiencies they perceived in IHS-funded health care. In the rural area, Medicaid consumers wanted to use private health care because there was a shorter waiting time, it was not as crowded, and they felt like they got more personal care and special treatment. In the urban area, people were more likely to use county services rather than private sector care, and the county services were not perceived in the same positive manner. For the urban consumers, as well as the rural consumers, a major reason to go outside the IHS-funded system was to receive specialty care not available within the IHS funded system. About 10 percent of those who used private and county health services said they did so out of "habit."

Areas for Improvement in Indian Health Care. Local conditions determined the consumer perceptions of what needs to be improved in IHS-funded care. In the rural area, consumers said that the health care system was too slow, the waiting times too long, there were not enough doctors to meet the need, too many appointments were scheduled at the same time and doctor turnover made it difficult to establish long term relationships with primary care providers. They also cited the need for improvement in the attitudes of doctors and nurses and the cleanliness of the facility. Two people said there needs to be more funding for Contract Health Services.

In the urban area there was a higher rate of satisfaction with the IHS-funded services and half those interviewed could not think of anything needed to improve the services. Those who did suggest improvements said that the clinic size needed to be expanded, more doctors were needed and a greater variety of services.
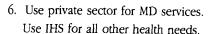
AREAS FOR IMPROVEMENT IN PRIVATE HEALTH CARE

Again, local conditions influenced the consumer perceptions. In the urban area, people said that waiting times should be reduced in county health services and that the clinics should be cleaner. In the rural areas, about half those interviewed had no suggestions for improving private services. Others in the rural area said that the cost of private care should be reduced and the length of stay in hospitals should be increased. About 30 percent of consumers said that doctors should spend more time with patients, show a more concerned attitude and explain things more thoroughly to the family and patient.

PREFERRED HEALTH CARE SYSTEM FOR SPECIFIC NEEDS

Even though people were selected for these interviews on the basis of using either the IHS-funded system or using another health care delivery system, 65 percent of those interviewed used both systems. When people were asked to explain how they decided which system to use, they expressed 7 different patterns of logic. These are:

1. Always use IHS-funded facilities
   and services   20 %
2. Always use private sector or county facilities
   and services   15 %
3. Use IHS for minor problems. Use
   private/county for major problems.   25 %
4. Use IHS unless referred by them to
   private/county.   20 %
5. Go to private doctor for second
   opinion of IHS diagnosis and
   treatment.   10 %

6. Use private sector for MD services.
   Use IHS for all other health needs. 5 %
7. Use urban Indian clinic for outpatient
   services. Use county for inpatient. 5 %[7]

Five of these 7 patterns rely on IHS-funded facilities for basic, on-going care. Only patterns 2 and 6, which comprise 20 percent of the responses, rely on private sector or county for basic, on-going care.

These decision-making processes are highly compatible with the IHS system which does not offer all services within the system and uses Contract Health Services to supplement care. However, in the current managed care environment consumers are asked to select from among comprehensive health plans and to seek all services from within the chosen system. The rural consumers in these interviews resided in a State where the Medicaid program reimburses IHS-funded facilities for services delivered out of plan. The urban consumers in these interviews reside in a State in which the IHS-funded facilities must be part of the health plan in which the Indian Medicaid consumer enrolls to receive reimbursement for the services provided.

Many of these decision processes are compatible with managed care plans where the IHS-funded facility is a provider in the plan, the Indian Medicaid consumer selects a primary care case manager at the IHS-funded facility and the case manager makes referrals to other parts of the system in a manner consistent with the needs and preferences of the patient.

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7 While only one person identified this pattern, it is a pattern more common than 5 percent because the urban Indian clinic does not provide inpatient care and does refer to the county hospital system.

Marketing Strategies

The I/T/U has seldom considered marketing its services, although this is often cited as a necessary part of competing for patients in the managed care environment. It is unclear whether the private sector in any managed care market is actively targeting its marketing to the Indian population, which may be considered too small a segment of the market to spend dollars on a developing and implementing a marketing plan. Six types of information are needed to develop a marketing plan: 1) Identifying consumer choices and the factors that affect those choices; 2) understanding the mission of the organization and its strengths; 3) identifying the unmet needs of consumers and potential consumers and how to offer them those services which will attract them to the organization and foster their loyalty; 4) understanding what the competition has to offer; 5) knowing how people get their information; and 6) identifying the most important messages to give to consumers.

CONSUMER CHOICES AND FACTORS THAT AFFECT THOSE CHOICES

This study has provided a broad overview of consumer choices and factors that affect those choices. The extent of choice in the Native American population is dependent on the availability of private sector health care near Native American communities and the level of alternate resources in the Native American population to pay for private health care. The factors that affect consumer choices are influenced by local circumstances. Therefore, it is difficult to generalize from one place to another unless the circumstances are very similar.

ORGANIZATION'S MISSION AND STRENGTHS

While many organizations have mission statements, it is necessary to know how that mission is unique within a particular market. If several organizations are serving the same mission in the same market, they are more likely to be competing for consumers. Marketing involves "playing to your strengths" and it is important to know what consumers perceive as strengths.

IDENTIFYING CONSUMER NEEDS

Most health care providers conduct patient satisfaction surveys. It is a requirement for accreditation by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO). It would be surprising if the organizations serving consumers in this study did not already know what types of improvements they need to make. For example, the IHS-funded facility in the rural area and the county hospital in the urban area are probably well aware that they have problems with waiting times in the clinic, patient flow, appointment systems and staff turnover. However, they may not know how to solve these problems. In the case of the rural clinic which is IHS-funded, plans are already underway for expansion to alleviate the crowding, but they may not see this as an important part of a marketing plan and may not have communicated this adequately to consumers.

UNDERSTANDING THE COMPETITION

Most of the I/T/U does not regard the private sector as competition, and the private sector probably does not see the I/T/U as competition. However, if they are competing

for the same patients, they need to know what the other system has to offer. This preliminary study shows that local conditions are so variable that findings cannot be generalized from one community or region to another. While patient satisfaction surveys are fairly easy to administer within your own system, it is more difficult to design a consumer survey for those that are using a different system. It is likely to be a more expensive proposition that involves hiring consultants and paying informants.

SOURCES OF INFORMATION FOR CONSUMERS

This study suggests that the three most important sources of information about Medicaid and managed care are pamphlets, State and county social workers and the individual's private physician. According to the consumers interviewed, neither the I/T/U nor HMOs play a significant role in providing information about managed care.

When Medicaid consumers were asked about advertising by HMOs, only 45 percent reported that they had seen advertisements. The types of advertising that they noticed were television ads, direct mail brochures, billboards, newsletters, and posters or pamphlets in health care organizations. No one reported awareness of advertising in newspapers, on the radio, in buses or at bus stops.[8] Most people could not recall the message in the ads and felt that the ads were not very helpful in giving them information.

Two strategies are suggested by this information. First, the health care organizations can use existing sources of information to reach consumers with their messages. This means becoming more involved in designing pamphlets distributed by the State or county, helping to train State and country social workers, and making sure that doctors are prepared to answer questions about managed care. The second strategy involves becoming a more

visible, recognized and accepted source of information on managed care. This could entail designing and distributing pamphlets and posters targeted to Indian consumers, designating staff to assist people in applying for Medicaid and explaining how it works, and having a publicized "hotline" to answer questions about managed care.

IDENTIFYING MESSAGES TO CONVEY TO CONSUMERS

Any organization that wants to make money on managed care has to give potential consumers the message to "enroll now, don't wait until you are sick." To attract consumers, the health care organizations need to communicate their advantages compared to the competition.

The results of these Medicaid consumer interviews suggest that the IHS-funded facilities in rural areas have a particular challenge in trying to explain to consumers that the Federal government does not fully fund IHS services, that IHS-funded facilities can and should bill Medicaid, and that third party income is needed to make the system work and to improve the things they want improved (such as hiring more doctors and decreasing waiting times).

This study has only begun to explore the meaning of "culturally competent care" for consumers. The most visible and tangible aspects of culturally specific care, such as the Tribal language being spoken and traditional healers available, are very important to about 20 to 35 percent of the Indian people who participated in this study. What seems to be more important to more consumers is a sense of belonging, an understanding of Tribal culture, a comfort level, friendliness, acceptance and respect. This is partially expressed in this study by provider experience with Indians, which is very important to 52 to 75 percent of those who participated in this study.

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8 None of the people interviewed said that they used buses for transportation, despite the fact that 9 out of 10 urban Medicaid consumers did not own vehicles.

Conclusions and Discussion

Consumer choices are a complex subject. American Indian and Alaska Native people have many different circumstances, both in their communities and in their individual preferences. There may be different perceptions of the programs that are operated by Tribes, urban Indian clinics and the IHS in terms of quality, feelings of ownership or control, responsiveness to consumers, and facilities. So, a study involving one type of Indian program cannot necessarily be applied to other Indian programs.

One of the findings from this study is that asking people to rank a list of factors important to them in choosing health care providers does not predict their behaviors. The ranking process produces an abstract, ideal description of a health care delivery system. The choices in their environment may be far from that ideal. When making a choice, they have to consider realities and tradeoffs. When the consumer is asked to suggest improvements in the currently used health care system, they may compare it to both the alternatives in their environment and to the ideal system.

While the findings from the Tribal employee survey suggest that cost of care is the major barrier to Indian people using private health care, it should not be concluded that people would be happier if the money spent on IHS were used instead to purchase managed care plans.[9] For Medicaid consumers, cost is not an issue and the State has essentially purchased a managed care plan. Nevertheless, many consumers prefer to use IHS-funded facilities. The reasons for this preference seem to be closely related to social and cultural factors.

For the I/T/U to improve the quality of care and to serve the growing number of Indian people in a time when Federal budgets are not increasing, it is important that they capture available third party resources, including health insurance, Medicaid and Medicare. As managed care is rapidly becoming the dominant model for both Medicaid and employer-purchased health benefits, it is important for the I/T/U to participate in managed care plans and to become primary care providers for enrolled Indian consumers. Because Indian consumers may be trying to maximize their range of options knowing that IHS services are free, they are likely to enroll in a plan which does not include the I/T/U and still continue to use I/T/U services. The I/T/U must develop marketing plans to attract and retain consumers, and to get them to enroll before they need health care.

Marketing plans are a relatively new concept for the I/T/U. In the new health care environment in which the I/T/U is competing for patients with alternate resources, marketing plans are becoming a new requirement for success. Marketing plans are not synonymous with advertising. In fact, this study suggests that advertising is relatively ineffective in reaching Indian Medicaid consumers with messages about the benefits of a particular health care system. Rather, marketing plans must be regarded in a more broad and holistic way that is integrated with planning, management and communications.

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9 It is unlikely that there is enough money in the IHS budget to do this. The expenditures per capita by the IHS are less than the per patient per month charges for most HMOs. Congress has never funded IHS in relationship to population growth. With Congressional intent to remove entitlement status from the Medicaid program, it is unlikely that Congress will fund Indian health by paying a fixed amount per capita. Furthermore, the IHS system would have to be maintained for those people who are living in remote areas where there is no private sector health care. This idea was considered in conjunction with President Clinton's proposal for sweeping health care reforms, and it was rejected by both Tribes and policy makers.

Recommendations

1. Tribes need to engage in long range health planning that assesses the extent of choices of health care providers for the population they serve, including the availability of private sector medical care near Native American communities and the level of alternate resources in the Native American population to pay for private health care.

2. Tribes need training and technical assistance to develop and use marketing plans in settings where consumers have choices of health care providers.

3. Within States, Tribes need to work together with State Medicaid officials to help design pamphlets distributed by the State or county and to train State and county social workers and people who answer managed care information "hotlines" to assure that Native American consumers receive information about managed care that will assist them in enrolling in plans that include I/T/U providers.

4. A national effort is needed to explain to Native American consumers that the Federal government does not fully fund IHS services, that IHS-funded facilities can and should bill Medicaid, and that third party income is needed to make the system work and to improve the things they want improved (such as hiring more doctors and decreasing waiting times).

5. Further research is needed to more fully understand the concept of culturally competent care and to develop methods of assessing how health care organizations deliver culturally competent care.

6. To help guide the development of Medicaid managed care programs that preserve and enhance the I/T/U, there should be an assessment of provisions in current State Medicaid managed care programs, the development of a draft set of model provisions, and a national meeting of Tribes, urban Indian programs, the IHS, States and the Health Care Financing Administration to discuss the model and develop consensus.

Appendix I

WHY DOES MEDICAID PAY LESS FOR NATIVE AMERICANS THAN THE REST OF THE POPULATION?

A State-by-State analysis of the average annual Medicaid payments per recipient shows that American Indian and Alaska Native Medicaid recipients had significantly lower Medicaid benefits than the Medicaid population as a whole (see the following pages). Based on FY94 data, the average difference in Medicaid payments was $1,036 for 29 of the 34 reservation States that report information with a category for Native Americans. The States with the highest gaps were:

New York	$3,997
Wisconsin	$2,461
North Carolina	$2,305
Minnesota	$1,755
South Dakota	$1,579

The States with the lowest gaps were:

Mississippi	$ 155
Oregon	$ 305
Alaska	$ 321
Texas	$ 512
Washington	$ 574

The differences in Medicaid payments cannot be explained by the health status of the populations. Statistics show that there is a higher rate of mortality and morbidity among Native American than the U.S. average. There could be several reasons for the differences between Medicaid vendor payments to Native Americans and others: 1) the I/T/U fees for service could be set at rates below the prevailing charges; 2) the flat rate that HCFA pays for services in IHS facilities could be below the market rates; 3) the Native American patients could be receiving fewer services (for example, fewer diagnostic tests) than other Medicaid patients; 4) the I/T/U could be failing to bill Medicaid for services delivered; 5) some States with expanded Medicaid programs have co-payments which Indians are unwilling to pay and therefore Medicaid cannot be billed for the services they receive.

Because 70 percent of Medicaid expenditures are for long term care, the most likely explanation is that there are proportionately fewer Native Americans in nursing homes. The reasons for this may be: 1) the Native American population is younger than the U.S. average; 2) there are few nursing homes on or near reservations. The Mississippi Choctaw Tribe does operate a nursing home, and this may explain why the gap in expenditures is lowest in the State of Mississippi.

2.4

MANAGEMENT DEVELOPMENT NEEDS IN NATIVE AMERICAN HEALTH CARE

Prepared by

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Introduction

This analysis seeks to identify the trends in management training needs of Native American health programs across the country through site visits and surveys of leaders currently working in the field. It attempts to capture the diversity of Indian Health Service (IHS), tribal, and urban health programs and their management needs from a local perspective in a manner which will provide guidance for development of Indian health management training programs nationally. Current management challenges in Indian health care are formidable. Health programs' daily operation (and survival) pose the most intensive management challenges given the constrained budgets, controls by federal and state agencies, and complex health program management in the context of local tribal governance and other governing bodies. A comprehensive analysis of current national management challenges in Native American health care is embodied in the recent work of the Indian Health Design Team (IHDT). Formed to design a new Indian health system, the IHDT submitted a preliminary report, "Design for A New IHS," in August 1995. While the IHDT report addresses principally the IHS it nonetheless reflects many of the challenges faced universally by American Indian health care including tribally operated and independent urban health programs. The IHDT proposes implementation of its recommendations over the next several years with completion by 1998.

The basic design strategy recommended by IHDT places control of Indian health care at the local level. The delivery level is referred to in this report as the local "I/T/U" ("I"=IHS operated, "T"= delivered by Tribes through compacts or contracts, "U"= Urban Indian health programs). The IHDT design strategies are: "(1) to restructure only those IHS organizational levels above the local level and to leave the choice of local restructuring to the local I/T/U; (2) to change the IHS levels above the local I/T/U from controlling to supporting the unique needs of the local I/T/U; (3) to pool and consolidate IHS Area Offices and Headquarters resources and expertise to support the local I/T/U; and (4) to invest resources gained as a result of Federal downsizing into local, direct clinical services" ("Design for a New IHS," November, 1995). Again, although the IHDT report addresses predominantly the IHS, the principles of local control and independence clearly apply to all Indian health care. Furthermore the report emphasizes the value of increased tribal influence at the local level and is consistent with recent trends toward conversion of some IHS clinical programs to full tribal operation.

Current Health Services

GENERAL DESCRIPTION

Facilities are currently organized in 12 geographic sections of the country called "IHS Areas" titled Aberdeen, Alaska, Albuquerque, Bemidji, Billings, California, Nashville, Navajo, Oklahoma, Phoenix, Portland and Tucson "Areas." Across the country there are 144 service units in the 12 areas (68 of which are IHS and 76 are tribally run). Tribally operated facilities under Title I, P.L. 93-638 are facilities with self-determination contracts, whereas tribally operated facilities under Title III, P.L. 93-638 are under self-governance compacts. The clinical sites in the 144 service units include 49 hospitals (38 IHS, 2 Tribal self-determination contracts or Title I, 9 Tribal self-governance compacts or Title III), 190 health centers (61 IHS, 88 Tribal Title I and 41 Tribal Title III), 7 School Health Centers (4 IHS, 2 Tribal Title I and 1 Tribal Title III) and 287 Health Stations (47 IHS, 74 Tribal Title I and 166 Tribal Title III).

Native American health services are provided through three inter-related approaches: 1) Indian Health Service (IHS) clinics and hospitals, 2) tribally operated health programs (largely funded by Congressional appropriations through the IHS, and 3) urban programs governed by Indian Health Boards in metropolitan areas and funded by a mixture of resources including partial funding by IHS appropriations (although in much smaller proportion than tribally operated programs). IHS has operated a network of patient and ambulatory care facilities across the continental United States and Alaska since 1955. In recent years however, responsibility for an increasing number of health programs has been assumed by tribal authorities predominantly through conversion from IHS operation to tribal governance. In addition, IHS directly subsidizes health care services through contracts with private providers (formally known as Contract Health Services), particularly for specialized services and other services not available in IHS direct care facilities or tribally operated clinics.

Urban Indian Health programs, under the Indian Health Care Improvement Act, were established in recognition of the growing trend of Indian people moving off reservations and the ill-fated federal relocation and termination policy that encouraged American Indians/Alaskan Natives to make this transition. According to the "Report on the Urban Indian Health Care 1994 Forum," the 1990 census shows that 62.4 percent of American Indians/Alaska Natives now reside off reservations, with over 56 percent living in larger metropolitan areas. The enactment of the Indian Health Care Improvement Act (P.L. 94-437, as amended) established funding for Urban Indian Health Programs. Title V of that bill provided Congress with the authority to provide assistance to all Indians, regardless of their residency or status under federal recognition.

Despite this large percentage of all Indian people living off reservations Urban Indian Health Programs have a somewhat limited relationship to the Indian Health Service, tribal governments, and other sections of the federal, state, county, and local governments, as compared to reservation health programs. Federal funding for urban programs has been historically less, in proportion to populations served, than funding for reservation health programs. Since Indian health care services have been rationed based on standards established by the Bureau of Indian Affairs (under the Indian Health Service) most Indian

Health Service support has been directed to federally recognized tribes, their members, and descendants living on reservations. The Urban Indian Health Program budget accounted for only one percent of the total Indian Health Service budget, or $22 million in 1994. That budget meets an estimated 22 percent of the level of identified need of existing urban sites. This does not include 19 additional sites identi-

fied as needed, on the basis of Urban Indian population, in a study commissioned by the Indian Health Service. The rapid growth in the off-reservation Indian population in the United States necessitates a second look at the responsibilities of the Indian Health Service toward all Indian people. A committee of Urban Program Directors and IHS personnel suggested that services offered by Urban Indian Health Programs should be based on population size and residences so as to reflect and accommodate the rise in the Urban Indian population.

Although urban programs differ significantly from reservation programs, health care delivery problems facing urban Indian health care are similar to reservation programs including (1) limited access, (2) availability of specialty consultation, (3) culturally insensitive services, (4) inadequate data systems, (5) confusion regarding eligibility, (6) funding, (7) poor health status, (8) incomplete infrastructure development, (9) institutional racism, and (10) state health care reform issues (Urban Indian Health Care 1994— Partnership: A New Vision for American Indian/Alaskan Native Health — Report on the Urban Indian Health Care 1994 Forum).

HISTORY OF FEDERAL INDIAN HEALTH SERVICES

The Indian Health Service (IHS) was established in 1955 to raise the health standards of American Indians and Alaska natives who are members or descendants of federally recognized tribes and reside on or near federal reservations and other American Indian and Alaska Native communities. The Indian Health program became a primary responsibility of the federal government as a result of the Transfer Act of 1954 (P.L. 83-568). The establishment of federal Indian Health Services is consistent with the authority Congress has exercised to regulate commerce with American Indian nations as provided for in the Constitution.

The federal responsibility for the provision of health care services for American Indians and Alaska Natives is established by treaties, legisla-

tion, executive orders and court decisions. The Indian Health Service is the federal agency authorized to fulfill this responsibility. The following are some key documents that form the legal basis for this unique relationship: 1921 Snyder Act, 25 U.S.C. 13; Transfer Act of August 5, 1954 (68 Stat. 674); Indian Self-Determination and Education Assistance Act (1975) P.L. 93-638 [which includes important amendments to the original act that established the current procedures for compacting and contracting including Indian Self-Determination Act Amendments of 1988-Title I, Title III (P.L. 100-472), Self-Determination Act Amendments of 1994, (P.L. 103-413), Technical Amendments Act of 1994 (P.L. 103-472)]; Indian Sanitation Facilities Act; Indian Health Care Improvement Act (1976) P.L. 94-437; Title II and III of the Public Health Service Act; Indian Health Service Budget for FY 1996 P.L. 104-134 (HR 3019); and finally, Indian Health Service Budget for FY 1997. The Code of Federal Regulations contains specific references to Indians in U.S. Code Title 25 "Indians," Chapter 18, "Indian Health Care, General Provisions."

POPULATION SERVED

While there is little doubt that the overall health status of Native Americans has substantially improved in the second half of the twentieth century, recent epidemiological data on Native Americans populations reveal several key features: (1) the rise in chronic diseases, especially diabetes; (2) the decline but persistence of infectious diseases, stabilizing at a level still higher than that of the non-Native population; (3) and the significance of multiple "social pathologies"—such as violence, unintentional injuries, and the ill effects of alcohol and drug abuse (Young 1996). Called "Western" diseases by Trowell and Burkitt (1981), the increase of these chronic diseases are also characteristic of other indigenous populations around the world that are undergoing rapid sociopolitical, cultural and economic changes. The long-term temporal changes in the pattern of health and disease

of a given population have been identified as epidemiological or health "transition."

The population also differs from the general U.S. population in that, IHS "beneficiaries" do not pay premiums for IHS coverage, and there are no deductibles or co-payments involved in receiving IHS-sponsored services, regardless of personal or family income level. Because IHS services are essentially free of charge to eligible persons, one might expect not to see significant differences in access to care by socio-economic status, as is the case for the general US population (Freeman et al., 1987; Rowland and Lyons, 1989).

Also while many in the general US population live in medically underserved rural or inner-city areas where few private medical providers are available (Lee 1991; Berk et.al 1983), IHS facilities and resources are targeted specifically in areas where IHS eligibles generally live, including many rural and sparsely populated areas. Thus IHS resources ideally can be distributed to areas where need is highest, without regard to other factors that affect the location decisions of private physicians.

Despite these above cited advantages, access to care is still limited to some IHS eligibles. Many of the areas inhabited by IHS eligibles are among the most sparsely populated areas in the United States, and residential areas are frequently spread across vast distances. Thus, although many IHS facilities are located directly in these areas, it is difficult for IHS providers to reach all eligible persons because transportation problems and long distances to medical providers are still a major barrier to care.

Further access limitations result from the fact that, unlike Medicaid and Medicare programs, IHS is not an entitlement program and its funds are obtained through an annual appropriation by the US Congress. Thus, short of a special supplemental appropriation (extremely rare) no additional funds are available for the year if additional resources for health services are needed. Consequently, access to care for IHS eligibles may be inhibited to the extent that resource limitations in some IHS service areas result in staff shortages even when IHS facilities are located in the area. Access may be particularly limited for Contract Health Services—

including expensive diagnostic and treatment services which may be delayed or denied to patients if funds are unavailable. At times, such services have been restricted to emergency cases because of budget constraint (Office of Technology Assessment, 1986). Given these resource limitations, some IHS eligibles may be compelled to obtain additional health care services from private providers. In fact, by law, IHS is required to be only a "residual" provider of health services (i.e. it provides only those services not available through other sources), even though it often serves as the primary or sole source of care for much of the eligible population. As a result of resource constraints, it is likely that IHS will depend increasingly on more effective use of and coordination with other sources of health care, at least in areas where these other sources exist. Such measures might include contracting with private health care organizations, such as health maintenance organizations (HMOs), to provide all health services to IHS eligibles in a given area. In other words, IHS would provide the financing for the health services, but would not be directly involved in service delivery. However, given the substantial variation in geographical location and socio-economic characteristics of the IHS population, it is doubtful whether complete privatization of IHS services could be implemented uniformly across the IHS service areas. While private providers could be used more effectively in some areas, it is likely that IHS direct care facilities would continue to be the sole or primary source of care for persons living in some of the most remote and sparsely populated areas of the United States, even for those Native American people who have private health insurance coverage.

Furthermore, IHS resources are not distributed evenly across all IHS service areas, since the method of distributing these resources has been based on historical funding patterns, rather than need (US General Accounting Office, 1991). This problem has been recently addressed through an all "needs based" formula in the resources allocation models to achieve greater parity in funding across IHS service areas.

Survey Description

PURPOSE

The survey sought the most valid assessment, which could be obtained in a four month time frame, of American Indian health management training needs and optimal training approaches. Given time constraints the survey necessarily comprised a modest sample of sites and Indian health care leaders. The approach chosen was a structured interview instrument combined with non-structured interviews administered on site in 41 locations throughout the country, involving 85 interviewees. The information was further enhanced by soliciting opinions by the 85 interviewees regarding management training needs for several key managers, in addition to those interviewed, in each organization. The resulting information provides a valuable resource of subjective opinion from key Indian health leaders, representing the major concentrations of Indian health programs, as well as some quantitative assessment of management training priorities.

DEVELOPMENT OF SURVEY

Before data collection began, intensive consultation with IHS leadership, tribal health directors, executives of intertribal organizations, and other Native American health care leaders was sought to gain preliminary insights into the key areas of management training and development needs. The consultation served several purposes including: (1) acquisition of relevant Indian Health Service documentation related to the objectives of this project; (2) a broad overview of management needs for both IHS sites and independent clinical sites; (3) advice on composition of an advisory group which could provide additional insights regarding data collection and interpretation; (4) advice on selection of existing clinical delivery sites for detailed analysis. From this initial consultation,

four regions of the United States, representing principal health care approaches for Native Americans, were selected. Sites were chosen to reflect representation of both regional and organizational/operational differences. Approximately one to two weeks were spent on site visits in each region. The perspectives of tribal authorities, clinical staff, organization management, and other Indian health care organizations in each region were targeted as respondents to the survey.

SURVEY INSTRUMENT

The survey instrument addresses five main topics, designed to gather views and recommendations from a variety of health program leaders including chief executives, physicians, nurses and other administrative staff. The five main topics are: priority management training needs; future management education or training methods and schedules best suited to the respondents personal needs; financial, staffing, and patient characteristics of the clinics, hospitals, or health program, as well as the organization's governance relationships; major current and potential organizational challenges or crises; and recent management training experiences and opinions on most effective management training programs. Additionally time was spent during each interview encouraging respondents to comment broadly on any management or management training issues of concern.

DATA DESCRIPTION

The survey was administered in two ways. Most respondents completed the survey as a structured interview in a personal meeting with the project investigator at the clinic/program site. Some respondents completed the survey independently without meeting the project

investigator. This very small group of independent respondents was necessary simply because of a few scheduling conflicts or unexpected emergencies.

Respondents were asked to speak both for themselves and other senior management staff as a way to include the most detailed information possible about clinics' staff structure and internal workings. Having respondents discuss their perceptions of management training needs for fellow colleagues also offers a sense of variations in internal management structures and needs.

In addition, preliminary results from the first 30 surveys conducted were presented to an Advisory Group comprising several regional health leaders from Wisconsin, Arizona, Montana, and Oregon in order to gather additional insights into the management training needs in Native American health care.

SITES AND SUBJECTS

Tribally operated and IHS clinics and health programs in five of the twelve IHS Service Areas were chosen as representative local sites of Indian health care systems nationally. Interviews, surveys, and site visits were conducted at 41 health program sites in Wisconsin, Minnesota, Michigan, Montana, Wyoming, Washington, Oregon, New Mexico, California and Arizona. The sites and survey respondents representing the four geographic regions (Midwest, Plains, Northwest, Southwest) are listed below:

TABLE 1	
Midwest (Minnesota, Wisconsin, Michigan):	
Forest County Potawatomi Tribe Health Center	Lac du Flambeau, Peter Christensen Health Center
Wisconsin Tribal Health Directors Association	Sokaogon Chippewa Health Center
Lac Vieux Desert Health Center	Menominee Tribal Clinic
Bemidji Area Office Indian Health Service	Lac Court Oreilles Community Health Center
Minnesota Tribal Health Directors	Minneapolis Indian Health Board
Grand Portage	Prairie Island Clinic
Plains (Montana, Wyoming):	
Indian Health Board of Billings	Ft. Belknap clinic and hospital
Rocky Boy tribal clinic	Northern Cheyenne clinic
Crow Hospital and clinic	Wind River Service Unit
Ft. Peck clinic	Service Unit Directors, Billings IHS Area
Northwest (Oregon, Washington):	
Warm Springs Indian Health Center	South Puget Inter-Tribal Planning Agency
Selvidge Health Center, Squaxin Tribal Clinic	Puyallup Tribal Clinic
Seattle Indian Health Board	NW Portland Indian Health Board
Southwest (New Mexico, Arizona, California):	
Kayenta PHS Indian Health Center	Chinle Comprehensive Health Care Facility
Northern Navajo Medical Center, Shiprock	Crownpoint Comprehensive Health Care Facility
Fort Defiance PHS Indian Hospital	Gallup Indian Medial Center
Whiteriver PHS Indian Hospital	Winslow PHS Indian Health Center
San Carlos PHS Indian Hospital	Phoenix Indian Medical Center
HuHuKam, Gila River Health Care Corporation	Fort Yuma PHS Indian Hospital
Parker PHS Indian Hospital	Keams Canyon Service Unit
Tuba City Indian Medical Center	

The five IHS Areas from which the study sites were selected are described in the Appendix.

SURVEY RESULTS

CHARACTERISTICS OF SURVEY SITES

The clinical sites surveyed varied substantially in size. Total annual budgets ranged from $427,000 to $44.8 million, as illustrated in the following chart.

Staff complement ranged from 11 to 750 and averaged 189. Annual patient volumes ranged from 2000 to 215,000 and averaged 62000.

Of the 33 sites surveyed 18 are IHS operated and 11 tribally operated (4 are operated by a combination of IHS and tribes or some other variant).
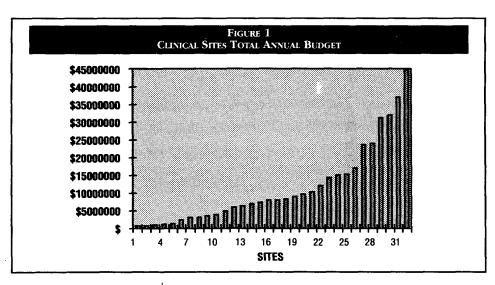
CURRENT MANAGEMENT RESOURCES

There exists little published information about the management needs and current resources of tribal clinics. This is consistent with the fact that there exist limited detailed demographic information about the health situation of contemporary American Indians in general. American Indians are a relatively small proportion of the total US population; their residences tend to be either highly clustered in a small number of geographic areas or they are very small minority populations in larger population geographic areas; they have experienced relatively high rates of marital exogamy, resulting in ambiguity about definition of "American Indian;" and over time and across data collection systems, there have been shifts in definition (see Sandefur et. al. 1996).

This project, seeks to identify the trends in management training needs of Native American clinics across the country by focusing principally on the needs perceived by sample clinic leaders currently working in the field. It attempts to capture the diversity of tribal health clinics and their management needs from local perspectives in a manner which will provide guidance for priorities in new management training programs nationally.

ANALYSIS OF CURRENT MANAGEMENT TRAINING RESOURCES: AVAILABILITY, RELEVANCE, QUALITY

It is difficult to inventory the kinds of management training programs already available to clinical program staff. Programs vary significantly between regions, as well as tribes, and are often reliant on the availability of and access to local educational facilities as well as

FIGURE 1
CLINICAL SITES TOTAL ANNUAL BUDGET

other factors such as staffs' personal interests and goals. Since a uniform listing of such programs is not in existence respondents were asked to list the management training programs, workshops, and skills development sessions they attended during the past year, including the topic, length of program, organization providing the training, relevance of topic, and quality of experience. Respondents were also asked to rate the relevance and quality on a five point scale. Most common management training program topics included (1) training in JCAHO accreditation; (2) advanced managed care strategies; (3) budget appropriations; (4) legal issues in medical care; and (5) risk management and leadership. Of the 31 cited programs 10 were offered by IHS, 7 by JCAHO, and 16 by local universities or management firms. Respondents spent an average of 4.6 days on management training each year and consistently rated IHS and JCAHO programs as being of average to extremely high relevance and quality. Only some more locally run programs (by private firms) earned extremely low quality or relevance ratings.

PRIORITY MANAGEMENT TRAINING NEEDS

Tribal Health Directors, Chief Medical Officers, Nursing Supervisors, and other administrative staff were shown a list of 48 management training topics. Respondents were asked to select the management training topics/skills which would most benefit their current roles and asked to narrow this list by rank ordering their top ten choices. Additionally each respondent was asked to indicate the top 10 training priority topics/skills for other members of the leadership staff in their clinic or health program.

The results were scored by assigning 10 points for items ranked first, 9 points for those ranked second, and continuing assigning scores for all ten ranked items to score value "1" for rank order 10.

Analysis of all respondents in the aggregate revealed the following priorities.

TABLE 2 MANAGEMENT TRAINING PRIORITIES, AGGREGATED ALL CLINIC ADMINISTRATORS: CEOs, MEDICAL DIRECTORS, NURSING DIRECTORS, OTHER ADMINISTRATORS		
Rank	Mean Score	Training
1	3.49	Managed care trends and effect on programs, particularly Contract Health Services
2	3.19	Board and manager education for effective, collaborative relationships and communication (tribal health boards, tribal councils, other tribal governance bodies, etc.)
3	3.04	Continuous quality improvement/total quality management for the organization
4	2.87	Creating customer orientation in services delivery and assessing customer satisfaction
5	2.67	Management of conflict among staff (e.g. communication and interpersonal relations)
6	2.44	Contract negotiation for clinical services (e.g. HMO contracts or discounts for referral services)
7	2.34	Methods for recruitment and retention of staff including processes involved: contact of candidates, matching staff to sites, contracts
8	2.26	Methods of strategic planning
9	2.12	Budget planning
10	2.08	Quality assurance for clinical services

Analysis of responses provided by chief executive officers (tribal health directors, service unit directors or equivalent roles) revealed the following priorities.

Rank	Mean Score	Training
		TABLE 3 **MANAGEMENT TRAINING PRIORITIES** **CHIEF EXECUTIVES (TRIBAL HEALTH DIRECTORS AND SERVICE UNIT DIRECTORS OR EQUIVALENT)**
1	4.67	Managed care trends and effect on programs, particularly Contract Health Services
2	3.64	Board and manager education for effective, collaborative relationships and communication (tribal health boards, tribal councils, other tribal governance bodies, etc.)
3	3.25	Management of conflict among staff (e.g. communication and interpersonal relations)
4	3.22	Creating customer orientation in services delivery and assessing customer satisfaction
5	3.03	Contract negotiation for clinical services (e.g. HMO contracts or discounts for referral services)
6	2.58	Methods of strategic planning
7	2.25	Continuous quality improvement/total quality management for the organization
8	2.14	Methods for recruitment and retention of staff including processes involved: contact of candidates, matching staff to sites, contracts
9	2.14	Approaches to staff stress management and burnout prevention
10	1.89	Methods for billing and collections from Medicaid and other funding sources

Analysis of responses provided by medical directors revealed the following priorities.

Rank	Mean Score	Training
		TABLE 4 **MANAGEMENT TRAINING PRIORITIES** **MEDICAL DIRECTORS**
1	4.37	Board and manager education for effective, collaborative relationships and communication (tribal health boards, tribal councils, other tribal governance bodies, etc.)
2	3.42	Methods for recruitment and retention of staff including processes involved: contact of candidates, matching staff to sites, contracts
3	3.16	Creating customer orientation in services delivery and assessing customer satisfaction
4	3.00	Managed care trends and effect on programs, particularly Contract Health Services
5	2.95	Quality assurance for clinical services
6	2.74	Contract negotiation for clinical services (e.g. HMO contracts or discounts for referral services)
7	2.68	Continuous quality improvement/total quality management for the organization
8	2.32	Use of information systems for clinical services (e.g. "Grateful Med" and other reference sources, continuing education, consultation, etc)
9	2.11	Design and acquisition of information systems
10	2.05	Approaches to staff education\inservice in clinical area (e.g. continuing medical and nursing education)

Analysis of responses provided by nursing directors revealed the following priorities.
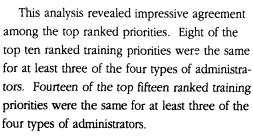
		TABLE 5 MANAGEMENT TRAINING PRIORITIES NURSING DIRECTORS
Rank	**Mean Score**	**Training**
1	5.33	Budget planning
2	4.67	Budget management
3	4.22	Continuous quality improvement/total quality management for the organization
4	4.11	Creating customer orientation in services delivery and assessing customer satisfaction
5	3.11	Methods of evaluating staff performance
6	2.78	Methods of strategic planning
7	2.67	Quality assurance for clinical services
8	2.56	Use of information systems for clinical services (e.g. "Grateful Med" and other reference sources, continuing education, consultation, etc)
9	2.56	Management of conflict among staff (e.g. communication and interpersonal relations)
10	2.33	Development and implementation of personnel policies

Analysis of responses provided by other administrators (excluding CEOs, medical directors, and nursing directors) revealed the following priorities.

Rank	Mean Score	Training
		TABLE 6
		MANAGEMENT TRAINING PRIORITIES
		OTHER ADMINISTRATORS
1	4.19	Continuous quality improvement/total quality management for the organization
2	2.62	Managed care trends and effect on programs, particularly Contract Health Services
3	2.48	Budget planning
4	2.33	Board and manager education for effective, collaborative relationships and communication (tribal health boards, tribal councils, other tribal governance bodies, etc.)
5	2.33	Methods of strategic planning
6	2.29	Management of conflict among staff (e.g. communication and interpersonal relations)
7	2.24	Methods for recruitment and retention of staff including processes involved: contact of candidates, matching staff to sites, contracts
8	2.19	Contract negotiation for clinical services (e.g. HMO contracts or discounts for referral services)
9	2.10	Methods for billing and collections from Medicaid and other funding sources
10	1.95	Contract negotiation for business and support services

Comparison of training priorities among the four types of administrators (CEOs, medical directors, nursing directors, and others) provides the following analysis.

TABLE 7 MANAGEMENT TRAINING PRIORITIES COMPARISON OF CEO's, MEDICAL DIRECTORS, NURSING DIRECTORS, AND OTHER ADMINISTRATORS				
RANK ORDER				**TRAINING**
TRAINING RANKED IN TOP 10 BY CEO'S				
CEO	Med. Dir.	Nurse Dir.	Other Adm.	
1	4	11	2	Managed care trends and effect on programs, particularly Contract Health Services
2	1	20	4	Board and manager education for effective, collaborative relationships and communication (tribal health boards, tribal councils, other tribal governance bodies, etc.)
3	11	9	6	Management of conflict among staff (e.g. communication and interpersonal relations)
4	3	4	16	Creating customer orientation in services delivery and assessing customer satisfaction
5	6	40	8	Contract negotiation for clinical services (e.g. HMO contracts or discounts for referral services)
6	19	6	5	Methods of strategic planning
7	7	3	1	Continuous quality improvement/total quality management for the organization
8	2	18	7	Methods for recruitment and retention of staff including processes involved: contact of candidates, matching staff to sites, contracts
9	12	12	38	Approaches to staff stress management and burnout prevention
10	13	23	9	Methods for billing and collections from Medicaid and other funding sources
TRAINING RANKED IN TOP 10 BY MEDICAL DIRECTORS, NURSING DIRECTORS OR OTHER ADMINISTRATORS BUT NOT RANKED IN TOP 10 BY CEO's				
11	9	27	15	Design and acquisition of information systems
12	5	7	13	Quality assurance for clinical services
16	14	1	3	Budget planning
17	18	2	11	Budget management
18	16	5	32	Methods of evaluating staff performance
33	45	29	10	Contract negotiation for business and support services
34	23	10	34	Development and implementation of personnel policies
36	8	8	21	Use of information systems for clinical services (e.g. "Grateful Med" and other reference sources, continuing education, consultation, etc)
38	10	13	15	Approaches to staff education\inservice in clinical area (e.g. continuing medical and nursing education)

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This analysis revealed impressive agreement among the top ranked priorities. Eight of the top ten ranked training priorities were the same for at least three of the four types of administrators. Fourteen of the top fifteen ranked training priorities were the same for at least three of the four types of administrators.

Four training topics were ranked in the top fifteen by all four administrative types, and two were ranked in the top 10 by all four:

Top 10 ranked by all:
- Continuous quality improvement/total quality management for the organization
- Creating customer orientation in services delivery and assessing customer satisfaction

Top 15 ranked by all (in addition to the above two topics):
- Managed care trends and effect on programs, particularly Contract Health Services
- Management of conflict among staff (e.g. communication and interpersonal relations)

However there were some glaring disagreements. Two topics ranked in the top ten by CEOs, medical directors, and other administrators were ranked 20th and 40th by nursing directors:

- Board and manager education for effective, collaborative relationships and communication (tribal health boards, tribal councils, other tribal governance bodies, etc.)
- Contract negotiation for clinical services (e.g. HMO contracts or discounts for referral services)

A topic ranked eighth by the clinical leaderships (medical directors and nursing directors) was ranked very low by CEOs and other administrators (36th and 21st respectively):

Use of information systems for clinical services (e.g. "Grateful Med" and other

reference sources, continuing education, consultation, etc).

However, the level of agreement is impressive among the top 15 ranked topics, and indicates the feasibility of training the leadership team primarily as a unified group, combined with modest time devoted to specialized training sessions by disciplinary specialty.

PREFERRED TRAINING APPROACHES

Schedule

Having identified the kinds of management training programs currently available additional information was sought from respondents on the best ways to create an educational program which would address management training needs. Questions asked for the ways in which a new educational program addressing management training needs in Native American health care could be topically relevant and appropriately scheduled and delivered. In answering the questions, respondents were asked to assume that the potential management training program would provide educational experiences specifically relevant to their needs, would begin within the year, occur during a one year period and would pose no cost to the individual or organization (except for the respondents time away from work during the training program).

Respondents were first asked to assess how much total time during a year long program they would personally devote to the experience, and how much time they thought others in their organization would devote, assuming no cost to the individual or organization. For the aggregate number of respondents, 16 (15%) said they could commit to a one-week session during the year, 40 (38%) selected two weeks, 21 (20%) selected three weeks, 14 (12%) selected four weeks, 6 (6%) selected five weeks and 9 (10%) selected six weeks.

These numbers break down by staff position in the following ways: Of the 27 CEO/Tribal Health Director/Service Unit Director inter-

viewed, 4 chose one week sessions, 10 chose two week sessions, five chose three week sessions, six chose four week sessions, 1 chose a five week session and 1 chose six weeks. Of the 25 Medical Directors/Chief Medical Officers who responded, six chose one week sessions, 9 chose two week sessions, 6 chose three week sessions, 2 chose four week sessions, and 2 respondents selected five and six week sessions respectively. Of the 25 Director of Nursing/Nursing Supervisors interviewed 2 chose one week sessions, 11 chose two week sessions, 5 chose 3 week sessions, 4 chose four week sessions, 1 chose a five week session and two chose a six week session. The remaining 27 respondents who fulfill other administrative roles 4 chose one week sessions, 10 chose two week sessions, 5 chose three week sessions, 2 chose four week sessions, 2 chose five week sessions and 4 respondents chose six weeks. No respondents expressed interest in a program which would take six or more weeks.

In addition to suggesting the total time individuals were willing to devote to management training experience, respondents were also asked to divide the time among the types of sessions. Respondents said they could commit training time totaling an average of 2.5 weeks in the coming year. They indicated an interest in dividing this total time among the three scheduling approaches as follows:

TABLE 8 SESSION TYPE	
% Time	Session Type
69%	Week-long sessions with cohort (requiring travel)
21%	One-Day sessions with local cohort (requiring only limited travel)
11%	Two hour sessions by teleconference at the work site

Barriers

Respondents were asked a series of questions which focused specifically on the most important factors affecting their ability to seek additional education or training, as well as the importance of their management education leading to a certificate or degree.

The most important barriers affecting respondents' ability to seek additional training were: (1) funding/cost; (2) time away from work; (3) lack of staff back-up during absences; (4) child care. "Time away from work" and "lack of staff backup during absences" were most often cited by respondents followed by "funding." Perhaps the most important finding from this question was respondents indication that the factors affecting their ability to seek additional training were complex and multiple. Such practical concerns were also reflected in the fact that most respondents indicated that it was of little importance that their management education led to a certificate or a degree, although some emphasized the importance of degree.

IHS BENEFITS, SHORTCOMINGS, RECOMMENDED CHANGES

Respondents ranked the benefits they received from their IHS Area Offices and Headquarters. Key benefits were (1) funding; (2) technical support; and (3) advocacy in the legislative arena. While every respondent cited funding as the most important benefit granted, affiliation with IHS also offered clinical programs substantial administrative support. For example, IHS was routinely credited with providing objective technical assistance, general consultation, organized recruiting, epidemiological data, and public health/preventive health guidelines. Valued technical assistance included a broad range of topics from administrative and budget directives to accounting guidelines and computer assistance.

When asked to list the three most significant problems or concerns individual organizations have in relationship to IHS Area and Headquarters, respondents cited (1) inade-

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quacy of funding; (2) inaccessible and slow bureaucracy; and (3) communication problems and lack of trust in the organization. Interestingly, "funding" and "inadequacy of funding" were cited as the top ranked benefit and greatest problem posed by IHS Area and Headquarters relationships. One respondent described this dual characterization as "one of the ways IHS works for and against us at the same time." Funding problems with IHS were further specified in this section as lacking most severely in Contract Health Services. As one respondent described, "Fourteen years with this arrangement and we have made no progress on budget projections...we annually go through fourth quarter shut down of procurement which disrupts [the operation of the clinic]." Bureaucratic processes were also routinely described as "autocratic" and "too slow." As summarized by one respondent, "IHS provides intertribal rules which may work well for office bureaucrats but not for workers providing services in the field." Ineffective bureaucratic processes were also pointed to as the cause for local clinics' management and personnel problems, procurement systems, and poor computer service communication. It is important to point out that while complaints about bureaucratic procedures were uniformly repeated, such processes have different impacts for different clinics depending on their demographic, geographic, economic and political standing. For example, as one respondent explained, "IHS does not like urban programs because they are seen too much as a bureaucratic problem for the funds involved."

Having specified both sides of their relationships to IHS, respondents were asked to consider the three changes in IHS that would result in the most benefit to individual local health programs. Respondents' most frequently cited changes were (1) decentralization; (2) local (facility) control of budget authority; and (3) increased training and experience of senior local management (with an emphasis on improved training for clinical administrators, particularly physicians with administrative duties). Suggestions ranged from "changing IHS to only a support organization," to "an entire restructuring of IHS with an emphasis on more local economic and political control." Furthermore, it was routinely suggested that "decentralizing' and "localizing" IHS could potentially lead to better patient access to specialty care; individual facility improvements; more latitude in budget planning and hiring at the local level; the growth of billable service departments; and a decrease in tribal interference.

CURRENT MAJOR CHALLENGES

Respondents were asked to cite the five most important challenges or crises facing their health programs and to assess these challenges with regard to their management training needs. Most common responses involved concerns about inadequate funding, described by one individual as "so unstable it paralyzes budget planning and staff morale." Related to the challenge of inadequate funding was the problem of out-dated equipment, facilities, and programs (i.e., including mental health care, prevention programs, and improved training in information management for the "lowest and highest levels of professional staff") as well as the reality of increasing tribal population growth. Summed up by one individual, the foremost challenge facing clinics are simply "limited clinical space and an insatiable demand for service." Inadequate funding was translated most starkly by one individual as "insufficient professional, nursing and administrative staff who need to learn how to make do with less."

Compacting or contracting by the tribe, as well as the recruitment and retention of professional staff were also repeatedly noted. As one individual explained, "tribal directors need ways to train native employees how to be managers so they can replace non-Indians who quit or leave." "We need to maximize the resources to deal with the rapidly increasing patient load and to retain clinical staff that is experienced," explained another respondent. The double-bind, however, is the longer a staff member

stays at one facility, the greater the likelihood that staff member will be "elevated" into administrative work. As one respondent explained, "trying to serve both masters means one will be underserved, and since most clinical staffs' sympathies lie with direct patient care they perform incompetently as administrators."

For example, a clinic staff member becomes more useful and effective as he/she acquires familiarity within a given community. A clinician that "knows a community's values and idiosyncrasies and disease patterns is both more receptive and more efficient." As one individual explained, these clinicians are not the staff that you want to move to administrative roles and thus take out of the clinic and out of contact with their patients for whom they alone can provide the best "continuity of care.

Concerns were often voiced regarding the health programs' roles in "the big picture" changes, particularly, Medicare, Medicaid and larger welfare reforms at the national and state level. As one respondent described, "health care is a business which is rapidly changing and administrators will need continuous updates in order to plan to meet changes as well as remain physically sound." In light of these changes, respondents repeatedly suggested that Native American programs need to have-less regulation and policies that discriminate "among and between tribes." Programs need to be more inclusive and less "top down" or bureaucratic. One respondent suggested that a training program which brought "our leaders in contact with HMO industry leaders who are doing excellent work in implementing/improving managed care in a way that benefits the satisfaction and health status of the enrolled" would meet this challenge head on.

In addition to the aforementioned challenges mounted from "the outside" (including geographical circumstances such as limited transportation services and housing for both clinical staff and patients) many respondents cited problems with conflict resolution among staff as an on-going challenge. Low worker morale and poor customer relations were also consistently brought up as a debilitating reality to clinics' daily operation. Such problems, one respondent explained, arise from the reality that most clinical staff have little interaction with the population they serve outside of professional capacities. Moreover, it was explained, many tensions between clinical staff and personnel resulted from conflicts between Native and non-Native staff, aggravated in part by "an ongoing lack of advancement of Native Americans in key positions of decision making and power." As one individual suggested, "I would recommend a training program on strategic planning with the importance of 'change' so all supervisors and managers are forced to effectively plan, organize and lead through consensus and cooperation." Moreover, "management training should focus on the different concepts, styles related to working with Native Americans, that is, management training for Native American managers should be customized to include traditional approaches to management as practiced by tribes."

Finally, under the rubric of "cultural awareness," many respondents described concerns with staff and patient morale, an aging patient population, and the difficulty in providing preventive health education sensitive to the unique cultural needs of their patient populations. Summarized by one individual as "acquired helplessness syndrome" respondents repeatedly included remarks such as "the devaluation of human life" among the major challenges facing clinics. One respondent said, "Somehow the communities being served must assume leadership roles in acquiring the special people and facilities they feel can serve their needs and wants."

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DISCUSSION

Acquisition of relevant management training is a very high priority for the leadership of American Indian health care organizations. However substantial constraints create barriers to accessing appropriate training. Management and clinical responsibilities combined with limited staffing prevent extended periods away from the work site. Turnover, particularly among medical directors, accentuates the need for training but also undermines the justification for investment by the health program in individual training experiences. Work site training programs, using distance educational methods or on site faculty, have clear scheduling advantages which can overcome the problems of time away from work responsibilities. However the disadvantage of frequent interruptions at the work site clearly counterbalances the advantages.

Among health program leaders interviewed the prevailing opinions regarding training approaches can be summarized as follows:

1) Training off site has major advantages, particularly for the senior leadership.

2) One or two day periods away from work can be readily accomplished with adequate prior planning.

3) Dedicated periods up to one week away have major advantages in quality of educational experience but cannot be tolerated more than two to four times per year and must be scheduled well in advance.

4) Distance educational methods typically suffer from inadequate personal interaction with faculty, an element considered quite important by most Indian health managers.

5) Interaction with colleagues from other Indian health programs has inherent educational value, and should be an integral component of training programs.

6) Mid-level managers such as department chiefs have significant management training needs, particularly in basic personnel management and other technical skills, and thus a training program should address the full range of program leaders—senior and mid-level.

7) A team approach, aimed at the senior management team of a given health program, is much more desirable and potentially effective than programs designed only for individuals.

8) Faculty effectiveness depends both upon understanding the unique aspects of Indian health care and its management and also academic expertise in management disciplines. The ideal faculty profile is someone who is a senior faculty member in an established university health management program who has also spent part of a professional career working as a leader in Indian health care.

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RECOMMENDATIONS

A health management training program responsive to the needs of American Indian health care systems should have the following characteristics:

1) Principal emphasis on training the entire team of five or six senior managers in each health care organization;

2) Week long retreats away from the work site a few times during the year;

3) One to two day retreats away from the work site frequently but in a nearby location easily accessible with limited travel;

4) Some on site training particularly for the mid-level management group (department chairs for example);

5) Advice, critique, and continual input on design, implementation and ongoing evaluation of the program by an advisory group comprising experienced American Indian health program leaders;

6) Faculty team representing both university level academic expertise and Indian health care experience. This characteristic could be most readily accomplished through team teaching by university health management faculty partnered with leading, practicing Indian health system managers; and

7) Continuity of curriculum characterized by planned, sequential relationships of topics and experiences from one session to the next, as opposed to episodic, unrelated training sessions.

References

Berk, M. L, A.B. Bernstein, A.K Taylor, "The Use and Availability of Medical Care in Health Manpower Shortage Areas," Inquiry, 20(4): 369-380, 1983.

Gribble, J.N., and S. Preston, eds. *The Epidemiological Transition: Policy and Planning Implications for Developing Countries.* National Academy Press. Washington, D.C. 1993.

Freeman, H.E., R.J. Blendon, L.H. Aiken, S. Sudman, C.F. Mullinix, C.R. Corey, "Americans Report on Their Access to Healthcare," *Health Affairs*, 6(2): 6-18, 1987.

Indian Health Service. *Regional Differences in Indian Health.* Rockville, M.D. 1994

Indian Health Design Team, "Design for a New IHS," November, 1995

Lee, R.C., Current Approaches to Shortage Area Designation," *Journal of Rural Health*, 7(4): 437-450,1991.

Office of Technology Assessment, U.S. Congress, *Indian Health Care* (OTA-H-290), Washington, D.C.: U.S. Government Printing Office.

Rowland, D., B. Lyons, "Triple Jeopardy: Rural, Poor, and Uninsured," *Health Services Research*, 23(6): 975-1004, 1989.

Olshansky, S.J., and A.B. Ault. The Fourth Stage of the Epidemiologic Transition: The Age of Delayed Degenerative Diseases. Milbank Quarterly 64:355-391. 1986.

Omran, A.R. The Epidemiological Transition: A Theory of the Epidemiology of Population Change. Milbank Memorial Fund Quarterly 49:509-538.

Sandefur, Gary D., Ronald R. Rindfuss, and Barney Cohen, Editors. *Changing Numbers, Changing Needs: American Indian Demography and Public Health.* Committee on Population, Commission on Behavioral and Social Sciences and Education, National research Council. National Academy Press. Washington, D.C. 1996.

Trowell, H.C., and D.P. Burkitt, eds. Western Diseases: Their Emergence and Prevention. Cambridge, MA: Harvard University Press. 1981.

U.S. General Accounting Office, *Indian Health Service: Funding Based on Historical Patterns, Not Need,.* (GAO/HRD-91/5), Washington, D.C., 1991

Young, T.K., C.D. Schraer, E.V. Shubnikoff, E.J. Szathmary, and Y.P. Nikitin. Prevalence of Diagnosed Diabetes in Circumpolar Indigenous Populations. International Journal of Epidemiology 21: 730-736. 1992.

Urban Indian Health Care 1994— Partnership: A New Vision for American Indian/Alaskan Native Health (Report on the Urban Indian Health Care 1994 Forum), Committee of Urban Program Directors and IHS personnel, San Diego, California. August 1994.

Appendix
IHS Areas Included in Survey

The Bemidji IHS Area for which the central office is located in Bemidji, Minnesota, oversees comprehensive health care services for approximately 118,000 Indian people. It administers three Service Units and 29 federally recognized tribal programs. Five urban programs also contract with the Bemidji Area Office for the provision of health services to approximately 59,000 Indian people in Minneapolis, Green Bay, Detroit, and Chicago. The Bemidji area includes Minnesota, Wisconsin, and Michigan. Though the primary population belongs to the Chippewa Tribe, others served are members of the Sioux, Ottawa, Potawatomi, Menominee, Winnebago, Oneida and Stockbridge-Munsee Tribes. The Bemidji area is unique in that 60 percent of its annual funding allocation is distributed among the 29 tribes through contacts. Each tribe contracts with IHS for health services ranging from outreach and contract health care to fully comprehensive health delivery systems, including environmental health services and sanitation facilities, and health facilities constructions. The major role of the IHS Area Office staff and those located at field offices in Rhinelander, Wisconsin, and Kincheloe, Michigan, is to provide technical assistance to IHS and tribal contractors.

The Billings IHS Area, for which the central office is in Billings, Montana, oversees the provision of comprehensive health services to approximately 52,000 Indian people on seven reservations in Montana and Wyoming. In Montana, there are Service Units on each of the following reservations: Blackfeet, Crow, Fort Belknap, Flathead, Fort Peck, Northern Cheyenne and Rocky Boy. In Wyoming, a service unit is located in the Wind River Reservation.

The Portland Areas IHS Office in Portland, Oregon, oversees the delivery of health care to approximately 120,000 Indian people who reside on 40 reservations in Idaho, Oregon, and Washington, as well as Portland, Seattle and Spokane urban areas. The Portland Area IHS operates 12 health centers and 4 health stations, but there are no IHS or tribal hospitals located in the area. Only ambulatory care health centers are available at the Service Units so patients are usually hospitalized at nearby community hospitals. Many locations run specialty clinics staffed by private specialists to supplement the family practice orientation of the IHS/tribal staff physicians. More than 300,000 direct ambulatory visits were provided by IHS, tribal and urban clinics in the Portland Area in FY 1990. An increasing numbers of health facilities throughout Portland Area are being operated by tribes.

The Navajo Area IHS Office, located in Window Rock, Arizona, administers numerous clinics, health centers and hospitals, providing heath care to 201,000 members of the Navajo Nation, the largest Indian tribe in the United States. The Navajo reservation is the largest in America, encompassing more than 25,516 square miles in northern Arizona, western New Mexico and southern Utah, with three satellite communities in central New Mexico. (The Navajo Area coordinates with both the Phoenix and Albuquerque IHS Area Offices for the delivery of health services to the Navajo, Hopi and Zuni Reservations because these reservations are close to each other.) Comprehensive health care is provided to the Navajo people through impatient, outpatient, contract and community heath programs centered around 6 hospitals, 7 health centers and 12 health stations. School clinics and Navajo tribal health programs also serve the community. The six hospitals range in size from 39 beds in Crownpoint, New Mexico, to 112 beds at the Gallup Indian Medical Center in Gallup, New Mexico. Health centers operate full-time clinics, some of which provide emergency services. Some smaller communities have health stations

that operate only part time. A major portion of the Navajo nation health care delivery system is sponsored by the Navajo Tribe itself which operates the Navajo Department of Health (NDOH) created in 1977. The NDOH also provides a variety of health-related services including nutrition, substance abuse programs, community health representatives, and emergency medical services.

The Phoenix Area IHS Office in Phoenix Arizona, oversees the delivery of health care to approximately 105,000 Indian people in Arizona, Nevada and Utah. The Phoenix Area Office operates primarily as an administrative center for ten Service Units, many of which include several health centers or hospitals which serve more than 40 tribal groups in the region. The Area has nine IHS hospitals: Phoenix Indian Medical Center and eight reservation hospitals in Fort Yuma, Owyhee, Keams Canyon, San Carlos, White River, Parker, Sacaton and Shurz. In addition, IHS operates seven health centers and six health stations. A growing number of health facilities throughout the Phoenix Area are tribally operated.

2.5

MEDICAID AND INDIAN POPULATIONS: ISSUES AND CHALLENGES

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Introduction

One of the great paradoxes of Medicaid is that despite its vital role in American health care financing, the program remains elusive to millions of individuals in great need of assistance. Nowhere is the paradoxical nature of Medicaid more in evidence than in the case of the 2.3 million American Indians and Alaskan Natives,[1] one of the poorest and most pervasively uninsured groups of individuals.[2] All of the traditional reasons that help explain Medicaid's failure to reach poor Americans generally (e.g., restrictive categorical and financial eligibility standards; locational, procedural, and administrative barriers to enrollment) apply to coverage of Indians. In addition, there is reason to believe that Medicaid participation among Indians may be lower than that of other low income populations[3] and that their disproportionately low rate of enrollment arises from certain aspects of the program which fall with greater force on Indians, particularly those who live on reservations.

Medicaid's low rate of penetration into the Indian population has a number of both direct and indirect consequences. First, given the strong relationship between health insurance status and use of health services,[4] limited coverage of Indian populations may further exacerbate their already reduced access to health care, most notably specialty care services not found through the programs of the Indian Health Service which emphasize primary care. Second, the low participation rate in Medicaid among Indians further reduces the already inadequate resources available to Indian health programs to develop or expand existing services. Discretionary appropriation levels for Indian health programs are well below the level of need[5] of Indian Health Service, tribes and tribal organizations, and other health care providers serving Indian populations. Third, low Medicaid participation in turn impedes the transformation of Indian health programs to managed care, a health care delivery arrangement which is designed exclusively for insured persons.[6] With only limited access to insurance revenues, it is difficult for Indian health programs financially to accommodate the further discounting of fees that characterizes network participation.[7]

This paper explores issues and challenges in the coverage of Indians. It begins with an overview of key Medicaid coverage elements and rules on enrollment and assesses their potential impact on Indian populations. Part 2 examines federal and state efforts over the past 20 years to improve Medicaid's performance for Indian populations. Part 3 concludes with suggestions for further areas of study and action.

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1   Throughout this paper the term "Indian" should be understood to refer to both the American Indian and Alaskan Native populations.

2   There are almost no data on the insurance status of the AI/AN population. Those data which do exist suggest that Indian populations may be the most uninsured of all Americans, with relatively low rates of Medicare and Medicaid enrollment. See AHCPR, 1991. "National Medical Expenditure Survey: Findings from the Survey of American Indians and Alaskan Natives" Research Findings 8:5 (HHS, Fall, 1991).

3   The NMES data on Indian participation suggest that in 1987, 11 percent of the AI/AN population had Medicaid coverage while only about one-quarter had employer coverage.

4   Karen Davis and Diane Rowland, 1983. "Uninsured and Underserved" Securing Access to Health Care (President's Commission for the Study of Ethics in Biomedical and Behavioral Research, Washington D.C. 1983) Vol. 4.

5   While all persons who meet the definition of "Indian" (as well as certain other persons) are entitled to receive care from IHS programs, the programs themselves are decidedly not structured as legal entitlements in the financial sense of the word. Funding is neither mandatory nor open-ended as in the case of Medicare and Medicaid but is instead subject to the annual appropriations process and limited in the aggregate.

6   Sara Rosenbaum and Ann Zuvekas, 1996. Integrating Indian Health Programs Into Medicaid Managed Care Systems: A Roundtable Sponsored by the Indian Health Service (Rockville, Md., March 13-14, 1996) (Prepared for the Indian Health Service under Contract No. 95-21).

7   Rand Rosenblatt, Sylvia Law and Sara Rosenbaum, 1997. Law and the American Health Care System (Foundation Press, Westbury, N.Y.) Ch. 2(J). It is also important to note that federal law prohibits IHS-operated programs from entering into managed care financial risk arrangements under the Anti-Deficiency Act. However, the Office of the General Counsel has interpreted financial risk arrangements to include capitated payment arrangements but not discounted fee-for-service contracts. Rosenbaum and Zuvekas, op. cit.

An Overview of Medicaid's Key Coverage Elements and Their Potential Impact on Indian Populations: Eligibility and Enrollment

ELIGIBILITY

It is difficult to overstate Medicaid's complexity for the poor. Medicaid eligibility rests on a series of criteria related to family composition, health status, age, income, citizenship and residency, any one of which can disqualify an otherwise eligible person.[8] The welfare reform legislation enacted in 1996 promises to complicate matters further by bifurcating Medicaid and cash welfare eligibility standards in the case of families with dependant children and by vastly increasing the number of individuals for whom eligibility redeterminations must be completed in light of changes in underlying cash welfare programs.[9]

Categorical eligibility

In order to qualify for Medicaid an individual or family must fall into one of the categories of persons for whom coverage is potentially available under federal law.[10] The principal Medicaid eligibility categories are displayed in Table 1. As with other populations, low income Indian families with children in which neither parent is absent, incapacitated or unemployed cannot qualify for coverage, although pregnant women and children in such families may be able to qualify under the "low income

pregnant women" or "low income children" categories. Similarly, non-disabled individual Indian adults and childless couples would not be able to qualify for coverage.

TABLE 1
PRINCIPAL MEDICAID COVERAGE CATEGORIES
Families with dependent children (i.e., in which one parent is absent, incapacitated or unemployed)
Poverty level pregnant women
Poverty level children
Children and adults with disabilities, as defined under the Social Security Act
Elderly persons

There does not appear to be any study which has examined the degree to which Indian population characteristics fall within recognized Medicaid eligibility categories (i.e., the proportion of the population which lives in single parent households, or the proportion of the population who can be expected to meet Social Security-level disability standards[11]) . However, because the Indian population is young, one would expect high rates of

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8 The eligibility criteria are also complex enough so that it is easy for a state agency to erroneously deny coverage to an eligible individual or family. It is worth noting, perhaps, that financial penalties attach to state agencies only in the case of wrongful approval of coverage, not wrongful denial. This peculiar definition of "error" may serve to further encourage the denial of assistance to individuals whose eligibility may be in doubt.

9 Sara Rosenbaum and Julie Darnell, "An Analysis of the Effects of Welfare Reform on Medicaid" (Prepared for the Kaiser Commission on the Future of Medicaid, September, 1996" [Revised and updated, February, 1997].

10 Some states extend coverage to individuals who do not fall into federal categorical eligibility groups. Unless the coverage is extended as part of a Section 1115 demonstration, a state may not qualify for federal financial assistance for such coverage. Congressional Research Service, 1993. Medicaid Source Book (Washington D.C.)

11 Unlike the definition of disability which is used under federal civil rights laws (and which turns on the presence of impairments that affect daily functioning) , the Social Security Act uses a disability definition which restricts a finding of disability to individuals who are virtually to engage in any substantial gainful activity. Recent amendments to the Social Security Act further restrict the definition of disability for both children and adults. See Rosenbaum and Darnell, op.cit.

Medicaid coverage among Indian children and pregnant women in light of their extensive poverty.

Financial eligibility

Perhaps the most difficult yet least understood aspect of Medicaid eligibility is the body of rules which apply to financial eligibility (both income and resources). In a number of ways these financial rules can work particular hardship among poor, disproportionately rural populations such as Indians. Moreover, certain aspects of Indians' existence may raise unique issues which affect Medicaid eligibility.

The first hurdle which applicants must negotiate is income eligibility. In order to qualify for Medicaid, applicants must have (or else spend down to) a low monthly income level. Income eligibility is determined on the basis of monthly, rather than actual or projected annual income. As a result, any fluctuation in income can lead to outright disqualification[12] even where the recipient's income increase is only very slight. The only exceptions to this monthly rule are found in the case of pregnant women, children under age one, and certain managed care enrollees whose financial eligibility is guaranteed for certain minimum coverage periods regardless of sporadic fluctuation in income. Income fluctuation may be common among Indian families, particularly reservation families who may be employed on a seasonal basis.

Moreover, in determining whether an individual's monthly income level falls below the Medicaid eligibility cutoff, welfare agencies take into consideration numerous sources of income. These sources can include the income of certain household members; while Medicaid rules related to the deeming of income (as it is known) limit the practice to certain defined situations[13], in fact it is easy for a local welfare agency to err and attribute other "non-deemable" household income to an applicant.[14] In families that live in extended arrangements this may result in the disqualification of otherwise eligible persons who are extemely poor and who ironically live with other extremely poor persons in order to make ends meet. To the extent that Indian families are likely to live in extended groups covering multiple generations and several degrees of relationships, income deeming may present a particular problem.

In addition to income eligibility, applicants must meet resource eligibility standards.[15] The possession of income-producing property, cars, trucks and other property valued over certain levels, as well as land other than the homestead all can disqualify applicants from assistance. Discussions at a recent Indian Health Service Roundtable meeting on Indian health programs and managed care suggested that resource disqualification may be an especially great problem for Indians because of their ownership of tribal lands and other tribal property.[16] Whether states' application of Medicaid resource standards and methodologies to tribal-owned property is lawful under federal welfare and treaty law is not known.

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12 Where an individual is eligible as a medically needy person, additional income may increase the size of the monthly spend-down liability without leading to disqualification. 42 U.S.C.A. §§ 1396a(a)(10) and (a)(17). As a practical matter the medically needy program applies only to persons with either long term institutional care costs or catastrophic health costs; as a result, it has only limited applicability to the vast majority of health needs among Indians and other low income populations.

13 Income may be deemed in the case of parents and minor children, for example.

14 State Medicaid agencies' family income deeming practices have led to extensive litigation over the years. Medicaid rules on income deeming are different from those used to determine eligibility for cash welfare, but at the local level these distinctions are often lost. Welfare reform may increase the number of persons erroneously denied Medicaid because of the incorrect application of welfare income deeming rules because of the obvious confusion inherent in trying to administer two distinct welfare programs at the local level.

15 Some states do not apply resource standards or else use liberalized resource standards in the case of children and pregnant women. Resource standards tend to be used in states with large numbers of Indians, however. See NGA, Medicaid Coverage of Children and Pregnant Women (Washington D.C., July, 1996).

16 Rosenbaum and Zuvekas, op.cit.

Citizenship and residence

In order to qualify for Medicaid an applicant must be a resident of the state in which he or she seeks benefits.[17] Residency is defined under federal law as living in a particular location with no intention of leaving. Indians who move between reservation homes and urban areas may find their residency questioned, particularly where the two points are located in two different states or counties (in the case of county-administered Medicaid programs). At the Indian Health Roundtable, noted supra, residency rules were identified as a potentially significant barrier to coverage because of population mobility.

Ironically citizenship also has proven to be a major barrier to coverage. Many people may tend to think of Indians as the nation's first citizens. Yet Indian citizenship exists only by statute[18] and Indians as an entire population have had citizenship status since 1924 (previously Indians had been effectively considered foreign wards of the federal government).[19] Until as late as the mid 1970s the citizenship status of Indians was in doubt at the state level, even though the Termination Resolution of 1953 attempted to end Indian tribal governance, rights, and status and integrate Indian populations into "mainstream" American life.[20] Despite the existence of the termination resolution and related laws, Indians routinely were denied basic rights of citizenship (including eligibility for public assistance programs) until relatively recently. The 1975 ruling by the Department of Health Education and Welfare (Appendix A) reaffirming the citizenship status of Indians underscores the limited degree to which state policy makers understood the citizenship status of Indians.

ENROLLMENT AND COVERAGE

The application process

The Medicaid application process is quite difficult. Forms typically must be obtained at local welfare agencies, and even simplified forms can be very hard to understand. Welfare offices frequently are not places that people want to go, and Indian populations may find these state and county-run locations particularly uncomfortable. In 1990 Congress amended the Medicaid statute to require state agencies to outstation the enrollment process for at least poverty level children and pregnant women at all federally qualified health centers (which include outpatient facilities operated by Indian tribal organizations and urban Indian clinics, discussed below), but outstationing is not required at contract inpatient facilities, nor is outstationing required at facilities operated directly by the Indian Health Service. While facilities can voluntarily operate outstationed enrollment assistance programs, there is no information on whether the IHS does so, nor is there information on how many Indian Tribal Organizations outpatient clinics or urban Indian clinics operate outstationed enrollment sites. Anecdotal evidence from FQHCs suggests that in some states outstationing is supported and encouraged, while in others the agency has effectively failed to implement the program. Outstationing would appear to be especially useful in the case of remote and culturally

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17 Certain special rules apply to children and adults in out-of-state placements, as well as individuals and families who are migrant farm-workers. 42 C.F.R. § 188 U.S.C.A. §1401(b). See 42 C.J.S. §8. The law applies to persons who are born in the U.S. and who are members of an Indian, Eskimo, Aleutian or other aboriginal tribe.

18 8 U.S.C.A. §1401(b). See 42 C.J.S.§8. The law applies to persons who are born in the U.S. and who are members of an Indian, Eskimo, Aleutian or other aboriginal tribe.

19 138 Cong. Rec. E-328-01 (Extension of remarks by Mr. Faleomavaega of American Samoa)

20 H.R. Con. Res. 108, 83rd Cong., 1st Sess., 67 Stat. B 132 (1953). However worthy were the stated intentions underlying its enactment, the Termination Resolution, along with the 1887 General Allotment Act, has been condemned as an "egregious" example of federal efforts to destroy Indian culture through legislative fiat, using the goal of integration as justification to terminate its obligations and decimate tribes. While the goal of the Termination Act was to put an "end to [Indians'] status as wards of the United States and to grant them all of the rights and prerogatives pertaining to American citizenship' * * * the termination policy was a euphemism for the eradication of the existence of tribes as governmental or cultural units." Isabella Timmermans, 1992. "Native American Self-Determination as Affected by Educational Funding and Its Sources" 29 Idaho L.Rev. 185, 189 (1992). The Indian Self Determination and Education Assistance Act was enacted in 1975 as a means of redressing these earlier Acts and of strengthening tribal self-governance. Id.

isolated populations who may need extensive encouragement to apply.

The recent welfare reform legislation offers the newest example of potential barriers to enrollment. Under the law, Indian tribes may elect to administer their own Title IV-A TANF programs (where tribes do not make such an election Indians remain eligible for assistance in the state in which they reside). However, although federal Medicaid law specifies that the Title IV-A agency is the agency which makes Medicaid eligibility determinations, federal officials apparently have notified tribes that while they may administer cash welfare programs they may not administer Medicaid eligibility determination and enrollment process (presumably because state Medicaid agencies do not wish to incur the potential liability for erroneous determinations by Indian welfare agencies, although why these agencies would be more prone to error than state or county-operated welfare agencies is unclear). As a result of this determination, one of the strongest incentives for tribes to assume operation of Title IV-A (i.e., the ability to make the Medicaid enrollment process more accessible) may have been lost.

"First Dollar" coverage rules

Even after an individual is found eligible for and enrolled in Medicaid, coverage can (and in fact must) be denied in instances in which the individual is deemed to have "third party liability" (TPL). TPL is similar to a coordination-of-benefits clause in an insurance contract. Where a third party is legally liable to pay for care, Medicaid acts as a "last dollar" payer and disallows payment until other coverage has been sought and obtained.

In the case of programs of the Indian Health Service, federal regulations specify that IHS facilities and funds are not to be considered a third party resource but are instead residual to Medicaid. As a result, state Medicaid plans "must provide that an Indian Health Service facility meeting state requirements for Medicaid participation must be accepted as a Medicaid provider on the same basis as any other qualified provider."[21] This regulation effectively grants "last dollar" status to both direct operated IHS facilities as well as those operated by a tribe or tribal organization pursuant to a self-determination contract.[22] It is also worth noting that federal contributions for state reimbursement of services furnished by Indian Health Service programs is 100 percent, but only in situations in which the facility remains directly operated by the Indian Health Service (i.e., the 100 percent FFP rule does not apply to contractor clinics).

Despite the relative clarity of federal requirements, there is continued evidence of barriers to Medicaid payments to Indian Health Service programs. The director of a tribal organization clinic in New York reported at the Indian Roundtable meeting that as recently as 1996 the state refused to treat his clinic as a FQHC because he would not submit to state licensure requirements, even though federal regulations governing reimbursement of Indian Health Service programs clarify that otherwise applicable state licensure requirements do not apply to Indian Health Service facilities.[23] While many of the services used at Indian Health Service facilities qualify for 100 percent FFP, at least one state has formally challenged its obligation to extend Medicaid to reservation Indians who have access to IHS programs.[24] Because the 50

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21 42 C.F.R. §431.110 (a).

22 Increasingly tribes and tribal organizations are entering into agreements with the IHS to take over the administration of IHS facilities (both inpatient and outpatient) facilities. Currently tribes and tribal organizations operate 9 hospitals and 342 outpatient clinics. AARP, Public Policy Institute, "Native Americans and the U.S. Health Care System" (Washington D.C., FS #55, 1997).

23 42 C.F.R. §431.110(b).

24 See e.g., Arizona v Bowen D. Ariz., 1989 [reprinted at CCH Medicare/Medicaid Guide at ¶ 38399] (declaring illegal the Arizona AHCCCS practice of denying coverage for eligible Indians on the grounds that the IHS was an alternate resource which effectively terminated reservation Indians' entitlement to benefits). See also McNabb v Bowen, 828 F. 2d 787 (9th Cir., 1987) involving Indian eligibility for state and county indigent care programs.

percent of Indians who live on reservations[25] rely so heavily on directly operated or contract care Indian health service providers, denial of coverage for these services would substantially undermine the value of coverage. Such a denial also would probably diminish the interest of Indian health providers in developing active outstationed enrollment programs which could benefit their own operations while enhancing patient access to the services they do not provide.

INDIAN HEALTH PROGRAMS AND THE TRANSFORMATION TO MANAGED CARE

The transformation to managed care is one of the most complex changes to ever overtake the American health care system. No purchaser of health care services faces a bigger challenge than state Medicaid agencies, given the pervasive poverty and reduced health status of their client populations and the basic resistance to large-scale participation in managed care programs among commercial companies serving the privately insured and Medicare markets. Managed care in rural areas is especially difficult because sparse populations make managed care economics less feasible. Among all Medicaid populations, no group may be a greater challenge than Indian families.

Indians who live on reservations often live in unusually isolated conditions, and their cultural expectations are unique. Moreover, Indian populations on reservations depend on a health care system that has virtually no experience with the managed care business (although Indian health programs have more experience than most providers ever would dream of at operating in a resource constrained environment). While urban Indians would appear to pose challenges no greater than other racially or ethnically unique population groups, their very mobility between two homes and two systems of health care creates challenges that are not found among other culturally distinctive subcultures.

The expectations of health services in a tribal home environment is not simply a preference to be considered; dating back to the Snyder Act of 1921 the federal government has committed itself to guaranteeing Indians at least some level of health care as part of its trust relationship with the populations. To the extent that Medicaid revenues are perceived as essential to the federal government's ability to carry out this commitment, then some accommodation between the needs of these programs and the imperatives of Medicaid managed care, with its closed provider networks[26], tight controls on access, and heavily discounted risk sub-contracts will have to be found. Thus far, while states have experimented with managed care integration of Indian populations and Indian health programs, the federal government has taken no formal position on the matter (see discussion below).

25 AARP Fact Sheet, op. cit.

26 Middle and upper income individuals may enjoy point-of-service plans. This is not the case for Medicaid beneficiaries. Sara Rosenbaum, et.al., 1997. Negotiating the New Health Care System: An Analysis of Contracts Between State Medicaid Agencies and Managed Care Plans (The George Washington University Medical Center, Center for Health Policy Research, Washington D.C.).

27 Pub.L. 94-437, codified at 25 U.S.C.A. sec. 1601

Federal and State Efforts to Improve Medicaid's Performance for Indians

Over the years both the federal government and some state governments have attempted to improve the performance of Medicaid for Indians. However, most efforts have been in the form of making Medicaid financing more available to Indian health programs rather than directly addressing the underlying issue of Indian eligibility for and access to coverage. The failure to address the issues of eligibility and enrollment may be attributable to a basic lack of understanding about eligibility-related barriers to coverage and enrollment and the absence of systematic studies of the problem rather than any unwillingness on federal or state policy makers' part to address these issues more directly.

FEDERAL EFFORTS

Federal Medicaid policy over the past 20 years has evolved in the following ways:

- The Indian Health Care Improvement Act[27], enacted in 1976, and subsequently amended on numerous occasions, authorized full participation in Medicare and Medicaid for Indian Health Service programs and established funds for the development of Urban Indian Health Clinics (there are now 49 such clinics). In 1991 the Act was amended to provide for Medicaid outreach activities through indigenous workers. The act also was amended in 1992 to authorize Medicaid managed care demonstrations involving Indian programs.
- The Federally Qualified Health Centers amendments of 1989[28] and subsequent amendments authorize the payment of cost-based reimbursement to certain entities that meet the criteria for federally qualified health centers. Among the entities that qualify for participation

in Medicare and Medicaid as FQHCs are, as noted, programs operated by Indian tribes and tribal programs under the Self Determination Act as well as urban Indian programs. While state reimbursement to these facilities does not qualify for 100 percent FFP, the program increases the potential for revenue generation under Medicare and Medicaid for outpatient care.

- Federal law authorizes federal financial participation of 100% for services furnished by IHS-operated facilities.[29]

In addition, HCFA has taken some interest in the manner in which states seeking authority to conduct mandatory managed care demonstrations under Sections 1115 and 1915 design their demonstrations to accommodate the unique service arrangements used by both on-reservation and off-reservation Indians. HCFA does not mandate any particular set of arrangements, although its Section 1115 Reviewer's Guide indicates that the manner in which a state proposes to address integration of Indian populations and the Indian health care service system into managed care is an issue that the agency considers when reviewing demonstration proposals.

The Indian Health Service periodically has attempted to address the issue of managed care integration for Indian Health Programs. The most recent effort to convene experts occurred in 1996, and the Roundtable discussion yielded a lengthy series of recommendations ranging from efforts to address basic eligibility barriers to greater levels of technical assistance on legal, business, actuarial, and data and information management matters. As noted supra, in 1992 Congress authorized an Indian health managed care demonstration. Interestingly, no discussion regarding the status of this demonstration occurred during the 1996 roundtable, and its current status is unknown.

28 42 U.S.C.L. §1396(a)(18), added by P.S.L. 99-509.

29 Added by Section 402(a) of the Indian Health Care Improvement Act.

STATE EFFORTS

There are no known studies at the state level of barriers to eligibility and enrollment among the Indian populations. As with federal Medicaid initiatives aimed at Indians, it is unclear whether in fact state policy makers ever have considered the specific impact of Medicaid eligibility and administrative requirements on the coverage of Indians.

It is clear that states with significant Indian populations are attempting to grapple with transition of both the population and its health care system into managed care. Table 2 sets forth information on how states with significant Indian populations have addressed basic Indian-health-related matters in designing their managed care programs. The design issues selected by the 1996 IHS Roundtable participants are as follows:

- the extent to which enrollment by Indians is mandatory or optional;

- whether managed care organizations that serve Indian populations must enroll Indian health providers;
- whether Indian health providers have the right to offer a non-risk-based primary care case management (PCCM) alternative to full risk enrollment and participate in managed care arrangements on that basis;
- whether Indian health providers may bill for out-of-plan services furnished to eligible managed care enrollees (viewed as particularly important in the case of urban Indians enrolled in managed care plans who periodically travel back to their reservations); and
- the rate at which Indian health providers are paid for their care when acting as PCCM providers.

TABLE 2 KEY INDIAN-HEALTH-RELATED CHARACTERISTICS OF SELECTED STATE MANAGED CARE SYSTEMS					
ISSUE	**Oregon**	**Oklahoma**	**Minnesota**	**New Mexico**	**California**
Managed care enrollment is at beneficiary option for Indian populations.	✔	✔	X[30]	X	✔[31]
Managed care organizations must include Indian health programs in networks.	X	X	X	X	✔[32]
Indian health programs have right to be fee-for-service PCCM managed care providers.	✔	✔	X	✔	✔[33]
Indian health programs have right to payment for out-of-plan services furnished to Indians enrolled in plans in which providers do not participate	X	✔	X	✔	✔
Indian health programs have right to reimbursement for 100 percent of reasonable cost of care when acting as PCCM providers.	X	X	X	✔	✔

Legend: ✔ = yes   X = no

Source: Rosenbaum and Zuvekas, Integrating Indian Health Programs into Medicaid Managed Care Systems

30 Reservation AI/ANs excluded from managed care demonstration.

31 Except where there are county plans.

32 Only in cases in which the model is other than the two-plan model or the county-organized system.

33 In two-plan and county-organized areas only.

Issues for Further Study and Action

Despite the importance of Medicaid to Indian populations, very little is known about the impact of categorical and financial Medicaid eligibility criteria on the population, Medicaid enrollment procedures and how they affect Indian populations living both on and off reservations, the degree to which Indian health programs (particularly tribal operated clinics) may be affected by state rules on provider qualification and payment, and how the various approaches which states have developed to address integration of Indian health populations and programs into managed care are affecting access to care and the viability of Indian health providers. In light of the extensive amount that is not known, research should be undertaken in selected states with high numbers of Indian residents (both on and off-reservation) focusing on several Medicaid issues, including:

- the effect of Medicaid eligibility standards on Indian populations,
- enrollment procedures used by states and barriers to acquiring and maintaining coverage,
- use of indigenous workers to conduct Medicaid outreach,
- the extent to which outstationed enrollment is used, and
- the relationship between Indian health providers and state Medicaid agencies in the areas of both participation and payment.

Research into how Medicaid eligibility is determined has taken on a new imperative following the enactment of welfare reform because of the potentially far-reaching conse-

quences of bifurcating Medicaid and cash assistance eligibility standards for families with children, as well as the effects of de-linking the enrollment system for cash assistance from that used for Medicaid in states that choose to do so. How states deal with the needs of isolated and highly needy populations under welfare reform is a matter of urgency generally.

A second key area of research includes evaluating how the various state approaches to managed care appear to affect Indian populations and providers. There is a critical need to develop strategies to provide the following:

- technical assistance to Indian health care providers attempting to negotiate managed care contracts and establish managed care networks and plans,
- technical assistance to state agencies as they attempt to design special Indian health-related aspects of their managed care arrangements,
- assistance to Indian tribes and tribal organizations to design and implement outstationed enrollment systems, and
- training in Medicaid policy and operations for Indian advocates familiar with the unique situation faced by Indian populations.

This author's experiences with Indian outpatient facilities that participate in training programs offered by the National Association of Community Health Centers underscores the value that Indian health programs, like all community providers, place on solid technical assistance in this most difficult of times.

¶ 27,222   MEDICAID—INDIAN ACCESS TO MEDICAID SERVICES

Memorandum of Agreement: Provision of Medical Services to Indians and Other Native Americans. Department of HEW, Jan. 7, 1975.

Indian access to Medicaid services.—Under the Constitution and the Civil Rights Act of 1964, Indians and other native Americans are entitled to equal access to State, local, and Federal programs to which other citizens are entitled. Since the U. S. Indian Health Service is a residual rather than a primary health service resource, Indians and other native Americans have the same rights to receive services funded by Medicaid as do all other eligible applicants. Therefore the eligibility of an Indian or other native American for Medicaid will not be affected by the use of Indian Health Services. Consequently, the State Medicaid agency is responsible for meeting the cost of services to native Americans to the same extent as provided other eligible individuals, and may not refuse to certify as eligible or fail to provide health services to Indians or other native Americans on the ground that Indian Health Services are available. The Office of Civil Rights and the Indian Health Service both have regulatory and informational duties under the new policy, which are enumerated in the text below. *Back references:* ¶ 14,341, 14,797.

[Text of Memorandum]

I. *Policy.*—Indians and other native Americans are entitled under the Fifth and Fourteenth Amendments to the Constitution of the United States, and title VI of the Civil Rights Act of 1964, 42 U. S. C. 2000-d *et seq.*, to equal access to State, local, and Federal programs to which other citizens are entitled.

The United States Indian Health Service is a *residual* rather than primary health service resource.

Pursuant to title XIX of the Social Security Act, 42 U. S. C. 1396 *et seq.*, the Snyder Act, 25 U. S. C. 13, and title VI of the Civil Rights Act of 1964, 42 U. S. C. 2000-d *et seq.*, Departmental policy related to health care for Indians and other native Americans is:

1. Indians and other native Americans shall have the same rights to receipt of medical services under a State plan approved under any of the public assistance titles of the Social Security Act, including title XIX, Medicaid, as do all other eligible individuals.

2. In the case of a person who qualifies as an Indian or other native American, eligible for services of the Indian Health Service/Public Health Service of the Department of Health, Education, and Welfare, this agency may assume *residual* responsibility for medical care and services that are encompassed by the appropriate State plan. The eligibility of an Indian or other native American under the State's medical assistance or other public assistance program will not be affected by the use of or eligi-

bility for services provided by Indian Health Service facilities or contractors.

3. Under the provisions of its approved medical assistance plan or other public assistance plans, the State agency is responsible for meeting the cost of the services provided therein for all individuals, regardless of race, who apply and are found eligible.

4. Eligible Indians or other native Americans, whether or not enrolled members of a State or Federally recognized reservation, colony, native village, or rancheria, or similar grouping, are entitled to all services for which other eligible persons are entitled.

5. Services available from the Indian Health Service cannot be considered as an alternative resource which would preclude eligibility of Indians or other native Americans for services available to the general population.

6. No recipient of Federal financial assistance may, therefore, refuse to certify as eligible or fail to provide health services to Indians or other native Americans on the ground that Indian Health Service services are available. Such refusals are a violation of title VI of the Civil Rights Act of 1964. They exclude persons from the provision of such services purely on grounds of race or national origin.

7. It is recognized that the Indian Health Service may be the only provider feasibly available and accessible to some groups of Indians and Alaska natives; however, this does not relieve the States from the obligation to make services available to eligible Indians and Alaska natives which they make available to other eligible members of their general populations.

II. *Implementation.*—A. The Office for Civil Rights, Department of Health, Education, and Welfare (OCR) shall:

1. Require State and local agencies receiving Federal financial assistance who are responsible for the administration, in whole or part, of any third-party payment schema for the provision of medical services, whether or not such third-party payments are Federally assisted, to provide information relating to such programs as may be specified by the Director, Office for Civil Rights, pursuant to his authority under 45 CFR 80.6.

2. Require medical services providers receiving Federal financial assistance to provide information relating to the acceptance of or refusal to treat Indian or other native American patients, and the source of any third-party payments for treatment received for the benefit of Indians, or other native Americans, as such information may be specified by the Director, Office for Civil Rights, or other responsible Department official, pursuant to 45 CFR 80.6.

3. Require, in the event that the Indian Health Service informs the Office for Civil Rights that treatment has been refused by a health care provider or eligibility for third-party payments for medical services denied by a State or local agency to an apparently eligible Indian or other native American, that such health care providers or State and local agencies thereafter report in writing to the Regional Director of the Office for Civil Rights in the DHEW Region in which they are located any refusal of certification of eligibility for any third-party payment benefits or any refusal of service to an Indian or other native American, together with the identity of the person to whom service was refused, and the reason or reasons for the refusal. Upon request, such providers and State and local agencies shall also produce documentation establishing the factual basis for produce documentation establishing the factual basis for the refusal, and records and supporting documents, if not already developed or retained presently, shall be developed and maintained for the purpose of providing such information.

4. Require that State and local agencies responsible for administration of medical services programs adequately publicize the availability of services to Indian or other native American communities where past practices may have created an impression that such services were, in fact, not available.

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5. Commence activities leading to formal enforcement proceedings resulting in termination of Federal financial assistance, or use other means authorized by law to obtain compliance with title VI of the Civil Rights Act of 1964, 42 U. S. C. 2000d-1 *et seq.,* where there has been failure to provide information as required in paragraphs one through three above, or where there has been refusal of service or eligibility for third-party payment benefits on the ground that an individual is eligible for IHS services.

B. The Indian Health Service, within the limits of its authorities, resources, and program scope, shall:

1. Although not an indigency program, work with the Bureau of Indian Affairs, Social and Rehabilitation Service, Department of Health, Education, and Welfare, other Government agencies, tribunal governments, and voluntary agencies to ascertain the number and identity of Indians and other native Americans who may be eligible for programs and services administered by other Federal agencies and by state, local, and private entities receiving Federal financial assistance.

2. Inform the Office for Civil Rights of the number, general location, and identity of such individuals identified as a result of action taken pursuant to paragraph one, above.

3. Inform the Indian and other native American people it serves, through tribal governments, national, area, and local Indian health boards, and other Indian health-oriented or health-interested organizations, groups activities, and events, about Federal, State, and local health services and health services payment programs for which Indians, as members of the general population, are eligible to participate on the same basis as others who qualify.

4. Provide the Office for Civil Rights Regional Offices, on a quarterly basis, with a listing of all Indians or other native Americans who have been referred to IHS hospitals by other health care providers, although eligible for services or third-party payment benefits at the referring facility.

5. Require that all contractors conform to requirements of their contracts with the Indian Health Service which shall require that vendors seek third-party reimbursement for services rendered to Indian people within the funded scope of the Indian Health Service program who are eligible to receive services under such third-party reimbursement mechanisms. Where such ven-

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dors refuse to utilize third-party payment mechanisms, the Indian Health Service shall notify the Office for Civil Rights, DHEW and any other Federal, State or local agency or private third party of such refusal.

C. The Social and Rehabilitation Service (SRS) shall, within the limits of its authorities, resources and program scope:

1. Assure that no State plan or practices shall permit a State or local agency to refuse to certify eligibility or fail to provide services on the ground that Indian Health Services are available.

2. Inform State agencies administering the Medicaid program that medical services must be made aavilable to eligible Indians and other eligible native Americans in the same manner as to all other Medicaid recipients, and that application procedures as specified in 45 CFR 206.10 must be adhered to in a manner assuring equal treatment in the application and eligibility determination process to all applicants.

3. At the request of State Medicaid agencies, provide technical assistance to State Medicaid program officials so that the State may develop procedures it deems appropriate by which the eligibility of Indians and other native Americans may be established prior to the time need for services or third-party reimbursment of medical costs may arise.

D. Nothing contained herein shall be construed as abrogating or limiting the rights of Indians presently established under any treaty, statute, or regulation.