

**STATE HEALTH CARE AND MEDICAID  
REFORM ISSUES AFFECTING  
THE INDIAN HEALTH CARE SYSTEM**

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## **EXECUTIVE SUMMARY**

Several states are planning and implementing statewide health care and Medicaid reform measures. Due to the unique structure and history of the Indian health care system (IHCS), these reforms are likely to affect American Indian people differently than other populations. The purpose of this study is to identify the salient issues for tribal and state governments arising from state health care and Medicaid reform initiatives and to assess the potential effects of reform on the IHCS and American Indian people. The investigation focused on states that recently have attempted to reform their health care systems and have substantial rural Indian populations.

The Indian Health Service provides comprehensive health care services free of charge to eligible Indian people regardless of their ability to pay. Despite this source of coverage, over one-half of IHS-eligible American Indians receive coverage from other public or private insurers at least part of the year, and over one-half receive some health care services from providers who are not sponsored by the IHS. How state health care reform affects Indian people will depend largely on who provides them with health services and how the services are financed.

State health care and Medicaid reform will have the expected impact on Indian people who do not receive services from the IHCS and on those who receive services from both the IHCS and the delivery system for the rest of the State. Health care and Medicaid reform efforts will likely have a positive effect on the former group, but due to unintended consequences, the effect on the latter group is less clear.

Our discussion of the possible unintended consequences of state health care and Medicaid reform on the IHCS and Indian people is organized according to the goals American Indian and state health care policymakers hope to achieve under reform. The goals of tribal leaders and state policymakers relative to health care reform differ, but the goals of the parties are not mutually exclusive and do not necessarily conflict.

### **Health Care Reform Goals of American Indians**

The health care reform goals of American Indians include 1) assuring the delivery of culturally appropriate services to Indian people, 2) maintaining or improving IHCS funding, and 3) respecting and preserving tribal sovereignty. Many tribal leaders are apprehensive that some state health care reforms, especially those relying on managed care, will channel Indian people away from IHCS providers toward providers who may not be as sensitive to the cultural needs of some Indian patients. For example, Indian people who do not select a managed care provider may be assigned automatically to non-IHCS primary care providers under Medicaid managed

care plans. One strategy for addressing this issue and achieving the goal of obtaining culturally appropriate services is to allow a presumptive exclusion for Indian Medicaid recipients from the managed care system. Indian Medicaid recipients who choose to participate in the managed care system would be allowed to "opt in." Allowing Indian Medicaid participants to choose their own primary care providers outside of the managed care system would allow them to select IHCS providers who might have been excluded from contracting with Medicaid managed care plans due to state service availability and non-discrimination policies.

Indian health care facilities have become increasingly dependent on third-party revenues to maintain levels of service. IHCS providers are concerned that state health care reform may affect both the volume of services reimbursable from third-parties and the amounts that third-parties pay for services. Some Indians who are automatically assigned to non-IHCS providers under managed care arrangements may continue to receive services from IHCS providers. Because the IHCS providers do not have contracts with managed care plans, they will not receive payment for the services they have provided. Most of the Section 1115 applications for statewide Medicaid demonstrations have proposed eliminating both cost-based reimbursement for Federally Qualified Health Centers (FQHC) and the list of covered services. Tribal clinics are automatically designated FQHCs. Eliminating cost-based reimbursement for FQHCs and the list of covered services would mean that tribal FQHCs might receive less reimbursement for some services and no reimbursement for other services typically provided to Indian Medicaid patients. Making FQHCs essential community providers (ECP) under reform efforts might help maintain IHCS funding. An ECP provision would require all managed care plans to contract with designated essential community providers. ECP provisions that are not time-limited and that specify that FQHC payments will be based on reasonable cost may more effectively maintain IHCS funding than those that do not. Implementing an ECP provision without a time limit would suggest that the provision would remain in place until it is no longer needed rather than "sun-setting" at the arbitrarily pre-determined time. Requiring cost-based payments would assure that payments for service provided to managed care patients are not less than those that would have been paid had the state not received a Medicaid waiver.

Tribal clinics may resist participation in managed care networks or functioning as managed care organizations themselves, because they may view network management rules and state consumer protection regulations as possibly injurious to tribal sovereignty. A strategy for mitigating these concerns might feature the imposition of a neutral third party, such as Joint Commission on Accreditation of Healthcare Organizations or National Committee on Quality Assurance, between the state and tribal governments. IHCS providers accredited by these independent accrediting agencies would be deemed to be in compliance with all of the clinical, administrative, financial, and governance criteria of the state and managed care networks.

## **Health Care Reform Goals of State Health Care Policymakers**

The health care reform goals of state health care policymakers include 1) reducing the amount spent on Medicaid, 2) improving access to health care insurance for the uninsured, and 3) obtaining agreement among policymakers and relevant interest groups sufficient to gain approval of the policies proposed. Medicaid is one of the largest and fastest growing components of any state budget. Managed care is viewed by many states as one strategy to help control the cost of providing Medicaid services. The number of Indian Medicaid recipients in most states is a small proportion of the total, therefore the Medicaid savings to be obtained from channeling Indian people into managed care systems will be relatively small. Implementing Medicaid managed care programs without consideration of the unique problems of the IHCS, however, might weaken the financial position of IHCS providers. The weakening of IHCS may have perverse consequences for Medicaid: to the extent that the IHCS is unable to finance and deliver services, Indian citizens of the state might be required to rely more heavily on Medicaid to obtain needed health care services. Strategies to satisfy the state's goal of lowering Medicaid expenses while also meeting the goals of Indian policymakers to assure delivery of culturally sensitive services and maintain IHCS funding include establishing primary care case management systems with IHCS providers responsible for managing the care of Indian Medicaid recipients, and adopting policies that remove the barriers from IHCS provider participation in managed care networks (e.g., allowing IHCS providers to choose to treat only Indian patients, allowing providers to promise to provide services free of charge in the case of default in lieu of standard health plan capital requirements).

A primary goal of policy formation is to obtain agreement among policymakers and relevant interest groups sufficient to gain approval of the policies devised. In formulating health care policy in most states, the Indian constituency is too small and its political advocacy efforts too diffused to play a major role in policy formation. As a result, the interests of Indians are frequently not considered during the planning phase of policy development, and problems that might have been anticipated had Indians played an active role do not become known until implementation. Strategies for improving the process of state health policymaking and improving the probability that Indian people will approve of the policies include establishing a state policy outlining the framework of government-to-government relations between the state and Indian tribes; assigning state staff to Indian issues allowing staff to gain subject expertise; and developing tribal resources and routines for acquiring information about state policymaking. The IHS Area Offices may provide technical assistance to both tribal and state governments during policy discussions. The goals of both American Indian and state policymakers relative to health care reform can be achieved. While each side has a different set of policy goals, the goals themselves do not conflict.

## INTRODUCTION

Comprehensive health care reform at the federal level is unlikely in the near term, but a number of states continue to plan for and implement their own incremental health care reform measures. Medicaid reform was among the most prominent of these reforms in 1995, as states attempted to control Medicaid expenditures by enrolling larger numbers of recipients in managed care programs. Due to the unique structure and history of the Indian health care system (IHCS), these reforms are likely to affect American Indian people differently than other populations.<sup>1</sup> The purpose of this study is to identify the salient issues for tribal and state governments arising from state health care and Medicaid reform initiatives and to assess the potential effects of reform on the IHCS and American Indian people.

The Indian Health Service (IHS) provides or finances services to approximately 1.4 million members of 540 federally-recognized Indian tribes throughout the continental U.S. and Alaska. The American Indian population is the most rural of the identifiable ethnic minorities of the United States: almost one-half of all Indians live in rural areas (John, 1994). The service population of the IHS is limited to members of federally recognized Indian tribes and their descendants who live "on or near" reservations (IHS, 1994a). Approximately sixty percent of American Indians live in IHS service areas located in 34 states. The IHCS provides health care services to Indian people directly through IHS facilities and through health programs operated by

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<sup>1</sup> We use the term Indian health care system (IHCS) throughout this paper to mean the system of providers (e.g., clinics and hospitals) and services (e.g., medical and environmental) developed for the use of Indian people and owned and/or operated by either the Indian Health Services or tribal entities.

tribes. Both methods of service delivery rely on health care contracts with more than two thousand private providers (IHS, 1994b). Connected primarily by their relationship to the United States government, IHCS providers form the largest rural health care system in the United States with an annual budget in 1994 of approximately \$2.1 billion (IHS, 1994a).

The federal obligation to provide health care services to members of federally-recognized Indian tribes is rooted in treaties between the United States and sovereign Indian tribes in which land was ceded in exchange for the promise of future health care benefits. The federal obligation is acknowledged in a string of Congressional acts beginning with the Snyder Act of 1921 which authorized Congress to spend money for Indian health programs. In the years since the 1955 transfer of Indian health programs from the Department of the Interior (i.e., Bureau of Indian Affairs) to the Department of Health, Education, and Welfare (i.e., Public Health Service, Indian Health Service), federal funding has created a health care infrastructure in and near reservations where none had existed and, due to the sparse population of the area and the poverty of its residents, none was likely to emerge.

Despite the existence of this delivery and financing system developed exclusively for Indian people, many Indians receive coverage and service outside of the IHCS. In 1987 over one-half (57.4 percent) of IHS-eligible American Indians received coverage from other public or private insurers at least part of the year, and over one-half (54.7 percent) received some health care services from providers who

were not compensated by the IHS (Cunningham, 1993).<sup>2</sup> Table 1 highlights the complex nature of Indian health care financing and delivery. Indian people participate in not only the Indian health care system and the broader health care system of the rest of the state, but a substantial proportion of Indian people span both systems. Indian people are diverse; how state health care and Medicaid reform affects them will depend largely on who provides them with health care services and how the services are financed.

To examine the issues of interest to tribal and state governments relative to health care reform and to assess the potential effects of reform on the IHCS and Indian people, we focused on seven states that have attempted to reform their health care systems and that have substantial rural Indian populations. Because Medicaid is the primary state health care program that affects American Indians, Medicaid reform is an important focus of this paper. State health care reform commission staff (or state health department staff in states without commissions) and Medicaid agency staff<sup>3</sup> were interviewed in the states of Minnesota, Wisconsin, Washington, Oregon,

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<sup>2</sup> Data presented in Table 1 are from the 1987 Survey of American Indians and Alaska Natives (SAIAN), a component of the 1987 National Medical Expenditure Survey conducted by the Agency for Health Care Policy and Research. The SAIAN contains a representative sample of approximately 2,000 American Indian and Alaska Native households in which at least one person was able to receive care from the IHS. Approximately 6,500 persons eligible for IHS services were included in the sample (Cunningham, 1993). The IHS Patient Registration System in 1996 indicates that patients with private insurance range from 12 to 40 percent and those who are Medicaid eligible range from 12 to 35 percent across service units (IHS, Smith, personal communication, 1996). The percentages of all persons obtaining private and public coverage all year, as reported using the 1987 SAIAN, fit within the IHS Patient Registration System 1996 ranges. SAIAN data represents all eligible Indians residing in the IHS service area; the IHS data are only for eligible Indians who use the IHS system.

<sup>3</sup> Four of the states selected for participation in the study, Arizona, Oregon, Washington, and Minnesota have statewide Medicaid managed care waivers. Arizona's program covers all rural areas in the state, while the other three states are in various stages of implementing their programs in rural areas. Wisconsin has requested an expansion of its existing Medicaid 1915(b) waiver to allow statewide expansion of its managed care program, which currently operates only in urban areas. Florida's section 1115 waiver request was approved, but has not been implemented, and New York's waiver request is still being reviewed by the Health Care Financing Administration.



**Table 1**  
**Health Care Coverage and Use for the American Indian Population, 1987**

	Place of Residence			
	All Persons	MSA	Non-MSA (rural)	
			At Least 10 Persons/Sq. Mi.	Fewer Than 10 Persons/Sq. Mi.
Health Care Coverage				
IHS only all year	42.5	24.4	48.7	57.7
Other coverage part year	16.5	21.4	13.0	14.4
Any private coverage all year	24.9	35.4	21.3	16.3
Other public coverage all year	16.0	18.9	17.0	11.6
Health Care Use				
IHS only	45.3	23.7	52.4	67.0
Non-IHS only	17.4	29.3	13.3	5.5
IHS and Non-IHS	37.3	47.0	34.3	27.5

Source: Cunningham, 1993

New York, Florida, and Arizona. One tribe in each of these seven states was selected for participation in the study. The tribes reflect a mix of experience in the provision of health services to Indians, i.e., services provided directly by the IHS, services provided by tribes, and a mix of the two. Tribal health care leaders representing the Leech Lake Chippewa, Menoninee, Yakima, Warm Springs, Seneca, Seminole, and Navajo tribes were interviewed. Finally, IHS area office staff representing the Bemidji, Portland, and Nashville Area Offices were interviewed.

Separate interview protocols were developed for each of the four different types of officials interviewed. The purpose of the interviews was to identify health care reform issues and opportunities relative to Indian people. The interviews were transcribed and analyzed for common themes 1) within states, 2) within types of persons interviewed, and 3) across all persons interviewed. Interviews were supplemented by documents supplied by those interviewed and by a review of current literature on Indian health services delivery.

State health care reform will have the expected impact on Indian people who do not receive services from the IHCS and on those who receive services from both the IHCS and the delivery system for the rest of the state. Health care and Medicaid reform will likely have a positive impact on the former group, but due to unintended consequences of reform, the effect on the latter group is less clear.

Overall, we found:

- Indian people who do not live in IHS service areas (approximately 40 percent of the total) will likely benefit from health care reforms that improve access to health insurance coverage, by lowering its cost,

improving its portability, eliminating pre-existing condition provisions, or expanding Medicaid eligibility. These reforms increase the probability that Indian people will be covered by non-IHS individual and family third-party insurance. As employment opportunities expand on reservations, Indian people living within IHS service areas also may benefit from small-market health insurance reforms that better allow Indian employers to offer health insurance to their employees. Expansion of private third-party payments to IHCS providers should improve the financial condition of the Indian health care system.

- State health care reforms that rely on managed care may create unique problems for Indian patients and the IHCS, if IHCS providers are excluded from managed care networks. Indian patients may be automatically assigned to networks that do not include IHCS providers or may be forced to select among plans and providers that do not offer culturally appropriate services. IHCS providers may have difficulty contracting with managed care organizations due to the restricted scope of their services and federal limitations on their ability to treat people who are not Indians. The inability to contract with managed care organizations may have negative financial consequences for IHCS providers.
- Indian people who receive their care exclusively from IHCS providers and whose care is financed exclusively by the IHS and/or Indian tribes likely will not be affected directly by state health care reform. These patients receive their care in a closed system that will not be affected by health care reform efforts. However, to the extent that state health care reforms weaken the fiscal stability of the IHCS, these Indian patients may be negatively affected.
- Tribal leaders have generally not been included in health care reform planning at the state level. Several reasons, including the small proportion of the Indian population to the total population of the state and the propensity of tribal leaders to focus their political attention on federal issues, may account for their not being included. The inclusion of Indians in state health care reform discussions may help to identify and solve problems in advance of implementation.

The balance of this paper will explore these findings in greater depth. The paper is organized according to the major goals American Indian and state health care policymakers hope to achieve under health care reform. We found that although the

goals of both parties were different, they were not mutually exclusive and need not conflict. Readers unfamiliar with the legal status of American Indians and the structure of the Indian health care system may wish to refer to the Appendix for a brief overview that provides background information for the discussion that follows.

## **HEALTH CARE REFORM GOALS OF AMERICAN INDIANS**

Like other Americans, tribal leaders hope that state health care reform initiatives will enhance access to health care services while improving their quality and lowering their cost. These overall objectives of health care reform, however, are largely of secondary importance to tribal leaders; they are more concerned that reform initiatives achieve certain objectives that are particular to the IHCS. Health care reform -- regardless of other measures of success -- will be successful in the eyes of most tribal leaders only if it 1) assures the delivery of culturally appropriate services to Indian people, 2) maintains or improves IHCS funding, and 3) respects and preserves tribal sovereignty. In pursuit of these overarching goals, Indian people may occasionally take positions that seem inimical to their interests and contrary to conventional wisdom. Their decisions are not based on the simple calculus of the costs and benefits of specific policy questions. Rather each policy question is interpreted and analyzed through the lens of tribal culture and experience. Components of health care reform that affect achieving these goals are discussed below.

## **Delivery of Culturally Appropriate Services**

Many tribal leader are apprehensive that some state health care reforms, especially those relying on managed care, will channel Indian people away from IHCS providers toward providers who may not be as sensitive to the cultural needs of some Indian patients. Some Indian people are uncomfortable seeking care outside of the IHCS, because providers may not be familiar with native languages, customs, and lifestyles. For example, traditional healers play an important role in the delivery of services to some Indians. In these cases tribal medicine men work side-by-side with physicians. Indian health policymakers feel that providers outside of the IHCS may be less tolerant of these practices than IHCS providers. The discomfort American Indians feel obtaining health care services in non-IHCS settings and the desire for culturally appropriate treatment may make some Indians reluctant to use providers outside the IHCS.

The reluctance of Indian people to use non-IHCS providers becomes an issue when the state, either through a Medicaid managed care plan or a state-subsidized health insurance plan that relies on managed care, requires Indian patients to select a primary care provider from a panel of participating providers and to obtain all health services through that provider. Most IHCS providers likely will not contract with managed care organizations and, consequently, Indian people will not be able to choose the provider from whom they have typically received culturally appropriate services.

There are several reasons why IHCS providers are unlikely to contract with managed care plans. In some cases, IHCS providers may not be able to affiliate with preferred provider networks and health maintenance organizations, because of state-imposed contracting specifications that IHS and tribal health systems cannot meet. For example, managed care providers may be required to have hospital privileges. IHCS providers in service units without hospitals may not have hospital privileges because their practices are located too far from a hospital to allow them to admit and follow patients conveniently. Instead, all of their patients requiring hospitalization are referred to contract care providers outside of the system. Another provision may require providers in the Medicaid system to offer services 24-hours per day. Due to the limited resources of the IHCS and the sparse populations it serves, some IHCS clinics are open fewer than 24 hours per day. Finally, providers who contract with managed care systems may be asked to make services available on a non-discriminatory basis. Most IHCS clinics are excluded by federal law from treating people who are not Indians (except in emergency situations), and would not be able to participate in the managed care system.

Some Medicaid managed care systems allow recipients a certain amount of time to select a primary care provider before one is automatically assigned. In cases where these systems were implemented (e.g., Washington and Oregon), our informants reported that large numbers of Indian Medicaid recipients did not declare a primary care provider and consequently were assigned one automatically. Many Indian Medicaid recipients, however, continued to receive services at IHCS facilities

even after they had been assigned to non-IHCS providers. Because the IHCS facilities were not participating network providers, the managed care plan refused to reimburse them for the services they provided, contributing to the financial burden of the Indian health care system.

To cope with the problems of automatic assignment, states may allow Indian Medicaid recipients the choice of opting out or into the managed care plan. An opt-out provision requires a Medicaid recipient to choose whether or not to participate in a managed care plan. Medicaid recipients who decide to opt out of managed care arrangements must make their desires known to the Medicaid agency within a prescribed amount of time. If an election is not made within the prescribed time, recipients are automatically assigned to managed care providers. Opt-out provisions address the issue of cultural sensitivity in the abstract, but practically, they are only a marginal solution. States that have used an opt-out provision (e.g., Oregon) have found that many Indians neglected to exercise their option and were automatically assigned to non-IHCS managed care providers.

An alternative to opting out of the Medicaid managed care system is to opt in. Opt-in provisions automatically exclude Indian Medicaid recipients from the managed care system unless they make an affirmative statement of their desire to participate. When they opt in to the managed care system, they are asked to select a primary care provider. Opt-in provisions, such as the one used in Washington State, assure that Medicaid recipients 1) understand their right to choose whether or not to participate in the managed care system and 2) select a participating managed care

provider. Opt-in provisions, however, may also have the unintended consequence of minimizing the enrollment of Indian people.

Providers who deliver health care services to Indian Medicaid recipients outside of the Medicaid managed care system are reimbursed on a fee-for-service basis. Fee-for-service payments may be based on discounted charges, costs, or a fee schedule. States may recoup some of the anticipated benefits of managed care by assigning Indian Medicaid recipients who do not participate in the state's Medicaid managed care plan to participating Indian clinics that agree to function as primary care case managers (PCCMs). PCCMs receive a fee, typically \$3.00 per client per month, to serve as "gatekeepers" for the Medicaid system, providing, coordinating, controlling, and monitoring all services of the patients assigned to him or her (Freund and Hurley, 1987). Participation as a PCCM would provide a new, albeit small, revenue source to Indian health clinics and would provide the Medicaid agency with some control over its fee-for-service expenditures for recipients not participating in the managed care system.

### **Maintain or Improve IHCS Funding**

Indian health care facilities have become increasingly dependent on third-party revenues to maintain levels of service. Although the national average for third-party revenues of Indian health care facilities is approximately eight percent of total expenditures, some tribes have substantially greater levels of third-party payments (IHS, 1994a). For example, the Menominee tribe in Wisconsin reports that 32 percent



of its revenue comes from third-party sources; 29 percent of the Seneca Nation's (New York) and 24 percent of the Yakima Nation's (Washington) income derive from third-party sources. In contrast, until recently the Seminole Nation (Florida) did not bill third-parties for health services provided to American Indians at IHS facilities. As federal funding for Indian health programs has failed to keep pace with both cost increases and need, IHCS facilities have become more vigorous in pursuing other third-party payment sources. Because of IHCS providers' increasing reliance on third-party revenues, the affect of state health care reform on both the volume of services reimbursable from third-parties and the amounts that third-parties pay for services is of major interest.

Health care reforms that concentrate on small employer insurance reform and state-subsidized health insurance are generally well-received by Indian health care leaders, if they do not channel Indian people into systems of care that remove their freedom of choice. They believe that these reforms will make health insurance more available to Indian businesses and Indian workers who have had difficulty obtaining health insurance. Tribal governments are major employers on reservations. Some tribal governments provide health insurance to its employees. For example, one tribe in Washington state purchases insurance through the state's Basic Health Plan for its member-employees, and the Navajo nation is self-insured. Indian-owned gaming operations employ Indians and non-Indians alike, and health care benefits at some operations are part of the employee compensation package. Greater availability of

health insurance for Indian people would improve the third-party revenues of IHCS providers and would remove some of the funding liability of IHS.

Tribal health leaders are apprehensive that other reforms will not have the same salutary effect on IHCS financing as insurance reform. Automatic assignment of Indians to non-IHCS primary care providers is cited as an example. Indian patients who are automatically assigned to primary care providers at more distant locations may continue to obtain services from the local IHCS providers from whom they typically received services. They may continue to use local services, because the cost of travel to the assigned provider is too high, because they desire services that are more culturally appropriate, or for some other reason. If an out-of-plan IHCS provider delivers services to an Indian person covered by a managed care plan, the IHCS provider likely will not be reimbursed by the plan for the care given. The burden of this new source of uncompensated care would be added to the funding problems of the IHCS.

We suggested a possible solution to this problem in the previous section. A presumptive exclusion/opt-in Medicaid policy would greatly reduce the number of plan members who are assigned to one primary care provider but routinely seek services from another. Another possible solution would be to hold IHCS providers harmless for the provision of services to Indian Medicaid beneficiaries. IHCS providers would be reimbursed for the services they deliver on a fee-for-service basis by either the state or the plan. In exchange for being held harmless, IHCS providers might be required to provide Indian Medicaid recipients counseling on the design of the

Medicaid system and of recipient responsibilities within the system. Because the number of Indian Medicaid recipients in most states is relatively small,<sup>4</sup> the cost of a hold-harmless provision would also be small. It would, however, help stabilize the financial position of some IHCS providers.

Tribal health programs (638 clinics) are automatically eligible for Federally Qualified Health Center (FQHC) designation. The FQHC program was created by OBRA '89 and modified by OBRA '90 to provide enhanced Medicare and Medicaid reimbursement to clinics who provide health care to primarily low-income or medically underserved patients. The program reimburses FQHCs for the reasonable cost of providing an array of legislatively-determined services to Medicaid and Medicare patients (Travers, Ellis, and Dart, 1995). Because cost-based reimbursement exceeds the rate paid to clinics by many Medicaid agencies, FQHC-level reimbursement is a distinct advantage to some tribal health clinics.

Most of the Section 1115 applications for statewide Medicaid demonstrations have proposed eliminating both cost-based reimbursement for FQHCs and the list of covered services (Rosenbaum and Darnell, 1994). Because Indian Medicaid recipients are likely to continue to seek services that were eliminated by the state's Section 1115 demonstration authority, the reduction in covered services will mean that the IHCS will have to fund more services from either tribal or IHS funds. At the same

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<sup>4</sup> There are, for example, 26 Indian tribes in Washington state. The Indian population of the state is 1.7 percent of the population of the entire state. The percentage of Indian Medicaid recipients is approximately 3.4 percent of the total. Overall, Indians comprise approximately 0.8 percent of the U.S. population; they equal 0.9 percent of all Medicaid recipients and services provided to Indians account for 0.6 percent of all Medicaid vendor (i.e., provider) payments (Health Care Financing Administration, Division of Medicaid Statistics, 1994).

time that costs for unreimbursable services are increasing, the level of payment for reimbursable services will be decreasing, because the state is free from the requirement to pay 100 percent of reasonable FQHC costs.

Participating health plans in states whose Medicaid programs include prepaid components may not be required to contract with FQHCs. Those Medicaid managed care plans that do contract with FQHCs will attempt to negotiate payment rates that are favorable to the plan and may be less than cost-based reimbursement. FQHCs apprehensive of the effect that the loss of all Medicaid revenue would have on their enterprises, may be willing to accept less than full-cost reimbursement from managed care plans to help defray their fixed costs. Accepting such contracts places a financial burden on the IHCS that likely will not be relieved by other income sources. Due to the small amounts of private pay and private third-party income currently received, the IHCS cannot effectively shift costs.

One method of assuring access and continuity of care under health care reform is to designate FQHCs "essential community providers" (ECP). ECPs are providers who have traditionally been available to treat underserved populations. Health plans would be required to contract with ECPs and to reimburse them at rates based on Medicare payment principles. An ECP provision may be time-limited if health plans, at the end of a transition period, were required to demonstrate their capacity to provide access for all participants.

The health care reform plan for Minnesota calls for the establishment of ECPs for a period of five years. During that period, all health plans (including integrated

service networks of insurers and providers) are required to offer provider contracts to designated ECPs within the plan's service area (Casey, 1995). The Minnesota reform plan, however, does not require that ECPs receive reimbursement based on Medicare principles.

ECP provisions for IHCS providers have not been incorporated into any of the Medicaid managed care plans approved to date. Participating health plans are not required to contract with IHCS providers and, when they choose to do so, they are not required to pay them on the basis of cost. It is not known whether the payment rates offered IHCS providers by participating Medicaid health plans are more or less than they would have received under cost reimbursement.

States with Medicaid waivers may also limit reimbursement for services received at FQHCs. Reimbursable FQHC services in Oregon, for example, are limited to the 581 "priority" conditions covered by its Medicaid plan. All other services are non-reimbursable. Medicaid services that are not reimbursable still may be medically appropriate. In these cases, IHCS providers may continue to offer a service to Indian people and receive no payment from the state Medicaid plan. States that consider an ECP provision for FQHCs should also consider maintaining the list of designated FQHC services. By doing so they not only assure access to providers who have traditionally treated underserved populations, but also assure access to a minimum set of diagnostic, therapeutic, and preventive services.

## **Respect and Preserve Tribal Sovereignty**

Some tribal governments that own or operate clinics may be reluctant to contract with larger provider networks, because they believe that management of the network by people who are not members of the tribe may provide a challenge to tribal sovereignty. Tribal governments are reluctant to surrender autonomy to another organization, and may view network management as an intrusion into the internal affairs of the tribe.

Some local IHCSs may wish to seek designation as managed care entities themselves. Under state reform efforts that rely on managed care to restructure the delivery and financing of health services, these IHCSs would provide services to Indians (and possibly others) who purchase coverage from them. To help protect consumers of managed care services, state governments may require all managed care entities to meet the same minimum reserve standards as existing health maintenance organizations. The reserves (i.e., net worth) of the managed care entity are intended to serve as a hedge against default should the entities incur greater losses than expected. Many Indian health care systems may not have sufficient liquid assets to fund the reserve at the required level.

To further protect the public interest, state managed care laws may grant the state authority to assume the operation of a managed care system for reasons such as insolvency or poor quality. Again, tribes are likely to interpret such provisions as an abrogation of tribal sovereignty and may refuse to participate in managed care

arrangements, even if they are large enough and offer enough services to accept risk for a covered population on their own.

There are a number of different ways to protect the public from poor quality and financial insolvency. One might be to deem IHCS providers in compliance with state and network rules if they are accredited by an independent, non-governmental body such as JCAHO or the National Committee on Quality Assurance. Failure to obtain accreditation would be grounds for terminating IHCS provider participation. Private, external accreditation does not challenge tribal sovereignty. As of January 1994, all IHS and tribally-operated hospitals and all eligible IHS-operated health centers were accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (IHS, 1994a). A deemed-compliance provision for IHCS providers under health care reform would build on that precedent to assure that service delivery, administration, finance, and governance meet objective standards of quality.

Reserve requirements are intended to assure that people who are covered by a plan that becomes insolvent continue to have access to care. Indian people covered by an IHCS managed care organization are in less danger than members of other plans should an IHCS-sponsored plan default on its obligations. IHS is the residual payer for all eligible Indians. In the unlikely event of default by an IHCS-sponsored plan, the IHS would assume the liability of financing services to eligible Indian people covered by the plan. People covered by an IHCS-sponsored managed care plan who are not eligible for IHS-financed services are still at risk of losing

coverage and services should the plan default. The Minnesota statute establishing Community Integrated Service Networks (CISNs)<sup>5</sup> allowed CISNs to pledge to provide services without payment to enrollees for up to 120 days following CISN insolvency in lieu of meeting net worth requirements. Providers in IHCS-sponsored managed care plans might make a similar pledge to provide services in the event of default to members who are not eligible for IHS services. Because many IHCS primary care providers are salaried employees, the likely financial risk of providing a "safety net" for these members would be small.

### **Summary of Indian Health Care Reform Goals**

It is apparent from this discussion that state health care reform, in many cases, provides certain challenges to the Indian Health Care System. It should also be apparent, however, that the goals of assuring the delivery of culturally appropriate services to Indian people, sustaining IHCS funding, and preserving tribal sovereignty can be achieved while implementing state health care reform. Strategies for achieving these goals are summarized in Table 2. State health care reform will likely have its greatest impact on the approximately 15 percent of Indians who have IHS and other coverage during the same year, and/or the approximately 30 percent of Indians who receive services from both IHS and non-IHS providers during the same year. Indians

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<sup>5</sup> A CISN is a small-sized integrated managed care organization created by the Minnesota Legislature in 1995 to provide small and rural networks with certain temporary competitive advantages over larger Integrated Service Networks. See Casey, 1995.



Table 2

Summary of American Indian Issues and Strategies  
Relative to State Health Care Reform

ISSUE	STRATEGY FOR ADDRESSING ISSUE
Automatic assignment of Indian people to primary care providers under managed care plans resulting from health care reform. (Goal: Deliver culturally appropriate services)	Presumptive exclusion for Indian insureds/recipients from managed care plans. Require Indian people to opt into managed care plans.
Automatic assignment of Indian people to primary care providers under managed care plans resulting from health care reform increases the probability that IHCS providers will provide services for which they are not reimbursed. (Goal: Maintain or improve IHCS funding)	Same as above. Hold IHCS providers harmless for delivering services to Indian insureds/recipients covered by managed care plans.
Medicaid waivers free states from the obligation of reimbursing FQHCs (i.e., 638 clinics) according to Medicare principles. (Goal: Maintain or improve IHCS funding)	Essential community provider provision that requires managed care plans to contract with FQHCs and reimburse them on a reasonable cost basis.
Medicaid waivers allow states to restrict services that were previously offered. Provision of these services to Indian Medicaid recipients will shift costs from Medicaid to the IHCS. (Goal: Maintain or improve IHCS funding)	Essential community provider provision that requires all federally mandated FQHC services to be provided.
State regulations and managed care network rules regarding quality and administration of Indian clinics may conflict with tribal sovereignty. (Goal: Preserve tribal sovereignty)	Deem IHCS providers to be in compliance with state regulations and managed care network rules if the providers are accredited by JCAHO or NCQA.
Reserve requirements for managed care organizations may restrict the ability of IHCS providers to function as managed care organizations for Indian people. (Goal: Preserve tribal sovereignty)	Allow the IHS (residual payer) to serve as guarantor in the event of IHCS health plan default for eligible Indians. For all other plan members, accept promise to provide services to members for up to 120 days at no charge in the event of default in lieu of a funded reserve.

whose care is financed and provided exclusively by the IHCS will not be directly affected by state health care reform. Indians whose are covered all year by non-IHS sources and who receive care from only non-IHS providers will likely benefit from state health care reform in proportions similar to the general public.

## **HEALTH CARE REFORM GOALS OF STATE HEALTH CARE POLICYMAKERS**

State health care policymakers also hope that health care reform initiatives will satisfy the overall system goals of improving access to and quality of health services and reduce their cost, but they too have specific goals in mind. In this paper we will focus on three. The first two goals, reducing the amount spent (i.e., reducing the rate of increase) on Medicaid and improving access to health care insurance, are aimed at correcting specific problems. The third goal, obtaining agreement among policymakers and relevant interest groups sufficient to gain approval of the policies proposed, is a characteristic of all public policymaking. How these goals might be achieved while also achieving the goals of Indian health care policy leaders is discussed below.

### **Reduce Medicaid Spending**

Medicaid is one of the largest and fastest growing components of any state budget. Fueled by enrollment growth and medical care inflation, Medicaid spending between 1990 and 1992 grew at an average rate of 28 percent per year (Winterbottom, Liska, and Obermaier, 1995). Managed care is viewed by many states as one strategy to help control the cost of providing Medicaid services. States

must obtain a waiver of sections of the Social Security Act relative to Medicaid to implement managed care systems. Medicaid managed care plans are implemented under either Section 1915(b) or Section 1115 waivers.

The proportion of Indians who are Medicaid recipients is very small in most states. Consequently, a presumptive exclusion/opt-in provision in the Medicaid managed care program for Indian Medicaid recipients as described earlier would likely have a small impact on the Medicaid budget of a state. Whatever the impact, it could be reduced by devices such as including IHCS providers in the provider network (i.e., increasing the probability that Indian Medicaid recipients would opt-in to the managed care system); establishing limits on fee-for-service payments (i.e., controlling the cost per unit of service); and developing primary care case management systems that help coordinate services. It seems clear that Indians may be treated differently under Medicaid managed care system without significantly endangering program savings. However, implementing Medicaid managed care programs without consideration of the unique problems of the IHCS might weaken the financial position of IHCS providers. The weakening of IHCS may have perverse consequences for Medicaid: to the extent that the IHCS is unable to finance and deliver services, Indian citizens of the state might be required to rely more heavily on Medicaid to obtain needed health care services.

## **Improve Access to Health Care Insurance**

No apparent conflict exists between the goal of state policymakers to improve access to health insurance coverage for citizens of the state and any of the goals of Indian health care policymakers. On the contrary, tribal leaders support initiatives that make coverage more available on the condition that coverage expansions are not made at the price of restricting the free choice of providers or limiting the services covered. Problems and possible solutions for the issues of freedom-of-choice and service restrictions were discussed earlier.

## **Obtain Approval From Relevant Constituents**

A primary goal of policy formation is to obtain agreement among policymakers (e.g., the Department of Health, the Governor's Office, and the Legislature) and relevant interest groups (e.g. consumers, providers, and insurers) sufficient to gain approval of the policies devised. In formulating health care policy in most states, the Indian constituency is too small and its political advocacy efforts too diffused to play a major role in policy formation. As a result, the interests of Indians are frequently not considered during the planning phase of policy development, and problems that might have been anticipated had Indians played an active role do not become an issue until implementation.

There are several reasons why Indian people do not play a larger role in health policy formation at the state level. State administrators may believe that the special needs of Indians are adequately addressed in state programs for the poor and

minorities. They may not acknowledge that Indians are fundamentally different from other minorities. Special treatment for Indians seems to run counter to an egalitarian strain in some state administrators and to federal requirements that all people be treated equally. Our interviews suggest that state administrators are not insensitive to the issues raised by Indians, but, for ease of administration, they may attempt to combine Indian concerns with those of other constituent interest groups.

Because of the special relationship of Indian tribes to the federal government and their frequently strained relations with state governments over issues such as fishing and land use, many tribes have focused all of their extra-tribal political energy on the federal government and, as a result, are largely uninformed about state politics. Unaware of the state policymaking process, they play no role in it.<sup>6</sup> These tribes are consistently in a reactive posture. When policies are created that conflict with their interests, they voice their dissatisfaction. Tribal inattention to policies that may affect Indians has two negative consequences. First, it may lead some Indians to view the actions of state governments as hostile to their interests, because their only exposure to state policymaking is when their interests conflict with state policy. Second, some state administrators may view the late entry of Indians into the policymaking process as obstructive.

Not only is the total population of Indians within a state likely to be small, but each tribe is an autonomous sovereign nation that demands that state administrators

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<sup>6</sup> Some tribes, however, are actively involved in promoting their interests to state governments. The Menominee tribe in Wisconsin, for example, employs a lobbyist who works with the tribe on many state policy issues including health care.

respect their government-to-government relationship. Some state administrators may be frustrated by the complexity of dealing with Indian affairs. They expect greater unanimity among tribes and may be unprepared for the amount of the time required to meet with tribes and gain consensus for an action. This frustration results in part from a lack of understanding on behalf of the state policymakers of the meaning of tribal sovereignty and the structure of the Indian health care system. If state administrators and legislatures were better informed in these two areas, they likely would be more sensitive to issues that Indians are apt to raise, better able to anticipate problems, and therefore more adept at proposing solutions before problems develop.

State governments would be better able to implement health care reforms that affect Indian people if a state policy outlining the relationship of state government to tribal governments were created to serve as a framework for organizing discussions. One model of such a policy is the Centennial Accord Between the Federally Recognized Indian Tribes in Washington State and the State of Washington. The Centennial Accord recognizes that each of the twenty-six sovereign Indian tribes in the state of Washington has an independent relationship with one another and the state. The signatories to the Centennial Accord (the Governor of the state of Washington and the chief executive of each tribe) acknowledge that implementation of the accord will require "a comprehensive educational effort to promote understanding of the government-to-government relationship within their own

governmental organizations and with the public." The Centennial Accord establishes the framework for the relationship between the state and tribes:

The parties recognize that in state government, accountability is best achieved when...responsibility rests solely within each state agency. Therefore, it is the objective of the state that each particular agency be directly accountable for implementation of the government-to-government relationship in dealing with issues of concern to the parties. Each agency will facilitate this objective by identifying individuals directly responsible for issues of mutual concern.

Each tribe also recognizes that a system of accountability within its organization is critical to successful implementation of the relationship. Therefore, tribal officials will direct their staff to communicate within the spirit of this accord with the particular agency which, under the organization of state government, has the authority and responsibility to deal with the particular issues of concern to the tribe (Centennial Accord, 1989).

To assure that tribes can fully participate in reform efforts, states might also offer tribes technical assistance regarding how policy changes will affect their programs and how to participate most effectively in the reform efforts. Such assistance would help secure the support of tribal leaders for state policies.

Because some tribal leaders may not be well informed about the policymaking process in the state where they reside, they may not have established on-going relations with state administrators in, for example, the Medicaid agency, the state Department of Health, or the state legislature. Tribal leaders may not have developed routines for scanning the political environment for issues that may affect them. By improving their political skills at the state level, tribes will be able to move from a position of simply reacting to proposals to helping shape them.

Tribes may be able to obtain some assistance from the IHS in improving their political effectiveness. The IHS Area Offices could play several different roles. As facilitators they could arrange for and moderate initial meetings between the parties. Once a structure is devised for institutionalizing exchanges between the Indian tribes and the state, the facilitation role of IHS may decline. IHS may also provide technical assistance to both tribes and the states, helping both parties bridge gaps in their knowledge. The IHS Area Offices may serve as advocates for tribes, promoting policies and programs that improve the health and well-being of Indian people. Finally, the IHS may serve as a mediator to resolve conflicts between tribal and state governments or between tribal governments when such disagreements occur. The Indian Health Service is eager to perform these roles (IHS, 1994a), however, the volume of work involved in tracking policies in multiple states, assessing their impact on tribal interests, consulting with tribal leaders, educating state officials, and advocating for Indian people, exceeds the capacity of the IHS staff currently assigned to these duties.

In summary, it is possible for the health care reform goals of the state policymakers to be achieved without conflicting with the goals of Indian tribes within the state. Table 3 reviews strategies for obtaining these goals.

## **SUMMARY AND CONCLUSION**

State health care reform will have little direct impact on the Indian people who obtain services only from IHCS providers and whose care is financed by only IHS or tribal sources. Indian people who obtain all of their health care services outside of



**Table 3**  
**Summary of State Policymaker Issues and Strategies**  
**Relative to State Health Care Reform**

ISSUE	STRATEGY FOR ADDRESSING ISSUE
Indian people not participating in Medicaid managed care arrangements. (Goal: Reduce Medicaid spending)	Establish primary care case management systems to allow IHCS providers to manage the care of Indian Medicaid recipients. Adopt policies that allow IHCS providers to participate in managed care networks.
Indian people become aware of issues only upon implementation and then only when problems arise. (Goal: Obtain approval from relevant constituents)	Develop tribal resources and routines to acquire information about state policymaking initiatives. Obtain technical support on policymaking from IHS Area Offices.
State health care administrators have limited experience dealing with Indians and are not well versed in issues of primary concern to Indians. (Goal: Obtain approval from relevant constituents)	Establish a state policy outlining the framework of government-to-government relations between the state and Indian tribes. Assign state staff to Indian issues allowing them to gain subject expertise. Obtain support from IHS Area Offices on IHCS and cultural matters.

the IHCS and whose care is financed by other than IHS or tribal sources are likely to benefit from reform. Delivering and financing health care services to Indian people who obtain care both inside and outside the IHCS and whose care is financed by both IHS/tribal sources and other public and private sources presents special challenges to Indian and state health care policymakers. This segment of the population is the primary Indian constituency for state health care reform.

Policy disagreements resulting from the attempt to integrate the relevant Indian population into state health care reform initiatives occur when either side fails to acknowledge and fails to accommodate the policy goals of the other. Indian health care policymakers believe that state health care reform programs should make use of the existing IHCS providers to provide culturally appropriate services to Indian patients. They believe that IHCS providers deliver services to a unique, underserved population. To assure that its vulnerable service population is not negatively affected -- directly or indirectly -- Indian health care policymakers want existing payment and coverage policies for Indian FQHCs to serve as a floor below which reform and managed care plans policies will not go. Finally, they believe that state regulations and managed care network rules might impinge on tribal sovereignty, a belief that might be mitigated by the imposition of a neutral third party, such as JCAHO or NCQA, between the state and tribal governments.

The goal of state policymakers to reduce Medicaid spending may be achieved in the Indian population by increasing managed care contracting opportunities for IHCS providers. Managed care contracting opportunities would include establishing

PCCM arrangements with IHCS providers, easing network participation criteria, and allowing IHCS providers to serve as Medicaid managed care organizations. Allowing greater participation of Indians in policy and program planning will improve the prospect of obtaining approval from the tribes of health care reform policies. The goals of both American Indian and state policymakers relative to health care reform can be achieved. While each side has a different set of policy goals, the goals themselves do not conflict.

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## **APPENDIX**

### **THE LEGAL STATUS OF AMERICAN INDIANS AND THE STRUCTURE OF THE INDIAN HEALTH CARE SYSTEM**

#### **Legal Status of Indian Tribes and American Indians**

Tribal sovereignty is a legal concept established by a series of Supreme Court decisions handed down by Chief Justice John Marshall in the early nineteenth century.<sup>1</sup> Sovereignty has many meanings and it is frequently used and occasionally misused in discussing Indian affairs with state governments. Fundamentally, the term refers to the inherent right or power to govern (Canby, 1981). According to one modern observer, "the principal attributes of tribal sovereignty today may, with some danger of oversimplification, be summed up as follows: (1) Indian tribes possess inherent governmental power over all internal affairs; (2) the states are precluded from interfering with the tribes in their self-government; and (3) Congress has plenary power to limit tribal sovereignty" (Canby, 1981, p. 66).

Tribal sovereignty also has cultural significance for American Indians beyond its legal importance. It is a symbol of the independence of Indians from the dominant culture, and is used as a shield to protect Indians from unwelcome intrusions into their affairs. In conflicts with states over issues such as wildlife management, land use, and gaming, American Indians have relied successfully on tribal sovereignty as their primary defense in blocking state actions.

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<sup>1</sup> Readers interested in a more complete discussion of the legal status of American Indians and of the federal trust responsibility for Indian health may consult a number of excellent sources, including Hall (1979), Canby (1981), Joe (1991), O'Brien (1991), and Moore and Wilson (1993).

Although tribal sovereignty is important, it does not constitute veto power over state actions. For example, some tribal representatives question the legitimacy of Medicaid waiver applications submitted without consultation with and approval of tribal governments. In order for Indian tribes to use sovereignty as a defense against unwanted health care reforms, they will have to show that sovereign interests are violated by the proposals.

Indian people are both members of their tribe and, since passage of the Citizenship Act of 1924, citizens of the United States. They are also citizens of the state within whose boundaries they live. Indian citizens are entitled to all of the benefits of other citizens, including Medicare and Medicaid and health programs of the Veterans Administration. Indian people are also entitled to participate in any program expansions caused by state health care reform.

Indian people are extremely diverse. Within states tribes may have significantly different levels of wealth, distinct political structures, and dissimilar historical experiences with the federal and state governments. Some recognized tribes are composed of culturally heterogeneous people. Federal recognition of tribes is a prerequisite for federal Indian services administered by the government, but the federal government has not always been ruled by "ethnological realities" in recognizing tribes. In the past, ethnologically distinct Indian tribes or bands have been grouped together in single reservations and thereafter considered a single

tribe<sup>2</sup> (Canby, 1981). Reflecting the historical, economic, and political diversity of Indian tribes, it is not always easy to find consensus among them. Even within tribes there may be substantial differences of opinions such as that initiated by the conflict between maintaining traditional ways versus greater assimilation into "white culture."

### **Structure of the Indian Health Care System**

The mission of the Indian Health Service was established by law in the Indian Health Care Improvement Act: to raise the health status of American Indian and Alaska Native people to the highest level possible. The IHS has achieved some notable successes, but a large gap still exists between the health status of American Indians and that of other Americans (IHS, 1994a). Most IHS funds are appropriated for American Indians living on or near reservations, although the agency also administers 34 urban projects. The urban projects account for only 1.1 percent of the 1994 IHS budget (IHS, 1994a).

The IHS is organized into 11 regional administrative units called Area Offices. An additional office in Tucson, Arizona is also considered an Area Office for statistical purposes. The local administrative division of the IHS is called a service unit. There are 143 service units throughout the United States, 70 of which are operated by tribes. The diverse American Indian and Alaska Native cultures require specialized methods of delivering appropriate health care in a variety of settings. The IHS

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<sup>2</sup> For example, the Colville Indian Reservation in Washington State is populated by eleven different tribes of Indians that were settled on the reservation. Nine of the tribes spoke one language (Salishan) and the other two spoke another language (Sahaptin). Although they now use English in their day-to-day lives and businesses, there is increased interest in preserving and teaching the historical languages of the Colville Confederated Tribes (Portland Area Office, Indian Health Service, 1994).

operates 41 hospitals, 66 health centers,<sup>3</sup> 4 school health centers, 44 health stations,<sup>4</sup> and 34 urban health projects. Indian tribes administer 8 hospitals, 110 health centers, 4 school health centers, 62 health stations and 171 Alaska village clinics (IHS, 1994a). The clinical staff of these facilities is composed of approximately 1,100 physicians, 380 dentists, 100 physician assistants, and 2,600 nurses (IHS, 1994b).

Medical services of the IHS have a family practice orientation. Most of the populations of the service units are too small to support specialists, but many locations sponsor specialty clinics staffed by private specialists to augment IHS/tribal staff. In addition to directly providing services, both IHS and tribally administered health programs purchase services through contracts with private physicians and community hospitals.

The programs of the IHS are based on a community health model. In addition to providing medical care, the IHS is responsible for sanitation, public health, and disease prevention. Other community health programs include injury prevention campaigns, nutrition and dietetics education and counseling, substance abuse prevention, public health nursing, and a program using indigenous community health representatives to provide selected services (Kauffman and Associates, 1993).

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<sup>3</sup> A health center is defined as a facility, physically separated from a hospital, with a full range of ambulatory services, including at least primary care physicians, nursing, pharmacy, laboratory, and x-ray, that are available at least 40 hours per week for outpatient care (IHS, 1994a).

<sup>4</sup> A health station is defined as a facility, physically separated from a hospital or health center, where primary care physicians are available on a regularly scheduled basis but for less than 40 hours per week (IHS, 1994a).



The Indian Self-Determination and Education Assistance Act of 1975 (Public Law 93-638), authorized Indian tribes to assume the operation and administration of certain programs previously administered by the federal government. Through P.L. 93-638 self-determination contracts (also known as 638 contracts), tribal health programs provide comprehensive preventive and curative services. One third of the agency's annual appropriation is invested in services delivered under 638 contracts (Trujillo, 1995). The number of tribes electing to assume responsibility for delivering health care services has increased steadily. Tribes have the option of deciding whether to contract or retain federally delivered health care services for their communities. By law, all 638 health centers are eligible for certification as federally qualified health centers (FQHCs).

The costs of administering the IHS are not covered by its Congressional appropriation. In fiscal year 1994, approximately \$173 million of the costs of administering the agency was funded by third party revenue. Approximately \$154 million was collected from Medicare and Medicaid, and approximately \$19 million was collected from private insurance companies. Taken together, these third party revenue sources funded 8.2 percent of the budget of IHS.

Although IHS provides comprehensive health care service free of charge to eligible Indian people regardless of their ability to pay, IHS services are considered "residual" to those of other providers. That is, other sources of payment for which the patient is eligible must be exhausted before IHS will pay for medical care. For direct IHS services, the residual payer role is discretionary. IHS will provide services

in its facilities even if other sources of payment are available, and will then seek payment from these sources. For contract care obtained from non-IHS providers, IHS's residual payer role is mandatory: other sources of payment must be exhausted before IHS will authorize contract care payments.

Medicaid reimbursement for care provided to Indians in IHS-owned facilities is made exclusively from federal funds. In contrast, tribally-owned facilities, like other health providers in the state, receive reimbursement that is a mix of state and federal funds. Therefore, tribal facilities are subject to state requirements in order to be eligible for reimbursement, while IHS-owned facilities are exempt from state rules and conditions. This circumstance leads to inconsistent treatment of Indian providers within a state. Some Indian health care leaders have suggested making Medicaid 100 percent federally funded for all Indian health services and exempting IHCS providers from state Medicaid rules.

Each service unit receives an annual budget from the IHS based on user population<sup>5</sup> with some adjustments for the health needs of the population. Funding for 638 contracting tribes and self-governance tribes is determined using a similar methodology to the IHS direct-care service units. Self-governance tribes also have access to funds for administrative functions that had previously been the responsibility of IHS Area Offices or IHS Headquarters. Over the past decade, IHS funding has experienced a 40 percent reduction in real dollars, adjusted for inflation.

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<sup>5</sup> The user population is defined as the number of people eligible for IHS services who have used those services at least once during the last three-year period. The user population is approximately 85 percent of the service population (John, 1994).

Less than 50 percent of the actual level of need documented by IHS is funded through annual appropriations to the agency (Kauffman and Associates, 1993).

In summary, federally recognized Indian tribes have a government-to-government relationship with the United States that is based upon a long history of treaties, laws, and Supreme Court decisions. The federal government has a duty to furnish the people of recognized Indian tribes with health care services and has chosen to fulfill that duty by either providing health services directly or financing the delivery of health services by tribes through the IHS. Although the IHS is the primary source of Indian health care system funding, public and private third-party funding is growing in importance.

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