



Native American Health and Welfare Poli- cy in an Age of New Federalism

Edited by
Robert Merideth
and Stephanie Carroll Rainie



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Communication and Action for American Indian Health and Welfare Working Together When We're Apart

AN INTRODUCTION BY

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The ongoing changes in the health care system have a direct impact on both American Indian communities and on those working to provide and secure health care for American Indians. The myriad points of view pooled together in this volume represent an invaluable opportunity and an important starting place to address these changes. This collection is an update of discussions and presentations made at a conference held in Tucson, Arizona, in November 1998, organized and sponsored by the Udall Center for Studies in Public Policy at The University of Arizona, the Henry J. Kaiser Family Foundation, and the Morris K. Udall Foundation.

There has been a remarkable array of responses in those communities that are already making changes in the effort to combat negative trends in Indian health care. The stories presented here speak of how some communities are wrestling with these problems and of the innovative solutions they are developing. With both determination and intelligence, an enormous variety of people are trying to find solutions; their stories offer remarkable testimony to the talent and intelligence that resides in and rallies against problems in Indian Country. Such examples also show how far Indian Country has come despite facing such diversity.

Many communities do a very poor job of communicating to each other about the successes that they have achieved. I've talked to people that said, "I am so glad to hear the Chickasaw report on what they have done and what they felt was important" or "I was really glad to hear what the Modoc are doing. We had not even thought of doing it that way."

Need for Communication

There should be a more effective means of communication than the occasional conference to keep each other abreast of what seems to be working so that fewer communities "reinvent the wheel" every time they encounter a problem.

Many communities face a change with the sense that they are the only ones dealing with that problem. Others feel fortunate to arrive at a solution when different people are finding solutions around the country every day. Communities throughout Indian Country are finding both cracks in the system as well as solutions to their problems.

One of the biggest improvements needed in Indian Country in health care, economic development, land-use planning, and dealing with federal policy is better communication about which solutions have been tried and which have been successful. There should be a universally accessible message board, utilizing a resource such as the Internet, where a community in need can see that assistance is available from communities who have overcome similar obstacles.

The overview of the changes faced by the Native American communities presented here is potentially discouraging. Hearing about the struggles that are happening everywhere makes the challenges ahead appear overwhelming. Then come the success stories, which are extremely inspiring.

I find these presentations to be a very hope-instilling for a number of reasons. In addition to the stories that are told, the collection of intelligence and talent, and the suggestions people have come up with elicit a pervasive feeling of hope, a sense of what can be accomplished if all of the talent and experience in Indian Country is put to work on a particular problem.

Need for Action

Along with improved communication, another need is for better ways of focusing the talents that are randomly distributed throughout various communities and entities. How can we form national teams that bring together expertise from many origins and disciplinary backgrounds? It is not possible to wait until the next conference six months from now to develop recommendations around a new piece of legislation. At times it is necessary to gather information and implement strategies on an ad hoc basis, but it is still critical that the right people are putting their minds to it. This is another systemic problem that must be solved. How can people work effectively together when they are apart?

Two issues I think need more discussion are the link between health care and the reservation economy, and the relationship between devolution and self-governance.

Economy and Health Care

Much of the research I have done in Indian Country is on economic development. To echo the remarks of Becky Adamson and Sherry Salway Black, health care is strongly linked to the reservation economy. Their comments reminded me of a remark by Tom Welty, an epidemiologist in the Indian Health Service. I first ran into Welty 10 years ago when he was working in Rapid City, South Dakota, and Joe Kalt and I were doing research at Pine Ridge. Welty is faced with the public health problems of the Northern Plains reservations. He said to us, "You know, I am acutely aware every day when I am on that reservation that most of the problems I am wrestling with are those correlated with poverty. All I am doing is fighting the fires. I am dealing with the symptoms. I am never going to solve these problems. What is going to solve them is building societies and economies that work. If we could do that, then my

job would become much easier.”

When Becky Adamson and Sherry Salway Black describe the link between health care and the economy, it occurs to me that one health care strategy that is not given enough attention is economic development.

Economic development is a health care strategy. It cuts to the heart of many of the problems that Indian Country is currently dealing with. If tribes can be provided with the resources to enlarge their capacity as developers, according to their own objectives, to build the kinds of economies that they want to build, we will in fact be fighting health care problems.

Devolution and Self-governance

The relationship between devolution and self-governance is also a significant issue. When reading presentations about devolution from the federal government to the states, it is evident that the danger is not a Congress that believes in devolution. More pernicious is a Congress that believes in devolution but does not believe in Indian nations.

Devolution to Indian nations has been one of the most successful policies of all time in the field of economic development. When tribes design their own programs, make their own decisions and run their own affairs, they are more successful because they are the most intimately familiar with Indian lives and communities.

Devolution should be a goal if it will strengthen tribes. The danger is devolution in which tribes do not exist; this type of devolution is the one being dealt with in Congress now. Unfortunately, the current Congress seems to be one that views devolution more positively than it views tribes and Indian nations themselves.

What should be challenged is not devolution in and of itself, but the idea that Indian nations will not be here in the future and the attitude that Indian nations who design their own futures are inconsequential. This attitude must be destroyed.

One of the best defenses of tribal sovereignty is its effective exercise. As Vernon James mentions, it is essential to build tribal infrastructures and governments that can effectively deliver the programs discussed at this conference.

Some of the best investments to be made are in tribal capacity building, or in building sovereign nations that can exercise their sovereignty effectively. Every time a bridge is constructed between an Indian nation and a state, more ammunition is available to defend sovereignty because that bridge is the state’s recognition of the Indian nation as a sovereign nation that must be dealt with one-on-one. Over time, those states that regularly interact in working relationships with Indian nations become dependent on that sovereignty and feel compelled to defend it.

Investment in self-governance capabilities at the tribal level will allow Indian nations to deliver health care programs effectively and to develop vigorously in their

Federal Perspectives on Native American Health and Welfare

A Congressional Perspective

Hon. John McCain
U.S. Senator (R), Arizona
Washington, DC

At the beginning of the new millennium, the most basic and fundamental qualities of life continue to elude Native American populations: healthy communities, healthy families, and healthy children. The perennial problems of providing basic health care and social services are a constant and growing dilemma.

Some members of Congress are led to believe that the standard of living for Indian people is improving due to the economic successes of a few Indian tribes. A large number of those in Congress believe that every Indian tribe is like the one in Connecticut that happens to own a very rich casino. While this new revenue stream associated with Indian gaming has helped a number of tribes, it has not helped and never will help the overwhelming majority.

If the Hualapai Tribe set up a casino tomorrow, it would not matter, despite the fact that the Hualapais need basic human services as much as the Pequot Tribe in Connecticut need them.

Some Conditions and Trends

The statistics are unpleasant. One-half of all Indian children under the age of six live in poverty. Approximately 50 percent of Indian families headed by females live in poverty, compared to the national rate of 31 percent. Reports of the abuse of Indian children continue to increase and unemployment rates are perpetually high.

American Indians still suffer the highest mortality rates of any group in the nation due to alcoholism, tuberculosis, diabetes, pneumonia, and influenza. The number of HIV and AIDS cases among American Indian communities is increasing at an alarming rate.

Tribes have indicated their limited ability to treat complex medical issues such as respiratory and cardiac care. Indian populations are growing, and the need for more and better services is critical. Federal Indian policy has evolved, and there has been some progress in addressing the very serious health care needs of Indian people. These and other issues require careful attention in Congress, as well as outspoken advocacy and support.

Over the years, Indian health care delivery has greatly expanded; tribes are taking

over more health care services at the local level.

Indian Health Care Improvement Act

Approximately 25 years ago, Congress enacted the Indian Health Care Improvement Act to meet the fundamental trust obligations of the United States to ensure that comprehensive health care would be provided to American Indians and Alaska Natives. The status of Indian people's health still remains far below that of other Americans.

The Indian Health Care Improvement Act covers nearly every aspect of Indian health care delivery systems. It provides grants and scholarships to recruit Indians into the Indian Health Service (IHS) system, and funds to expand the health care infrastructure. In addition, the Act lifted the prohibition against Medicaid and Medicare reimbursement for health services provided by IHS or the tribes and established service for Indian health care in urban areas.

Today childcare and senior issues are critical, as is exploration of the options for long-term care. During the reauthorization process, many of the programs will be re-examined and possibly streamlined, and others will be expanded. The Act should also be compatible with tribal self-governance. The Act came up for reauthorization in Congress in 2000. As of the beginning of calendar year 2001, this act has not yet been re-authorized.

IHS is essentially the sole health care provider and payer for more than half of Indian families nationwide, serving approximately 1.4 million American Indians and Alaska Natives each year.

Impact of Devolution

In an era of devolution and federal downsizing, IHS is finally making the move towards tribal self-governance. Legislation was extended to IHS as a demonstration effort to replace the paternalistic federal management of Indian programs with management at the local tribal level, where Indians most benefit by direct services.

The self-governance program through Public Law 93-638 within the Department of Interior was made permanent because of its success in Indian Country over the past 15 years. One of the great successes facilitated by Public Law 93-638 is that more than 200 tribal governments now directly administer the Bureau of Indian Affairs Program. By contrast, though the Public Law 93-638 Program within IHS has been largely successful but limited as only 45 compacts and 64 annual funding agreements have been made with 264 tribes to administer IHS programs through this law.

Legislation to make IHS self-governance program permanent and to remove federal obstacles to full implementation by tribes was considered in the 105th Congress. During negotiations, tribes and the Administration made progress; however, unresolved issues regarding contract-support costs, or the administrative costs resulting from the Public Law 93-638 contract with the federal government, held up further action.

Those involved with direct tribal operations of health facilities need to know that the issue of contract-support costs will be a priority consideration for the Congress. The core issues are a lack of sufficient funds in the short-run and structural adjustments

that would affect how administrative costs are negotiated and allocated. Successful resolution will necessitate close involvement.

Restricting eligibility, however, is not the answer to controlling costs for contracted Indian health care. The Administration must work closely with the tribes and Congress to find equitable solutions while maintaining its commitment to tribal self-determination.

Push for IHS Status

For the past four Congresses, I have sponsored legislation to designate the IHS director as Assistant Secretary of Indian Health within the overall Department of Health and Human Services. The bill successfully passed through the Senate but stalled in the House. I will continue to push for this bill as long as I see inequitable treatment of Indian health programs in our national budget and hear about dire health conditions of Indian people. This bill is consistent with the federal/tribal relationship and would provide IHS with a stronger advocacy role within the Department of Health and Human Services and better representation during the budget process.

Decisions about tribal health issues continue to be made without directly consulting IHS and Indian tribes. This process needs a senior policy official who can sit at the table with the highest officials in federal government and provide knowledgeable leadership for the health care needs of American Indians and Alaska Natives.

High rates of poverty and unemployment prevent Native Americans from securing employer-sponsored or other types of private health insurance. Public programs such as Medicaid and Medicare become more important in ensuring that eligible children, families, and elderly Native Americans receive health care.

Medicaid is also an important source of revenue for tribal health facilities. IHS figures in 1997 indicated that 39 percent of Native Americans were enrolled in Medicaid, and 10.1 percent were enrolled in Medicare. Compared to the national population where virtually all of the elderly are covered, only two-thirds of elderly Native Americans were covered. All Native Americans who meet Medicaid and Medicare eligibility criteria, regardless of whether or not they live on a reservation or if they qualify for IHS services, are entitled to coverage.

In 1997, expenditures required to cover a person in an IHS program was \$1,939 less than that of a Medicaid beneficiary, and \$4,025 less than that of a Veteran's Administration patient. The country is falling far short of ensuring adequate coverage for all eligible Native Americans.

Congress must tackle health care issues with an emphasis on senior health care, Medicare, and Medicaid, which will have significant implications for tribes and the status of health conditions of Indian populations.

I firmly support services necessary to protect our nation's most vulnerable citizens, particularly children, the elderly, and the disabled. We must continue to provide the opportunities and resources for all Americans to become self-sufficient, productive

Perspective from the United States Department of Health and Human Services

Secretary Donna Shalala
U.S. Department of Health and Human Services
Washington, DC

People must come together to map the destination and action necessary to build a brighter future for Native American families and their children, wherever they live. The federal government must fulfill its solemn obligation to maintain a unique relationship with Native American leadership.

There are four common sense guidelines for what the federal government has done and must do as partners in a common future.

Consistency and Trust

The first guideline addresses that too often in the past, beginning with this country's first Americans, Washington has not been guided by a majority of thinking members. The relationship between Native Americans and the federal government has been long on promises and short on promises kept. Too often the government's answer to sky-high rates of poverty, the alarming rate of diabetes, and high rates of alcoholism and suicide among Native Americans has been to dismiss these issues as "Indian problems."

President Clinton reinforced that these are not Indian problems. He has maintained that when any American is left out in the cold it is the entire country's problem, and he committed his Administration to bringing all Americans into the fold. He recognized that "business as usual" is not the best way for the federal government to do business with the nation's first Americans. He realized that change means a less centralized government; more opportunities for states, communities, and reservations to shape their own destinies; increased demands for more effective use of resources and more accountability; and a renewed focus on the health of racial and ethnic populations.

The Administration helped to foster this change by protecting and strengthening the bridges of understanding and cooperation with Native American sovereign nations. One of President Clinton's first official acts was to direct all federal departments and agencies to include tribal governments in discussion of matters that directly affect their people. This inclusion can increase the number of opportunities for tribal governments to help shape and strengthen their agendas.

The Department of Health and Human Services took President Clinton's charge to heart, recruiting the brightest and most dedicated leaders to head its efforts. Many of them are now familiar names on reservations across the country.

With help and insight from these colleagues, a new tribal consultation and participation policy was issued, the first of any federal department. This policy directs each

agency, including the National Institutes of Health, the Food and Drug Administration, and the Center for Disease Control and Prevention, among others, to create its own plan to embrace and engage tribal representation and to improve all departmental activities affecting the tribes.

This policy was not merely a memo circulated to a few division directors or the addition of a program or two but was a revolutionary process of tribal consultation that is building upon a long tradition of consultation in the Indian Health Service. This process of tribal consultation is becoming a routine part of the way the department carries out daily business.

Real change, however, will not come unless the consultation that takes place is meaningful and valuable. Change will only happen via discussion with, collaboration with, and, most importantly, listening to Native Americans.

Involving Many Voices

The second guideline that is important to follow is that one cannot stand up for Native Americans unless one is sitting down with them. And upon sitting down with them, it becomes evident that there is no one Native American voice.

American Indian tribes and Alaska Native villages have very different traditional cultures with unique perspectives and priorities. Due to the recognition of these differences, the Department of Health and Human Services' leadership has traveled around the country to meet with Native American leaders on their home turf from the start.

One common refrain heard in our first listening council with tribes in the Southwest was that listening and learning are not enough if there is not adequate action.

Action, Not Empty Promises

This brings to mind the third guideline, the idea that empty promises are not needed; action gets the job done. That is why over the last decade many have worked hard to translate the health concerns of Native Americans into quick action. The structures of the Indian health programs throughout the department have been elevated and strengthened.

The Director of the Indian Health Service does not report through a bureaucracy; he reports directly to me. Methods of strengthening the Administration on Children and Families and the Administration on Aging in relation to Indian programs are continually developed.

New and better ways to empower Native Americans and to provide health and hope to children and to families are continually being found. These include improving the health status of Native American women by focusing on their high rates of injuries, alcoholism, cervical cancer, and diabetes.

They include working to brighten the twilight years for the most respected members of Native American communities, the elders, by focusing on improving the quality

of elder health services. Further empowerment can happen by working to build a better standard of living for Native American children, for example, by making sure that more children who are living without health insurance get the coverage they need. It is also important to take a closer look at critical problems such as substance abuse, mental health difficulties, teen suicide, and violence in the home and at school.

Beginning with the balanced budget in 1997 and in partnership with the tribes and the urban Indian health centers, a five-year, \$150 million battle is being waged against diabetes, a disease that strikes at the heart of many Native American communities. Expansion of diabetes prevention and treatment services is now under way at the community level, and early testing and intervention efforts were aimed at those communities overwhelmed by the devastating effects of diabetes.

One of the most important steps that has been accomplished is that disparities among Native Americans are now being viewed as American problems rather than as Native American problems. The Department of Health and Human Services Racial and Ethnic Health Initiative was launched for this very reason, to target six key health disparities: Infant mortality, diabetes, cancer screening and management, heart disease, HIV/AIDS, and immunizations. For the first time in American history, there has been an end to separate and lower national health goals for minorities in these areas; instead there is now a commitment to health equality for all. The goal is not to address or reduce the health disparities but to eliminate them, ultimately leading to better health for all Americans.

These important efforts should be a source of pride, but there is a long way to go. The challenges faced ahead will undoubtedly require collaboration, creativity, unfailing dedication, and money.

It is time for the federal government to make a serious, sustained investment in the health of Native Americans. In light of this, for Fiscal year 1999 I requested the largest budget increase in the history of the Indian Health Service. And each subsequent year I asked for more. We cannot get it unless we ask.

Building Consensus

This leads up to the final guideline: If a goal is found that everyone can work on together, it will be the right one. Helping Native Americans enjoy the promise of

Perspectives from the Indian Health Service

Michael Trujillo
Director, Indian Health Service
Washington, DC

Indian Health Service (IHS) is a federal Indian health care program that delivers health care services directly to tribes, facilitates tribal programs in which tribes manage and administer their own health care delivery systems, and delivers health care to urban Indians in various metropolitan centers.

There are three components of the Indian Health Service: “I” for federal, “T” for tribal, and “U” for urban. This is the I/T/U system.

How can the feasibility, comprehensive programs, and communication process of each of the components of that core delivery system be unified?

Furthermore, how does IHS reach out into the rest of the medical and business world it has to deal with on a day-to-day basis? Business aspects, such as the financing and accountability of health care delivery, are now becoming key issues in Indian health.

All over the country, in this changing health care system, there are dedicated staff and providers delivering services to those in need.

However, there are many complexities in the IHS program, including the challenge of the politics and personalities of the many individuals coming into contact.

Over the past several years, IHS has tried to change ties that are presented to Congress.

Large, national, Indian health care programs such as the National Indian Health Board; tribal health programs; and urban programs are now directly involved in setting those priorities for Indian health care in IHS. They themselves advocate before and present the budget to Congress. This process fosters hope that through a step-by-step process IHS may be able to attain increases of revenue and allocations to the Indian health care program over the next several years.

IHS has begun to present a needs-based budget derived from a great deal of noteworthy though incomplete data. Although the budget is not always fully funded, it begins the discussion of what the program needs.

Outreach Efforts

IHS has established various work groups to examine accountability and actuarial studies of several service units and tribes. This will allow IHS to better understand some of the care costs and will enable comparative studies across the nation.

IHS has established programs to reach out to foundations, private groups, universities, and medical centers, illustrating ways they may become involved in the

process of advocating, understanding, and providing a wide realm of services for Indian people nationwide.

This not only involves health care or manpower training; it also includes encouraging other entities to become involved in economic development, social services, and the analysis of viable communities. Hopefully, this will result in better health care, healthier communities, healthier families, and most importantly, healthier individuals.

There are many chronic diseases related to alcohol and substance abuse prevalent in Indian communities. Given IHS's limited funds, the complexities of such problems presented daily by patients needs to be addressed.

There should be equity in services, in programs, and in the ability to negotiate the strategies deemed necessary to make improvements. However, there are significant obstacles to achieving this equity. For instance, not even 50 percent of the need for Indian health care dollars is met across the nation. Subsequently, it is difficult to know how to change the system and health care so that the purchasing power of each dollar is best utilized.

Tribal Management of Health Care

In some instances, looking internally rather than externally for lessons on how to improve Indian health care can be more productive. Tribal, urban, and IHS programs have acquired a vast amount of experience. IHS may not have up-to-date or specialty data systems or health care equipment, but it has a great deal of the ingenuity and creativity needed in the face of daily adversities.

On a different note, the Indian health care system may in turn have something to offer the United States health care system. IHS comprises major programs that are used as models for the development or improvement of diverse programs worldwide. IHS is able to communicate across 548 different tribal groups, spanning the spectrum of health care across the country and all of its diversity, traditions, culture, and languages. There is no other health care system in the world that does or has the responsibility to perform in that capacity, or has the sufficient resources to create such a service.

The Indian health care program is one of the best programs in the world. However, it must still be strengthened through communication, understanding, and focus on the goal of serving people in need. To do this, IHS must unify and advocate for resources.

COMPETING IN THE CHANGING HEALTH CARE MARKETPLACE

Challenge in Building Sustainable Indian Health Care Programs

of Indian leaders' work to begin to shift health care control towards tribal management, bringing their ideas to fruition.

Soon after, in the 1970s, the Indian Policy Review Commission traveled across the country, assembling a portrait of significant health care and Indian affairs concerns in Indian Country. Its report served as a basis for other actions in the late 1970s and early 1980s.

In addition, the Indian Health Care Improvement Act (IHCIA) Amendments, which occurred in the mid-1970s during the 94th Congress, for the first time gave authority, by law, to IHS and tribes for provision of health care to Native Americans. These amendments provided the foundation for increased appropriations for IHS. But in the 1980s, upon the re-authorization of the IHCIA by Congress, President Reagan would not sign them. For at least two years, there was no written authority for the Indian health program, and it was unclear whether the authorization was going to continue with the appropriations. The Indian leaders again had to pressure the government eventually to sign authorization.

Significantly, the re-authorization increased the IHCIA, allowed Medicare and Medicaid to be billed by IHS and tribes as third-party payers, and initiated additional funds for the Indian health care system. Some budgets now use these additional funds for up to 40 to 50 percent of their operating finances.

In the late 1980s, self-governance re-emerged. The concept was originally promoted in the BIA and spread throughout the country. Self-governance began to apply to IHS in late 1991, becoming Title III of Public Law 93-638. The law further allowed tribes to develop and customize health care to their communities and to fit the needs of Indian people.

Changes in Indian Health Service

An Abridged Modern History of Indian Health

James Floyd

Department of Veterans Affairs Medical Center

Salt Lake City, Utah

The health care system Indians benefit from today is the result of a great deal of work that began around the time the Transfer Act of 1954 and Public Law 89-121 were enacted.

In the report, Current Issues in Indian Health Policy, Yvette Roubideaux identifies the Transfer Act as the beginning of the modern health care system for Indian people, creating the Indian Health Service (IHS). At that time the health care responsibilities were transferred from the Bureau of Indian Affairs (BIA) to the Department of Health, Education and Welfare (HEW).

At that point, the Public Health Service, as part of HEW, began to implement public health practices. Public Law 89-121 came about soon after, initiating the installation of water and sewage systems on reservations where before there were none.

Furthermore, IHS started immunization programs and home visits from community health representatives (CHRs) similar to those developed by Indian people years earlier. Many of these services are still offered today.

Today IHS is roughly 45 years old, the length of one long generation. But over these years there have been a number of significant barriers to the continuance of IHS.

Shift to Tribal Management

The late 1960s and early 1970s saw the beginnings of self-determination. The Nixon Administration enacted Public Law 93-638, the Indian Self-Determination Act. This was the culmination

The economy is booming, yet the uninsured in this country have reached a record level of 45 million people. The devolution of authority for programs like Medicaid and Welfare certainly present new challenges, including the challenge to develop better and more effective relationships with state governments.

In order to develop these tribal-state relations, tribes must constructively engage with state officials at every opportunity. They must find and cultivate their advocates and friends inside state agencies and in the media. And finally, they must never forget that it is the “squeaky wheel” that grabs attention from cabinet officers, legislators, the media, and governors. There is no substitute for aggressive and intelligent advocacy in the real world of state government.

In the face of all of these realities, the challenge is how to find the opportunities in the current world to make things better for people in need. In Medicaid, managed care, IHS, Welfare, and children’s health insurance, the points of leverage needed to improve lives must be found.

U.S. Health Care Environment: Challenges to Indian Health

Ron Pollack
Families USA
Washington, DC

To create a context for discussing health care, one needs to focus disproportionately on children and the poor. The Native American population has a higher concentration of children. One out of three Indian people is 15 years of age or younger. This is one-and-a-half times greater than the general U.S. population, which comprises 22 percent children 15 years of age or younger. So many of the changes in health care have a disproportionate impact on children. One also needs to focus on the concerns of low-income people. The poverty rate among Native Americans is two-and-a-half times as great as it is for the general U.S. population, and many of the key changes in health care disproportionately

affect low-income populations.

Five Issues of Relevance to Health Care

There are five health care related phenomena occurring around the country of relevance to Indian health.

The first is a clear, significant, and growing movement to push policy-making control from the national to the state to the local levels. This is what some people call devolution.

The second is an overwhelming movement towards managed care health-delivery systems throughout our private and public sector health care systems.

The third are significant new health-coverage opportunities that could provide increased access and affordability to care, although there has been an ongoing failure of people to get the health care coverage that they are entitled to receive through previous advances, and possibly, in some of the most recent advances as well.

The fourth is the increasing importance of the intertwining relationships among different public programs, which will become clear later on.

And lastly are the increasing inequities in the health care system and what those inequities mean to the numbers of people without adequate access to health care.

Let us look first at devolution. Devolution is the pushing of authority further away from a national source and towards state governments and local entities.

Devolution of Authority

The proponents of devolution say that devolution helps to facilitate more responsive decision-making. They also believe that it creates greater flexibility—having one set of rules that applies to everybody does not often work. They suggest that when moving in the direction of devolution, decisions better reflect local conditions.

The opponents of devolution say that it is an exercise of passing the buck without the buck. Devolved authority occurs in key health care programs today.

In addition to the significant barriers to its continuance, IHS has changed from a single federal system initiated by the Transfer Act to an entity that encompasses numerous systems. Today there are more than 550 federally recognized tribes; and IHS has numerous contracts and compacts with tribes for the administration of programs and provision of services. Thus, the system has gone from one to many.

The Indian health care programs must be viewed as facets of a system with many independent parts. It consists of federal, tribal, and urban programs that deliver care to people in at least 39 states throughout the country. It is a challenge to predict how this system will evolve. Yet, it is critical to the future of Indian health that the issues related to the changing system are discussed and that a plan of action is implemented.

Early in its history, IHS was an independent system. It was protected by federal rules and regulations, as well as by appropriations. Therefore, the factors that affected the health care economy in general did not affect IHS a great deal. That has changed significantly.

Many issues are raised when IHS is compared to the private sector. For instance, the health care systems, managed care companies, and suppliers of health care services are beginning to group together so that they can jointly utilize their resources in order to maximize cost efficiencies. It is a very competitive and dynamic system.

Although IHS is scaling down from the large system to many small ones, it now needs to integrate these systems so that it can also begin to consider the economies of scale available and determine how a cohesive approach can best serve IHS.

Managing Costs

Indian health care interests also need to examine private sector issues and how those concerns may affect Indian health care in the future. For example, during the health care reform debate in the early 1990's, the managed care industry began to analyze its administrative costs in order to make cuts where possible. The industry

wanted to be a more competitive alternative to national health care and the health care reform that President Clinton promoted.

Now more than five years later, managed care companies are raising their costs. They found that they could not keep administrative and other costs down and remain competitive. Thus, managed care rates and other insurance prices will increase over the next few years to recover some of the lost resources.

The same thing is occurring in IHS. Administrative costs have been a big issue, and IHS must begin the process of pooling available resources together to sustain the system as a group of many parts, many different interests, and many different people.

If we promote a benefits package to the Indian people, its universalism throughout Indian Country will have to be guaranteed. Whether an Indian person resides in Florida or Alaska, one will be eligible for the same benefits. It is difficult to price and administer such a package, to find a data system that tracks those benefits that people already have, and to then to utilize that data to support the Indian health care system. These questions remain to be answered, but are the issues at our door today.

Challenges and Opportunities for Indian Health

Drew Altman

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These are difficult times full of unmet needs in Indian communities and elsewhere. However, the attention of our national leaders, unfortunately, is elsewhere.

There is a need for more and stronger government leadership, and certainly for substantially more money for Indian health care. Yet anti-government sentiment and the desire for a smaller government are at or close to an all-time high.

sultation process should work, nor are there any sanctions if the state fails to do so. Still, we must exercise every opportunity we have, in every avenue, to influence the design of CHIP, as well as Medicaid and Welfare.

Managed Care

Another point one needs to consider is the overwhelming movement to managed care. The definition of managed care is fairly elusive, but essentially it is a process by which some party, other than the physician, the patient, or additional providers, makes health care decisions. Managed care comes in many different forms.

Managed care has its roots in a group of non-profit visionaries who genuinely wanted to improve America's health care system. They thought that managed care would be a prescription for improving the coordination of health care. They believed that managed care would establish a system of care accountability, that it would increase knowledge about good health care and disseminate that knowledge to various practitioners, and that it would help to emphasize primary and preventive care. The idea of managed care was largely conceived as a staff-model health maintenance organization (HMO).

Managed care did not really take hold until sometime in the 1990s, when it caught on like a prairie fire. It started in the private sector, as a result of the needs of employers. Now it has moved rapidly into the Medicaid Program and is moving somewhat rapidly into Medicare Programs.

Managed care eventually caught on, and not as a result of the goals of the non-profit visionaries or the founders of health care. It caught on because the payers of health care, employers who pay for their workers' health coverage and government entities that pay for public programs, thought that managed care was going to be the magic bullet to save money. Clearly, the payers of care as well as the health care insurance industry saw it as a far more palatable option than the direct regulation of costs.

As managed care has evolved, some significant changes have occurred. There is far greater involvement today in the for-profit sector. There

is much less of a staff-model-type system, such as a staff-model HMO, and there are now more new and evolving networks of delivery systems. HMOs and insurance companies are far less in the business of managing care than they are in the business of managing allocations of risk among different provider entities that actually provide health care services.

There has been a revolution in the financing of health care. It may have been silent, but it was clearly a revolution.

The fee-for-service health care system is still in use, but its applicability to the health care system is decreasing. The old health care fee-for-service system had every economic incentive for providing more and more services, more and more tests. The way providers in the health care system made money was by providing more. The fee-for-service system played some role in the significant increase in costs, which for many are viewed as unsustainable.

Today, however, we have a capitated system with one payment, irrespective of the services provided. Therefore, the economic incentives today work in the opposite direction than they did in our fee-per-service system.

There are incentives for providing less care. As a result, there has been a tremendous amount of public concern and backlash. That backlash undoubtedly is fueled by media stories about people who feel that they were improperly denied health care.

New Health Coverage Opportunities

There are many new opportunities in health care coverage. In 1998, about five-million uninsured children were eligible for Medicaid but were not receiving it, and some estimates were even higher. The CHIP program is a remarkable victory in that respect. CHIP is probably the most significant expansion of public health care coverage in over three decades. Many people worked hard to pass CHIP, but it was still a surprising victory. However, in Fiscal Year 1999, some states did not spend a significant amount of the available federal money.

We must do a good job of program imple-

There was an unsuccessful effort to devolve authority and to essentially eliminate the Medicaid Program by establishing a block grant in its place. While that effort was defeated, there has clearly been greater authority vested in state governments for their Medicaid programs.

This is evident in the way that the federal government has given state governments greater authority to reconfigure how the health-delivery system works. Therefore, states can move towards a managed care system without being encumbered, as they felt previously they were by various federal rules.

Welfare reform is perhaps the prototype of devolution of authority. The elimination of the Aid to Families with Dependent Children Program (AFDC) and the creation of the state-established Temporary Assistance for Needy Families Program (TANF) will have a very profound, and potentially damaging, impact on health care coverage for low-income families.

Perhaps in a much more positive vein is the Children's Health Insurance Program (CHIP). The federal government designed CHIP to expand health care coverage to low-income children and essentially established it as a block grant with substantial flexibility at the state level to design and implement the program. Devolution is by no means ending. In fact, the outcome of the 2000 election promises more debates about how far devolution should extend.

To the extent that we want to take the proponents of devolution at their word, namely that devolution will result in more responsive decision-making, there is a more localized opportunity and a deep need for true, genuine, and meaningful consultation and input by the constituencies affected by decisions being made now at the state level.

Working with devolved programs is difficult. These programs are extraordinarily complex. The laws, the regulations, the program designs require a tremendous amount of homework. To have a meaningful role in trying to shape state decision-making, one has to become an expert on such programs.

Another difficulty is that those groups

representing the interests of communities' low-income constituencies tend to be sparsely capitalized. These groups have few resources with which to do their work.

Thus, those organizations in the middle of that fray tend to have only a few staff people who do everything for the organization. They raise the money; they do the lobbying; they contact the media; they try and do the policy analysis; they work with their colleague organizations in different parts of the country; and these tasks require Herculean efforts.

An additional hurdle lies in the fact that state decision-makers who have the responsibility for implementing these devolved programs often have higher priorities than taking the advice of those people from low-income communities. These people have other pressures on them—from different levels of state government to save money as well as other political considerations. Those constraints often dominate state decision makers' day-to-day tasks, making it difficult for them to provide a genuinely collaborative process in designing these programs.

There are other interest groups with stakes in the issues, and these interest groups are quite stronger. They contribute significantly to political campaigns and are able to grab the ear of policymakers much more easily than those who represent low-income communities. Constituents in low-income communities, by definition, cannot contribute much to political campaigns, and, unfortunately, do not vote in as great a proportion. Therefore these communities are not seen as important in the political equation.

With respect to the new CHIP program, the Department of Health and Human Services (HHS) has encouraged the consultation of a variety of different Native American organizations when establishing and implementing CHIP. HHS has specifically asked the states to consult with federally-recognized tribes, other tribes, regional Indian health boards, urban Indian health organizations, and service units of the Indian Health Service. It is difficult to judge how closely the states have followed this suggestion. HHS has not given clear guidelines as to how this con-

ones who have to implement it.

Then the states say they are the ones that are supposed to implement this benefit, but they are subsidizing the benefits of the Medicare program, which is a federal program. The states wonder why they should be picking up those costs.

As a result, one agency points to the other agency, which points to the other agency. It is essential that we find a way for people who are eligible for these benefits to actually receive them.

Reduced Equity

We are experiencing decreasing equity. The clearest manifestation of that is to look at those uninsured in America. In fact, for each and every year over the past decade, there has been an increase in the number of people who are uninsured. Ten years ago, fewer than 32-million people were uninsured; today, the figure has grown to 45-million people.

Even more alarming is a September 1998 Census Bureau report providing the numbers for their latest three-year survey. That survey tried to show how many people over the course of a three-year period experienced a lack or loss of insurance coverage for at least one month.

There were 71-and-a-half million Americans who experienced a lack or loss of health insurance coverage for at least one month over that three-year period. That is three out of every 10 Americans. Most of these people experienced a loss or lack of coverage for a significant period of time; most did not have health care coverage for at least five months.

The context in which this has happened is surprising. The economy, at the national level, has been terrific. Unemployment is at an all-time low. The poverty rate has declined. Interest rates are down. Inflation hardly exists.

What is going to happen when the economy gets worse, as it inevitably will? What happens when health care spending accelerates once again, as we are told by the Department of Health and Human Services that it will? Our

aggregate spending on health care in 1997 was 1.1-trillion dollars, projected to be 2.1-trillion dollars by 2007.

What happens when we have more unemployment? What happens when we have higher poverty? What happens when, as a result of a downturn in the economy, businesses and governments are under increasing pressure to keep costs down and to cut coverage and to pass those costs to those people who are supposed to be getting that coverage? What will happen to the uninsured in terms of the health care coverage that they actually receive?

We know already that people without health insurance get lesser care. As we create new systems—managed care systems and self-insured systems by employers, with the purpose of creating fire-walls so that employers do not have to subsidize care for those people outside of their plans and minimizing cost-shifting—it is going to become even more difficult to provide care for people who are uninsured. Inevitably, more people will be uninsured, and those who are uninsured are likely to receive lesser care.

IHS's expenditures are quite a bit lower than they are for general Americans. In 1997, the per capita spending was \$1,650 for Native Americans by IHS and \$3,600 for Americans in general. There will be more difficulties with respect to the allocation of resources.

We need to expediently provide all Americans healthcare coverage. Clearly many people thought there were opportunities to make this happen in 1993 and 1994. Our failure to achieve this is not due to political reasons such as Hillary Clinton's task force, the timing of the proposal, or the fragmentation of the Democrats in Congress. Perhaps the reason we have failed is that we have not come to grips with the fact that when we talk about increased coverage, we are talking about a serious re-allocation of resources. We are talking about a re-allocation of resources from those who have to those who do not. That is a tough sell in the United States.

Even if this does not happen in our lifetime, there are many things we can do to make a difference.

mentation, not only because uninsured kids deserve and need coverage, but also because if we do not ensure the success of this historic improvement in supposed coverage for people, it will auger poorly for improvements in future years.

For example, the Qualified Medicare Beneficiary Program (QMB) and the Specified Low Income Medicare Beneficiary Program (SLMB), jointly known as the QMB-SLMB benefit, is designed to subsidize Medicare premiums, deductibles, and co-payments of low-income seniors and people with disabilities, and exemplifies a significant expansion in eligibility.

In terms of full subsidy of premiums, one can now be eligible with an income up to 135 percent of the federal poverty level. And yet, as a report issued in July of 1998 shows, there are approximately four million low-income seniors eligible for this growing benefit that are not receiving it. As a result, they are losing approximately two billion dollars a year in benefits that they are entitled to.

These are not minor benefits. The premium alone for the Medicare Part B program in 2001 is \$600 a year, which is a lot of money for people below the poverty line. For people below the poverty line, the benefit also pays their \$792

deductible for each and every hospitalization.

Integrating Program Activities

This QMB-SLMB example also addresses the complexities of different agencies that have different responsibilities. The people who are eligible but do not receive this benefit have deductions taken from their Social Security payments each and every month to pay for the Medicare premium. Because they are not enrolled in these programs, their Social Security checks are reduced each and every month.

Then one wonders what the agencies are trying to do about this? One would think the Social Security Administration (SSA), as the agency that deducts from the checks, would play some role in trying to make sure that those people for whom deductions are taking place that should not take place, receive the benefit. But the SSA says, and correctly so, that it is not responsible for this program. The responsibility for this program is vested in the Health Care Financing Administration (HCFA; as of July 1, 2001, HCFA became the Centers for Medicare and Medicaid Services, CMS).

HCFA says that it is responsible for this program, but the program is actually implemented at the state level because it is done through the Medicaid Program. One can tell the states what they should do but the states are ultimately the

BEYOND THE CAPITAL

Can Indian Health Care Survive?

Indian Health in the Market Economy

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I am interested in the issues beyond the Beltway that facilitate change in a community to allow a health system in this era to function and thrive. This is a situation that easily becomes discouraging.

In working with communities to redesign health care systems to adequately serve tribal nations, it is important to consider the corporatization in thinking about how health care ought to function and operate. Corporatization is a phenomenon that is affecting individuals as well as organizations. Individuals in the system find that they are dealing with increasingly brittle and wooden reactions to their needs from health-care providers. They feel less like individual patients and more as if they are members in a large company plan.

Large corporations face a tremendous dilemma, particularly large health-care corporations. They are among the most complex corporations, and they are selling very complicated products (i.e., integrated health services), often for a fixed fee—although, that is less true than we are led to believe. There is, in fact, much more elasticity in what various buyers, including state Medicaid programs, pay for these products than we generally understand.

Developing a State Plan

I am working with a particular state on its Medicaid and managed care plan. Their plan has been in operation for several years. The state Medicaid agency is having the normal range of dilemmas that any state Medicaid agency has in trying to make managed care function.

One of the most interesting things that this state has done is to assemble groups of people for the purpose of creating practice guidelines for managed care plans to follow. Those in the state have done a lot of work around diabetes, in part because the state has a substantial population of Indians as well as other minorities. It produced what it thought was a tremendously successful set of diabetes practice guidelines. It felt that if its plans would follow these guidelines, then it would begin to yield more successful results for its members.

I told the state that if it wanted to make this a reality in its managed care system, it would have to write the practice guidelines into the agreement that it has with the companies; regarding the management of patients, the state's special practice guidelines trumps whatever guidelines the companies would ordinarily use.

And I could hear over the phone a sort of sucking in of breath. Now, this was the state Medicaid agency that was buying care for tens of thousands of people. It is a relatively sparsely populated state. However, in the markets of managed care purchasing, the state is, without question, the dominant buyer. The state said that the biggest managed care company it buys from, which sells probably about 30 percent of the product that the state buys, says that it only follows its corporate headquarters' practice guidelines.

The state and its employees comprise 70 percent of this company's business in this state. If it wanted to make an issue out of it, the state could have separate diabetes practice guidelines. As the purchaser, if the state wanted to use its practice guidelines, it should.

The state considered this and ultimately decided to try it. This was a remarkable discussion because one of the most sobering aspects of devolving power down to the local community level—and doing so in a market-driven system—is that the tools that should play directly into the

their patients about plan selection. That is not a very good idea. There are many other opportunities in the managed care system for things to go wrong. If the worst offense committed was that a patient was given the option to stay with his/her current provider, our worries would be minimal.

Regardless of whether or not formal managed care enrollment can be done at a clinic, the First Amendment allows communication with patients about what is important in managed care. It is important to know which doctors are in which plans and where doctors are located before you pick a plan. It is also important to disenroll immediately, which is a right under federal law, if you find yourself in the wrong plan. These things are essential to groups of people who have unique service-delivery systems.

Another issue is one of unique product. In managed care, the purchaser is generally the driver of the system. That is the way it is in any market economy. But where you have suppliers who offer unique products, in terms of the lingo used in the market system, the buyers who are agents of the consumers will naturally want to include those products in their systems to keep consumers happy.

Community-based Providers

This is where the issues of forming coalitions with other community-based providers become so critical. Whether it is an Indian Health Service operated clinic, a tribal organization clinic, or a community health center that serves other types of patients along with tribal members, there are many commonalities. When one of us who works with community-based providers walks into one type of clinic, we could be walking into any of them. The language, mix of services, or cultural setting may differ, but the unique quality of the clinic is the same. It does not feel, look, or function as a traditional doctor's office does.

There are so many more commonalities than differences among these providers. Where there is a mix of community providers, it is very important to learn how to come together. Doing so in a market system is not easy. There are anti-trust problems among many others; this is

where technical counsel is needed.

Providers come together very often, though it is not so easy to accomplish. It is important that we use the leverage gained by supplying a unique service when trying to create inroads in the method that Medicaid agencies use to direct companies dealing with community-based programs.

This is not easy. In the collective sense, we have been working on these issues for many years now. It is a change that will only come with a generation of hard work. Despite the battering that social welfare programs have taken, the elasticity of the Medicaid program can allow amazing results in Medicaid managed care today. Medicaid agencies and managed care companies need to be reminded of just how elastic the consumer response of the program continues to be.

Tribal Efforts Beyond the Capital

Julia Davis
Nez Perce Tribe
Idaho

As a tribal leader for the Nez Perce, it is my job to work towards the betterment of the health and welfare of our people. Those of us who are in tribal governments know that we are held fast by our tribal members to do so.

I attended a 1998 meeting of the National Indian Health Board (NIHB) in Anchorage, Alaska, about "Sustaining our Sovereignty, Protecting our Environment and Restoring our Health."

In his keynote address, Dr. Trujillo, director of the Indian Health Service (IHS), spoke about diabetes in Indian Country and the health initiatives on his agenda for IHS. A few such initiatives were traditional healing, women's health, and substance abuse.

As tribal leaders, we support this effort, but there are no funds available for such initiatives. A positive step taken by Dr. Trujillo is that IHS

community's hands are completely overlooked.

In a market system like the one we are in, where small communities buy products, the notion of collective purchasing action is the single most important lesson to learn. And it must be learned in similar communities.

Developing a Tribal Plan

What does all this mean for American Indians and Alaskan Natives? Well, I am privileged to serve on the Blue Ribbon Panel that is considering future changes in the Navajo Nation's health system. In Window Rock in August 1998, the panel spent some time observing various delivery units within the Nation's lands. The panelists had seen many of these issues before, though we had not seen them in the Navajo Nation setting. There were, without question, aspects of what we saw that were quite extraordinary. When forces that no longer listen to its voices are limiting a small community, the solution to the problem seems more remote than ever.

There are some basic rules to consider in the context of the Medicaid program. Medicaid is clearly the key to financial survival for the health system that has served Indian populations, particularly those who live on reservations. In the next few years we will see a fundamental rethinking of the Medicaid program because it is the only program we have that is going to be able to play the compensatory roles in addressing problems such as devolution and managed care.

The first issue is eligibility. If Indian children and adults are not enrolled in this program, not only are they uninsured, but all leverage is lost.

Indian populations have much leverage over Medicaid agencies as big customers of those agencies. In the Navajo Nation, only a small number of the 275,000 residents were enrolled in the program. If more were enrolled, tribal leaders could make considerable demands on the Medicaid agencies in the three states (AZ, NM, UT).

This is a market economy. Let us learn some of the market lingo. With Indian children and adults as major customers of the Medicaid program, Medicaid agencies in many places must

already pay increasing attention to whether the products they are buying for their customers, (because they are market driven) are responsive to their needs. The agencies do not become the regulators who control access to benefits and coverage; they become the agents of the people who are enrolled. And that is a very different position.

If there is not a huge effort to enroll Indians in the Medicaid program through off-site enrollment, no leverage is gained. Furthermore, in this system, it is not enough just to enroll in the program. It is necessary to become a member of a managed care company.

Managed Care Enrollment

That sounds like a dry, simple task. In fact it is not. The single largest and most complex study of managed care enrollment ever done, funded in part by the Henry J. Kaiser Family Foundation, was completed in the late 1990s. One of the most significant findings in the study is that the only thing that really matters to people in terms of enrollment is whether or not they will be able to stay with their current providers. Everything else seemed meaningless.

Community-based programs that provide a great deal of care to many people through thick and thin are the definition of continuity. They have everything to gain by this emphasis on managed care enrollment.

There should not be a state left in the Medicaid program that does not spend all of its time and resources during the enrollment period making sure that people can keep their current provider. This is incredibly important for Indian nations and for the clinics and programs that deliver care because of the unique nature of the delivery system.

A tremendous amount of good will has been fostered. It should not be squandered. Clinics must supplement the enrollment work of all of the states with a huge amount of managed care enrollment assistance for patients.

Some states make enrollment assistance very hard to provide because of the limits placed on how much providers can communicate with

these communities have traditionally had limited interaction with tribes.

I am involved with many councils, committees, subcommittees, and projects on health care in the state. I want to educate and understand our neighbors.

Change is difficult to bring about because it is so uncomfortable, but in due time, communication and education will allow that change. I advocate progress in these areas as a method for tribes to deal with health care and, ultimately, to survive.

Health care issues and social issues intermingle. Tribes must develop an infrastructure to deal with this phenomenon. One aspect of such an infrastructure is the data system. The state does not have adequate data on Native Americans. IHS has its Resource and Patient Management System (RPMS), but IHS does not serve the tribe's needs.

My tribe's population, the San Carlos Apache, sits in two counties. Trying to bring the two counties together to deal with an issue is almost impossible, and it requires educating them, as well as us, as to how their health care and other systems work.

In closing, tribes must accept the challenge of learning the multitude of systems that exist. Collaboration with these systems will ultimately enhance a tribe's ability to provide services for its people. Partners for collaboration include federal and state governments, state and federal legislatures, county supervisors, and universities. Universities are a resource useful in fostering smooth interaction with the other key players.

The Similarities of Community Health Centers and Indian Health: Their Implications for Action

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There are a lot of parallels between the community health center programs that I represent and the Indian health clinics. Our patients have greater health disparities than the larger populations. Less money is spent on our patients than on patients in the general population. Managed care has raised significant issues.

From a philosophical standpoint, the most difficult thing for health centers was transitioning away from being essentially independent programs. These centers sprouted from the community and were driven by their mission, supported by the federal grant program, but ultimately were forced to become more business-like to cope with the onslaught of managed care, particularly in Medicaid.

Public programs fund over 80 percent of our patients' health care. To care for the uninsured we have grants under the Public Health Service Act. That funds about 27 percent of care at health centers, but it varies all over the country.

Medicaid is our biggest source of funds, covering about 37 percent of our patients. Medicare covers approximately five to six percent. Coping with the changes, first in Medicaid and then in Medicare as it becomes Medicare Plus Choice, has been quite a challenge. Nationally, we have done this through two different approaches.

First, the National Association for Community Health Centers has done a lot of training to help health centers move into managed care. About 38 health center plans are operating around the country. Health centers have actually formed their own managed care plans, negotiating with the states and taking on the risk of contracting to be the health care insurer. That is a big change, which has worked in some places and yet not in others.

Health centers have also created networks, joining with other providers to negotiate with HMOs. This allows the benefit of shared purchasing as well as increased leverage in negotiating contracts. However, it does require rethinking

promoted a needs-based budget for the years 2000 and 2001. He stressed the importance of building partnerships.

I also attended the 1998 National Congress of American Indians (NCAI) conference on "Many Nations, One Family." This meeting promoted the concept of empowering tribal government.

One of the promising facts learned at the NCAI meeting was that \$35 million was placed in the 1999 IHS budget for contract-support costs. This money covers tribes that have contracted or compacted their clinics and hospitals through the Public Law 93-638 process.

Unfortunately, the need for contract support for the American Indian and Alaska Native (AI/AN) peoples is \$110 million, not \$35 million. Thus, AI/AN peoples have the miserable challenge of deciding with IHS how this small amount will be distributed.

The AI/AN peoples have been through many, many battles other than the white man coming to our country. IHS reports that in 1997 \$3,600 was expended for the health care of the average American citizen compared to \$1,650 for an AI/AN person. That is 54 percent less than the American public in general. Many federal agencies have begun consulting with tribes and Alaska Natives about the IHS budget and other policy issues. This and our efforts "Beyond the Capital" work towards the betterment of the health and welfare of our people.

Strength Through Collaboration

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San Carlos Apache Tribe Health and Human Services
Arizona

In life we encounter events that stimulate a response, a reaction that equates or determines the outcome. This is a simple formula: An event plus a response equals the outcome. Tribes need to change their response. They must change the way they respond to an event, and this event is devolution and managed care.

However, change is difficult and uncomfortable. The San Carlos Apache Tribe has to make changes that are very uncomfortable, changes from the norm where interactions are only with the federal government, the Indian Health Service (IHS), and the Bureau of Indian Affairs.

Change with devolution comes about in the way that an entity reacts to or interacts with the state. It is necessary to learn the systems of state operation. Many tribes do not have the resources or the manpower to do so.

My title is very impressive and long, but the funds behind it are very limited. I know that many tribes face this. Facing the challenge is often our payback in terms of what tribes gain by working through the difficult times. It is the challenge of learning about legislative actions that are taking place and about managed care and its constantly changing dynamics. Tribes must be able to understand what the state is thinking and what influences that thinking. Tribes are challenged to influence those in federal offices on their behalf, as the dollars come through the state. Tribes must identify public organizations and public groups that can also advocate on their behalf, such as the Arizona Children's Alliance, the Arizona Public Health Association, or the Arizona Behavioral Health Association.

The future of tribes is in understanding how the system works and how to productively enter those systems. However, like tribes, the policy-makers are uncomfortable with changes. Changes, such as working with state systems, stray from the idea of sovereignty. Changes that turn away from sovereignty tend to divert from the idea of a government-to-government relationship. That is scary.

I am involved with these systems in a number of ways, which is a change for me. One must get involved to change the outcome. My schedule is always full. Not only am I reading, I am also meeting with, interacting with, and educating the community. The community is educating me. I communicate with the community and with the policy-makers in the tribe. I educate the policy-makers; they educate me. I educate the outside communities, which is essential since

because of managed care.

Part of survival in this environment is advocacy on the federal, state, and local levels. It is time-consuming. There are a myriad of groups that have influence on these issues, but contact and relationships need to be made in order to leverage their support.

One surprise in this process was the number of people who seemed conservative on many issues, but supported community health centers because they saw them as successful, locally based programs. If you go out and sell both your challenges and your work, you can make a difference.

No one in this field is satisfied that centers have enough funds to take care of all of the uninsured people in the country. The lesson learned is that we need to keep fighting.

Surviving and Thriving as a Health Care Business

Sylvia Drew Ivie
T.H.E Clinic
Los Angeles, California

I direct a 25-year-old community clinic in Los Angeles, California. T.H.E (To Help Everyone) Clinic is an example of a community-based organization that is treading water. The situation, as an urban clinic largely serving a minority population with great upheavals and losses in funding, parallels what is happening to the funding and organization of health services for American Indian and Alaska Native peoples.

Burdens for a Community Clinic

T.H.E. Clinic has had nothing but troubles for its entire existence. Simply becoming established 25 years ago was difficult. Private physicians feared that our services for women might attract their patients to our clinic.

Regardless of the obstacles in our path, we managed to establish ourselves. Then there were the riots in Los Angeles when buildings

all around us were burned down. We survived that. Then we had the earthquake in 1994 that severely damaged our facilities. The latest upheaval is managed care.

Managed care has pummeled us harder than any of those environmental threats. It has swept all of our patients right out of the clinic. We do not know where the patients are. They may still be with us but just without Medicaid. They may also have chosen to opt out of Medicaid eligibility so that their eligibility can accumulate and be used when they really need it. Since the new policy mandates a limit of five years of benefits in a lifetime, some, feeling that they are able to survive on their own now, are waiting to use their eligibility in anticipation of tougher times in the future. Or they have become employed and been removed from Welfare, yet not been informed that they could continue their Medicaid.

We are not sure where the patients are, but in terms of cash flow, the dollars are gone. Furthermore, more uninsured patients are coming to the clinic. Some of the uninsured who are coming to us are new patients with more severe health problems. Not only is T.H.E. Clinic adjusting to an unsteady flow of Medicaid dollars, it is paying more expenses than it used to. When caring for a population with poorer health, there are higher pharmacy and provider bills because more physician expertise is needed, more referrals are needed, and therefore, more time must be spent making referrals.

We are in the process of changing our approach to caring for our patients. In the past, when T.H.E Clinic dealt with a healthier population, our former philosophic approach involved 80 percent support (health education, nutrition, counseling) and 20 percent medical services. Currently the population we serve has a greater frequency and severity of sickness. Therefore roughly 80 percent of our resources is applied towards medical treatment and 20 percent towards support services.

This is not progress from our standpoint, because the formula for good health care is a holistic one. This holistic approach takes into account the whole person, the whole family, and aspects of the person's situation. When you only

the notion of being an independent provider in the community and understanding the need to collaborate with others.

It is not always easy and there are tradeoffs, but this is the way the market and the state governments are moving. The change involves shifting away from dealing with many individual providers and towards dealing with groups of providers through HMOs. It is a reality that we have had to face, and consequently, the association has started many programs to help health centers do that.

The association's programs review the centers' contracts, teach centers how to go into managed care, and help centers work through the financial ramifications of doing so. It does require hiring people with different kinds of skills other than those of medical providers.

Good accountants, good lawyers, and good negotiators are needed, and that has been a difficult philosophical shift for some to make. Many of our health centers have become quite successful at it, but it is a long row to hoe.

The reimbursement rates that health centers receive from managed care plans provide a challenge, generally covering between 40 and 60 percent of what a health center needs to give the kind of care required under the Public Health Service Act. Consequently, our ability to care for the uninsured has diminished.

This presents people with the hard choice between shutting down or limiting services, or providing the minimum that a physician might feel ethically and morally obligated to.

We are also doing a great deal of work to enroll eligible individuals, either for the Medicaid program or for the Children's Health Insurance Program (CHIP). Most of the state Medicaid programs are financially responsible for this activity, at least with the Medicaid program. This does not always happen, but there is a real emphasis at health centers on having people enroll when they check in, which allows more revenue.

On an everyday basis, the difficulty of receiving the money from policymakers necessary to do the job we want to do is frustrating. It requires every one who cares about the health

of underserved communities in this country to take on the responsibility of educating these policymakers. This takes a tremendous amount of time. Institutions would rather spend time delivering health care than spend time at meetings with policymakers describing their success. We know that we do our jobs well and we know the situations in our communities.

Challenges for Health Centers

Nationally the health center program has faced some big challenges in the years leading up to 1998. The governors who wanted to block the Medicaid program grants early on also wanted to take away the cost/space reimbursement that the health center program had, which lawfully entitled health centers to the cost of caring for a patient. Through much hard work by health centers around the country advocating to their members of Congress and developing long-term relationships, it was possible to stop and delay that action for six years. Despite a lot of budget cuts, over the period from 1996-98 health centers were also able to get an increase of \$168 million in grant money for programs on the grant side to care for the uninsured.

Health centers accomplished this by seeking out and talking with local and state officials, federal legislators, and those in the executive branch about the challenges they were facing. They asked the policymakers to go out and develop relationships with those who would sympathize with and support the work of the health-center program.

These actions required a long-term commitment and did not happen overnight. Representatives of the health centers told policymakers there are more uninsured on their doorsteps every day and explained that from 1996 to 1998, the centers took in one million new uninsured people without an increase in funds to take care of them. Policymakers were told that despite the changes in Medicaid managed care and the subsequent drop in revenues, the uninsured still come to the centers' doors to be taken care of, but the program will no longer pay for them

It is our job to help these private sources understand what we are losing, and how private funders can use their dollars most effectively to keep these programs alive. Private funders are realizing that they must sustain clinics because they are taking care of the vast number of uninsured people.

Forming community coalitions, recognizing commonalities with other health care organizations, and utilizing private funders will assist in restoring our sense of power.

Step Three: How does turning some power over to the community help?

If institutions relinquish pride and admit to being in trouble, denial is destroyed. Institutions tend to deny vulnerability to one another, to our grantors, to everyone. Admitting to being in trouble helps by marshalling energy to solve problems together.

Step Four: What character defects have been identified in this process of repositioning ourselves?

In addition to the defect of being so prideful of uniqueness and identity that it impedes the ability to work successfully with others, there are other problems.

Envy. Institutions spend a lot of time envying other programs. Venice Free Clinic in Los Angeles has 400 volunteer physicians on its roster; T.H.E. Clinic has none. It is not functional to dwell on this. I have to devote my energy to T.H.E. Clinic, which has done something successful and admirable.

Anger. Being angry about the insensitivity of policymakers is not fruitful. This is not to say that we should not be angry. After all, people are endangering the lives of our patients by threatening the existence of our institutions. In this case, productive anger is not a character flaw. However, anger that is paralyzing is not going to help us.

Gluttony. Gluttony is attempting to gobble up all of the available resources without sharing it with similarly situated institutions. T.H.E.

Clinic applied for a grant to do gang prevention in Los Angeles. A partner group, the African Unity Center, also applied. It could not get the proposal written because it had little to no experience writing grants, and it did not know how to respond to the request for proposals (RFP). The center came to T.H.E. Clinic for assistance and we gave them our whole proposal. From the framework of our proposal, the center was able to develop its own. In the end, the center was funded. It turns out the center is doing a much better job than T.H.E. Clinic could have because it has men who can reach out to the boys. The center just needed a little help in the beginning paperwork steps. Share what you are able to.

Sloth. Sloth, in these terms, is not chasing opportunities. Sloth is becoming so discouraged by the unfairness of the situation that institutions do not go out to fight every day for resources that will keep their programs going.

Step Five: Admitting your mistakes.

T.H.E. Clinic thought that it could be self-sufficient. It thought that it could put all of its money into care for patients without building an infrastructure. That is one of the worst mistakes the Clinic has made.

T.H.E. Clinic hired a minimally trained bookkeeper, believing it was more important to have nurses and doctors. That was a mistake. It is absolutely necessary to find someone who knows numbers.

In addition, T.H.E. Clinic thought that it could continue to attract patients without marketing, simply by being so wonderful. It is essential to learn how to market and to find someone who understands and facilitates these concepts. For institutions that are already marketing, do more of it, consistently and repeatedly.

Step Six: Admit to your higher powers when you cannot find solutions.

One of the things T.H.E. Clinic wanted to maintain was its policy of hiring people from the community who did not have a high level of education. These people learned to do the job at the Clinic.

have increasingly limited resources to keep the people alive, you cannot provide nurturing and support services. But we are doing what we are able to in the moment that we find ourselves.

I recently attended a conference where someone used a 12-step model for discussing racism in this country. This 12-step construct can be made compatible with a managed care program by altering its central theme. I took T.H.E. Clinic through the 12 steps because the recent developments in health care have changed the clinic's focus. Hopefully, seven of these steps will resonate with your situations.

In this process, T.H.E. Clinic addressed how to examine itself as an institution greatly threatened by changes in health care financing and delivery and as an institution becoming a business rather than a provider of human support services.

Step One: In what way is the institution powerless?

Institutions are made powerless by social environmental concerns such as gender, race, and inequity. Institutions are powerless in their dependence on federal, state, city, and county contracts and Medicaid dollars. If T.H.E. Clinic is going to exist as a clinic, it will continue to be dependent on those contracts from government agencies and those fee-for-service or capitated dollars from Medicaid.

T.H.E. Clinic is helpless in the sense that a huge county government that nearly went bankrupt a few years ago surrounds it. Los Angeles County then turned to the smallest institutions, the community clinics, and explained that it had made a deal with the federal government to increase the number of outpatient visits by 50 percent, but it was unable to meet this challenge and asked the community clinics to help.

Always up for a challenge, T.H.E. Clinic agreed. So it is now trying to serve the uninsured population for Los Angeles County. That is a situation that T.H.E. Clinic could not have anticipated.

Step Two: How are powers greater than the

individual institutions helping to restore a sense of power in the situation institutions find themselves in?

The community has to be brought into the situation. In the field of health care, it is necessary to be involved with many different programs and sources of funding. The community does not understand this, but the community does understand that it needs health care.

Institutions must start a dialogue with the community by explaining its desire to serve the community's health care needs, by explaining the situation the institution is in, and by asking the community for help. The community will come in and find ways to help. Institutions have to involve the community in their situations to raise awareness about what is happening.

Second, institutions need to recognize their commonalities as health care providing organizations. Community clinics, including Indian health programs, find it very difficult to recognize their commonalities. Each institution thinks that it is completely unique. T.H.E. Clinic didn't believe there was another institution like it.

However unique individual clinics are, every community clinic, indeed every health care delivery service today, must employ a basic set of functions. Health care deliverers need management information systems and quality assessment tools. They must learn how to market, how to improve financial projections, and how to achieve better strategic planning. No matter how special or perfect, every deliverer of health care must accomplish these things. Unfortunately, none of these institutions are currently in a position to do so successfully. T.H.E. Clinic is reaching out, finally, with a community coalition.

The third source for restoration of power is private funders. As an instrument of government funding, health care has kept away the private funders. Now that the government, at all levels, is trying to eradicate community clinics and the responsibility of paying for these clinics' patients, private sources of funding are being forced to rethink the funding of clinical programs in terms of the need for these programs and programs are being forced to consider private sources of funding.

component of business health care delivery. The tribe is learning what third-party billing opportunities exist, improving on those opportunities, maintaining consistent dialogue with those organizations, educating them as to how we operate, and educating ourselves as to how they play the game.

The tribe can cut expenses in several ways. Some are long-range plans. The tribe wants to increase services, yet reduce the cost of increasing those services. For example, many Indian Health Service (IHS) services in San Carlos are referred out to specialists in the Phoenix area as a consultation, which could be reduced with the use of telemedicine. Telemedicine utilizes real-time video and other technology to enable providers to view patients and their diagnostic tests and talk with patients and providers at remote sites. We are looking at the opportunities that telemedicine offers. In addition, IHS is somewhat slow in this particular area, so we are encouraging them, stimulating them, pushing and shoving them.

IHS, our primary health care provider on the reservation, is also involved in treatment. You get hurt, you go there, and you get treated. The tribe is emphasizing prevention to minimize the need for treatment, thereby minimizing costs in the long run.

The tribe has expensive manpower; healers are very costly. Also, there is a constant turnover with physicians, psychologists, and psychiatrists. Only those health professionals who are tribal members seem to stay longer, or even permanently, an investment in their home, in their community. Another opportunity to minimize additional expenses is to draw more manpower from the tribe's own community.

Julia Davis: All tribal clinics throughout the United States need business training. However, as a tribal leader, I am aware that this will involve a mutual exchange between the state and tribal peoples. The state does not realize when we sit down and meet with them that it is a difficult process to learn from one another about what does and does not work in the clinics. It is a learning curve that may take a year or longer. It would

help if the state and the tribe could collaborate to find a process that would benefit both parties.

Another issue is the limits placed upon progress due to the turnover state offices. Just as a comfortable working relationship is developed with them, they may be suddenly transferred out or into another department, leaving the tribe to start all over again.

How can managed care start and continue to build bridges and share resources?

Susan McNally: There is a significant cultural difference between the way that community-based providers approach health care and (our perception of) the way that managed care approaches health care. The incentives appear to be diametrical. What would be helpful, at least on the local level, would be for the managed care organizations to reach out to the community providers. Look at this in terms of balance of power issues. When health centers go in and talk to managed care organizations, it is generally in the context of a contract negotiation where the managed care organization holds leverage over those who are covered and determines the rates that it will pay, without any alternative. Despite discussion, that becomes the bottom line. The managed care organization at times will need the community provider to fulfill services in that area, especially if the community provider is the only one in town, but there is a definite imbalance of power. Balancing that power would be the most helpful thing.

Sylvia Drew Ivie: Respect for and rights of low-income people have been pushed far to the side, perhaps never to be brought up again in the managed care environment, because the managed care plans are in trouble themselves. Community providers of health care are also in trouble. The plans are in trouble because now it is expensive to take care of the people who are covered by those plans. While the plans are running their businesses, they are also trying to stay out of the red. The vulnerability of new enrollees coming onto the managed care plans is the last thing considered.

They came out of the goodness of their hearts to help people from the communities that they served.

T.H.E. Clinic now understands that these individuals are unable to do everything that must be done. Thus, a difficult choice must be made — either to train the people who are currently with T.H.E. Clinic to perform the necessary skills, or to bring in people with a higher level of training, or a combination of both. It is unthinkable to recognize that these people from the community have helped for all of these years, but decide that the clinic needs to be saved at their expense. That is not going to save the patients in the end.

Step Seven: What is necessary to heal the wrongs that institutions have committed internally?

The answer is to communicate, communicate, and communicate. Be vocal about what is happening with vendors, hospitals, and government grantors. If people know what is happening, they can work with institutions, but if those factors are hidden, people will not help.

Review repeatedly where your institution is, what it is doing, and whether it works today. Reflect on what is happening outside of the clinics. And as you strengthen your organization, share what you have learned with others.

This will reinforce what your institution has learned, it will help people, and it will broaden your organization's base of support in the community.

Discussion

Are there resources for contacts to assist an institution in changing from a clinic that provides services to a business that has products for consumers?

Sylvia Drew Ivie: The National Association of Community Health Centers has been trying to help with trainings. Some of the managed care companies have been trying to provide

some support for clinics that have recently become managed care providers. On the whole, there are not any resources. At conferences by commercial HMOs to try to train institutions as non-profit clinics, there has been a lack of connection between their positions and those of the clinics they are training. Although this gap can be closed, we begin by speaking very different languages. The real assets and skills community providers have as businesses must be recognized. Most have just never thought of them as business assets. Our centers have to think about the skills they do have and talk about them in slightly different terminology, and our centers must use that language to sell themselves to people who have been identified as good business partners. It is simply a process of learning language. Our centers are, in a sense, business illiterates trying to gain business literacy.

Susan McNally: Much of it is an issue of translation. Our health centers have many assets, particularly for companies that are going into the Medicaid managed care market. We are able to deliver the care that is needed in those areas, and in many places, we are the only ones there to do so. There is a question of translation and there is a question of marketing. It is a question of transition.

Vernon James: For the San Carlos Apache Tribe, it is a little bit different. We enter this realm understanding what health care business is all about, but we need to figure out what managed care is about and driven by.

In this our state, the gatekeeper for managed care is Arizona Health Care Containment System (AHCCCS). They are educating themselves as to the issues in Indian Country, as we are educating ourselves about what AHCCCS is all about, who the key players are, how the rules are made, and how the game is played.

This requires a big time commitment. Entering the private realm of the health care market requires strategic planning: identifying the mission and how to reach it. Tribes are beginning to understand in this.

Third-party billing is a very important

We recently hired a Japanese-American woman who worked for one of the big plans in Los Angeles. She has been an advocate for language access for patients who do not speak English as their primary language for many years. She was conversant with federal laws under Title VI of the 1964 Civil Rights Act and was very familiar with what was required under law. She pushed and pushed, and ultimately, she was fired.

It is very difficult to get the attention of managed care about those issues. The legal service lawyers or the former legal service lawyers, who now work in a different professional capacity because they cannot file class action suits, will present these kinds of issues in a legal forum so that managed care will pay attention. Managed care will have to pay attention to the diversity of their patients and ensure that the plans are accessible in terms of language, culture, and other needs of respective communities.

If the plans do not recognize that, they will not succeed in their communities. If the plans do recognize those issues, people in the community will identify them as a good choice of care for themselves and their families and they will seek those plans out. If the plans run as a business, people will not identify those as plans that work for them. People will not take advantage of the health care and become more ill, ultimately costing the plans more.

Cultural diversity and respect for all patients should be seen from the human perspective rather than a business perspective. The plans need to determine what human beings require to be happy in their care. That kind of training and interface between people who have been in the field would be extremely advantageous.

Vernon James: I am always devising ways of improving health care on the reservation. As I analyze HMOs and begin to understand the concept of managed care, I see a resemblance to the

THE ECONOMICS OF INDIAN HEALTH CARE

Leveraging Resources and Market Share

Improving the Health and Welfare of Indian People: An Assets-based Strategy

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In 1993, a delegation of foundations went to South Africa during the reign of Apartheid to view the situation and the conditions of Black South Africans. They were inhumane. They were the worst conditions that I have ever seen in my lifetime, but they were very much like those for Native American people throughout the early part of this century.

I told a story at one of the villages of the colonization of Native peoples in the United States, of the forced removals, of the exploited labor, of the cultural genocide, and of the many cases of complete genocide of our people. This African village wept to hear our story, gathered strength from it. When we were leaving, they sang a song as a gift to us, part of their cultural tradition, for what we had shared with them. It was an extremely moving experience.

I spent the early years of my career in the Indian-controlled school movement as a part of the Coalition of Indian Controlled Schools. This was in 1970 when President Nixon had impounded the Title IV monies. There were just five Indian-controlled schools in the country. I worked in the field with tribes to create Indian-contract schools.

Tribal Control, Economic Independence

At that time, it was considered extremely radical for tribes to control anything. I traveled from Indian community to Indian community and talked about our need to control the educational future of our children. And in order to control the

educational future of our people, it was necessary to control the purse strings.

Then Public Law 93-638, or self-governance through contracting with the federal government, came into being. In many negotiation sessions in the mid-seventies, the window of opportunity provided by Public Law 93-638 shrank. Contracting was becoming a method of receiving money to do what the Bureau of Indian Affairs allowed tribes to do.

Eventually, the real problem became evident. Real tribal control and tribal sovereignty must come through economic independence, rather than through dependency on federal programs. The federal government was completely obligated to fund tribal programs and meet certain needs at the tribal level. However, tribes had to look at ways to decrease dependency and build economic self-sufficiency.

This concept served as the basis for creating the First Nations Development Institute in 1980 with a \$25,000 grant. Now it is a three-and-a-half-million-dollar organization and does not accept any federal monies. First Nations allocates roughly one-and-a-half-million dollars per year for grants to tribal communities, and it also has a close to one million-dollar loan fund for "program-related investments," or recoverable grants or loans, to different tribal community enterprises or loan funds.

One of the things that First Nations gained notoriety for since 1980 is the creation of the first micro-enterprise loan fund in the United States. Micro-enterprise lending became one of the cornerstones of President Clinton's economic legislation when he first took office.

The Community Development Financial Intermediary Act had micro-enterprise loan funds, community credit unions, and community-development banks as three progressive financial intermediaries or financial institutions. This act moved community development forward and directed capital and credit back to communi-

ties. It is a little-known fact that this concept of micro-enterprise loan funds was created in Indian Country at the community level.

First Nations also did some of the early tribal investment planning, worked on tribal trust funds, and looked at the Tribal Trust Fund Reform Act. What is evident in all of First Nations' work is a very clear focus on controlling assets and strategies that tribes can utilize to control their assets.

The other important aspect of First Nations is its cultural strength. Culture and economic development were considered oxymoronic back in 1980. The idea that culture was the strength of Indian people, and that economic, community, and tribal development should build upon the strength of that culture was not considered 20 years ago. The fundamental principles behind First Nations are that tribes should begin small and diversify their income base.

First Nations wondered how a \$2-billion Indian health industry could have absolutely no impact on reservation economies. Sure, monies came in, and in some cases, jobs were created. Some of those jobs even hired local people. But no secondary or tertiary economic activities were ever realized out of this \$2-billion industry. There is not another industry operating in any community that does not have economic spin-offs.

The same thing was happening across all reservations. For example, with the federal Housing and Urban Development monies, 10, 20, 100 houses would be built. Housing construction is a huge industry in this country's economy; yet those same housing construction projects had no real effect on reservation economies.

Expanding the Impacts of Health Care

How could this be happening? In some cases, the answer became apparent through the purchasing mechanisms of Indian Health Services (IHS). In other cases, it could be seen in the way that the health care itself was delivered. By and large, though, it was due to the regulatory framework of IHS.

One of First Nations' staff members, who

previously worked at IHS, was involved in some of the IHS facilities' construction. She saw the length of time it took for tribes to be added to the facilities construction list, and once that happened, it took additional time to move to the top of that list. It took more time to be approved once you reached the top of the list. Once approved, construction negotiation required even more time. Finally, by the time construction began, the costs had actually risen.

That was in 1984. First Nations used to wonder why tribes did not secure the financing to build their own facilities and lease them back to the health care programs. Now that is happening.

Warm Springs owns its health facility and leases it back. Umatilla also owns its health facilities. And the Chickasaw Nation worked through a unique approach to acquire its hospital.

Owning the hospital, the clinic, and the facilities puts a multi-million-dollar asset on the tribal books. An asset-based strategy goes a long way towards paying for the actual programs that tribes want to operate, as well as towards economic independence for the community and for the tribe. Furthermore, an asset-based strategy contributes a great deal towards earning revenues that will continue to expand those tribal programs and continue to meet wider needs.

When First Nations began, people thought it was only focused on micro-loan funds. However, it had set forth an asset-based strategy: for tribes to control, leverage, increase, and retain their assets. Hospitals, clinics, direct care health programs, and contracted health services are all assets.

Health care is a trillion-dollar industry with more and more profit companies moving into the market. It is a trillion-dollar industry of which one half comprises health care dollars that flow from Medicare and Medicaid. That asset must be captured and used to the benefit of Indian people to meet their health care needs.

The political and economic landscape for IHS is drastically changing. The centralized, government-driven structure is giving way to a more locally controlled system. This is called

devolution. However, that devolved authority is taking place without devolved dollars. So where do we go from here?

Some Basic Economic Principles

First Nations has three basic economic principles that explain its asset-based strategy.

The first principle is to identify untapped resources. In business terms, this means knowing the market. The trillion-dollar health industry out there is an untapped resource.

Secondly, tribes must build upon what they already have. In economic terms, this is called leveraging resources. The Chickasaw Nation took its existing health care programs and dollars, invested additional tribal funds, leveraged grants and outside monies, generated third-party revenue, increased its overall health dollars, and, by controlling those assets through sound investment strategy, are realizing even higher financial returns.

The third principle is economic embedding. This views every economy as part of its surrounding economy, or in this case, industry. Every industry is inter-related, interdependent, and connected to other industries or to a larger industry. For example, the entertainment industry is part of the media industry. The agricultural industry is part of the food industry, which is part of the restaurant industry.

Applying these three principles to the current Indian health situation provides a basic framework for developing reservation economies and improving the health status of Indian people.

Economies in Transition: Shifting from Federal Toward Tribal Government Control

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There is a changing and changed political and

economic environment confronting Indian health care.

The Indian Health Service (IHS) budget has been drastically cut for the past 20 years. The structure of the health care delivery system is changing. IHS is being redesigned, downsized, and transferred to tribal governments and Indian communities.

The health care industry in and of itself is changing. But this current situation cannot be examined without considering the larger economic environment in which Indian communities operate, whether they comprise the reservation, city, state, or the regional economy.

Twenty years ago, almost all reservation economies were centrally planned and controlled by the federal government. Furthermore, the beneficiaries, the Native American people, had little or no choice in health care.

There were few or no alternatives to resources from the federal government for any kind of development. There was no competition and no need to compete. IHS was a centrally controlled economy, and there was no relationship with the states; IHS related directly and only to the federal government.

IHS was centralized even though there was a decentralized mainstream health care economy at the time. The early 1980s also saw the beginning of a decline in federal resources for Native American people, not only for health care, but also across the board.

An Economic Transition

Indian Country has undergone tremendous changes in the last 20 years, and it remains today an economy and a society in transition at many different levels. Today the reservation economy, while still dominated by government, is shifting from federal towards tribal government control. The average rate of government-sector employment on the reservation is 48 percent.

The latest Department of Commerce statistics on nonfarm minority business development, for the year 1997, report that there are more than 197,000 enterprises owned by Native Americans

in the United States. Between 1987 and 1992 and, there was an especially dramatic increase in the number of Native American businesses. Of all minority groups reported on, Native American-owned enterprise both on and off the reservation was the fastest-growing business sector in the United States between 1987 and 1992 and again between 1992 and 1997.

The emerging nonprofit sector in Indian Country has taken off in the last 15 years and has accelerated even more so in the last eight years. New nonprofit organizations are forming daily.

Of the nonprofit sector in the U.S. economy, the largest component is health care. However, that is not the case in Indian Country because the federal government has dominated the health care system. The largest sectors of growth in Indian Country are education, arts, and traditional tribal arenas.

Tribal members are increasingly more educated, informed, and creative. They are also active participants, not only in health care but also in all aspects of the economy. There are more choices now. There are choices in health care. There are alternative resources, such as Medicare, Medicaid, and private insurance that were not available 20 years ago.

Tribes are moving away from a deficit-planning model to an assets-based development model. This shift is absolutely critical and is the focus of welfare reform. Income and jobs result from the assets-based model, which also examines ways to leverage resources.

Federal downsizing and reorganization has moved programs and money to the states. Often these are states with which tribes have either never had a relationship or have had a bad relationship. Partnerships and collaboration will be the key components in resolving the issue.

While poverty and its subsequent conditions are still unacceptably high, there are ongoing efforts to reduce them. There have been dramatic changes over the past 15 years, including successes in sustainable economical development, health, business, education, and many additional areas on the reservation.

There is a relationship between the economy and health. Productive people are healthier. This relationship must be further examined.

In the last 20 years the relationship between urban centers and reservations has expanded. Models of this expansion could illustrate possible strategies for overall changes in IHS. IHS is currently decentralizing, while the rest of the health care system is centralizing, conducting mergers and acquisitions, becoming larger, and realizing economies of scale. Whether this trend is positive or negative, it is a trend that must be examined and responded to.

Twenty years ago, the centralized IHS never recognized the role it played in the reservation economy. An enormous amount of money came and continues to come into the reservation economies through IHS. Those monies are not realized by the local economy. The monies go directly to the border towns and do not subsequently generate business development and housing creation. Local tribal control of IHS services and administration brings a wealth of possibilities; tribes can link the health care system to the economy.

Integrating programs is absolutely critical. We can look at past economic trends. As the mainstream health care system is now becoming centralized, IHS is becoming decentralized. Over the next few years, tribal health care systems will most likely be looking at partnerships and collaborations, and at merging complementary and supplementary activities.

We are now being confronted with market forces and competition. One of the lessons taught in economics is that the market creates haves and have-nots. The market creates inequities; government and the nonprofit sector mitigate against inequities. The nonprofit sector is now beginning to meet needs that the tribal or the federal governments are unable to meet. When analyzing market strategies, great care must be taken to recognize the unacceptability in Indian Country of not serving all of the people. It is essential that health care in Indian Country serves everyone.

In the midst of all of this change, the fundamental relationship between the federal

government and tribes must be preserved. Self-determination is self-termination. The actions needed to protect this unique sovereign relationship between the federal government and tribes must be taken.

Leveraging Resources: Harnessing Available Capital

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In our health care system today, it is necessary to maintain flexibility and to take advantage of opportunities whenever they arise. However, there are difficulties ahead in terms of maintaining and improving funding for basic services. There have been many battles concerning the survival of the Medicaid program, especially over whether or not it would survive as an entitlement program.

Establishing a broader context of U.S. health care financing can help to identify opportunities for Indian health. Additional appropriations for the work done by the Indian Health Services (IHS) are important but probably insufficient to meet the growing needs of the population. People must be as opportunistic as possible in examining available revenue sources.

Health-care Economy

There is a trillion-dollar health care economy today. Roughly one-third of this economy is financed by private health insurance: 20 percent comes from the Medicare program for the elderly; 14 percent comes from the Medicaid program for the low-income population; and 13 percent comes from other government programs.

Despite the fact that the privately-financed health care system is the system most often discussed by health professionals and policy makers, 47 percent of all money flowing into health care comes from Medicare or Medicaid, Civilian Health and Medical Program of the Uniformed Service (CHAMPUS), Veteran Affairs, or IHS.

Thus, this country is approaching a time when nearly half of all health care services are government-sponsored. Another 17 percent of health care services are paid directly by individuals out of their own pockets.

After studying the different types of health care coverage people have, an altered picture of what financing supports emerges. In 1990, a little over half of the U.S. population received health insurance coverage through an employer-based plan, and another five percent individually purchased health insurance.

Roughly 10 percent of all Americans received assistance from Medicaid and 12 percent from Medicare. The appallingly high rate of our uninsured was 16 percent, which translated to 43-million Americans with no coverage at all. Today at least 45-million Americans are uninsured.

Additionally, the 1990 Census reported sources of insurance coverage for the American Indian and Alaska Native (AI/AN) population. The numbers for AI/AN were generated by identifying sources of coverage and extracting duplicate coverage.

At least 1.4 million of the 2.3-million AI/AN surveyed in the 1990 Census relied to some extent on IHS; many also identified other sources of coverage. In addition, much of the Native American population did not and continues not to live in the IHS service areas. Their services were being covered by insurance elsewhere. Only 43 percent of the AI/AN population is reliant on employer-based coverage, much less than in the general population. This population is more reliant on the Medicaid program (at 21 percent, versus 10 percent in the general U.S. population) and has a slightly higher rate of people who are uninsured.

Just eight percent of the people reported to the 1990 Census that their only source of coverage was the IHS; many of the rest reported other coverage, including Medicare.

The fact that 60 percent of the Native American population lives in an IHS service area means that for 40 percent of the population, financing and provision of care must occur away from those areas. This will have significant

consequences for financing care for the AI/AN population.

Allocations for Health Care

Of the \$1.8 billion appropriated to IHS for health services in 1997, roughly 57 percent was allocated for IHS's operation of some 40 clinics, 65 health centers, five school health centers, and 50 smaller clinics in roughly 17 states. About 41 percent went to hospitals and clinics, and 1.4 percent went to urban health clinics. These allocations do not include dollars for renovation of facilities, nor do they include the funding that is coming in from third-party reimbursement. These allocated funds are supply-oriented: They come from an appropriation model where monies are distributed to support the IHS and its services rather than monies distributed on a per capita basis.

In the past, programs assisting low-income populations experienced freezing or cutting of appropriations. These changes prevented programs' growth. Today, many of these programs look for support through entitlement programs, which generate money according to the number of people that these programs cover.

It is and will always be important to advocate aggressively for improved funding for IHS and the services it finances, and to aggressively watch and engage in the appropriations process. It is a challenge today to find the impetus for substantial increases to fill unmet needs. Over the years, IHS appropriations have been extremely consistent. The Medicaid funding increases dwarf IHS funding increases. The history of IHS funding manifests both fixed appropriations and efforts to serve a growing population.

For every dollar put into an appropriated program, there is another program that will not receive that dollar. The reason that entitlement programs are unpopular with many politicians is that they are not subject to this characteristic of the appropriation process. Entitlements are funded to the extent that those eligible for a program actually apply for and utilize its services.

Finally, Medicaid and Medicare served as supplements to IHS funding by the appro-

priations process beginning with the FY '99 IHS Budget. The actual budget for IHS was therefore a combination of capital appropriations, reimbursement from third parties like Medicare and Medicaid, and when it existed, private insurance funding. In 2000, Medicaid, Medicare, and private insurance contributed \$405 million to the IHS budget, which flowed into both tribally-operated and IHS facilities.

It is an obligation of Medicaid, Medicare, or private insurance to first pay for the services that their participants receive. For those benefits or services that are not covered by insurance or Medicaid, IHS assumes the costs. Third-party reimbursement and recoupment are important ways to supplement coverage, especially when so many low-income Native American people, including children, are eligible for the Medicaid program. Medicaid accounts for nearly two-thirds of all third-party reimbursements and is currently a source of increased revenue relative to the more limited coverage provided by both Medicare and private insurance.

Health Insurance Coverage

The Native American population is somewhat less likely than other U.S. population groups to have full-time employed adults and more likely to have part-time employed adults. Health insurance coverage is generally not an option of part-time employment, which partially explains why coverage may not be as readily available to Native Americans.

There is a much higher poverty rate in the AI/AN population than in the general population. Fifty percent of the AI/AN population is poor or near poor, which is defined as living on an income of less than 200 percent of the federal poverty level. This is why Medicaid as a low-income coverage program is integral to recouping resources for IHS.

In the 1990 Census, private insurance covered 61 percent of the U.S. population. Private insurance is generally a job-based benefit for full-time employees; however, workers are often asked to pay substantial premiums or a share of the premium that their employers provide

for coverage. In 1995, the average cost to the worker for health care was 30 percent of the premium cost, or approximately \$1,615 a year. The full cost of an annual policy would have been \$4,000-5,000. Many people cannot afford either partial contribution or the full responsibility for coverage at that price.

Individual coverage is both expensive and limited. In addition, most of the privately-sponsored insurance plans require substantial cost sharing and are therefore in direct competition with some IHS provisions requiring no cost sharing.

In the United States, the greater one's income is, the greater one's access to health care coverage. Financial equity remains an issue in this battle.

Ninety percent of workers earning \$15 or more per hour have health insurance, while the number drops to 42 percent for those earning \$7 or less. Jobs requiring lower skill are less likely to provide insurance; when these jobs offer coverage, the likelihood that an employee can afford the required contribution is very low. Therefore, it is surprising that 47 percent of the AI/AN population reportedly had private insurance in 1998. That number, although lower than the general U.S. population, is one worth exploring. It is necessary to find to what extent those numbers come from tribally-sponsored private insurance or from employment-related private insurance, and to what extent those private insurance policies can be used as a source of revenue for bringing in payments to tribally-operated and IHS-operated facilities.

Reimbursement from private insurers may be difficult for some IHS providers to collect due to a legal prohibition regarding collecting third-party recoupments from tribal policies that are privately insured. Despite the possibility of a Catch 22, it is necessary to examine who has private insurance, what the nature of that private insurance is, and whether all opportunities to benefit from third-party recoupments are being taken advantage of within the IHS service areas.

Medicare and Medicaid Coverage

Many people argue that private insurance is not likely to provide a significant base of revenue, especially in the reservation area. However, reservations include an aging population, and Medicare has a role in covering virtually all senior citizens in the United States, some permanently and totally disabled people, and those with severe renal disease in need of dialysis. Unfortunately, a senior citizen who does not need renal dialysis or is not permanently disabled may encounter difficulties in obtaining Medicare coverage.

To be eligible for Medicare coverage, one has to be eligible for Social Security; to be eligible for Social Security, one must have been employed for 40 quarters of work or 10 work years.

When Medicare coverage is available, it does cover hospital and physician care; however, patients share in the cost of their physician services and have a large hospital deductible. Medicare does not currently cover prescription drugs, outpatient eyeglasses, dental care, or long-term care as part of the Medicare benefits package.

Medicaid has been set up to assist low-income Americans in paying premiums and to help the poorest of Medicare beneficiaries pay for cost sharing. However, one must first become a Medicare beneficiary. Therefore, tribes need eligibility workers and caseworkers to analyze which people over age 65 qualify for Medicare and methods of helping people accumulate work quarters so that they are eligible for Medicare at age 65. Another option is advocating on legislative agendas for all those over 65 to automatically qualify for Medicare.

In 1998, Medicare covered about six percent, or 130,000 AI/AN peoples. The numbers do not specify how many of the people covered under Medicare are elderly; many are qualifying on the basis of their renal dialysis needs. It is essential to determine who is eligible for Medicare and to ensure that those who are eligible are enrolled.

There is a low participation rate in Medicare's Part B, which offers physicians' services. In 2001, Part B medical insurance coverage requires a monthly payment of \$50. IHS does not allow for payment of those premiums. If individuals cannot pay the premium, then they are not able to

enroll in Medicare. If participants are enrolled in Part A and not Part B, IHS cannot be reimbursed for physician services and other ambulatory care services.

In addition, Medicare does not cover long-term care needs. Medicaid supplementation by the states has been poorly administered, with little outreach. Therefore many people who might be eligible for Medicaid assistance in paying for Medicare cost sharing or premiums are not being informed of this option.

As the population ages, it will become essential to enroll more people in Medicare. Yet issues surrounding premium payments and alternative-provider participation with Medicare will require resolution.

The percentage of people over age 65 is smaller in the AI/AN population than in the general U.S. population. Subsequently, Medicare is unlikely to become a significant source of reimbursement. Furthermore, there are a substantially higher number of children under age 18 in the AI/AN population compared to the general U.S. population. Among the AI/AN population, 11 percent is under age five compared to eight percent in the nation. The Medicaid program provides the majority of coverage to children in America. Medicaid now covers over 40 percent of all births nationwide, and the health care of one in five children in the general U.S. population. Therefore, Medicaid remains the best alternative source of financing for many of the clinics and facilities operated by the tribes, and by IHS.

Medicaid is a source of coverage for physician, hospital, and health care services, as well as for long-term care. Medicaid can help with premiums and cost sharing. Furthermore, the program is an excellent source of additional revenue for Indian health facilities as well as a purchaser of managed care products.

There are two main issues for tribes to consider when dealing with states about the Medicaid program. The first concerns achieving the maximum number of eligible people, and the second concerns the 100 percent federal reimbursement for individuals covered by Medicaid when they use IHS or tribal facilities. It is not

required in these cases that the reimbursement be matched by state dollars, thus it is a source of financing from federal revenue that does not require states to raise money in their own budgets.

Medicaid is an entitlement rather than an appropriation. When those services are used and billed for, the reimbursement follows.

In 1998, Medicaid covered roughly 11 percent of the general U.S. population, and about 20 percent of the AI/AN population. Medicaid is a program with some categorical limitations for eligibility, largely geared towards coverage of low-income children and some of their parents. Single men and single women, no matter how poor, are generally ineligible for this program. Most of the beneficiaries include the elderly, the blind, the disabled, and families with dependent children.

Among low-income adult men 18-64 in the general U.S. population, 42 percent were uninsured in 1998, and Medicaid reached only 20 percent of the men. In comparison, 51 percent of low-income children now have Medicaid coverage and only 13 percent are uninsured.

Medicaid is both a federal and state program that varies widely from state to state. States such as Montana, New Mexico, Alaska, and New York have both large AI/AN populations and high rates of non-elderly Medicaid coverage. Therefore, these states would benefit from analyzing the determinants of eligibility.

In addition to its eligibility drive toward increasing coverage through both Medicaid and the new Children's Health Insurance Program (CHIP), the Medicaid program is also undergoing a transformation in its method of financing care. Many more people are enrolling in managed care programs rather than having their care reimbursed on a fee-for-service basis. In 1999, 56 percent of all Medicaid beneficiaries were enrolled in managed care.

The Balanced Budget Act has given the states much greater authority in terms of mandatory enrollment into managed care. The states can only require the AI/AN population enrolled in Medicaid to receive care from a managed care plan if it is an IHS, tribal, or urban health plan.

However, the states can ask for a waiver from the federal government in order to be able to mandate more individuals into the state-financed managed care plan, which is a practice that must be carefully reviewed.

There are many strategic choices that IHS and tribal plans have to make about how to proceed with Medicaid managed care. There

is clearly an opportunity for revenues but also an opportunity to lose patients to private sector care.

Careful attention must be paid to making sure that AI/AN peoples' rights are preserved and protected by states and other parties in discussions that concern waiver opportunities and implementation of managed care. There-

DEFINING A “PACKAGE” OF INDIAN HEALTH CARE BENEFITS

The Advantages of an Indian Health Service Defined Benefits Package

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In 1998, the Congressional appropriation for the Indian Health Service (IHS) was the lowest increase in 20 years; 60 percent of the allocated amount was going to one area based on that area's level of influence rather than level of need. Fortunately, the appropriations for Fiscal Years (FYs) 1999 through 2001 have seen much larger increases; the FY 2001 appropriation was 9 percent higher than the previous year.

Under the Snyder Act, Congress periodically appropriates funds for the benefit or the relief of the Indian community. Therefore, IHS was set up to be a discretionarily funded program.

Indian Health Service Funding

IHS as a discretionary program has evolved over time into a budget-based program funded by Congress through a lump sum appropriation. It is an allocation process.

IHS, as a federal government program, is characterized by under-funding. In addition, as with other federal programming, its discretionary funding is based on line-item appropriations. Those funds are then distributed from Congress to IHS, where its 12 service areas further compete for those resources. These 12 areas then allocate the money into operating units such as tribes and tribal health programs. None of these equations give much thought to the per capita needs of the Indian people being served or to the work that needs to be done to improve the health status of the Indian community.

This IHS experience does not mirror occurrences in the non-Indian community. In this era of plummeting resources, in which the IHS system appears to be devolving into a series of unrelated and uncooperative programs that do not communicate well, IHS must move towards a defined-benefits-package strategy. The defined-benefits-package strategy would detail a defined set of services to be consistently provided by IHS to all parts of the country. A clear strategy is necessary to convince Congress in an era of devolution that IHS should offer a defined-benefits package as an entitlement to either individuals or to tribes.

Reasons for Defined-benefits Package

A defined-benefits-package strategy would improve resource quantification and allocation. Currently, the IHS appropriations process is driven by a set of random events. Members of Congress who have the power to do so drop money into the IHS system to meet local needs. Programs within the IHS system advocate for differential growth of services between and within the 12 service areas, creating more complications throughout that system.

A second reason to move towards a defined-benefits-package strategy is to allow for internal and external comparability. The IHS system lacks both, which is one of the reasons why budget growth has not been able to keep pace with the population's growth or service needs.

A third reason to move in this direction comes in the way a defined-benefits-package strategy will facilitate attempts to determine the true cost of providing care. The lack of actual, credible quantification of Native American needs prevents Congressional funding from being granted.

An \$800 million increase in the tribal budget for the Fiscal Year 2000 budget proposal was

tors and tribal health program directors were asked to provide their own feelings about the availability of services, which cannot be interpreted in monetary terms. Finally, geographic and regional variations in prevailing health care costs, which vary widely, were not considered. This lack of internal comparability, illustrated by the statistic that the California Area has only 31 percent of the services that it needs, destructively positions one area against another.

As long as IHS operates outside the realm of a defined-benefits-package, there is no standard with which to compare the availability of services. Subsequently, particularly in an underfunded environment, needs and competition to satisfy those needs will persist. In this environment, tribal health program leaders should develop tribal data sets and arguments based on those data sets.

Lack of external comparability will cause difficulties when the Interior Appropriations Committee, which has very little health experience and no other health programs within its jurisdictions, examines the funding received by IHS. Even if the Committee was familiar with Medicaid or the level of spending per person on Medicaid, IHS' lack of a defined-benefits-package will prevent comparisons. Therefore, Congress will look at IHS as a singular entity, perceiving no pressure on the Appropriations Committee to increase funding.

The Interior Appropriations Committee claims that if it received more money from the Budget Committee, it would surely give more to IHS, but it perceives a shortfall in the money it receives to allocate funding, as well. Its shortfall is blamed on the Budget Committee; IHS' shortfall is blamed on the work of the Appropriations Committee; IHS' clients' shortfall is blamed on IHS.

Since there is no comparability, many Americans and members of Congress act as though there is no economic basis for the distribution of health care resources. Although IHS lacks a method for disproving this, Medicaid and Medicare have mechanisms for quantifying and modifying allocation by area and by cost. In ad-

dition, these mechanisms illustrate how health care expenditures or costs vary by the nature of the population.

IHS has ignored regional differences in population makeup. Some tribes might be more expensive than others because of the age distribution, the health status of the population, or, most importantly, the structural nature of the system that is trying to gain funding.

Targeting health care resources through a defined-benefits-strategy would increase I/T/U cohesiveness. It would improve IHS' effectiveness with Congress and, ultimately, health care delivery to the Indian people.

An Indian Health Service Defined Benefits Package Strategy

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The current system of allocation of resources in the Indian Health Service (IHS) has led to an uneven rationing of health care for Indian people. More specifically, the lack of a defined-benefits-package has led to inequity in resource allocation. A lack of cost-specific and efficacy data exists. Given the absence of these resources, IHS cannot tell Congress what has been accomplished on a per capita basis. While generalities can be made regarding mortality and morbidity data, those in the field of Indian health care cannot show the impact that prevention activities in IHS' Health Education Program have had on the incidence of diseases.

Need for Standards and Data

There has been a lack of consistent standards and defined outcomes. In the past few years, IHS has been required to move toward an outcome-based provision of health services. Thus, programs are forced to be more efficient and more effective with the resources that they have

developed. However, when it came time for Congress to consider this, it asked for concrete numbers that are currently unavailable.

A fourth reason to embrace a defined-benefits-package strategy is its facilitation of the IHS federal, tribal, and urban (I/T/U) participation in managed care. Medicaid, Medicare, and private insurance are moving towards managed systems of care, leading to communication problems developing between those organizations and IHS due to IHS' budget being based on an allocation system. IHS does not have the information systems necessary to manage the care that it provides or to describe to these potential partners how it could be useful to them due to the financial restrictions of allocated funding.

There are other reasons that a defined-benefits-package strategy would improve the well being of a tribally operated health care program. For instance, such an approach would provide information at the local level to improve management decisions. When managed care moves into Indian Country, the potential increases for Indian clients to move out of the IHS system and into other provider systems. This possible loss of patients would result in reduced income flow, lessening the ability to provide services to the community.

Furthermore, a defined-benefits-package strategy would focus health care resources on solving problems and improving outcomes. Managed systems of care are primarily a gamble in which funding sources give providers a lump sum of money on the supposition that providers subsequently improve the health and well-being of clients. By shifting the focus onto health outcomes rather than to the numbers or types of services provided, IHS is afforded the opportunity to remodel and shape programs in the most efficient ways. Managed care, like self-determination contracting, fosters local control.

Working within a defined-benefits-package would help managed care systems maintain quality of care. Measuring the outcomes of services in addition to the number of services provided would allow an opportunity to focus

on and improve the quality of work being done, which could elevate the health status of American Indian/ Alaska Native peoples.

Need for Comparability

Comparability can be either external or internal, and IHS is lacking on both counts. IHS suffers in the absence of a defined set of services consistently provided to all parts of the country.

Externally, IHS is unable to compare its own activities with those of managed care systems, insurance providers, or other governmental systems. This lack of external comparability subsequently fosters a belief in Congress that IHS is well-funded, with adequate resources to care for the Indian population. This lack of comparability data and the erroneous impressions that result also allow the information presented to Congress about IHS' under-funding to be discounted; consequently, IHS' budgets are unable to keep up with either inflation or population growth.

Internal comparability, however, is the more pernicious of these two problems because it pits IHS service areas against each other. The IHS health system's inventory survey of 1994 implies that the California Area has only 31 percent of the services that it requires to provide adequate health care. This compares rather unfavorably with other service areas such as the Tucson Area, the Nashville Area, and the Aberdeen Area that report having as much as 70 percent of the services they need. These numbers allow IHS to present a credible request to Congress for more funding.

Those familiar with Indian Country realize the vast difference in size between IHS service areas. The number of people receiving care in the Oklahoma City Area is vastly larger than the number in the California Area. In addition, the nature of the services offered on the Navajo Nation, for instance, is very different from those being provided to California Indians. However, there is no independent standard for the purpose of comparison. There is no defined-benefits-package to use as a planning or resource-distribution tool, or to compare services.

The inventory survey done in 1994 was a subjective measurement. The service unit direc-

discretion to assist clients in receiving services that may not be medically necessary but that would restore function and improve quality-of-life.

Fourth, the benefits package should mandate that the current level of consumer input be continued. This may be a challenge to build into a model, but it is necessary to maintain.

Fifth, a defined-benefits-package should allow for patient advocacy and education on how to use the system. This is necessary due to the integration of current systems that has created a complicated delivery system. In addition to specific, individual, patient education about the progress of the disease a client is afflicted with, instruction on accessing services beyond the internal, immediate IHS system is essential.

Sixth, a benefits package should create connectivity within the system for patients.

Seventh, a defined-benefits-package should promote the quality of care by allowing people to envision the proposed modality of health care and its overall goals.

Finally, a defined-benefits-package should maintain and continue to develop the infrastructures of Indian health programs.

Those in the field of Indian health care must advocate for and improve the health status of Indian people by providing quality and effective health care through the efficient use of the resources with which they are entrusted.

Discussion

A defined-benefits-package in the market economy raises concerns such as the number of doctor visits or hours of mental health coverage a client receives. How are you thinking about the process by which a defined-benefits-package for Indian health is actually codified, and what is your thinking about how to proceed from a benefit package to equity?

James Crouch: Services around the defined-benefits-package include both personal-health

care services and community-focused health care services. The larger issue is moving from a defined-benefits-package to equity, which must begin with a stealth policy. A section in the Indian Health Care Improvement Act addresses equity. Rather than merely a commitment to equity, the field of Indian health care needs science that is precise and illuminating. An actuarially based distribution model incorporated into the section of the Indian Health Care Improvement Act that addresses equity would affect a balance between governmental, market, and administrative distortions and actuarial science. To move from a defined-benefits-package to equity, then, there must be an actuarial review of the cost of providing health care in the 12 Indian Health Service areas. The next step would be to figure out how much money is actually available, which is difficult to achieve. Many entities would rather conceal their resources than be forthcoming about them, and this practice extends the illusion that there is a great deal of gaming or Medicaid money that will satisfy American Indian/Alaska Native peoples' needs. People must be open about the resources available.

James Floyd: As economies develop on the reservation, more programs could provide benefits to employees, many of who are tribal members. When looking at equity, a health care system needs to coordinate all of the resources and benefit funds that are available on the reservation. Different services must work together. There are at least three different types of programs on a reservation; those of the tribal administration, those of tribal businesses, and those provided by the Indian Health Service. These programs result in three different types of services. If these resources, both financial and human, were coordinated and pooled, then the resulting services could benefit a tribe by providing better services that enable equity to exist. The Department of Veterans Affairs started a benefits package October 1, 1998, and there are problems with it, including the Department's unexpandable budget. Subsequently, the inflation of health care costs will consume a significant percentage of its resources at a time when all veterans are being

been given through IHS for health care delivery.

There has also been a lack of data to use in negotiating or advocating for integration with other health care resources. Providers of Indian health care lack the necessary tools to define risk for their service population or negotiate with health care plans and funding sources. These providers lack actuarial data to illustrate for these health care plans the service costs and needs of the Indian people who would be their prospective clients, and lack sufficient data to even project the costs of implementing their own health plan.

IHS has received a number of lawsuits from various parts of Indian Country regarding uneven program development. What is provided for one service area may not be provided in another. This has resulted from inconsistent professional interests and advocacy. There are committed and dedicated individuals providing health services, but they often have defined specialties. Specialists may advocate for certain services or equipment, which results in some areas within IHS having greater access to those services than areas with different specialists.

Uneven tribal advocacy further explains inconsistent development. Tribal advocacy has occasionally resulted in targeted monies, or funding going directly to the particular area that tribe comes from. Consequently, programs have developed erratically across Indian Country.

Other Impacts on Health Care

Other occurrences that impact unevenness in the Native American health care field are federal policies and unevenly targeted federal funding. Federal funding often targets specific disease prevention or certain modalities of treatment. Once an IHS area receives funding, the service becomes available for the whole population. All of IHS or Indian Country does not benefit from funding of one IHS service area.

While there is currently an unevenly developed system, there are also positive characteristics of the present health care system. IHS' federal, tribal, and urban (I/T/U) system of health care delivery to Indian people is unique and very

different from the model used in mainstream health care delivery, with advantageous developments achieved by Indian leaders who have fought for specific changes to be incorporated into the health care system.

Furthermore, IHS is a community-based model of providing primary care coupled with public health for Indian communities, which is different from the health care plans of most Americans. Still, there is an uneven distribution of program services within the model.

Currently, IHS is a world-renowned public health model of health care that emphasizes community-based primary care and improves the overall health status of Native Americans.

Another unique feature of the current system is its high degree of consumer ownership. IHS involves Indian peoples through Indian health boards, the Indian Self-Determination Act (Public Law 93-638), and consultation. These features are absent in most health care plans. Other health care plans have personal primary health care without the emphasis on consumer involvement in planning and development.

There are also cultural values and traditional medicines now included in IHS health services.

Future of Indian Health Care

Where must Indian health care go from here? The defined-benefits-package that Indian people should consider and the strategy that IHS should adopt must include the following:

First, a benefits package should maintain the present community-based primary care model.

Second, the public health model should continue in Indian communities, as it has both lowered the incidence of many infectious diseases and decreased infant mortality by getting mothers into prenatal care and improving health care of children in the home and in the community.

Third, a defined-benefits-package should allow for discretionary benefits, which are those actions necessary to help restore an individual to a functional level in the community or their family. This would allow an IHS caseworker the

guaranteed benefits and their eligibility is less stratified than it has been in the past. As more and more veterans require services, two areas bearing the largest cost increases are pharmacy and prosthetics or other assistive devices. Indian health care should consider working toward a benefits package guided by a refined rather than a radical strategy. Strategy is essential given the risk of achieving a benefits package without achieving additional funding. This would result in having less money to provide for an unprecedented increase in people and their needs for more services. Tribes should examine the possibility of obtaining government contracts for acquiring pharmaceuticals and other health care goods. However, as government prices are not always the lowest, there is a window of opportunity for pharmaceutical or other companies

to offer more competitive prices.

Yvette Roubideaux: In terms of the defined-benefits-package, consider the federal government's trust responsibility to provide health care for Indian people. While it is true that the benefit package is currently undefined, there is the possibility that in defining it, something will be forfeited, unwittingly limiting something that those in the field of Native American health care might not want to limit. If the decision is made to limit benefits to a defined package, will another part of the federal trust responsibility be lost?

Do tribes use contracts with pharmaceutical companies, such as Department of Veteran

THE ECONOMICS OF BUILDING SUSTAINABLE, TRIBALLY GOVERNED HEALTH SYSTEMS

The Experience of the Navajo Nation

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Approximately 200,000 Navajos live within the area of the Navajo Nation itself. Additionally, as Indian life expectancy increases, the future of health care delivery will be greatly impacted by these demographic shifts.

Despite improvements in Native Americans' health status, many problems with health care delivery persist. However, the Navajo Nation has initiated action that responds to both the health disparities and the changing population.

There are 102 chapters on the Navajo Reservation, each one wanting a health clinic within its boundaries to ensure and improve access to health care. A lack of resources has previously prevented this from happening.

When the Indian Health Care Improvement Act (Public Law 94-437) was appropriated over 20 years ago, people expected urban Indians to create an urban Indian health plan, tribes to create a tribal health plan, and rural areas to create rural health plans. Yet, ultimately, the plans that were submitted could only be funded at 20 percent. Today Indian health programs continue to be under-funded.

The technical, legal, and managerial arenas continue to be areas of focus for the Navajo Nation's goals. Duplication of services is common on the Navajo Nation. The Division of Social Welfare may deal with the same patients as the elder services, food-distribution services, the Community Health Representatives (CHRs), or the public health nursing service. Somehow these services must collaborate to preclude individuals from repeating the same process with

myriad agencies.

In Tuba City, various Navajo Nation vehicles, government vehicles, and tribal vehicles could be seen en route to Window Rock to carry out business. It is difficult to understand why these programs never consolidated their efforts. Likewise, it is incomprehensible that the Indian Health Service (IHS), the Bureau of Indian Affairs (BIA), the school districts, and the Navajo Nation do not collaborate more often.

However, government policy indirectly prevents complete consolidation of efforts. When the government appropriates funds to an individual agency, that agency must spend these funds as a means to demonstrate its financial need for the monies. Consolidation may result in less spending and, consequently, a budget surplus that could lead to decrease in appropriations to an agency.

To ensure survival, the Navajo Nation has attempted to identify processes to augment the limited resources available within IHS. The most important of these is the development of a tri-state Medicaid agency on the Navajo Nation, which has proven to be a challenge.

Developing Navajo tri-state Medicaid services is now necessary as Arizona, Utah, and New Mexico Medicaid agencies do not provide the needed services and attempt to dictate to Indian Nations what services they are willing to pay for. Consequently, this causes tensions in the government-to-government relationship because the Indian nations and IHS have difficulty collecting third-party reimbursements. Subsequently, the Navajo Nation suffers, as the quality of service is limited when IHS facilities are not being reimbursed. IHS and its professionals have to make tough decisions about the type of care to be delivered.

Fortunately, the tribal government of the Navajo Nation has resources and general funds

revenue is possible from wisely investing interest monies.

The loss of even one dollar should be avoided as each dollar represents a service that can be provided to patients.

In addition to financial resources, other assets are required. Information systems must be in place as well as adequate facilities that provide easy access to patient information.

The Chickasaw Nation has completely assumed ownership of its facilities from IHS. Such "real" property adds to the capital assets of a tribe, allowing it to lease property back to IHS, generating further revenue.

Ideally, patients have to own the system, as they are customers as well as beneficiaries. Tribes are competing with regional hospitals in the same community for patients, including Medicaid patients who can easily choose one facility over another. Eligible Indian patients must understand that their tribal hospital will treat them better than any other. Patients without a feeling of ownership in a hospital or facility will be lost as customers. Patients must want to come to a tribal facility, must be treated with respect and dignity, and must see the hospital community as a family.

Tribes need utilization management (UM). UM affords for quality assurance, keeping your patients happy, and hard working staff who work within guidelines. It is yet another tool to a successfully run tribal health program.

Both tribes and IHS must overcome the historical perception of health care as a beneficiary system. Today's health care system is competitive. Patients are needed customers, just as in any other aspect of the market economy.

The Experience of the United Indian Health Service

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The United Indian Health Services (UIHS) was incorporated as a non-profit agency in 1970, when the term "Indian-owned organization" was not used. Initial funding came from non-federal sources, including Turn Child Health, the State Health Department, and California regional medical programs. As a tribal health program that is a consortium of nine tribes from the northern coast of California, it was originally part of the community-clinic movement in the late 1960s and 1970s.

In California, the effect of the Termination Act of 1954 was even more far-reaching than the Transfer Act. At the same time that the Bureau of Indian Affairs (BIA) transferred responsibility for Native American health services to what is now the Indian Health Service (IHS), it left California.

The early years of the UIHS were spent forming an organization that was, most importantly, Indian-owned.

Revenue came from sources such as the National Service Corps, a program of IHS. UIHS became involved with third-party billing in its first years of existence, and has relied on it ever since.

Later, UIHS realized first an increase, and eventually a plateau, in IHS funding.

We now know that IHS is funded by the federal government to meet 30 percent of its need, which would place UIHS at about 15 percent of its need. It used to be that IHS received funding to meet 58 percent of its needs. Obviously, then, IHS and UIHS must seek other sources of funding out.

In 1998, third-party income represented about 15 percent of UIHS' health care revenue, another 23 percent came from MediCal (California's Medicaid system), four percent came from Medicare, and 26 percent came from private insurance.

However, welfare reform is bringing about a lot of changes, including the fact that many MediCal recipients are gaining employment without health insurance. Thus, the 23 percent of third-party revenue attributed to MediCal was formerly closer to the mid-30s, a number maintained only through constant and proactive efforts to enroll people. Enrollment efforts are

to help support IHS. To increase these funds, the Navajo Nation is considering third-party reimbursement by developing a mechanism for collecting Medicare/Medicaid dollars, exploring opportunities for funding from foundations, and changing various tax laws on the reservation. Changing tax laws translates into pursuing gross receipts taxes to help improve local governments, health care, or other areas.

The Navajo Nation is also pursuing needed changes in services through compact negotiations with IHS' in regards to the Navajo Area.

The Experience of the Chickasaw Nation

Mickey Peercy
Chickasaw Nation
Ada, Oklahoma

In October of 1994 the Chickasaw Nation compacted an Indian Health Service (IHS) service unit that included services for 10 tribes. That was in the day of the old IHS. There is a new and improved IHS, although there remain issues that must be resolved.

Though the Chickasaw Nation did not want to compact in 1994, the health system at the IHS hospital had deteriorated to such a degree that conditions became intolerable. The Nation attempted to garner assistance through its IHS area office, but received no response for over a year. The nation implored the director of IHS to address the issues but received no attention. Although compacting was initiated as a last resort, the Chickasaw Nation is pleased with the end result, as the inability to retain physicians at the IHS hospital was a travesty in contract health service.

As a result of both luck and strategic maneuvering, the Chickasaw Nation's program is a success. Successful compacting requires a tribal government comprised of stable leadership and legislature, and a solid, realistic vision for achieving compacting. Past successes and failures can offer invaluable lessons to future compacting

processes.

Risk-taking is necessary. Compacting in 1994 was a serious risk for several reasons. Many Chickasaw citizens were opposed to the action. In addition, the Nation's Governor Anoatubby, who is very conservative, warned that failure to succeed in the effort could lead to the demise of both of our individual political careers. The goal must be important enough to risk what is at stake.

Furthermore, employing qualified professionals in all areas is critical, which may require a broad search outside of the tribe and region for someone with adequate experience and ability.

Compacting requires financial resources as well. When compacting, an entity receives the same amount of money required by the federal program to provide the services. In both compacting and contracting, tribal shares, or administrative dollars from the IHS area office and headquarters, are needed. The Chickasaw Nation was able to turn tribal shares previously used for administration into service dollars through downsizing and operation methods.

Grants are the key to expanding revenue. Entities must be able and willing to seek grants from foundations and alternative sources of funding.

Another avenue for revenue expansion is third-party revenue. When IHS ran the Chickasaw hospital in 1993, third-party revenue totaled \$1.3 million. In 1997, it totaled \$8.3 million. This substantial rise came from aggressive registration and billing of Medicaid, Medicare, and private insurance, which are essential to the success of third-party billing as a vehicle to improving and expanding services.

Other tribal resources can augment compact monies when a tribe's council, legislature, and people are willing to put dollars where they are needed to expand services. Another resource is interest revenue, which is infrequently considered but potentially lucrative.

If a tribe's program is large enough under compacting, it receives a lump sum, in both direct and indirect money. Tribes invest that money. Those dollars can subsequently be re-generated into health care services. Additional

patients, clinics must compete responsibly and fight strategically.

UIHS recently purchased 40 acres of land adjacent to the local hospital at the apex of two major intersecting highways. Thus, the Indian population throughout the 5,000-mile radius will have increased access to the clinic.

To do this, UIHS first pursued banks and funding opportunities at foundations. A task force of people now exists with the sole charge of educating foundations about the Indian population.

UIHS used to live year-to-year but now project a budget for the upcoming 10 years to convince banks that the money they loan will be returned.

UIHS usually secures loans with community banks. In a local area, a small community bank is relying on its clients to honor their loans. If the terms of the loan are not honored, other lenders in that community will not cooperate with a violating client again for fear of the subsequent impact on other accounts and businesses.

Discussion

Ervin Chavez: Medicaid and Medicare monies used to be viewed as resources for tribes to use for services. Now it seems that monies from Medicare and Medicaid are received in lieu of other resources. This is a runaway train that Congress must be told to stop.

Jerry Simone: Congress seems to feel that it can give Native Americans less funding because the population can find it elsewhere.

James Crouch: Native Americans need all of their funding sources. There is a sense that the Medicaid and Medicare monies are vaguely supplanting Indian Health Service (IHS). Some perceive that there is no need to facilitate IHS growth because Medicaid dollars are growing. Actuarial science is necessary to establish whether this assumption is true and to assess the amount of each resource. IHS appropriations should be the dominant source of funds for IHS, but people must not forget the need for additional sources

of funding.

Mickey Peercy: When doing third-party billing there is a ceiling to aggressive registration and billing. When that ceiling is reached, an entity finds that it is dependent on third-party billing as another source of funding. While it is another resource, it does not supplant or replace direct service or any other dollars.

Erin Forrest: The Modok Indian Health Project in California has contracts and agreements with virtually every department in the county. Everyone benefits from pooling resources to achieve what is necessary. As an example, the county dentist would not accept MediCal, so the Project had no dental services unless it paid a fee. The Project helped the county do a survey on dental needs among schoolchildren and found that 60 percent of the non-Indians had never been examined by a dentist. Given that the Project was already paying a fee for dental services, it concluded that everyone would benefit by collaborating to develop the Project's own dental unit in the county. The Project bought the needed dental equipment and the county hired the dentist, constructed the building, and provided funding for the services. State and local governments and collaboratives need help just as much as Indian tribal governments and programs do. The financial and other advantages are too great to be overlooked. An entity must consider many factors related to funding equity before it embarks upon third-party billing. Entities are not all the same and the same standards cannot be applied to all of them. Since one program comprises contract health care entirely and another comprises direct care entirely, universal principles and standards will not succeed. A discussion among representatives with diverse experiences and different vantage points is essential to comprehending and achieving the full scope of a population's needs.

Is there any kind of plan for protecting existing programs from being adversely affected by re-allocating funds?

James Crouch: There is a base amount and contract clauses that prevent money from being reallocated away from Indian Health Service (IHS)

often challenged by Indian peoples' reticence to sign up for MediCal. Many fear that their owning property would bring disqualification. Others believe that they will receive services from IHS anyway and thus, that MediCal is unnecessary. It is a constant challenge to educate Indian clients about the importance of funding, and the fact that third-party reimbursement is not "double-dipping."

The same misunderstanding exists among private insurance companies. Private insurance companies often assume that when an Indian client comes to a tribal clinic, reimbursing that clinic is not necessary, which means that clinics must constantly send friendly legalese letters to remind such insurance companies of their obligation and to warn them of the consequences of not paying immediately. The perception persists that tribal clinics have abundant resources in addition to IHS support.

One of the best economic boons to an Indian tribe is a casino, but many incorrectly assume that casinos solve all of a tribe's financial problems. Foundations often assume that tribes with casinos that ask for funding are not truly in need. This creates a barrier to building more resources.

The money UIHS receives from IHS has never been enough to keep pace with the ever-growing patient population. The methods long relied upon for funding are no longer sufficient.

The new federalism has transferred control to the local level in many cases. Many of the local, state, or other funding agencies that tribes deal with do not understand or support the concept of sovereignty. Banks are unnerved when dealing

with a sovereign people, fearing that the money they lend cannot be salvaged if the sovereign people go bankrupt.

Managed care is another threat at the local level. For example, the health care providers in UIHS' area formed an independent practice association (IPA) whose membership is limited to physicians. Though UIHS has to pay fees in the physician's name, UIHS loses its identity as members of the IPA only through its physicians. The local community clinics are required to enroll their physicians but have no voice in the IPA. Patients who look at the list of IPA physicians are able to see addresses of other clinics where physicians practice, increasing the possibility that they may go elsewhere. When clinics try to restrict their patient load to only serve Indians, IPA bylaws mandate that clinics accept all patients sent to them. Clashes occur at all levels of government and with local agencies. Disagreements with IHS were preferable to the more complicated fight in a clinic's own backyard with other local practitioners.

Clinics must never take their clients for granted. There are predatory health care practices, even in isolated and rural areas that pursue patients who have money through private insurance or some other source. If there is a value placed on an Indian patient, someone will try to draw that patient to a different facility.

UIHS' small clinic in Trinidad covers 5,000 square miles, two counties, and a consortium of nine tribes. UIHS has six satellite offices to ensure that patients have access to it, and to guard against patients being drawn to clinics in closer proximity to their homes. To keep those

REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

Key Policy Issues

The Reauthorization Path of the Indian Health Care Improve- ment Act

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It is interesting to trace the path of the Indian Health Care Improvement Act (IHCIA). In the political arena, the Reagan Administration vetoed the Act. It has also failed to make it out of the Congress for consideration and reauthorization in the past and during this current 2000 reauthorization process. Thus, there is a period of time where the Indian health care programs are left dangling in the wait for authorization. That was not a bad place to be in a period when there was a Democratically-controlled House and Senate. In today's situation on Capital Hill, however, there is a strong, tried-and-true effort by the House Budget Committee to recommend that those programs that operate without authorization lose their funding.

In September 1998, the national surplus of \$70 billion was continually talked about, and although a positive thing economically, the surplus' negative impact is evident in the programs that have been cut to produce it.

Background of the IHCIA

The Indian Health Care Improvement Act was up for reauthorization in 2000. When working on the 1992 amendments, those involved decided that rather than revisiting this bill every two or four years (as was done in 1988 and 1990), it should be an eight-year authorization period. In 1992, when the bill was ultimately enacted into law, it was given a "sunset" of the year 2000.

It was not apparent that the Republicans

were going to take over Congress. Fortunately, this bill was not up for reconsideration in the past two to four years and was protected. Now, again the Indian Health Care Improvement Act is in limbo as the reauthorization year passes by and Congress fails to authorize the bill. It must be enacted into law.

The Annotated Codification of the Indian Health Care Improvement Act, Public Law 94-437 is called the cordon rule and illustrates the existing law with proposed amendments, or what the new amendments will be when it is actually enacted into law.

The bill provides for health manpower. Back in 1976, health manpower was a male term. In 1992 the term was changed to "health profession" to be more inclusive to those involved with the program.

Components of the IHCIA

Title I outlines health professions scholarships. Title II explains health services programs. Title III details health facilities. Title IV mandates receiving the support of other committees, and contains the section on access to health services, which includes essentially minor amendments to Title 18 and Title 19 that enhance access to Medicaid and to Medicare.

Medicaid actually amends the Social Security Act, which is a major piece of legislation. It is the foundation of the work for the Senate Finance Committee and the House Ways and Means Committee. These committee members need to be involved in the issues.

Back in 1992, and even in 1988, many tribes were fearful of accessing private resources or other third-party care. In fact, some believed that their health care services in Indian Country would be terminated if they sought out such entities. In one respect, this is logical, but it

Streamlining the IHCA

Over the years, tribes, scholars, and health professionals, among others, have frequently discussed reauthorization of the Indian Health Care Improvement Act. They want to know why this authority must be so expansive, and whether the Act can be streamlined to give more flexibility and authority to tribes for designing their own programs.

In addition to streamlining the Act, tribes would like to move away from the 108 sections and eight titles the Act now contains to a form that will allow better fund management and a focus on real priorities.

As we look at the reauthorization of this Act, a number of factors need to be considered. One of the big factors is the changing health care environment, which includes the shift of formerly federally administered programs from the federal government in Washington, D.C., to the states. Unfortunately, the shift to managed care through state Medicaid waivers and welfare reform has left tribes and urban Indian organizations out in the cold. Tribes end up fending for themselves with little or no advocacy from the federal government.

Many individuals and organizations recognize the difficulty that tribes experience in trying to fit into a devalued managed care system. This will be an important consideration in the negotiations over reauthorization of this Act.

Tribes also need to develop working relationships with states. Some tribes do not have previous experience working with states. And in some parts of the country, there is animosity between tribes and the states, which is yet another issue to deal with.

There is and continues to be a legal obligation for the federal government to provide health care to Indian people. That must be one cornerstone of this legislation. The other cornerstone is the Indian Self-Determination Act, Public Law 93-638, involving the self-governance authority. Self-governance authority extends beyond the basic self-determination Title I program and philosophy.

Public Law 93-638 gives tribes more flexibility, allowing them to take lump sums of dollars to redesign their health care programs. This process allows for more local control.

Issues for Reauthorization

Therefore, the two major issues in the reauthorization of the Indian Health Care Improvement Act are the rapidly changing health care environment and the increased authority of tribes through self-determination and self-governance.

IHS has the responsibility to move tribes into the next millennium. In June 1998, IHS hosted a round table that included tribes, health professionals, and medical finance professionals to discuss what IHS, tribes, and Indian health professionals should focus on in terms of the reauthorization of the Act.

The round table concluded that IHS is to take a global view of the reauthorization process and consider the future of Indian health care. A careful examination and identification of the environmental influences and changes in the health care industry impacting the IHS federal, tribal, and urban (I/T/U) health care systems is essential. The reauthorization process and opportunities for change need to be carefully considered.

IHS, tribes, and Indian health professionals must envision how Indian Country will work with U.S. Congressional committees to identify the key issues and goals of the new legislation and to provide guidance to IHS on how to proceed with the consultation process. In addition, those involved need to discuss the impact of emerging trends such as managed care, welfare reform, and increased tribal contracting and compacting on Indian health care without limiting the discussion to the existing Indian Health Care Improvement Act.

Round table participants also voiced the opinion that tribes throughout the country are calling for a patient bill of rights for Indian people. This would establish a guaranteed level of health care benefits, including an emphasis on prevention, for all American Indian and Alaska Native beneficiaries of the I/T/U system.

makes Indian Nations subservient to state governments, which tribes do not traditionally deal with very amicably.

IHS resources on a per capita expenditure basis are meeting only one third of the need. In terms of the health care resources available to Indian people, this is 68 percent below that available to any other American who accesses care through Medicaid. That means that in 1996 Indian people were acquiring about \$1,200 worth of services per year on a per capita basis, as compared to Medicaid recipients, who each secured about \$3,600 in care.

There is a definite need to educate the American public, as well as Congress, about the disparities in health care. Title IV is especially important as a potential opportunity to bring at least a billion dollars worth of new business to IHS in terms of Medicaid and Medicare reimbursements.

Title V centers on urban Indian health authorizations.

Title VI involves actual organizational improvements. Essentially, it has elevated the position of director of the IHS to a Senate-appointed position. It took a lot of hard work to see the Director's position elevated to Assistant Secretary for the U.S. Department of Health and Human Services in 1998. Title VI amends the Indian Health Care Improvement Act to reflect that. It was hoped that Title IV would be enacted into law by March 1999. Unfortunately, Title VI has not yet been passed.

Title VII discusses substance abuse. Title VIII deals with miscellaneous items.

In 1998, the National Indian Health Board (NIHB) released a 185-page executive summary of a yearlong study called "Tribal Perspectives on Indian Self-Determination and Self-Governance and Health Care Management." As part of this study, every tribal chairman and every health director in 1997 was asked for their perspectives on the policy of self-determination and self-governance.

The findings are a part of what has been incorporated into Title VIII. There is a great movement, different from the movement that took

place from 1988 to 1992, for tribes to take on their own health care management. The study aimed to figure out what is necessary to enhance tribal understanding of the process.

This study also looked at issues related to quality care, training and technical assistance, health care management, and economic expenditures for health care. The study's conclusions help to frame what the tribes perceive as the primary health care needs that should be incorporated into a law for tribal health care management.

In 1998, a national meeting was held to discuss a nine-month study that examined Medicaid and managed care. The meeting addressed nine states and their most successful practices in the implementation of managed care. Hopefully, these findings will be integrated into the Indian Health Care Improvement Act during the 2000 reauthorization process.

The final portion of the study comprised a three-hour tribal session that focused on concerns about and possible solutions to environmental health issues in the tribes' own areas.

Major Issues for Indian Health in the Reauthorization of the Indian Health Care Improvement Act

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Indian Health Service
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The Indian Health Care Improvement Act was passed in 1976. It is important to acknowledge that tribes consider the Indian Health Care Improvement Act as health care reform for Indian people.

Part of the Indian Health Service's (IHS) basic authority on health care comes from the Snyder Act. Many believe it is the ideal piece of law because, although brief, it gives IHS broad discretion in terms of what its scope of authority allows.

Care Improvement Act is a series of sections that authorize appropriations for various scholarship, loan repayment, and improvement programs, or "such sums as may be necessary," through Fiscal Year 2000. These particular authorizations of appropriations actually have been used very successfully. Everyone's general hope would be that with some modifications, they would be extended.

Another example of an authorization of appropriations is the urban Indian programs in Title V. Again, there are some rules about what Congress had in mind within an urban Indian program. Title IV defines urban Indians and Indian health organizations, and it also authorizes Congress to appropriate such sums as were necessary in any fiscal year for this purpose, up to fiscal year 2000. These two examples are one set of provisions that are sprinkled through the 108 sections.

Then there is what I call permanent authorizations or policy provisions. For example, Section 206 provides a set of rules about recovery of third-party payments, recovery by IHS of private health insurance payments, and rules for dealing with self-insured payments by tribes with tribal members as employees covered by tribal employment-based private insurance plans.

Another example of a permanent policy provision is the definition of Indian in Section 4C of the law. This definition is actually cross-referenced in several other parts of law regarding other authorities like the Public Health Service Act as well as in the Medicaid statute.

In Section 601 a provision says that IHS is going to be an agency of the U.S. Public Health Service, and provides for its establishment as such. That does not authorize the appropriation of any funds for that purpose. That just states that the government is moving IHS out of one position in the bureaucracy and moving it into another.

Therefore, the Act has two different types of provisions: those that exist for appropriation of funds and those that make policy provisions. When reviewing the second type that does not

actually appropriate funds during the reauthorization process, it should be decided whether or not anything should be done. Can they be left alone? Should they be left alone?

The second question is whether, when an authorization exists for appropriations, like Title I scholarships or Title V urban Indian health programs, the appropriations should be extended? If so, the question becomes how do we best accomplish that extension given the following year's political climate?

The Indian Health Care Improvement Act's Path through Congress

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It is difficult to bring issues to the floors of the U.S. House and Senate. Therefore, it is difficult to improve Indian health care in terms of improving access to and the quality of care through Congress.

The people on the U.S. House of Representatives Committee on Resources want shared jurisdiction on improvement within the Indian Health Care Improvement Act. The Committee members would like to improve quality and access, but it will be impossible without money, which is a big question when dealing with a very conservative, Republican-led Congress. Hopefully this situation will ease as a result of the evenly seated Congress created after the 2000 elections.

In Medicaid reform, those involved looked at numbers of about \$3.7 billion to significantly improve the level of care. Certainly, though, there are even larger estimates on the resources necessary to achieve this. The Medicaid reform bills must be submitted to the Congressional Budget Office. Yet, it must be expected that the office may balk at another \$4 billion.

The Fiscal Year 1999 appropriations had very

To be successful, this effort would require a definition of the standard services or guaranteed package of the benefits that are available. These services must then be articulated to the beneficiaries so that there is an adequate understanding from the users of the I/T/U system. Finally, a mechanism for the continued monitoring and evaluation of services should be in place. Then services could be improved based upon the needs and input of patients, and not deteriorate based upon the shortcomings of the federal budget.

Round table participants also raised the issue of re-examining urban health programs within the I/T/U system and how services can be improved when there is a large shifting of the Indian population from reservation and rural settings into the urban areas. This becomes political because it needs to be accomplished without diminishing the government-to-government relationship or the legal foundation that created this obligation on behalf of the federal government to tribal governments. Neither the relationship nor the obligation can be diminished.

The final issue from the round table is managed care. Participants felt that the defined set of services in a package should be based upon the health needs of a particular community.

IHS conducted consultation sessions with each IHS area to identify policy issues and recommendations related to the Indian Health Care Improvement Act. IHS also consulted with tribal leaders, urban health professionals, federal agencies, states, members and staff from Congress, and other interested parties in order to draft and issue the "National Steering Committee Proposed Bill to reauthorize the Indian Health Care Improvement Act."

Discussion

Yvette Joseph-Fox: A traditional person once told me that we have to look at trying to enhance and improve services to Indian people through the widest lens possible. I understand the chaos created by the large number of provisions in the Indian Health Care Improvement Act. However,

at some point and at some time, different tribes have different requests. For example, some states do not want to provide private insurance payments to Indian health care providers. Therefore, it is almost necessary to have the language explicitly stated so that judges who do not want to make resources available to tribes are compelled to make resources available in their court decisions. This is a very touchy issue.

The Statutory Context of the Indian Health Care Improvement Act

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The Indian Health Care Improvement Act sits in the statutory context. This provides many choices as to how to proceed on the reauthorization. It is not just an issue of whether it should be a one-line bill or 108 sections spread over eight titles.

There are no entitlement provisions in this legislation. Medicaid or Medicare eligibility and benefits issues in Indian Country will raise entitlement issues. That raises a completely different set of jurisdictional and budgetary questions.

There are no actual appropriations in this legislation. It incorporates no language that says Congress will appropriate funds obligated for Indian health care purposes of a particular nature. That is what appropriations bills do; this is not one of those types of bills.

This Act authorizes appropriations for certain purposes, but it also has what I call permanent authorizations, which are not authorizations of appropriations of funds but rather authorizations that denote the policy on a particular issue. This is a timely issue, as all or parts of this legislation expired in Fiscal Year 2000.

Some authorizations of appropriations serve a specific purpose, such as scholarship loan repayment programs. Title I of the Indian Health

limited increases for Indian Health Services (IHS). Larger dollar increases are beyond the yearly budget's capacity. In order for increases to happen, the Committee must be convinced that a great need exists in the Indian health care field, and that the need mandates at least double or triple the current appropriations. As a result of much hard work related to these aspects, IHS realized greater increases of eight and nine percent in the Fiscal Year 2000 and 2001 appropriations.

An alternative approach to increasing IHS and tribal funds would be to move some of the dollars off budget, which touches on the idea of accessing Medicaid and other third-party funds.

It would be advantageous for Indian programs or Indian beneficiaries to participate in Medicaid, which would require the Committee on Resources to work with other committees, primarily, the House Commerce Committee.

Reauthorization of the Indian Health Care Improvement Act was projected to be a two-year process, and indeed it is. People must be encouraged to be as involved as possible. Improving health care access and health care quality will require spending a lot more money. Then the question becomes one of getting Congress to spend more money, which will take a lot of work. In the House of Representatives, this involves dealing with the Resources and the Commerce Committees, and addressing Medicaid will require dealing with the Ways and Means Committee. In the Senate, the Indian Committee will have to be addressed, and finally, the Finance Committee, which deals with both Medicaid and Medicare, will be involved. Thus, five major committees require our focus. They carry a lot of influence with them and a lot of tribal resources will be required to educate and collaborate with them. Medicare and Medicaid probably hold the best hope for improving the access and care for Indian people.

As a last matter, the Democrats on the House Resources Committee will fight to whatever extent possible; although, many are opposed to devolution, they support self-governance.

On the other hand, Democrats oppose weakening the federal/tribal link or the federal/tribal relationship in terms of the responsibility for providing health care. The Democrats disagreed with the Republicans on Medicaid reform. Republicans wanted to block grant programs to the states. Generally, when Congress is trying to block such programs, Democrats oppose that and try to retain the programs. For example, Democrats would like to keep Medicaid as a capitated entitlement.

People must begin working to pass bills early and become familiar with people who are on the Commerce, Ways and Means, Finance, and Indian Affairs Committees, to make their difficult jobs much easier.

Discussion

Yvette Joseph-Fox: I know from working on the bill to elevate the Director of the Indian Health Service (IHS) within the Department of Health and Human Services to Assistant Secretary for Indian Health the importance of working with Congressional Committees. The end of the 1990's was peculiar because of the actions of Congressional members who make referrals to a variety of committees on important Indian legislation. This is their method of slowing down the bills. It also requires Indian health professionals and tribes to learn to work with numerous committees. Many years ago it was clear who

IS WELFARE REFORM WORKING FOR NATIVE AMERICAN COMMUNITIES?

Tribal Implementation: The Temporary Assistance for Needy Families Program

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The Temporary Assistance for Needy Families (TANF) program under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is commonly referred to as welfare reform. In 1997, the Kaiser Family Foundation asked me to analyze tribes in certain states that are implementing their option under welfare reform to administer their own cash-benefit system, otherwise known as TANF.

The welfare-reform law rode in on a wave of public sentiment that wanted to end welfare, as we know it. The law basically eliminated welfare as an entitlement and created a new block grant system in TANF. TANF replaced the Aid to Families with Dependent Children (AFDC), Job Opportunities and Basic Skills (JOBS), and emergency assistance programs. However, on Indian reservations where JOBS existed prior to the 1996 federal legislation, the JOBS programs will continue to exist as Native Employment Works (NEW) programs.

Elements of Welfare Reform

Welfare reform set up a new system where families that met certain income requirements and had children could continue to receive cash assistance under certain conditions, which included participation in work activities. The federal law created a five-year lifetime limit of eligibility for cash assistance.

This was a new philosophy, which has been examined by Indian and non-Indian people from

a variety of perspectives. Some people see this reform as a change away from compassion as we have known it and towards ending a cycle of dependency and creating a pathway into the work force.

Welfare reform is a controversial new experiment being administered throughout the United States. Section 412 within the new law provided the opportunity for American Indian tribes, in lieu of states, to administer cash assistance to tribal members. If a tribe chooses to, it needs to develop its own tribal assistance plan in which it can change several aspects of the state TANF plan – the rules, the work-participation rates, time limits, cash amounts, and support services.

We have been hearing the word “devolution” a lot lately. Indian people and Indian tribes in particular need to remember that the ability to administer cash assistance to families might be devolution of authority from the federal government to the tribes. Yet, it is important to remember that Indian tribes have always included, within their definition of inherent sovereignty, protection of the welfare of their families, elders, the children, and the most vulnerable people within the community. Looking at the history of Indian tribes, one sees that the motivating force in the negotiation of treaties and the base of sovereignty has always been the protection of the welfare of those families.

As I interviewed tribal leaders and members in Oregon, Arizona, and Wisconsin, one idea was repeated over and over again. Many said that whatever happens with this social experiment in welfare reform, ultimately the tribes are going to accept the responsibility for the welfare of their people.

With regard to devolution, sovereignty, in terms of authority over the welfare of their people, is something that has never been extinguished. Thus, it is beneficial that tribes now have the opportunity to choose to implement

subcontract back with the state so that the state would administer those services. In effect, rather than setting up an infrastructure to administer the cash-assistance services, the tribes negotiated their own TANF plans, changed the time limits and the work activities, and instituted their own philosophies in regards to how their people would be treated. They then contracted back to the state and now those services are administered within the state office, but under the tribes' rules.

The White Mountain Apache and Pascua Yaqui Tribe's model is a much more integrated model: the Pascua Yaqui administers the plan through Social Services; at White Mountain Apache, the Planning Department administers it. For the client, this model allows one-stop shopping for cash assistance, Medicaid, and food stamps.

Case Studies: Wisconsin

In Wisconsin, we visited three tribes: the Forest County Potawatomi Tribe, the Stockbridge-Muncie Band of Mohican Indians of Wisconsin, and the Oneida Nation. Each of these tribes has a fairly small population. However, the State of Wisconsin was administering welfare reform before the federal government passed the welfare reform laws. Therefore, there was already a system in place and a clock ticking.

The State of Wisconsin wanted out of the business of administering welfare. Even prior to welfare reform they asked any non-profit, local county, or tribe that wanted to take over the administration of welfare programs, medical assistance, and food stamps to do so. They call this the W-2 or the Wisconsin Works Program. As an incentive for participating in the program, the state will match federal funds for tribes that administer the Wisconsin program under the Wisconsin rules.

Two tribes decided to change the rules because they wanted a 60-month lifetime cash-assistance limit as opposed to the 24-month limit. They administered their own TANF Program, but they received no state match due to the change to the 60-month limit.

The state has given the determination authority and approval of Medicaid applications, regarding food stamps and medical assistance to the tribes. It is the only state that I am aware of that has done so.

The Wisconsin program is an integrated model. Here, the tribe administers the state Welfare medical assistance, food stamps, and TANF Programs under the tribal umbrella.

Eight key conclusions can be drawn from our visits to these three states.

First, even though tribes have received a lot of flexibility allowing them to change the programs, the programs have changed very little. Most often, the tribal plans mirror the state.

Second, these programs need a great deal of tribal-state coordination to be successful.

Third, as evidenced by the three states analyzed, there is flexibility, and therefore, range in the way tribes approach TANF.

Fourth, medical assistance is not always integrated, or given a priority in terms of planning TANF services, which is going to be a major problem.

Fifth, work activities, work hours, and time limits are the tribes' largest welfare reform concerns. Subsequently, the job opportunities that are going to be required for those families on TANF are limited. Most tribes identified their clients as working at the casino or in Tribal programs.

Sixth, the anticipated internal restructuring of tribes is not taking place.

Seventh, tribes have the challenge and the difficulty of dealing with families that are facing multiple barriers in trying to move off of cash assistance and into the job market. The tribes assume that the Indian Health Service or tribal alcohol, drug, and mental health counseling resources are going to help these multi-barrier families to move off of cash assistance and into the workforce. Given the funding for those programs, that is an unrealistic expectation, even without the impact of TANF.

Finally, among all the tribes we visited that are operating their own TANF Program, there is a

their own TANF Program. More opportunities are available when tribes choose to do so, including the ability to design their own system or establish their own priorities and policies in their TANF plan.

Some tribes have restructured tribal services in order to respond to client needs such as job placement, daycare, vocational rehabilitation, mental health, or alcohol counseling. The tribes reconfigure tribal services in order to meet the needs of families.

Welfare reform has provided a new, motivated, entry-level workforce due to the requirements for continuing eligibility for cash assistance. It has also sparked a higher degree of state and tribal coordination.

There is no deadline for a tribe to decide whether or not they will administer the TANF services. Tribes fundamentally feel that they can do a better job than states. Given the harsh approach of welfare reform and the sanctions included, many tribes feel the responsibility to intervene and administer the programs.

One of the challenges, however, is that there are no start-up funds. States have had the infrastructure to administer Welfare and cash assistance that tribes have not had. There are no monies available to tribes to construct such a system.

Case Studies: Oregon

We visited with three tribes in Oregon: the Klamath, the Siletz, and the Warm Springs. The Klamath were the very first tribe to receive an approved TANF plan and to administer the program. The tribe opened its doors without much of an infrastructure and developed its program as it was serving its clients.

Conversely, the Siletz program had somewhat of an infrastructure in place, as it had been administering general assistance through the Bureau of Indian Affairs (BIA). In addition, unlike other tribes, the Siletz changed its allowable

work requirements to include higher education as the focal point for allowable work activities.

While the Klamath Tribe has emphasized movement into the workforce and the Siletz Tribe has focused on higher education, the Warm Springs Tribe has relied upon the State of Oregon to provide those services. The Warm Springs Tribe has been referring clients to the state and the state has been referring TANF plans back to tribal resources. The people at Warm Springs told us that the impact they have seen has been depletion of tribal resources including commodity foods, jobs, and day care.

The TANF Programs that the Klamath and Siletz Tribes have set up are basically parallel to that of the state. The programs have not been integrated with state resources, but the tribes operate similar services and provide them to their designated clients. The tribes administer their own system for their own clients; the state is operating its own system for its own clients.

In terms of Medicaid and food stamps, the tribal programs have to refer those clients to the state system. The Siletz Tribe has negotiated a way to complete the application for medical assistance, but the application still has to be sent to the state for processing.

Case Studies: Arizona

In Arizona, we visited the White Mountain Apache and the Pascua Yaqui Tribes. These two tribes were caught in a situation where the State of Arizona was about to implement a two-year cutoff for cash-assistance eligibility. Each tribe was working against the clock to implement a TANF plan that would help a majority of their families who were dependent upon cash assistance. In order to accomplish this, they changed the rules. They changed the allowable work activities and expanded the two-year time limit to 60 months.

What the tribes did was very clever. Both tribes negotiated a contract with the state so that after they had changed the rules by changing the policies for their TANF recipients, they could

dian and Native American Employment Training Coalition, "Welfare reform is now on the doorstep of every needy Indian and Alaska Native family in the country. The challenge will ripple through the Indian extended family structure, they will impact the fabric of life in Native communities for years to come."

Those of us working on this project have been very humbled by visiting reservations and talking to TANF recipients. This study, as limited as it is, is critical in telling the story of women and children living on reservations and what impact welfare reform will have on their future.

The Welfare to Work study aims to document the characteristics of American Indian families receiving welfare. We want to identify the community, family and individual barriers to employment and self-sufficiency. We want to explore strategies used by parents to attain self-sufficiency. We want to monitor the survival strategies used by families who are sanctioned or terminated. Finally, we want to monitor the social and economic conditions on reservations as welfare reform progresses.

This is a five-year study. After the first year, we began to analyze administrative data from the Arizona Department of Economic Security (DES), the Bureau of Indian Affairs, and Tribal Social Services. We will do this each year to look for growth or decline in numbers. We have conducted focus groups with current and former welfare recipients, with service providers on reservations, and with state DES staff that serves the reservations.

Interviewers from the community have been trained to interview 400 women whose families receive TANF. These women have been and will continue to be tracked from years from the study's second year through its conclusion in 2002.

Finally, we have been interviewing the employers of TANF recipients who find work. This

1. Welfare, Work, and American Indians: The Impact of Welfare Reform by E.F. Brown, S. Cornell, et al. A Report to the National Congress of American Indians, November 2001, published by the George Warren Brown School of Social Work, Washington University, and the Udall Center for Studies in Public Policy, The University of Arizona, 66pp.

will enable us to find out what kind of work they are doing, how are they trained, and what their salary is, as well as what other areas may need research attention.

Results of the Welfare-Work Study

In the study's first year we collected opinions about TANF from providers, those affiliated with the state, and recipients themselves. The data presented here is derived from in-depth interviews with service providers on 15 of the 21 reservations in Arizona. The information was substantiated by site visits to reservations, where we conducted group interviews with state and tribal social service providers. Information collected from focus groups with current and former welfare recipients on other reservations also supports the data. Here are ten findings of the study:

1. One of the first findings was that welfare recipients have increased their participation in work, training and educational programs, which was expected. According to reports from residents and service providers, TANF recipients are anxiously looking to enroll in education and training programs. As a result, on all four reservations we visited, there were lists of women waiting for admission into General Education Degree (GED) programs and/or Job Training Partnership Act (JTPA) programs.

One state JTPA coordinator reported that many tribal members, seeing that the federal government is serious about welfare recipients finding work, are seeking and obtaining employment. Most welfare recipients are complying. A local DES worker, who is also a tribal member, commented that TANF is opening people's eyes: "It is going to change the way we think as Indian people." Another state worker commented that welfare reform woke a lot of people up.

2. A second finding is that, in addition to motivating change, there are psychological impacts on Welfare recipients facing uncertainty. We have seen that welfare reform has initially increased the stress levels of welfare recipients.

significant sense of accomplishment about what they have done.

Refocusing on Welfare: The Recipients' Experiences

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Many times when we talk about the Temporary Assistance for Needy Families (TANF) Program, we focus on structure and politics. However, we often forget to focus on just whom these programs are supposed to help and what is happening to those recipients.

Until 2002, it is going to be critical that we understand the impact that welfare reform will have on the Indian community. With that in mind, let me explain the Welfare to Work project, which monitors the impact of welfare reform on American Indian families and children through a five-year longitudinal study funded by the U.S. Department of Health and Human Services.¹

The study is being conducted on American Indian reservations in Arizona. Ideally, we would have liked to do it in three, four, five, or even 26 states. However, dollars for research on American Indians and welfare reform are almost non-existent. Right now we have the only research grant currently funded by the federal government to study this impact.

Because the grant is so small, we had to focus on one state. We chose to look at the state with the largest number and variety of reservations.

As the principle investigators, Dr. Shanta Pandey and I represent the Katherine M. Buder Center for American Indian Studies at George Warren Brown School of Social Work. We are very happy and pleased with the study's progress, and we are determined to do research that is critical to Indian communities, not as outsiders, but working in partnership with tribal governments. We intend to assist tribal governments

in determining and identifying key areas that need to be examined as well as collaborate in a joint research team to develop the methodology and the approach to working with the key areas identified. We talk about the legislation, but often fail to recognize whom we are talking about or what the state of the field is.

Human Face of the Issue

Single women head 27 percent of American Indian families, both on and off the reservation; this is one of the highest percentages of any group, and the number continues to grow. Fifty percent of American Indian families maintained by single women presently live in poverty. Forty-six percent of women living on reservations, 25 years of age and older, have less than a high school diploma. Fifty-five percent of the children living on reservations live below the poverty level.

One-third of TANF recipients are adults, while the other two-thirds are children. We are talking principally about women and many, many children.

The unemployment rate on reservations averages 26 percent, depending upon the statistics one consults. The Bureau of Indian Affairs labor-force statistics report that potential unemployment is roughly 35 percent. Twenty-three percent of households on reservations receive some form of welfare assistance. In Arizona, we found that more than 25 percent of the total Indian population residing on reservations is receiving TANF services.

These figures illustrate that the majority of TANF adult recipients are single-parent mothers with children. We become preoccupied with other things, but it is essential to remember just whom we are working with and what they need.

On the reservations that we visited in Arizona alone, over 90 percent of the TANF caseload (and in some cases, as high as 98 percent) is single-parent mothers with children. American Indian women and their children who live on reservations may be more severely impacted by welfare reform than any other racial or ethnic group in the United States. As stated by the In-

remote, rural areas. One DES office manager reported, "The biggest problem is that people tend to live far out from the nearest town. There is no public transportation. Their available transportation is not adequate for maintaining employment."

A TANF recipient on another reservation said, "My truck is always broken down."

Other TANF recipients offered the following quotes: "The further I go with my education and training, the harder it is;" "I'm not close enough to town and not close enough to stores;" "My aunt has to take me shopping;" "I have to go 30 miles for gas."

A tribal social service provider close to an urban area said: "Our transportation problems are shocking. We're close to the city, yet we're still isolated. It's like there is a big wall around the community." Overall, many attributed the shortages of services to the shortages of funding.

6. A sixth finding provides evidence that personal/ individual barriers, such as a lack of education or job experience and individual and family problems are evident. Let us look, for instance, at low levels of education. In one tribal program, 50 percent of the participants had an eighth-grade education or less. Some had only a third-grade education.

Some JTPA programs required applicants to have GEDs before they could even participate in the program. Other JTPA programs offered GED classes, but service providers in several communities said that they did not have enough GED slots to meet the need.

An employee-training coordinator said that most TANF recipients who apply for his program need extensive assistance with reading, writing, and basic math. The majority of service providers describe their available educational services as "inadequate." They said that they were having a difficult time meeting increased demands for services because "a lot of the individuals referred to us are hard to serve. They need the most basic skills."

Many of the focus-group members had never held a paid position outside of Job Corps

or some type of community-service program. However, they were aware of the importance of experience.

One job seeker explained, "The employers I see each month to sign my monthly activity form tell me the same thing. You need a GED and you need job experience. Although I would have to apply for their jobs if there were openings, I know they won't pick me because I don't have experience."

7. The study's seventh finding concluded that the lack of basic necessities such as telephones, food, fuel, and clothing is another barrier between reservation residents and work. Of all the focus group participants interviewed, only a few had telephones. Employers are usually reluctant to hire people they cannot reach by phone.

Most participants also reported lacking basic household supplies at the end of each month. In some communities, residents still rely on wood fuel for heating their homes. One woman reported, "The money I get from welfare is not enough to cover rent and butane. My fuel runs out and we have to sit in the house with blankets over us." The lack of basic necessities also impedes employment opportunity.

8. An eighth finding concerns individual and family programs. Some focus-group members report that having children with health and behavioral problems makes it difficult to find childcare and work. Grandmothers caring for their grandchildren, in the absence of the children's mothers, are included in these reports.

9. A ninth finding cites alcoholism as a problem in many communities. Both service providers and focus group participants reported this. As one service provider said, "Alcohol abuse is a big problem. It impacts employment, parenting, violence, suicides, crime, and other things."

10. Finally, early findings reinforce that women are forced to struggle against stereotypes and discrimination. This phenomenon exists both on and off the reservation. Women

The director of social services for one tribe stated, "Welfare reform has made women scared that they would get cut off when they received their general letter from the state informing them of changes." One JTPA director noted that while more TANF recipients are requesting services, they are still "afraid of change".

Anxiety about new TANF requirements is also leading people into depression. Additionally, they may be more vulnerable to turning to alcohol if they lose their jobs or Welfare benefits.

One focus-group member said, "The money goes too fast. People don't live like we do [in remote areas]. They don't understand what I'm going through. The world is going to change. Soon there won't be any assistance."

3. A third finding is that the 50-percent-unemployment rule and Arizona's waiver of the 24-month work requirement has postponed many welfare reform impacts. The 50-percent rule exempts any Indian reservation with 50 percent or more unemployment from the five-year welfare cash-assistance time limit. In Arizona, that applies to five tribes. Those five tribes represented approximately 87 percent of the total Indian population in Arizona during our study in 1998. Therefore, 87 percent of the Arizona Indian population will not be subject to the five-year time limit on welfare. Furthermore, because the State of Arizona is unable to deliver adequate employment services to those reservations, it has waived the requirement that welfare recipients find work within 24-month of first receiving assistance or when the law was put in place (for those who were already on welfare).

The 24-month work-requirement waiver has worked as both a blessing and a curse. It has been a blessing in that it postponed many of the possible sanctions that single parent, Indian mothers would have faced when they reached their 24-month work requirement. It is somewhat of a curse because it delayed the change, and therefore, did not require recipients to look for work as soon as the 24-month limit would have. As one individual said, "it pretty much took the gun away from our heads." A local DES staff member commented that these waivers "would

be negative if people returned to complacency because of the work time-limit waiver brought on by the unemployment rate."

4. A fourth finding concludes that the lack of economic development and employment opportunities, especially in rural, isolated communities, is an extremely serious problem. One of the greatest barriers faced by American Indian communities in implementing Welfare to Work is the shortage of employment opportunities on or near reservations.

All of the tribal service providers and state staff alike mentioned the shortages. One service provider said, "Even if we trained everybody we wanted, we don't have enough jobs."

Another service provider echoed that thought: "The big concern is that we can train people until we turn blue, but if we don't have the jobs, where will we put these people once they're trained?" He continued, "It doesn't just take tribal government to create jobs, but it also takes the state and local governments and employers".

Service providers predict that welfare reform will, as one tribal planner stated, "Force the tribes to quit being lackadaisical about economic development."

Another tribal planner explained that welfare reform would not work in rural areas without economic development. He felt, however, that it might be necessary to take capital from other tribal economic development projects in order to "make work for TANF recipients."

5. A fifth conclusion is that lack of transportation and childcare creates major obstacles. There has been an increase in childcare money on reservations through the Child Development Fund, however the lack of support services in transportation and childcare are barriers to employment and training on reservations. On virtually every reservation where a representative was interviewed, transportation was mentioned as one of the main barriers in putting TANF recipients to work.

This is especially true for reservations in

funding. If a tribe wants to start child-support enforcement they should say to the federal government, “The federal government is allocating millions of dollars for the state to develop a child-support system. We want to develop our own system. We are requesting that you give us some start-up funds to do so.”

Nothing in the child-support law denies that, whereas in the welfare reform law there are more constraints regarding how dollars can be spent. The real challenges for tribes are setting up these systems and determining how to positively reinforce the role of the father and his responsibility for the child.

Yvette Joseph-Fox: Whenever a new national policy is implemented into law, only about 1.5 percent of what that program will cost is made available for implementation. This creates a nightmare in relation to the infrastructure.

Cynthia Mala: We need laws to prevent kids from being dropped from the rolls due to their mothers being sanctioned. Many times the non-Indian caseworkers are overworked, and they do not understand the tribal systems or infrastructures. Even the tribal social workers and administrators do not understand that these kids are eligible for Medicaid. The state, non-Indian social workers end up telling people to come back in and re-apply. That’s a big problem.

Eddie Brown: That is a big problem. Many times tribes believe that they do not have to worry about Temporary Assistance for Needy Families (TANF) since the state is administering it. They do not realize that tribal job programs need joint coordination if someone on state TANF fulfills the job requirement in the tribal program. It is critical that the tribe ensures that the state is fulfilling its obligation to provide services.

Mim Dixon: At the National Indian Health Board (NIHB), we have heard anecdotally that one of the consequences of Temporary Assistance for Needy Families (TANF) is that people who are getting sanctioned, getting cut off, or who are getting initial letters warning of being cut off or

sanctioned are moving back to the reservations. This influx of reservation residents then places a greater demand on the reservation health care facilities. Has your work validated this?

Jo Ann Kauffman: That did occur in some of the communities that we visited during our study. Warm Springs did not implement their own Temporary Assistance for Needy Families (TANF) program. Their social services were impacted by people moving back to the reservation after being dropped by state TANF. However, the tribes that did have their own TANF programs did not see noticeable changes in their client loads. We believe this is due to the fact that the changes in their TANF programs were minimal when compared to the state programs. The problem has a lot to do with how tribes and the federal government estimate the numbers for their service population. Reliable and tribe-specific sources are not used very often. For instance, the Klamath Tribe received its money based on an estimated number of clients. They were eventually inundated by 30 percent more clients than expected. This forced the tribe to make subsequent adjustments. These issues remind us of a need for to study where Indian people are living, working, and receiving aid.

Eddie Brown: We also have heard anecdotes about people leaving the reservation to find work and other stories of people returning to the reservation after losing their welfare eligibility. In addition, we have heard of people putting their children in boarding schools because of the stress related to these issues.

There are communities that have changed the lifetime cash-assistance cut-off because of a 50 percent or greater rate of unemployment. Is there a greater influx back to the communities where they have not instituted a change?

Eddie Brown: As tribes take on Temporary Assistance for Needy Families (TANF), the debate grows about work and human capital development. The TANF-recipient group is often marked by low human capital. In other words, people are undereducated and do not have experience.

The debate, particularly for tribes that take

attempt to obtain work but are sometimes seen as competing directly with men for jobs and seen within the limits of stereotypical roles.

Welfare to Work and welfare reform, in general, have positively impacted tribes. When we visited reservations, we found that welfare reform has increased communication, coordination, and collaboration among tribal service providers. Many of these programs, though they might have coexisted in one tribe, have never before shared dialogue or coordinated efforts. However, now people are beginning to come together to discuss welfare reform.

The increased opportunity for tribal sovereignty and culturally sensitive assistance programs is another positive impact of welfare reform.

One of our management gurus said, "If you want to change, change a little, change your attitude. But if you want to change a lot, in revolutionary ways, change your frame of reference." For example, Navajos have taken their traditional frame of reference, incorporated this new paradigm of Welfare to Work, and are trying to bring them together.

If tribes are going to provide some kind of quality services to their citizens, changing the frame of reference will be their ultimate challenge.

Discussion

How do women access Medicaid and Medicare?

Eddie Brown: In February 2000, there were 22 Temporary Assistance for Needy Families (TANF) Programs in 12 states that serve 94 tribes and Alaska villages. There are an additional 22 pending. If all plans are approved, tribes could potentially serve over half of all tribal families. As an applicant for welfare you go to the state and fill out a form. Usually it is a three-part form, so if you qualify for TANF you are also eligible for food stamps and Medicaid. When a tribe takes over TANF, applicants then need to fill out

two forms: the state form for food stamps and Medicaid and the tribal form for TANF. People are concerned about coordinating the application process to ensure that people know what they are eligible for.

Another concern with welfare reform and Medicaid is that if a woman gets sanctioned, for instance, if she refused to divulge the name of her children's father, she will fall off the rolls for TANF, food stamps, and Medicaid. This happens when women feel that they are being asked for too much information. There is a need for communication and agreements between states and tribes to ensure that a woman and her children who are dropped from TANF due to a sanction do not also lose their food stamp and Medicaid eligibility.

All the statistics reveal that the women in our communities are vulnerable. Many of them choose not to seek child support in their communities. What has your study found about this?

Eddie Brown: We did not find anything of that sort in the study. I have found it through personal experience in Arizona as the director of the Department of Economic Security. When the child-support concept first came about, it was difficult to work with local judges to bring a court order against people who did not pay child support. No one theorized that the state could utilize child support to decrease the revenue spent on welfare.

In addition, no one recognized child support as a way to understand the responsibility of the father. The federal government had to push states and assist states through funding in order for them to develop child-support systems. The systems for child-support enforcement are complex. Under the law, tribes can develop their own child-support enforcement systems. However, these systems are often too costly and technical for tribes to administer. Thus, many tribes opt to develop an intergovernmental agreement with the states for child-support collection.

Another issue for tribes wishing to set up child-support systems is the lack of start-up

people out of poverty through asset accumulation. Recipients can withdraw the money for the purposes of home ownership, education or small business development. The accounts appear with various names such as American development accounts, individual development accounts, and household development accounts. Also, it is important to recognize that a few states have initiated similar programs separately from the federal initiative. This is one recent initiative that has emerged. Have there been others?

Jo Ann Kauffman: I believe they have client saving accounts in Wisconsin. I think the state law set up the provisions and it is part of the tribal TANF programs.

Yvette Joseph-Fox: I like the term human capital development because I think of it in the reverse: human development in the Capitol. Recently Congress gave states and counties the right to have lotteries, but they did not want to give the same permission to Indian nations. There was a member of Congress who did not want to extend the privilege to Indian tribes. He does not believe that Indians should rely on the BIA or gaming. That member of Congress is Native American. I could not believe that he did not want to protect tribes' rights. It is important to protect Indian peoples right down to the most fundamental level. We must find out what improved services families and individuals need. In ceremonies you can start a fire a number of ways. Sometimes you can start a ceremony fire with a lighter; sometimes you can start it with a pair of matches; and sometimes you have to get down to the most fundamental level and start the fire with a flint. When you have a flint fire it takes a lot of time, but it is the purest form of fire. That really makes a difference in terms of your prayer and ceremony. Starting at the fundamental level is what is essential and important in terms of addressing welfare reform and health care delivery in Indian Country. When you understand what the issues are at this local level, then you can progress and hopefully enhance not only human capital development, but also human development in the Capitol.

We are seeing a significant rise in elder abuse, but we do not have statistics. We only have anecdotal information. This issue comes up again and again when we meet with elders. I think elder abuse is rising as a result of welfare reform. It is not physical abuse as much as financial abuse and neglect. Children usually return to their parents if they have nowhere else to go. Many children who are parents themselves leave their children with their elderly parents when they go to work or if they have a substance abuse problem. The elderly parents are often frail and do not have the resources to adequately feed and care for themselves and the youngsters. In addition, over 30 percent of these elders do not have a telephone or a mode of transportation. Talking about elder abuse with the elderly population is difficult; they bring up the topic of abuse, but do not want to talk about it in specifics. We have developed a survey where participants do not need to identify themselves or their tribes. We know that elders talk about added stresses, but the survey did not answer a lot of our questions, and we are unsure of how to collect the data beyond anecdotal stories or how to address the issue with elders. We need to start addressing these concerns and recognizing that the elder population needs protective services. Tribal communities need elder-abuse laws. Many tribes do not have an abuse code or legal mechanisms to deal with abuse. What are your ideas for developing mechanisms to track the experiences of elders beyond the anecdotal?

I also have a serious concern about the elder population. We talk about single parents and mothers, but the elder population is often left out of the conversation. The stresses accumulating for the elder population are significant. How do we incorporate the elder population into the groups being considered (single mothers and children)?

Eddie Brown: I would love to have a research

on their own TANF programs, centers on whether tribes will prioritize work first or focus instead on the human capital-development approach. If tribes require recipients to find a job quickly (and potentially receive only minimum wage), they may still be eligible for food stamps and other benefits. In addition, they will have the added complication of working and being on assistance.

The other approach favors the flexibility to provide training and education in order to prepare recipients for additional jobs. The new legislation allows tribes to make the choice between the “work first” approach or “human capital-development” approach.

I think it makes sense for Indian communities to invest in their community members by providing job training and education. In order to do this, Tribes need to do some critical and creative thinking on how to document and approach the process, and how to adjust the time frames for assistance.

Human capital truly is an economic way of looking at people. Congress has recently authorized legislation for individual-development accounts. This demonstration project looks at welfare recipients who enter a savings program. For every dollar that the recipient saves, the government matches the savings (in varying ratios). We have worked to insure that tribes are included in this project. We have launched a few demonstration projects prior to the legislation. The purpose and understanding behind these savings programs is asset development. Individual assets are developed through savings thereby moving

project on the impact of welfare reform on the elderly population. However, the limited funds constantly force us to narrow our topic, although the issue of welfare reform and the elderly is important. Elderly who care for children have questions about TANF and TANF eligibility. Unfortunately, we do not have the funding to address the issue at this time.

Supposedly, Congress budgets \$15 million each year to evaluate welfare reform. When we approached the assistant secretary of Health and Human Services and asked what portion was available for American Indians, we were told that the money had all been allocated to the states. They then threw out this minor \$200,000 grant for “extensive” research in American Indian communities. That is nothing. In addition, carefully delineated policies no longer exist for welfare. States are now allowed to be creative within certain guidelines. Therefore, every state is different. In addition, tribes within states may work out different agreements with the states.

Mary Ann O’Neal: I would like to reiterate how decoupling Temporary Assistance for Needy Families (TANF) from Medicaid is going to negatively impact Indian Health Service (IHS) revenues. IHS must consider different state and tribal TANF programs as a resource for third-party dollars. Foundation funding is needed to support studies in this area.

Yvette Joseph-Fox: Being an employed single mother, it is staggering to think of what the unemployed must face, especially in Indian Country. Fifty-five percent of children in Indian Country live below the poverty level. In 1998 that was 1,425,000 children. That spells out the

IMPLICATIONS OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM FOR NATIVE AMERICAN CHILDREN

The Children's Health Insurance Program: Opportunities for Indian Children

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The conditions that have affected American Indian/Alaska Native (AI/AN) infant mortality have changed over the past 50 years. Infections and trauma-related health issues in children have diminished. Furthermore, although Sudden Infant Death Syndrome (SIDS), congenital anomalies, and injuries have also declined, they are now the three leading causes of infant mortality among the AI/AN population.

These conditions do not have clear causes and are often associated with behavioral or environmental issues.

Accidents, though the third leading cause of infant mortality, have markedly decreased over the past 50 years.

Infant mortality has significantly declined. However, there is still a serious and significant gap between the rates among U.S. whites and the AI/AN population.

The gap grows when taking into account the fact that many AI/AN infant deaths are racially misidentified on death certificates, which, when corrected, would raise the rate of infant mortality even higher still than the general population's rate.

Another gap in infant mortality is manifest among urban Indian populations. Data from one

Indian Health Service (IHS) area was analyzed and published in the *Journal of the American Medical Association* in 1994.

While the data does not reflect conditions in all IHS areas or all of Indian Country, it suggests that there might be important differences between urban and rural AI/AN infant mortality.

The leading cause of mortality among AI/AN children between one and four years of age is accidents, a large segment including motor vehicle accidents.

Motor vehicle and other injuries are the major cause of mortality among children between five and fourteen years old. The only leading cause of mortality among these children that can be medically treated is the fifth cause, pneumonia. None of the other leading causes are related to immunizations or antibiotics, but involve more complex issues.

Diabetes is an epidemic in many AI/AN communities. An emerging problem is that Type II Diabetes, usually associated with adults, is now being diagnosed in AI/AN children less than 15 years of age. Such trends and gaps illustrate how the Children's Health Insurance Program (CHIP) might help AI/AN children. Although many negative trends are on the decline, there remain serious gaps that CHIP might be able to bridge.

Significant risk factors need to be addressed, including access to health care for AI/AN children, particularly for those living outside IHS service areas. Native Americans must focus primarily on the social and the community aspects of health issues to preserve the integrity of a sphere of health that involves mental, physical, and spiritual aspects of individual and community health. CHIP may be able to help with this process.

with tribes and to advocate for and embrace government-to-government relations. The letter, citing the original executive order, directed all state officials to design and initiate meaningful consultation processes in their initiatives.

This letter further directed that these procedures must determine how feedback on Indian children would be included in proposals submitted to HCFA.

Study of State Plans

The goal of the 1998 study that I conducted involved a quick analysis of five state plans that were submitted to HCFA to determine whether states were aware of these recommendations and were in compliance with inclusion of Indian children. Baseline information was established as a springboard from which to advocate for more studies, more analysis, and better relationships, and to urge enhanced, improved, and increased advocacy for tribal/state relations at the local level.

Analysis consisted of an extensive literature review of Web sites from a wide variety of sources on CHIP.

Informal telephone interviews consisting of 12 questions were conducted with representatives from the five states. The interview was a limited sample poll designed to look at the level of inclusion of Indian children, provisions in the plans, and the consultation process.

The states were selected based on their approach to CHIP at the time the study was undertaken, their progress within the plan, the drafting and implementation stages, the number of Indian children within the states, and geographic diversity.

The states included are representative of the whole country; however, the study must be expanded to look at all 34 reservation states.

Because of the diversity of the Indian people and relationships within each of these states, the study paints an adequate picture of processes undertaken at the beginning of CHIP.

The analysis looked at both plans for health care insurance expansion and the provisions within these plans that specifically cited the

inclusion of Indian children. California created a combination plan; Montana and Utah designed a completely new, innovative program; and New Mexico and Oklahoma expanded upon their original Medicaid plans.

The state plans do cite Indian children in various ways; however, there was not specific written language on many aspects of their inclusion. The telephone interviews and the survey showed that activity was happening with respect to Indian children. There were relationships, conversations, consultations, and demonstration projects being initiated locally that were not reflected in the documents submitted to HCFA.

Only two of the five states specifically cited numbers representing Indian children. Several of the states, including California and Oklahoma, submitted their plans prior to HCFA's directive on tribal consultation. States were given the benefit of the doubt under the tremendous pressure to submit plans to the federal government by the deadline in order to gain access to funds.

State officials, tribal leaders, tribal health directors, urban health administrators, and IHS personnel were interviewed as part of the study. IHS personnel were the most responsive at the area and service unit level. Federal regional contacts that were designated as local coordinators were also interviewed in an effort to meet the study's goal to establish at least five information contacts in each state.

Survey responses came from five sources: 32 percent came from urban Indian organizations, 32 percent from Indian health organizations, 26 percent from state representatives, five percent from tribal sources, and five percent from federal sources.

Twelve broad questions were asked to determine what provisions people were familiar with, including questions pertaining to HCFA guidelines, CHIP, the consultation process, and Indians' inclusion during discussions.

Respondents were also asked about their familiarity with the HCFA letter and the Western Governors' Association recommendations; 73 percent said they were, yet, a quarter had been unaware, which can most likely be attributed

The Federal Government, States, and Indian Children: Leveraging Children's Health Insurance Program Resources

Cynthia Mala

North Dakota Indian Affairs Commission
Bismark, North Dakota

The 1990 U.S. Census reported that there were roughly 2.4 million American Indians/Alaska Natives (AI/AN) in the population. That number is incorrect, though no one is certain of the exact number. The AI/AN population is composed of a very young population with an average age of 22; children under the age of 20 comprise 43 percent of this group in the United States. In addition to this characteristic, there are complex issues in Indian Country surrounding health care delivery.

Wonderful opportunities are being created in this country with changes in the health care systems; the Children's Health Insurance Program (CHIP) is one such opportunity. The State Children's Health Insurance Program (SCHIP) is a replica of CHIP with the addition of the "S" in the acronym.

There were nearly 45-million uninsured people in this country in 2000, and that number is increasing dramatically. A quarter of that number is children. To address this tragedy, in the fall of 1997 Congress passed Title I of the Social Security Act through the Balanced Budget Act. Title I allocated \$20 billion in federal funds to match state dollars used to expand health insurance programs for uninsured children. The Health Resources and Services Administration (HRSA) and the Health Care Financing Administration (HCFA; now known as the Centers for Medicare and Medicaid Services, or CMS), federal agencies within the U.S. Department of Health and Human Services, have joint oversight authority. CMS is taking the lead.

Under CHIP, the states have three planning options in expanding programs for uninsured

children. One option allows expansion using the state's current Medicaid program as a base. A second option allows the expansion in a new, creative, or innovative direction. And a third option allows a combination of Medicaid expansion and creation of a new program. Each state is expanding in a different way.

Each state is devising and implementing its own respective program. The law and legislation give the states much flexibility in designing their programs, providing a unique opportunity for creativity and inventive partnering.

Specific language exists in the law to include AI/AN children. Section 23-32B.3d of the Social Security Act requires each state to include a description of the procedure to be used to ensure the provision of health assistance to targeted low-income, Indian children in the respective state.

HCFA has gone to great lengths to disseminate information that explains Indian children's eligibility for CHIP regardless of eligibility within the Indian Health Service (IHS) systems.

In concert with events surrounding Congress in the fall of 1997, the Western Governors' Association formed an Indian Health Task Force. It issued specific recommendations for CHIP and for the development of states' plans.

The Western Governors' Association urged the exploration of innovative options in meeting the needs of the populations to be served. It urged each governor to work with tribes to develop flexible approaches for new programs. The Association requested that children's health-policy directors also collaborate with tribes to establish new programs. It also advocated for early and consistent consultation throughout the process. Its efforts were rewarded, in part, when in October 1999 the U.S. Department of Health and Human Services announced that AI/AN families are exempted from CHIP co-payments.

HCFA was a bit slow in distributing information and specific guidance regarding consultation and the inclusion of Indian children in CHIP. HCFA's director sent a February 1998 letter to all state officials as part of President Clinton's executive order to federal agencies to consult

Some of the respondents, however, did talk about the second phase of the plans, where targeted outreach as a specific part of the plan was a focus.

When participants were asked for suggestions on how to strengthen tribal/state relations, 54 percent suggested increasing tribal consultation and its process; 46 percent, however, were unsure how to develop this relationship. This illustrates the lack of understanding and awareness that permeates all aspects of bureaucracy, government, and public perception. Even in Indian Country, the complexities and nuances of accessing health care are not understood.

Tribal/state consultation is new, and tribes are establishing different relationships with the state. Clearly, trust needs to be established. To both establish and develop trust, one must understand and continually emphasize the historical context of the American Indian relationship with this country, a political relationship based on treaty, trust, and responsibility.

Communication in all sectors has improved, which is essential given the lack of awareness among the study's respondents.

Federal agencies, because of their legacy, must take the lead in facilitating and coordinating tribal/state relations.

There must be an identification of and agreement on the process at the local level, which needs to be codified in writing. There must be documentation that clearly represents all sides.

Direct tribal and Indian organization contact is essential. The study found that people relied on IHS or HCFA, assuming that these organizations represent tribal and Indian leadership and Indian urban organizations. This is not so. They provide care, but Indian people, Indian nations, and Indian organizations are independent, distinct and different. Their inclusion in the process must be enhanced.

Native Americans need to be present at meetings as a means towards becoming educated about and making informed decisions on issues once at the table. This will involve time-intensive work incorporating culturally appropriate protocols.

Consultation must be issue-focused and

accommodate the distinctions and differences between processes and protocols at the entity, state, and tribal level. By focusing on specific health or children's health issues, less attention will be given to issues such as gaming compacts and disclosure of finances that tend to cloud the topics at hand.

In every aspect of action, participants must remember what these efforts are about. To complete the enormous amount of work that must be done, it is important to stay focused on our children. Let us foster, build, develop, and enhance their spark and hope.

CHIP is clearly a new opportunity, the most specific program for children in 30 years. More effort and cooperation are required to create and submit a CHIP plan acceptable to state legislatures so that available money is not lost.

The concepts of stewardship, sharing, and giving in American Indian culture must be extended and remembered in the battle to change, develop, and influence policy and legislation.

It is critical that Native Americans engage, become involved, and determine their roles. Advocates must be sought out and cultivated. In light of the old adage "the squeaky wheel gets the oil," AI/AN people must be vocal.

Additionally, credibility and knowledge must be brought to the table of goal-oriented participants who are utilizing reliable, accurate information and data.

It is essential that Indian people understand the points of leverage, the processes, and the necessity to get out and vote.

Discussion

George Brenneman: At Johns Hopkins in 1998, data from each of the states was analyzed to determine how many children the Children's Health Insurance Program (CHIP) might help in the United States.

After calculating the percentage of uninsured children and the proportion of those that would be covered by CHIP in each state, one finds that approximately 130,000 American Indian and Alaska Native children might benefit from CHIP

to the breakdown in communication and information sharing that tends to permeate many aspects of Indian health and consequently prevents distribution of information in a timely fashion.

Results of Survey

The survey found that 34 percent of the respondents included tribal representatives in the planning process; however, 24 percent had no participation, and 42 percent reported that planning was an internal process not conducive to consultation, which to some extent reflected the time constraints the states were under in trying to submit a plan to HCFA.

Many respondents felt that planning was an internal process specific to the state, particularly within the state's departments of health or human services because Medicaid falls within their jurisdiction. Some cited lack of internal communication as a reason state departments were unaware of the need to include Indians; still, respondents concurred that this inclusion was a state responsibility.

The survey also asked if, prior to CHIP, Indian children had received the same level of health

care as other uninsured children to illuminate how knowledgeable people were about Indian health, specifically about children and access issues.

An alarming 40 percent of the respondents believed that Native American children did receive the same level of care as other uninsured children before CHIP; 31 percent disagreed, 25 percent strongly disagreed, and 25 percent had no opinion. This reflects the need to educate people at many different levels, which is the responsibility of Indian people, particularly Indian professionals. The complexities of Indian health care must be better understood as well as the need for help. AI/AN need partnering collaboration.

An additional question focused on whether each state's CHIP plan included specific provisions for the inclusion of Indian kids. While 60 percent of the respondents thought there were specific provisions, few could cite one of these provisions. Most responses included references to regulatory action that the state was taking, deferring responsibility to HCFA or IHS.

ADVANCING NATIVE AMERICAN HEALTH AND WELFARE

Opportunities for Tribal-State Collaboration

Recognizing the Interests of State and Local Governments and the Sovereignty of Indian Tribes in Tribal-State Collaborations

Wayne Taylor, Jr.
The Hopi Tribe
Kykotsmovi, Arizona

Indian Country, like any other community, has many economic and social challenges. Negative public perceptions have indirectly harmed the overall health of Indian communities in this country. Contrary to such perceptions, most reservations, despite recent modern advances, continue to suffer from markedly high unemployment, low levels of educational attainment, over-dependence on government jobs and welfare, and the correlating social problems that accompany such harsh economic challenges.

Persistent and erroneous public perceptions have affected Indian Country by creating lasting challenges for our young people. Indian people and Indian tribal governments are under attack across the country by non-Indian interest groups who oppose the concept of Indian tribes as autonomous governments with the right to exercise governmental, regulatory authority within territorial boundaries and the concept of tribes as entities that enjoy a unique relationship with the federal government. Many non-Indians are under the mistaken impression that all tribes engage in hugely successful gaming enterprises and, consequently, are wealthy. The Hopi and Navaho people recently voted down gaming as a way of improving economic development on their lands.

Unfortunately, Indian gaming has become the lightning rod around which the critical de-

bate over the future of Indian Country is being structured. The Congressional and state agendas are again leaning towards the idea that the federal and state governments should have as little responsibility for the welfare of Indian tribes as possible. Especially in Congress, there is a growing sentiment that the special relationship that has historically existed between the United States and tribes should be severely restricted and, perhaps, eliminated.

All leaders, including tribal chairmen, feel a pressing and compassionate need to improve the economic and social lives of their people. It is difficult to reflect upon the early days of European presence when Indians struggled to obtain even the most basic life necessities and realize that today's young people continue to face the same struggle. Naturally, tribal leaders desperately want to ease such burdens for children, to brighten their way, and to make life better. Tribes seek ways to accomplish this that are compatible with Indian traditions and cultures, and that will protect, in tribal homelands, the honorable qualities its citizens cherish. Most of all, tribal leaders seek to avoid anything that would diminish political and social sovereignty. Tribes never want to give up the freedom to live on their own lands, under their own rules, according to their own customs.

Comfort can be found in the fact that all problems have a solution, even problems of public perception. Policy can serve as a guide for present and future decisions; it determines the course of action to be taken, and is formulated in the light of existing circumstances. Policy attempts to link present planning with future decisions. Decisions made today must be made with full consideration of their effects on the future.

Tribal leaders often err by failing to take into consideration the interests of state and local governments. The most pressing needs for

progress in other areas in addition to relations with the states.

Two famous phrases are words to live by, especially in the Indian health care arena. The first is Emily Dickinson's notion of "dwelling on possibilities," which, in this context, means keeping an open mind and pondering and dreaming about a vision for the future of Indian health care. The second is Ross Perot's *modus operandi*, "Ready, aim, fire." It is important not to spend all of one's time making plans and gathering information. Instead, one must figure out a strategy, gather as much information as possible within a reasonable period of time, and then make the move. Mistakes are likely, but at least some progress can be made. One must be thoughtful, but must not idly wait for the pieces to fall into place before taking the first steps.

Nine years ago, regional action led to the creation of the Western Summit on Indian Health Care in Utah to bring federal, state, tribal, and Congressional leaders together to discuss what was necessary to move forward in a collaborative, cooperative way. The first meetings were fairly rocky as the leaders tried to become acquainted and sort through the initial confusion, but they were eventually able to codify some concrete steps to make the Indian health system stronger in the West.

Five years ago, the Western Summit went through Utah's governor to enlighten governors in other western states about the efforts being made and about how their staffs could most effectively cooperate with the tribes. In the process, the Western Summit gained the support of these governors. In fact, the Western Governors' Association adopted the Western Summit on Indian Health Care as an advisory group. The governors then sent a letter to all of their staff members requesting that they closely observe the process and endorse the conclusions arrived at by the Summit. That was an impressive step for the western governors to take, as they had many issues come before them where agreement and resolution with the tribes could not be reached.

The Summit has tried to stay focused on

concrete issues and goals. In this effort, eight topical categories were identified and assigned at the 1998 Summit, including attempts to expand managed care plans and move traditional health services or other medical services onto reservations.

For states such as Utah that chose not to use the Medicaid expansion option of the Children's Health Insurance Program (CHIP), the largest barrier to doing so was the federal interpretation that any of those expansion expenses must come from the CHIP's administrative budget. The law mandates that only 10 percent of the total, actual CHIP expenditures can be used for administration.

When the costs of the eligibility process, publicity, enrollment outreach, and running the health care system are added up, most states are already well beyond the designated 10 percent available. The 10-percent rule financially prevents the Summit's goal of assisting each tribe with planning individual programs that will enrich tribes' offerings available to their children.

Barriers such as these creep into the rules that the states must abide by, limiting progress. The Summit can bring attention to these imposed limits through direct work with the U.S. Department of Health and Human Services and state governors.

On a state level, it is important to highlight the Youth Tribe Initiative. The State of Utah went to the Navajo Nation and developed an agreement that acknowledged their right to govern their children and take on child welfare issues in the form they deem most appropriate. Unfortunately, though, the structural components were not left in place for the agreement to lead anywhere. The state gave the Navajo Nation a challenge, a commitment that we would work with them, but never created a bridge to get there.

As a different example, the Utah Department of Human Services worked with the Ute Tribe in a very different way than the work done with the Navajo Nation in the previous example. Not only would responsibility be transferred to the Ute Tribe, but also money would be moved out

tribes are policies and strategies for managing the clash between tribal and state interests. Such strategies must balance the tribal need for continued self-government with the state's need to regulate tribal affairs on tribal lands. Tribal leaders must commit to the principle that the first responsibility of tribal government is to preserve and enhance tribal sovereignty as the most vital characteristic of Indian people and Indian Country.

In recent years, when a tribe or state takes the position that certain rights are inherent, it is frequently misinterpreted as lack of concern for the interests of other parties. The use of the word "sovereignty" or the insistence that absolute right is the entitlement of either party regardless of the circumstances has become a battle cry indicating that immovable battle lines have been drawn. In such a case, it is common for all possible measures to be taken to protect tribal or state interests, up to and including complete destruction of sovereignty itself. This is analogous to total warfare. It is a drive for finality. How can this be changed?

Sovereignty, from the Hopi perspective, is a principle that recognizes the ties of family, history, language, and culture to a tribe's identity. For Hopi, sovereignty binds Indian people together, primarily as individual tribes and secondarily as constituent parts of Indian Country. This principle teaches that without sovereignty, the freedom to choose a tribal way of life within tribal homelands, Indians become simply one more minority lost in the current of American society.

When tribes firmly commit to achieving or maintaining sovereignty, that principle becomes the standard by which all decisions in Indian Country are made: If any proposed action poses the risk of undercutting or diminishing sovereignty, the action should not be taken and a decision is made accordingly; if the same action will preserve and enhance tribal sovereignty, it is embraced and usually implemented. Any proposed action carries with it certain downsides, and decisions can be complicated. Thus, potentially mixed benefits mandate a careful balancing of interests, a thorough risk analysis,

and remediation strategies.

The major struggle in Indian Country throughout history has been the struggle for freedom to live as tribal members choose, within a well-defined homeland, and to pursue the vision of the future that individual tribal cultures foresee for themselves.

Without collaboration between tribal, federal, and state governments, extreme positions on programs and services essential to the constituencies of each will rise to the status of sovereign rights rather than simply be expressions of that sovereignty. There are distinct differences between the status and expression of sovereignty. Without collaboration, tribal governments will be placed in direct and intense adversarial relations with non-Indian governments. Perception leads to beliefs and opinions; opinions lead to action and inaction. These beliefs are eventually translated into Congressional initiatives.

Debates within Indian Country must be refocused onto the critical issues of what the future of Indian America should and must be. Discussion must begin about what Indian people want for their futures and how to determine effective tribal approaches to realizing these goals. The debate must define the principles that will guide Indian leaders as they attempt to move Indian Country forward.

Tribal leaders have recently begun building relationships with numerous state, federal, and university agencies and departments. These emerging collaborations give hope to our challenges as Indian people in Indian Country.

Moving Forward with Collaborative Relationships

Rod Betit

Utah Department of Health
Salt Lake City, Utah

Over the last decade tribes have shown a tremendous ability to handle sovereignty issues with the states while simultaneously making

of the state budget and into their control. Over a period of time, but as quickly as possible, more money would be transferred into Ute control. This would ultimately send a powerful message to the State of Utah staff that the Department of Human Services wanted to see the Utes take over governance of their children and child welfare issues and gain the ability to build an infrastructure to do so, not only in the area of human services, but in the area of health care.

This time, the Department of Human Services tried to write a simple contract explaining what the state was offering to the tribe and what the state expected in return.

Within a year, the responsibility had been moved to the tribe. Office space was created for them on the reservation, and staff and money were moved into their control.

This arrangement brings with it funds for creating foster-care-parent programs, mentor programs, residential care programs, and on-reservation mental health and medical services that can be paid for through programs like Medicaid and CHIP, as well as funds for staff positions. It not only created a future occupational opportunity for children on the reservation, but also created an economic opportunity that the tribe needed.

Once there is evidence of this arrangement's success, this process is going to be implemented with other tribes. Much can be achieved by simply trying.

Beginning with Tribal Consultation

Ed Fox

Northwest Portland Area Indian Health Board
Portland, Oregon

The Northwest Portland Area Indian Health Board is a 25-year-old organization that develops health care policy. It does not deliver health care services, but it has had a dramatic impact on the health care of Indian people in the nation.

One advantage among the northwestern

states is that their 41 tribes cooperate well. Tribes will listen to the issues, and they will argue with each other. There is not always agreement on the issues, but when a decision is finally made, the northwestern tribes maintain solidarity.

The northwestern tribal leaders are very active; they understand the definition of sovereignty, which is the basis for analysis of any policy development. The tribes are also very sophisticated when it comes to consultation.

In the past, there was no consultation at all; a policy of termination or relocation didn't allow for feedback. As the federal government became a bit more humane, it began to use consultation to appease tribes and to ask for tribal input on ideas. The government used to include tribes only at the end of the policy process, regarding policy implementation.

Tribal leaders understand that consultation is not simply hearing the description of a program and then being asked to comment on it; tribes really want to be included in the whole cycle of policy development. Tribes want to help define problems on their own terms, which is why they insist on carrying out research on their own terms. Tribes want to decide what should be on the agenda each year, and they want to help develop the policies that are going to solve those problems they have helped to identify.

Tribes are careful not to let anyone slip out of the system because they are difficult to deal with due to drug and alcohol abuse, mental health problems, or poverty. Tribes will work hard to make the worst program work.

Some day tribes will be successful at policy evaluation, which is the final stage in a policy cycle. More evaluation needs to be done to show Congress what has and has not been effective. Evaluative information assists in the development of alternative policies.

In Washington, Oregon, and Idaho, the tribes are involved from the beginning when a budget is developed. The states present their problems, and the tribes share possible solutions.

The tribes do this in a number of different ways. One way of communicating with the states is through quarterly health policy meetings that

have been held for nearly five years now in Washington, Idaho, and Oregon, in which consultation plays a major role.

Politically, tribes are very similar to counties, the main difference being that tribes are mentioned in the U.S. Constitution. Subsequently,

tribes have the right to direct funding from states. The Oregon tribes argued this point successfully, despite resistance from many in the Oregon Health Division.

The State of Washington does not have a

APPENDIX A

Contributors

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Michael Trujillo is a member of the Laguna Pueblo in New Mexico and is the first President-appointed, Senate-confirmed director of the Indian Health Service (IHS) for the Department of Health and Human Services.

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APPENDIX C
Organizations and Web Sites

Administration for Native Americans

Mailstop 348F3

370 L'Enfant Promenade

Washington, DC 20447-0002

Website: www.acf.dhhs.gov/programs/ana/

Phone: (202) 690-7776

Fax: (202) 690-7441

Email: ana@acf.dhhs.gov

The Administration for Native Americans (ANA) promotes the goal of social and economic self-sufficiency of American Indians, Alaska Natives, Native Hawaiians, and other Native American Pacific Islanders, including Native Samoans.

American Indian and Alaska Native Programs

at the University of Colorado Health Sciences Center

4455 East 12th Avenue

Box Ao11-13

Denver, CO 80220

Website: www.uchsc.edu/sm/ncaianmhr/aiarp.htm

Phone: (303) 315-9232

Fax: (303) 315-9579

The mission of the American Indian and Alaska Native Programs (AIANP) is to promote the health and well-being of American Indians and Alaska Natives, of all ages, by pursuing research, training, continuing education, technical assistance, and information dissemination within a biopsychosocial framework that recognizes the unique cultural contexts of this special population. The five programs affiliated with the AIANP are: Circles of Care Evaluation Technical Assistance Center (COC); Healthy Nations Initiative (HNI); National Center for American Indian and Alaska Native Mental Health Research (NCAIAN-MHR); Native Elder Health Care Resource Center (NEHCRC); and Native Elder Research Center/Resource Center for Minority Aging Research (NERC).

American Indian Policy Center

749 Simpson Street
 St. Paul, Minnesota 55104
 Website: www.airpi.org and
www.americanindianpolicycenter.org
 Phone: (651) 644-1728
 Fax: (651) 644-0740
 Email: info@americanindianpolicycenter.org

American Indian Policy Institute's mission is to provide government leaders, policy makers and the public with accurate information about the legal and political history of American Indian nations and the contemporary situation for American Indians.

Buder Center for American Indian Studies
 Website: www.gwbweb.wustl.edu/Users/Buder/bcais.html
 Phone: (314) 935-4510
 Fax: (314) 935-8511
 TTY: (314) 935-7252
 Email: bcais@gwbssw.wustl.edu

The Kathryn M. Buder Center for American Indian Studies (BCAIS) at the George Warren Brown School of Social Work, Washington University offers advanced professional education to American Indians to prepare them for leadership positions in social service agencies dedicated to improving the lives of American Indians. The Center also works with welfare reform and American Indian issues.

Bureau of Indian Affairs
 Office of Public Affairs

1849 C Street, NW
 MS-4542-MIB
 Washington, DC 20240-0001
 Website: www.doi.gov/bureau-indian-affairs.html
 Phone: 202-208-3711
 Fax: 202-501-1516

The mission of the Bureau of Indian Affairs is to act as the principle agent of the United States in carrying out the government-to-government relationship that exists between the United States and the federally-recognized American Indian tribes; and, to act as principle agent of the United States in carrying out the responsibilities the United States has as a trustee for property it holds for federally-recognized tribes and individual American Indians.

Children's Defense Fund
 25 E Street NW
 Washington, DC 20001
 Website: www.childrensdefense.org
 Phone: (202) 628-8787
 Email: cdfinfo@childrensdefense.org

The Children's Defense Fund's mission is to Leave No Child Behind® and to ensure every child a healthy Start, a Head Start, a Fair Start, a Safe Start, and a Moral Start in life and successful passage to adulthood with the help of caring families and communities. This website provides information on the State Children's Health Insurance Program.

Cook Inlet Tribal Council (CITC) Welfare Reform

Site

670 West Firewood Lane

Anchorage, AK 99503

Website: www.citci.com/welfare

Phone: (907) 256-5900

Email: webmaster@citci.com

Cook Inlet Tribal Council (CITC, for short) is one of twelve Alaska Native Regional nonprofit organizations. Along with our counterparts in other areas of the state, we provide a variety of services to Alaska Native people. Through this web site, CITC is providing information of interest to Alaska Native organizations on the implementation of welfare reform.

Division of Indian and Native American Programs (DINAP)

Employment and Training Administration
200 Constitution Avenue, N.W.

Room N-4641

Washington, DC 20210

Website: www.wdsc.org/dinap/

Phone: (202) 693-3754

Fax: (202) 693-3818

Email: jdeluca@doleta.gov

This web site has been designed to provide general information about the Workforce Investment Act (WIA), Section 166 Indian and Native American Program, to enrich the lives of Indian and Native Americans, and to help them achieve economic self-sufficiency through employment and job training. For this fundamental reason, it is our shared vision that the WIA, Section 166 program be administered in a manner consistent with the traditional cultural values, beliefs, and ways of the people it is designed to serve. This shared vision should result in policies that respect and honor the partnership at all levels within the Department of Labor, and lead to an established policy commitment to Indian self-determination.

First Nations Development Institute

11917 Main Street

The Stores Building

Fredericksburg, VA 22401

Website: www.firstnations.org

Phone: (540) 371-5615

Fax: (504) 371-3505

Email: info@firstnations.org

The non-profit First Nations Development Institute was founded in 1980 to help tribes build sound, sustainable reservation economies. First Nations helps tribal members mobilize enterprises that are reform-minded, culturally suitable, and economically do-able. Their strategy coordinates local grass roots projects with national program and policy development to build capacity for self-reliant reservation economies.

Harvard Project on American Indian Economic Development

79 John F. Kennedy Street

Cambridge, MA 02138

Website: www.ksg.harvard.edu/hpaied

The Harvard Project on American Indian Economic Development is an attempt to understand the conditions under which sustained, self-determined economic development might be possible on American Indian reservations. The Harvard Project's central, continuing activities include comparative and case research and the application of that research in services to Indian nations.

Health Information Resources

Website: nhic-nt.health.org/Scripts/Tollfree.cfm

National Health Information Center's web site with links to various health care, medical, and institutional web sites.

The Henry J. Kaiser Family Foundation

2400 Sand Hill Road
Menlo Park, CA 94025
Website: www.kff.org
Phone: (650) 854-9400
Fax: (650) 854-4800

The Henry J. Kaiser Family Foundation is an independent philanthropy focusing on the major health care issues facing the nation. The Foundation is an independent voice and source of facts and analysis for policymakers, the media, the health care community, and the general public. Major initiatives and focus areas in the Health Policy Program include the Kaiser Commission on Medicaid and the Uninsured, the Medicare Policy Project, the Changing Health Care Marketplace Project, minority health, HIV, and women's health policy. The website contains a wealth of information and publications related to Medicaid and the State Children's Health Insurance Program

Indian Health Service (IHS)

Website: www.ihs.gov
The Indian Health Service (IHS) is an agency within the US Department of Health and Human Services and is responsible for providing federal health services to American Indians and Alaska Natives.

Institute of Social and Economic Research

Website: www.iser.uaa.alaska.edu
Phone: (907) 786-7710
Fax: (907) 786-7739
E-mail: ayiser@uaa.alaska.edu

The Institute of Social and Economic Research at the University of Alaska Anchorage is devoted to studying economic and social conditions in Alaska.

Johns Hopkins Center for American Indian and Alaskan Native Health

Johns Hopkins University School of Public Health
621 N. Washington Street
Baltimore, MD 21205
Website: ih.jhsph.edu/cnah
Phone: (410) 955-6931
Fax: (410) 955-2010

Email: abarlow@jhsph.edu

The Johns Hopkins Center for American Indian Health mission is to research, design and implement, in partnership with tribes, strategies to raise the health and well being of American Indians to the highest possible level. Founded in 1991, the Center is based in Baltimore, Maryland, at the Johns Hopkins School of Public Health and is directed by Mathuram Santosham, M.D., M.P.H. The Center operates 13 field offices on the Navajo, Fort Apache, Gila River and Wind River Indian Reservations and is engaged in projects with American Indian communities across the country including tribes in Arizona, New Mexico, Wyoming, South Dakota, North Carolina, Oklahoma, California and Alaska.

Medicare Information

Website: www.medicare.gov
The official US government site for Medicare information.

The Morris K. Udall Foundation

110 S. Church Ave.

Suite 3350

Tucson, AZ 85701

Website: www.udall.gov

Phone: (520) 670-5529

Fax: (520) 670-5530

Email: info@udall.gov

The Morris K. Udall Foundation was established by the U.S. Congress in 1992 to honor Morris King Udall's thirty years of service in the House of Representatives. Morris Udall's career was distinguished by civility, integrity, and consensus, as well as a commitment to preservation of the nation's natural environment. Consistent with these values, the Udall Foundation is committed to educating a new generation of Americans to preserve and protect their national heritage through studies in the environment, Native American health and tribal policy, and effective public policy conflict resolution.

National Congress of American Indians (NCAI)

1301 Connecticut Ave., NW

Suite 20

Washington DC 20036

Website: www.ncai.org

Phone: (202) 466-7767

Fax: (202) 466-7797

The National Congress of American Indians (NCAI), founded in 1944, is the oldest, largest and most representative national Indian organization serving the needs of a broad membership of American Indian and Alaska Native governments. Our founding members stressed the need for unity and cooperation among tribal governments and people for the security and protection of treaty and sovereign rights.

National Indian Child Welfare Association (NICWA)

5100 SW Macadam

Suite 300

Portland, OR 97201

Website: www.nicwa.org

Phone: (503) 222-4044

Fax: (503) 222-4007

Email: info@nicwa.org

Since its founding, NICWA has served hundreds of American Indian tribes throughout the country by helping to strengthen and enhance their capacity to deliver quality child welfare services. NICWA's major activities are: community development, public policy development and information exchange.

National Indian Health Board (NIHB)

1385 South Colorado Blvd.

Suite A-707

Denver, CO 80222

Website: www.nihb.org

Phone: (303) 759-3075

Email: yjoseph@nihb.org

The National Indian Health Board (NIHB) represents Tribal Governments that operate their own health care delivery systems through contracting and compacting, as well as those that receive health care directly from the Indian Health Service.

Native Health History Database (NHHD)

Website: hsc.unm.edu/nhhd/

The NHHD is a centralized, nationally accessible, computerized information resource containing complete bibliographic information and abstracts on historical American Indian and Alaska Native (AI/AN) medical/health research reports. The database entries cover a time period from 1652 to 1970.

Native Health Research Database (NHRD)

Website: hsc.unm.edu/nhrd/

The NHRD is a joint venture between the Indian Health Service and the University of New Mexico Health Sciences Center Library. The database represents resource documents and other materials from approximately 1970 to the present time for tribal health professionals and health care practitioners working with Native American populations.

Native Nations Institute

Udall Center for Studies in Public Policy

The University of Arizona

803 East First Street

Tucson, AZ 85719

Website: udallcenter.arizona.edu/nativenations/index.html

Phone: (520) 884-4393

Fax: (520) 884-4702

Email: nni@u.arizona.edu

The Native Nations Institute for Leadership, Management, and Policy (NNI) is a joint enterprise of the Udall Center for Studies in Public Policy at the University of Arizona, the Harvard Project on American Indian Economic Development at Harvard University, and the Morris K. Udall Foundation. The purpose of NNI is to serve as a self-governance resource to Native nations. It pursues this purpose by providing the present and future leadership of American Indian nations and other indigenous people with practical leadership and management training, policy analysis, and basic research that meet the highest academic and professional standards while reflecting the goals, circumstances, and concerns of those nations and peoples.

Northwest Portland Area Indian Health Board

527 SW Hall

Suite 300

Portland, Oregon 97201

Website: www.npaihb.org/

Phone: (503) 228-4185

Fax: (503) 228-8182

Email: npaihb@npaihb.org

The mission of the Northwest Portland Area Indian Health Board is to assist member tribes in their delivery of culturally competent health services and to improve the health status and quality of life.

Pauktuutit Inuit Women's Association

131 Bank Street

3rd Floor

Ottawa, ON K1P 5N7

Website: www.pauktuutit.on.ca

Phone: (613) 238-3977

Fax: (613) 238-1787

Email: pauktuut@comnet.ca

Pauktuutit is the national non-profit association representing all Inuit women in Canada. Its mandate is to foster a greater awareness of the needs of Inuit women, and to encourage their participation in community, regional and national concerns in relation to social, cultural and economic development.

Rural Information Center: Native American and Welfare Reform Resources

10301 Baltimore Avenue

Room 304

Beltsville, MD 20705-2351

Websites: Native American – www.nal.usda.gov/ric/ruralres/nativeam.htm

Welfare Reform – www.nal.usda.gov/ric/ruralres/welfare.htm

Phone: (800) 633-7701

Fax: (301) 504-5181

Email: ric@nal.usda.gov

The Rural Information Center as a part of the U.S. Department of Agriculture provides information and referral services for rural communities, officials, organizations and citizens in order to facilitate the revitalization of rural America. The Native American Resources web page provides internet-links for organizations, funding and program assistance, statistics and data resources, and publications. The welfare reform Resources web page provides internet-links for organizations, statistics and data resources, and publications related to welfare reform.

Udall Center for Studies in Public Policy

803 East First Street

Tucson, AZ 85719

Website: udallcenter.arizona.edu

Phone: (520) 884.4393

Fax: (520) 884.4702

Email: udallctr@u.arizona.edu

Established in 1987, the Udall Center for Studies in Public Policy sponsors policy-relevant, interdisciplinary research and forums that link scholarship and education with decision-making. The Center specializes in issues concerning environment, natural resources, and public lands; American Indian governance and economic development; the U.S.-Mexico border; and related topics.

Welfare Information Network (WIN)

1000 Vermont Ave NW

Suite 600

Washington, DC 20005

Phone: (202) 628-5790

Fax: (202) 628-4206

Website: www.welfareinfo.org/tanf.htm

Email: rbrown@financeproject.org

WIN provides information on policy choices, promising practices, program and financial data, funding sources, federal and state legislation and plans, program and management tools, and technical assistance. WIN's web site provides one stop access to over 9,000 links on more than 400 web sites.

Western Governors' Association

1515 Cleveland Place

Suite 200

Denver, CO 80202-5114

Website: www.westgov.org/wga/initiatives/indian_health.htm

Phone: (303) 623-9378

Fax: (303) 534-7309

Email: porbuch@westgov.org

Established in 1984, the Western Governors' Association is an independent, non-partisan organization of governors from 18 western states, two Pacific-flag territories and one commonwealth. The Association was formed to provide strong leadership in an era of critical change in the economy and demography of the West. The Western Governors recognize that many vital issues and opportunities shaping our future span state lines and are shared throughout the West. WGA actively seeks to resolve policy issues and improve communications between state, tribal and federal agencies to ensure that quality health care is available and accessible to Native Americans and Alaska Native tribes.