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# Policy Issues in American Indian Health Governance

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Perhaps the most significant law affecting the provision of health services to the American Indian and Alaska Native (AI/AN) population is the Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA, PL 93-638).<sup>1</sup> This Act allows tribes to assume the management and control of health care programs from Indian Health Service (IHS) and to increase flexibility in health care program development. Under ISDEAA, tribes have the option to contract or compact with IHS to deliver health services using pre-existing IHS resources (formula-based shares tables determine funding for various IHS sites), third party reimbursements, grants, and other sources. Typically, tribes develop their own non-profit health care corporations to provide services to their community, and as a result are eligible for grants and other types of funding not available to federal agencies like IHS.

Due to the increased revenue available to certain tribes under ISDEAA, “638 Tribes” are generally able to provide more services in their communities than they were able to under IHS control. Currently, over half of the IHS budget goes to 638 programs. Numerous tribes have improved access to health care services and increased flexibility of health programming for their communities.

## **Tribal Health Services: A Brief Background**

The provision of health care services for AI/ANs presents a complex interaction between federal, state, tribal, and other programs with diverse funding streams and systems of governance. The result is that

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there are multiple systems of Indian Health with a great degree of variability among IHS regions, states, and tribes. There is no single AI/AN culture; rather each tribe is different in terms of governance, cultural perspective, and health needs. IHS’ origins began in the early 1800s under what was at that time called the Department of War. It was the role of army physicians to work at military outposts to contain the spread of contagious diseases such as small pox and measles. In 1832, the federal government began entering into treaties with tribes to provide health care, housing, and education to AI/ANs in exchange for land and natural resources. In 1955, IHS in its current form was established under what is now the Department of Health and Human Services (DHHS).<sup>2</sup> Health care services for AI/ANs continues within 12 regions (“Areas”) today (see Figure 1), with some significant modifications including increased tribal control of health care programs, services, and functions, as well as greater integration with Medicare and Medicaid.

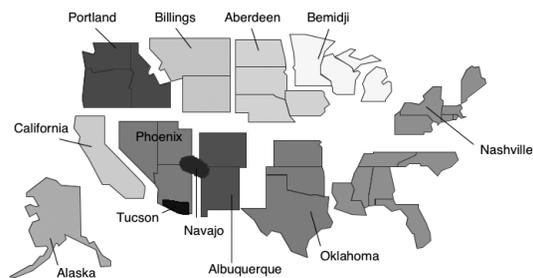
## **Advantages of Tribal Control of Health Care**

The AI/AN health care delivery system is called the IHS/Tribal/Urban (I/T/U) system. Each component of the delivery system has unique funding streams and systems of governance. IHS is predominantly funded by congressional appropriations with some additional funding in the form of third party revenue (see Figure 2). Currently, tribes manage more than half of the IHS budget through 638 contracts and compacts (see Figure 3). Tribes typically supplement their 638 funds through third-party revenue and grants.

Urban Indian Health Centers funded through Title V of the Indian Health Care Improvement Act<sup>3</sup> represent a small fraction of overall IHS funding. The much larger non-Urban health care delivery systems are

Figure 1

**Indian Health Service Areas**



typically categorized as either Direct Services (IHS) or Self-Governance (Tribal). For health care delivery systems that fall under the Direct Services category, IHS manages the hospitals and clinics. For health care delivery systems that fall under the Self-Governance category, tribes manage their hospitals and clinics through compacting permitted under ISDEAA. Most tribes engage in some degree of 638 contracting or compacting permitted under ISDEAA. Tribes that choose to have IHS manage the hospitals and clinics on their reservations may manage some other components of their health system. For example, a tribe can contract for the management of Community Health Representative program funds, alcohol and substance abuse prevention and treatment funds, emergency medical services and other programs that are not directly managed under the hospital or clinic organizational chart.

A tribe's choice to have IHS manage its health care programs is a form of self-determination and an expression of the tribe's sovereign right to make this decision. However, self-determination under 638 contracting or compacting has several advantages, including the following: carry-over funding, third-party revenue, eligibility for grants, contract support costs, lump sum payments, Federal Tort Claims Act coverage, more local control, and ability to lobby.

*Carry-Over Funding*

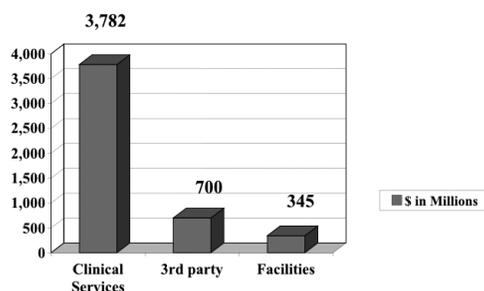
As with most governmental programs, funds that are appropriated for specific purposes in a fiscal year cannot be carried over into subsequent fiscal years. IHS is no exception. Congressionally appropriated funds for IHS hospitals and clinics cannot be carried over into subsequent fiscal years. Typically at the end of a federal fiscal year (which begins October 1), there is a "spend down" period in which programs are required to utilize their funding or potentially lose that funding in the subsequent fiscal year. Under ISDEAA, "any funds for any fiscal year which are not obligated or expended during such succeeding fiscal year for which they were originally appropriated, contracted or granted. No additional justification need be provided by the tribal organization."<sup>4</sup> Therefore, ISDEAA health care delivery systems have an advantage over IHS management because they can focus on cost efficiencies without concern for losing unspent funds. Without the need to focus on fiscal year funding, tribes can conduct and use funds for long-term health planning (e.g., investments in community-based diabetes prevention).

*Third-Party Revenue*

Under tribal self-determination, third-party revenue (e.g., Medicaid, etc.) is treated as supplemental income and has no impact on funds received through ISDEAA contracts and compacts. Tribally managed delivery systems thus have a significant financial incentive to coordinate community outreach and enrollment into third party revenue streams such as Medicare and Medicaid to add revenue to the local health care system. In addition, tribes are also employers through their economic enterprises and can coordinate utilization of private sector health insurance and tribally self-funded health benefits programs IHS managed hospitals and clinics cannot bill tribal self-funded health insurance programs unless they receive special permission from the tribe.

Figure 2

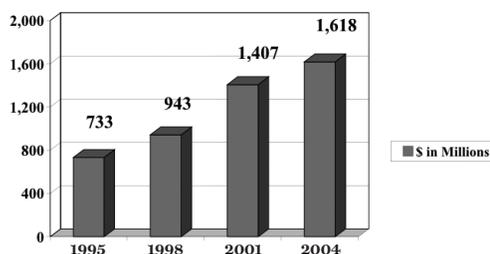
**IHS Budget 2008**



(Source: Indian Health Service)

Figure 3

**IHS Funds Managed by Tribes**



(Source: Indian Health Service)

*Eligibility for Grants*

As a federal agency, IHS is ineligible for numerous health-related grant programs from DHHS and the private sector. Tribally managed health care systems under PL 93-638 are typically organized as 501(c)3 not-for-profit corporations, and are therefore eligible for most types of health-related grants. This includes grants from the Community Health Center program administered by the Health Resources and Services Administration (HRSA).<sup>5</sup> This program is intended to improve access to primary care services in underserved communities. Although IHS cannot apply for these grants, tribes and non-profit agencies are eligible for these funds, which provide approximately \$600,000 per year per clinic. Currently, there are over thirty tribal Community Health Centers, organized under ISDEAA, throughout the nation that combine IHS 638 funds with HRSA funds in addition to third party revenue.

*Contract Support Costs*

One component of the ISDEAA is a funding line item for Contract Support Costs (CSC), which are administrative costs in addition to the costs for providing health care services. These funds are added to the negotiated funds for services. However, in recent years, the funding for CSC has not been available to new PL 93-638 contracts and compacts. The 2010 federal budget included an increase in CSC for which the tribally managed health systems are eligible. However, additional increases are required to meet all CSC needs. IHS-directly managed hospitals and clinics do not have an equivalent funding stream or line item for administrative costs — providing an additional advantage for tribal programs under ISDEAA.

*Lump Sum Payments*

At the beginning of the fiscal year, tribes that have a good financial audit history may receive their ISDEAA contract funds as a lump sum payment. If the tribes choose to do so, they may invest a portion of these funds into interest-bearing accounts and keep the interest generated from these investments. Tribes can use these funds to provide more services to community members. IHS has no equivalent opportunity to invest congressionally-appropriated funds into interest-bearing accounts.

*Federal Tort Claims Act Coverage*

When a tribe contracts or compacts for the management of health services under PL 93-638, they are able to utilize Federal Tort Claims Act (FTCA) coverage for employees.<sup>6</sup> Therefore, the tribes do not have to invest additional funds into professional liability insurance

for their health care providers (which can be a significant cost in the private sector). Even as an ISDEAA tribal program grows, it can add new providers onto its payrolls, and the providers are covered under FTCA as long as they are providing services consistent with the original purposes of IHS services.

*More Local Control*

Tribes are the managers of the health care system as well as the health policy makers in their communities. Community members and tribal leadership have a greater stake in the success and quality of services, and community members become “customer-owners” of the health system. These additional controls at the community level allow for increased types of services (e.g., traditional AI/AN medicine, alternative medicine, etc.) as determined by local preferences. Funding and programming can also be directly linked to locally based health priorities (e.g., additional investments in primary prevention, development of cultural competency programs, etc.). Self-determination in health care allows for improved expression of tribal sovereignty in health care.

*Ability to Lobby*

IHS employees are federal employees and are thus unable to lobby on behalf of community health care needs. Limited advocacy within IHS minimizes opportunities to create new funding streams and health programming. Health care leadership (tribal leadership) and administrators have more freedom to advocate on behalf of community health needs. Many tribes have developed effective means of communicating and advocating at the federal congressional and state legislative levels concerning their local health care issues.

**Recommendations to Improve Tribal Health Policies**

Policy recommendations to improve tribal health fall within two broad categories: (1) additional health policy research opportunities to better quantify and qualify the advantages under PL 93-638 and (2) modification of some of the restrictions and regulations that put IHS-directly managed hospitals and clinics at a financial disadvantage.

First, numerous AI/AN tribes and tribal organizations throughout the country have operated successful ISDEAA programs. If those tribes and organizations were willing to participate in health policy research related to the quantitative (e.g., finances, numbers of health services) and qualitative (e.g., patient satisfaction, provider satisfaction) potential advantages under PL 93-638, the resulting dataset could assist tribes considering 638 procedures in their decision-

making process. Several successful models of ISDEAA programs (e.g., Alaska Native Medical Center) have facilitated numerous tribes to visit their facilities to gain a better understanding of the ISDEAA process and potential outcomes. These efforts could be linked to formal health policy research and health services research to advance the body of evidence related to PL 93-638. New opportunities in comparative Effectiveness Research may provide funding opportunities to support this type of research.

Second, some of the advantages of tribal management of health care services over direct-IHS management can be addressed to assist IHS managed facilities. For example, CSCs available to ISDEAA programs for administration of programs could have an equivalent administrative cost line item in the IHS budget. Some IHS facilities would benefit as well from eligibility for additional grant programs (e.g., HRSA programs). These types of modifications would require congressional legislation. Perhaps the Direct Services Tribes Advisory Committee (which includes tribal officials from communities using IHS-direct services)<sup>7</sup> could consider adding these types of priorities to their legislative and policy agendas. The feasibility and impact of these types of potential policy modifications neces-

sitate further study prior to consideration of formal recommendations for changes. The tribes would need to be the driving force behind such potential studies and potential modifications to existing policy.

#### References

1. The Indian Self-Determination and Education Assistance Act, Public Law 93-638.
2. U.S. Department of Health and Human Services, *The Indian Health Program*, 1980, DHHS Publication No. (HAS) 80-1003.
3. The Indian Health Care Improvement Act, Public Law 94-437.
4. 1988 Amendment to ISDEAA, 102 Stat. 2285, Public Law 100-472.
5. Title 42 of the U.S. Code, Chapter 6A, Public Health Service Act, and section 254b, (the equivalent of Section 330) *available at* <<http://www4.law.cornell.edu/uscode/42/254b.html>> (last visited November 17, 2010).
6. Public Law 101-512, Title III, § 314, 104 Stat. 1915, 1959-60 (1990). In 1990, Congress enacted that “any civil action or proceeding” against “any tribe, tribal organization, Indian contractor or tribal employee” involving claims resulting from the performance of self-determination contract functions “shall be deemed to be an action against the United States” and “be afforded the full protection and coverage of the Federal Tort Claims Act.”
7. Indian Health Services, “Direct Service Tribes,” *available at* <<http://www.ihs.gov/NonMedicalPrograms/otp/dst/index.cfm>> (last visited November 17, 2010).