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AMENDING THE INDIAN SELF-DETERMINATION AND EDUCATION ASSISTANCE ACT TO PROVIDE FOR FURTHER SELF-GOVERNANCE BY INDIAN TRIBES, AND FOR OTHER PURPOSES

NOVEMBER 9, 1999.—Ordered to be printed

Mr. CAMPBELL, from the Committee on Indian Affairs, submitted the following

REPORT

[To accompany S. 979]

The Committee on Indian Affairs, to which was referred the bill, S. 979, to amend the Indian Self-Determination and Education Assistance Act to provide for further self-governance by Indian tribes, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill as amended do pass.

PURPOSE

The purpose of S. 979, the Tribal Self-Governance Amendments of 1999, is to create two new titles in the 1975 Self-Determination and Education Assistance Act ("ISDEA" or "the Act"), in order to make permanent the Self-Governance Demonstration Project for Indian Health Service (IHS) programs with the Department of Health and Human Services (HHS), and to establish a demonstration project for non-IHS services within the HHS after a feasibility study has been undertaken to identify which, if any, non-IHS programs within the HHS should be subject to self-governance.

BACKGROUND

In 1970, President Nixon delivered his now-famous "Message to Congress on Indian Affairs" in which he laid the foundation for a change in federal Indian policy for termination and assimilation to Indian self-determination. The ISDEA was enacted in 1975 as an

outgrowth of this policy and continues to be one of the guiding tenets of federal Indian policy.

As enacted, the ISDEA authorizes the Secretary of the Department of the Interior to contract with Indian tribes for the provision of various services and programs that would otherwise be performed by the Department with the tribes acting as end-line service providers to their citizens.

Building on the successes of the original Act, in 1988 Congress amended the Act and created the Self-Governance Demonstration Project in the DHHS. The Demonstration Project authorizes tribes to administer health care programs and enables participating tribes to redesign programs and reallocate funds among the different programs they operate. Program design and implementation flexibility provide some of the major benefits to participating tribes.

In 1994, Congress enacted the Tribal Self-Governance Act, Pub. L. 103–413, which made Self-Governance permanent with regard to the Interior Department. The IHS Self-Governance Project continues to operate as a demonstration project. S. 979 would make the Demonstration Project in the HHS permanent and expand the program to other, non-IHS programs within the HHS, but only after a feasibility study is conducted to determine whether other non-IHS programs should be brought into the Act's scope.

HEALTH CARE DELIVERY IN NATIVE COMMUNITIES

As of FY1999 there were 557 federally recognized Indian tribes in the United States. Of those, 146 tribes were provided health care services directly by the Indian Health Service (IHS); and 431 were either contracting or compacting tribes under the ISDEA. Tribal participation in contracting or compacting is strictly voluntary and is carried out through a negotiation conducted between a federal agency and tribal representatives.

Charged with delivering health care to 1.3 million American Indians and Alaska Natives (AI/AN), in FY1999, the IHS budget was $2.24 billion. The IHS delivered these services through 150 service units composed of 543 direct health care delivery facilities, 49 hospitals, 209 health centers, 6 school health centers, and 279 health stations, satellite clinics, and Alaska village clinics.

1. Self-Governance Compacting. In FY1999, the IHS negotiated 42 self-governance compacts with 254 tribes involving the transfer of $508 million to 213 tribes in Alaska and 41 tribes in the lower 48 states. In FY2000, it is projected that $564 million will be transferred to tribes pursuant to 57 compacts. Self-governance tribes receive 42% of the IHS budget in 12 hospitals, 149 health centers, 3 school health centers, and 233 health stations and Alaska Native village clinics.

Since 1993, there has been a reduction in IHS Headquarters Staff (−57% to 406) and IHS Area Office Staff (−55% to 1,213), but there has also been an increase in IHS Service Unit Staff (+10% to 12,963). In addition to staff reassignments and reductions due to cuts in administrative funding, the transfer of Area Office functions and funding to tribes under Self-Governance has helped re-shape health care delivery in Indian country.

2. IHS-Provided Health Care. Participation under the Act is voluntary and tribes that have elected to retain federal administration

of their health services collectively receive some 58% of the IHS budget in 37 hospitals, 60 health centers, 3 school health centers and 46 health stations.

3. Urban Indian Care. Various health care and referral services are provided to Native people in off-reservation settings through 34 urban Indian health care programs authorized by the Indian Health Care Improvement Act (Pub. L. 94–437). Approximately 150,000 American Indians utilize urban Indian health care program services because they are not able to access hospitals, health clinics or contract health services administered by the IHS or tribal providers either because they fail to meet IHS eligibility criteria or reside outside IHS or tribal service areas.

4. The Impact of Self-Governance on Indian Health Care. Because self-governance transfers programming and budgeting authority for health programs from the federal government to tribal governments, participating tribes have benefitted from the flexibility inherent in the program that enables them to tailor the programs to local needs. Participating tribes report that self-governance has had a significant and positive impact on the health and well-being of their members.

Significant improvements are reported in program administration as well as in the quality, quantity and accessibility of services provided to health care recipients resulting in a more efficient use of federal funds. A 1998 study by the National Indian Health Board (NIHB)[1] reported that improved health goes hand in hand with tribal contracting and compacting for health care services.

The ISDEA authorizes Indian tribes and tribal organizations to contract for the administration and operation of certain federal programs which provide services to Indian tribes and their members. Subsequent amendments to the ISDEA created Title III of the Act which provided for a Self-Governance Demonstration Project that allows for large-scale tribal Self-Governance compacts and funding agreements on a "demonstration" basis.

The new title V created by S. 979 would make this contracting by tribes permanent authority for programs contracted for within the Indian Health Service (IHS). Thus, Indian tribes and tribal organizations would be able to contract for the operation, control, and redesign of various IHS activities on a permanent basis. In short, what was a demonstration project would become a permanent IHS Self-Governance program.

Under the terms of S. 979, Indian tribes or tribal organizations which have already contracted for IHS activities would have the option of continuing under the provisions of their existing contracts or, alternatively, could negotiate under the authority provided by S. 979. Mirroring existing law, the bill authorizes an additional 50 new tribes each year to enter into self governance compacts.

The amendments contained in S. 979 continue the requirements of the existing Self-Governance law which requires that before any tribe or organization can enter the Self-Governance program they must fulfill certain criteria—that the tribe have experience in government contracting, a record of clean audits, and a demonstrated

[1] See attached Tribal Perspectives on Indian Self-Determination and Self-Governance in Health Care Management, 1998.

management capability—in order to exercise the right to compact for the operation of IHS functions, including the funds necessary to run them.

S. 979 also adds a new title VI to the Act which authorizes a feasibility study regarding the execution of tribal Self-Governance compacts and funding agreements of Indian-related programs outside the IHS but within the Department of Health and Human Services on a demonstration project basis.

The Self-Governance program recognizes that Indian tribes care for the health, safety, and welfare of their own members as well as that of non-Indians who either live on their reservations or conduct business with the tribes and are thus committed to safe and fair working conditions and practices.

LEGISLATIVE HISTORY

S. 979, the Tribal Self Governance Amendments of 1999, was introduced on May 6, 1999 by Chairman Campbell, for himself and for Senator McCain. Senator Inhofe was added as cosponsor on July 19, 1999. S. 979 was referred to the Committee on Indian Affairs, where a hearing was held on July 19, 1999.

COMMITTEE RECOMMENDATION AND TABULATION OF VOTE

On October 27, 1999 the Committee on Indian Affairs, in an open business session, adopted an amendment in the nature of a substitute to S. 979 by a unanimous vote of the members present and ordered the substitute amendment reported favorably to the Senate.

SECTION-BY-SECTION ANALYSIS

Section 1. Short title

This section sets forth the short title, "The Tribal Self-Governance Amendments of 1999."

Section 2. Findings

This section sets forth the findings of Congress which reaffirm the inherent sovereignty of Indian tribes and the unique government-to-government relationship between the United States and Indian tribes. The findings make clear that while progress has been made, the federal bureaucracy has eroded tribal self-governance. The findings state that the federal government has failed to fully meet its trust responsibility and to satisfy its obligations under treaties and other laws. The findings explain that Congress has reviewed the tribal self-governance demonstration project and concluded that self-governance is an effective mechanism to implement and strengthen the federal policy of government-to-government relations with Indian tribes by transferring to Indian tribes full control and funding for federal programs, functions, services, or activities, or portions thereof.

Section 3. Declaration of policy

This section provides that it is Congress' policy to permanently establish and implement tribal self-governance within the Depart-

ment of Health and Human Services with the full cooperation of its agencies. Among the key policy objectives Congress seeks to achieve through the self-governance program are to (1) maintain and continue the United States' unique relationship with Indian tribes; (2) allow Indian tribes the flexibility to choose whether they wish to participate in self-governance; (3) ensure the continuation and fulfillment of the United States' trust responsibility and other responsibilities towards Indian tribes that are contained in treaties and other laws; (4) permit a transition to tribal control and authority over programs, functions, services, or activities, (or portions thereof); and (5) encourage and provide a corresponding parallel reduction in the federal bureaucracy.

Section 4. Tribal self governance

This section sets out the substantive provisions of the Self-Governance program within the Indian Health Service and authorizes a feasibility study of the applicability of Self-Governance to other HHS agencies by adding Titles V and VI to the Indian Self-Determination and Education Assistance Act of 1975, as amended.

Section 501. Establishment

This section directs the Secretary of HHS to establish a permanent Tribal Self-Governance Program in the Indian Health Service.

Section 502. Definitions

Subsection (a)(1) defines the term "construction project". The Committee does not intend this legislation to preclude agreements between self-governance tribes and the Indian Health Service for carrying out sanitary facilities construction projects pursuant to a "Project Funding Agreement" or "Memorandum of Agreement" executed as an addendum of a Title V Annual Funding Agreement as authorized by Section 7(a)(3) of Pub. L. 86–121, 73 Stat. 267 (42 U.S.C. § 2004(a)).

Subsection (a)(2) provides that a "construction project agreement" is one between the Secretary and the Indian tribe that, at a minimum, establishes start and completion dates, scope of work and standards, identifies party responsibilities, addresses environmental considerations, identifies the owner and maintenance entity of the proposed work, provides a budget, provides a payment process, and establishes a duration of the construction project agreement.

Subsection (a)(3) defines "inherent federal functions" as those functions which cannot be legally delegated to Indian tribes. This definition states the obvious. Inherent federal functions are functions which the Executive Branch cannot by law delegate to other branches of government, or non-governmental entities. The Committee's definition is consistent with the Department of the Interior Solicitor's Memorandum of May 17, 1996 entitled "Inherently Federal Functions under the Tribal Self-Governance Act of 1994."

The Committee's definition is expressly intended to provide flexibility so as to allow the Secretary and the tribes to come to agreement on which functions are inherently federal on a case-by-case basis. It is important to note that, in the tribal procurement context, there is another factor the Committee has considered. When

the federal government "restores" tribal governmental powers and functions that are inherent in tribes' governmental status such as those possessed by tribes before the establishment of the federal Indian bureaucracy, the scope of this restored authority is broader than in the transfer of federal governmental powers to private or other governmental entities.

Subsection (a)(4) defines "inter-tribal consortium". The Committee notes that during the Title III Demonstration Project the IHS authorized inter-tribal consortia, such as the co-signers to the Alaska Tribal Health Compact, to participate in the Project and that participation has experienced great success. The definition of "inter-tribal consortium" is intended to include "tribal organizations" as that term is defined in Section 4(l) of the Indian Self-Determination Act, Pub.L. No. 93-638. This would include consortia such as those involved in the Alaska Tribal Health Consortium. It is the Committee's intent that inter-tribal consortia and tribal organizations shall count as one tribe for purposes of the 50-tribe-per-year-limitation contained in section 503 (a).

Subsection (a)(5) defines "gross mismanagement". The inclusion of this term is intended to govern one of the criteria that the Secretary is to consider in the reassumption of a tribally-operated program. The Secretary will be given the authority to reassume programs that pose an imminent endangerment to the public health where the danger arises out of a compact or funding agreement violation.

The Committee believes that the inclusion of a performance standard, in this case gross mismanagement, is also an appropriate grounds for reassumption. Gross mismanagement is defined as a significant, clear, and convincing violation of compact, funding agreement, regulatory or statutory requirements related to the transfer of Self-Governance funds to the tribe that results in a significant reduction of funds to the tribe's Self-Governance program. The Committee's definition of gross mismanagement is narrowly tailored and will require a high degree of proof by the Secretary. The Committee is will aware of tribal concerns and agrees that the inclusion of this performance standard must not be utilized by the Secretary in such a manner as to needlessly impose monitoring and auditing requirements that hinder the efficient operation of tribal programs. Requiring intrusive and over burdensome monitoring and auditing activities are antithetical to the goals of Self-Governance and the intent of the Committee.

Subsection (a)(6) defines "tribal shares". This definition is consistent with the Title IV Rulemaking Committee's determination that residual funds are those "necessary to carry out the inherently federal functions that must be performed by federal officials if all tribes assume responsibilities for all BIA programs." Fed. Reg. Vol. 63, No. 29, 7325, (Fed. 12, 1998) (Proposed Rule, 25 CFR Sec. 1000.91). All funds appropriated under the Indian Self-Determination and Education Assistance Act are either tribal shares or Agency residual.

Subsection (a)(7) defines "Secretary" as the Secretary of the Department of Health and Human Services.

Subsection (a)(8) defines "Self-Governance" as the program established under this title.

Section (b) defines "Indian Tribe". This definition enables and Indian tribe to authorize another Indian tribe, inter-tribal consortium or tribal organization to participate in self-governance on its behalf. The authorized Indian Tribe, inter-consortium or tribal organization may exercise the authorizing Indian tribe's rights as specified by Tribe resolution.

Section 503. Selection of participating tribes

This section describes the eligibility criteria that must be satisfied by any Indian tribe interested in participating in the Self-Governance program.

(a) Continuing Participation. All tribes presently participating in the Tribal Self-Governance Demonstration Project under Title III of the Indian Self-Determination Act may elect to participate in the permanent Self-Governance program. Tribes must do so through tribal resolution. Tribes may also choose to "roll over" and renegotiate their compacts under the authority provided by S. 979.

(b) Additional Participants. (1) This section allows an additional 50 tribes a year to participate in self-governance program.

(2) This section authorizes an Indian tribe that chooses to withdraw from an inter-tribal consortium or tribal organization to participate in self-governance provided that the tribe independently meets the eligibility criteria in Title V. Tribes and tribal organizations that withdraw from tribal organizations and inter-tribal consortia under this section shall be entitled to participate in the permanent program under section 503 (b) (2) and such participation shall not be counted against the 50 tribe a year limitation contained in section 503 (a).

(c) Applicant Pool. The eligibility criteria for self-governance tribes are the same as those that apply under Title IV. To participate, an Indian tribe must successfully complete a planning phase, must request participation in the program through a resolution or official action of the governing body, and must have demonstrated financial stability and financial management capability for the past three years. Proof of no material audit exceptions in the tribe's self determination contracts or Self Governance funding agreements is conclusive proof of such qualification. The Committee notes that the financial examination addressed in subsection 503(c)(3) refers solely to funds managed by the tribe under Title I and Title IV of the Indian Self-Determination Act. The bill has been deliberately crafted to make clear that a tribe's activities in other economic endeavors are not to be the subject of the Section 503(c) examination. Similarly, the "budgetary research" referred to in section 503(d)(1) of the bill requires a tribe to research only budgetary issues related to the administration of the programs the tribe anticipates transferring to tribal operation under Self-Governance.

(d) Planning Phase. Every Indian tribe interested in participating in the self-governance program shall complete a planning phase prior to participating in the program. The planning phase is to include legal and budgetary research and internal tribal government planning and organizational preparation. The planning phase is to be completed to the satisfaction of the tribe.

(e) Grants. Subject to available appropriations, any Indian tribe interested in participating in self-governance is eligible to receive

a grant to plan for participation in the program or to negotiate the terms of a compact and funding agreement.

(f) Receipt of Grant not Required. This section provides that receipt of a grant from HHS is not required to participate in the permanent self-governance program.

Section 504. Compacts

This section authorizes Indian tribes to negotiate compacts with the Secretary and identifies generally the contents of compacts. While the compact process was not specifically part of prior legislative enactment, the committee understands that compacts have developed as an integral part of the Self Governance program. The committee believes that compacts serve an important and necessary function in establishing government-to-government relations, which is noted earlier, is the keystone of modern federal Indian policy.

(a) Compact Required. The Secretary is required to negotiate and enter into a written compact consistent with the trust responsibility, treaty obligations and the government-to-government relationship between the United States and each participating tribe.

(b) Contents. This section requires that compacts state the terms of the government-to-government relationship between the Indian tribe and the United States. Compacts may only be amended by agreement of both parties.

(c) Existing Compacts. Upon enactment of Title V, Indian tribes have the option of retaining their existing compacts, or any portion of the compacts that are not inconsistent with the provisions of Title V.

(d) Term and Effective Date. The date of approval and execution by the Indian Tribe is generally the effective date of a compact, unless otherwise agreed to by the parties. A compact will remain in effect as long as permitted by federal law or until terminated by written agreement of the parties, or by retrocession or reassumption.

Section 505. Funding agreements

This section authorizes Indian tribes to negotiate funding agreements with the Secretary and identifies generally the contents of those agreements.

(a) Funding Agreement Required. The Secretary is required to negotiate and enter into a written funding agreement consistent with the trust responsibility, treaty obligations and the government-to-government relationship between the United States and each participating tribe.

(b) Contents. An Indian tribe may include in a funding agreement all programs, functions, services, or activities, (or portions thereof) that it is authorized to carry out under Title I of the Act. Funding agreements may, at the option of the Indian tribe, authorize the Tribe to plan and carry-out all programs, functions, services, or activities, (or portion thereof) administered by the IHS that are carried out for the benefit of Indians because of their status as Indians or where Indian tribes or Indian beneficiaries are the primary or significant beneficiaries, as set forth in statutes. For each program, function, service, or activity (or portion thereof) included

in a funding agreement, an Indian tribe is entitled to receive its full tribal share of funding, including funding for all local, field, service unit, area, regional, and central/headquarters or national office locations. Available funding includes the Indian tribe's share of discretionary IHS competitive grants but not statutorily mandated competitive grants.

The Committee is concerned with the reluctance of the Indian Health Service to include all available federal health funding in self governance funding agreements. We note, as an example, the refusal of the IHS to so include the Diabetes Prevention Initiative funding. As a result, funding was delayed and undue administrative requirements diverted resources from direct services. This section is intended to directly remedy this situation.

The Committee has received ample testimony demonstrating the benefits of self governance. In 1998, the National Indian Health Board released it's "National Study on Self-Determination and Self-Governance," providing empirical evidence that self-governance leads to more efficient management of tribal health service delivery, especially preventive services. This study consistently observed an overall improvement in quality of care when tribes operate their own Health Care systems. Less than full funding of agreements will result in less than maximum use of federal resources to address the health care in Indian country. Accordingly, this section is to be interpreted broadly by affording a presumption in favor of including in a tribe's self-governance funding agreement any federal funding administered by that Agency.

(c) Inclusion in Compact or Funding Agreement. The eligibility of Indian tribes does not need to be specifically identified in authorizing legislation for a program to be eligible for inclusion in a compact or funding agreement.

(d) Funding Agreement Terms. Each funding agreement should generally set out the programs, functions, services, or activities, (or portions thereof) to be performed by the Indian tribe, the general budget category assigned to each program, function, service, or activity (or portion thereof), the funds to be transferred, the time and method of payment and other provisions that the parties agree to.

(e) Subsequent Funding Agreements. Each funding agreement remains in full force and effect unless the Secretary receives notice from the Indian tribe that it will no longer operate one or more of the programs, functions, services, or activities, (or portions thereof) included in the funding agreement or until a new funding agreement is executed by the parties.

The Committee is concerned with reports that the IHS has been able to use the annual negotiations provisions of Section 303(a) of the Act to obtain an unfair bargaining advantage during negotiations by threatening to suspend application of the Act to a tribe if it does not sign an Annual funding agreement. This subsection is meant to facilitate negotiation between the tribes and the Indian Health Service on a true government-to-government basis. The Committee believes the retroactive provision is fair because this assures that no act or omission of the federal government endangers the health and welfare of tribal members.

(f) Existing Funding Agreements. Upon enactment of Title V, Indian tribes may either retain their existing annual funding agree-

ments, or any portion thereof, that do not conflict with provisions of Title V, or negotiate new funding agreements that conform to Title V.

(g) Stable Base Funding. An Indian tribe may include a stable base budget in its funding agreement. A stable base budget contains the tribe's recurring funding amounts and provides for transfer of the funds in a predictable and consistent manner over a specific period of time. Adjustments are made annually only if there are changes in the level of funds appropriated by Congress. Nonrecurring funds are not included and must be negotiated on an annual basis. The Committee intends this section to codify the existing Agency policy guidance on stable base funding.

Section 506. General provisions

(a) Applicability. The provisions in this section may, at a tribe's option, be included in a Compact or funding agreement negotiated under Title V.

(b) Conflicts of Interest. Indian tribes are to assure that internal measures are in place to address conflicts of interest in the administration of programs, functions, services, or activities, (or portions thereof).

(c) Audits. The single Agency Audit Act applies to title V funding agreements. Indian tribes are required to apply cost principles set out in applicable OMB Circulars, as modified by section 106 of Title I or by any exemptions that may be applicable to future OMB Circulars. No other audit or accounting standards are required. Claims against Indian tribes by the federal government based on any audit of funds received under a Title V funding agreement are subject to the provisions of section 106(f) of Title I.

Records. An Indian tribe's records are not considered federal records for purposes of the Federal Privacy Act, unless otherwise stated in the compact or funding agreement. Indian tribes are required to maintain a record keeping system and, upon reasonable advance request, provide the Secretary with reasonable access to records to enable HHS to meet it minimum legal record keeping requirements under the Federal Records Act.

(e) Redesign and Consolidation. An Indian tribe may redesign or consolidate programs, functions, services, or activities, (or portions thereof) and reallocate or redirect funds in any way the Indian tribe considers to be in the best interest of the Indian community. Any redesign or consolidation, however, must not have the effect of unfairly denying eligibility to people otherwise eligible to be served under federal law.

(f) Retrocession. An Indian tribe may fully or partially retrocede back to the Secretary any program, function, service, or activity (or portion thereof) included in a compact or funding agreement. A retrocession request becomes effective within the time frame specified in the compact or funding agreement, one year from the date the request was made, the date the funding agreement expires, or any date mutually agreed to by the parties, whichever occurs first.

(g) Withdrawal. An Indian tribe that participates in self-governance through an inter-tribal consortium or tribal organization can withdraw from the consortium or organization. The withdrawal becomes effective within the time frame set out in the tribe's author-

izing resolution. If a time frame is not specified, withdrawal becomes effective one year from the submission of the request or on the date the funding agreement expires, whichever occurs first. An alternative date can be agreed to by the parties, including the Secretary.

When an Indian tribe withdraws from an inter-tribal consortium or tribal organization and wishes to enter into a Title I contract or Title V agreement on its own, it is entitled to receive its share of funds supporting the program, function, service, or activity, (or portion thereof) that it will carry out under its new status The funds must be removed from the funding agreement of the participating organization or inter-tribal consortium and included in the withdrawing tribe's agreement or contract. If the withdrawing tribe is to receive services directly from the Secretary, the tribe's share of funds must be removed from the funding agreement of the participating organization or inter-tribal consortium and retained by the Secretary to provide services. Finally, an Indian tribe that chooses to terminate its participation in the self-governance program may, at its option, carry out programs, functions, services, or activities, (or portions thereof) in a Title I contract or Self-Governance funding agreement and retain its mature contractor status.

(h) Nonduplication. This section provides that a tribe operating programs under a Self-Governance compact may not contract under Title I (a "638 contract") for the same programs.

Section 507. Provisions relating to the secretary

This section sets out mandatory and non-mandatory provisions relating to the Secretary's obligations.

(a) Mandatory Provisions.

(1) Health Status Reports. To the extent that the data is not otherwise available to the Secretary, compacts and funding agreements must include a provision requiring the Indian tribe to report data on health status and service delivery. The Secretary is to use this data in the Secretary's annual reports to congress. The Secretary is required to provide funding to an Indian tribe to compile such data. Reporting requirements can only impose minimal burdens on an Indian tribe and may only be imposed if they are contained in regulations developed under negotiated rulemaking.

(2) Reassumption. Compacts or funding agreements must include a provision authorizing the Secretary to reassume a program, function, service, or activity, (or portion thereof) if the Secretary makes a finding of imminent endangerment of the public health caused by the Indian tribe's failure to carry out the compact or funding agreement or gross mismanagement that causes a significant reduction in available funding. The Secretary is required to provide the Indian tribe with notice of a finding and a hearing on the record. The Indian tribe may take action to correct the problem identified in the notice. The Secretary has the burden at the hearing of demonstrating by clear and convincing evidence the validity of the grounds for reassumption. In cases where the Secretary finds imminent substantial and irreparable endangerment of the public health caused by the tribe's failure to carry out the compact or funding agreement, the Secretary may immediately reassume the

program but is required to provide the tribe with a hearing on the record within ten days after reassumption.

(b) Final offer. If the parties cannot agree on the terms of a compact or funding agreement, the Indian tribe may submit a final offer to the Secretary. The Secretary has 45 days to determine if the offer will be accepted or rejected. The 45 days can be extended by the Indian tribe. If the Secretary takes no action the offer is deemed accepted by the Secretary.

(c) Rejection of Final Offers. This provision describes the only circumstances under which the Secretary may reject an Indian tribe's final offer.

A rejection requires written notice to the Indian tribe within 45 days of receipt with specific findings that clearly demonstrate or are supported by controlling legal authority that: (1) the amount of funds proposed exceeds the funding level that the Indian tribe is entitled to: (2) the program, function, service, or activity (or portion thereof) that is the subject of the offer is an inherent federal function that only can be carried out by the Secretary; (3) the applicant is not eligible to participate in self-governance; or (4) the Indian tribe cannot carry out the program, function, service or activity, (or portion thereof) without a significant danger or risk to the public health. The Committee believes the fourth provision appropriately balances the Secretary's trust responsibility to assure the delivery of health care services to Indian beneficiaries, with the equally important goal of fostering maximum tribal self-determination in the administration of health care programs transferred under Title V. The Committee has included the requirement of a "specific finding" to avoid rejections which merely state conclusory statements that provide no analysis or determination of facts supporting the rejection.

The Secretary must also offer assistance to the Indian tribe to overcome the stated objections, and must provide the Indian tribe with an opportunity to appeal the rejection and have a hearing on the record. In any hearing the Indian tribe has the right to engage in full discovery. The Indian tribe also has the option of proceeding directly to federal district court under section 110 of Title I of the Act in lieu of an administrative hearing.

The Secretary may only reject these portions of a "final offer" that are supported by the findings and must agree to all severable portions of a "final offer" which do not justify a rejection. By entering into a partial compact or funding agreement the Indian tribe does not waive its right to appeal the Secretary's decision for the rejected portions of the offer.

(d) Burden of Proof. The Secretary has the burden of demonstrating by clear and convincing evidence the validity of a rejection of a final offer in any hearing, appeal or civil action. A decision relating to an appeal within the Department is considered a final agency action if it was made by an administrative judge or by an official of the Department whose position is at a higher level than the level of the departmental agency in which the decision that is the subject of the appeal was made.

(e) Good Faith. The Secretary is required to negotiate in good faith and carry out his discretion under title V in a manner that maximizes the implementation of self-governance.

(f) Reduction of Secretarial Responsibilities. Any savings in the Department's administrative costs that result from the transfer of programs, functions, services, or activities, (or portions thereof) to Indian tribes in self-governance agreements that are not otherwise transferred to Indian tribes under Title V must be made available to Indian tribes for inclusion in their compacts of funding agreements. The Committee has consistently indicated that Self Governance should achieve reductions in federal bureaucracy and create resultant cost savings. This subsection makes clear that such savings are for the benefit of the Indian tribes. Savings are not to be utilized for other agency purposes, but rather are to be provided as additional funds or services to all tribes, inter-tribal consortia, and tribal organizations in a fair and equitable manner.

(g) Trust Responsibility. The Secretary is prohibited from waiving, modifying or diminishing the trust responsibilities or other responsibilities as established in treaties, executive orders or other laws and court decisions of the United States to Indian tribes and individual Indians. The Committee reaffirms that the protection of the federal trust responsibility to Indian tribes and individuals is a key element of Self Governance. The ultimate and legal responsibility for the management and preservation of trust resources resides with the United States as Trustee. The Committee believes that health care is a trust resource consistent with federal court decisions. This subsection continues the practice of permitting substantial tribal management of its trust resources provided that tribal activities do not replace the trustee's specific legal responsibilities. Section 507 (a)(2) (reassumption) with its concept of imminent endangerment of the public health provides guidance in defining the Secretary trust obligation in the health context.

(h) Decisionmaker. Final agency action is a decision by either an official from the Department at any higher organizational level than the initial decision maker or an administrative law judge. Subparagraph (h)(2) is included to assure that the persons deciding an administrative appeal are not the same individuals who made the initial decision to reject a tribe's "final offer."

Section 508. Transfer of funds

(a) In General. The Secretary is required to transfer all funds provided for in a funding agreement, pursuant to Section 509(c) below. Funds are also required to be provided for periods covered by continuing resolutions adopted by Congress, to the extent permitted by such resolutions. When a funding agreement requires that funds be transferred at the beginning of the fiscal year, the transfer is to be made within 10 days after the Office of Management and Budget apportions the funds, unless the funding agreement provides otherwise.

(b) Multi-Year Funding. The Secretary is authorized to negotiate multi-year funding agreements.

(c) Amount of Funding. The Secretary is required to provide an Indian tribe with the same funding for a program, function, service, or activity (or portion thereof) under self-governance that the tribe would have received under Title I. This includes all Secretarial resources that support the transferred program, and all contract support costs (including indirect costs) that are not available from the

Secretary but are reasonably necessary to operate the program. The bill requires that the transfer of funds occur along with the transfer of the program. Thus the bill states that "the Secretary shall provide" the funds specified, and the Secretary is not authorized to phase-in funds in any manner that is not voluntarily agreed to by a Self-Governance tribe.

(d) Prohibitions. The Secretary is specifically prohibited from withholding, refusing to transfer or reducing any portion of an Indian tribe's full share of funds during a Compact or funding agreement year, or for a period of years. The Committee is aware that for the first twenty-one years of administration of the Indian Self-Determination Act, the Department had never taken the position that it has the discretion to delay funding for any program transferred under the Act absent tribal consent. However, a 1996 IHS circular purported to do just that. Since this circular was issued, several Area offices have refused to turn over substantial program funds to tribal operation. In one instance both an Area office and Headquarters refused to transfer portions of programs for several years, and with respect to several Headquarters functions the IHS refused to transfer the functions altogether. A recent Oregon Federal district court decision declared the Indian Health Service's actions in these instances illegal and the Committee agrees.

Additionally, funds that an Indian tribe is entitled to receive may not be reduced to make funds available to the Secretary for monitoring or administration; may not be used to pay for federal functions (such as pay costs or retirement benefits); and, may not be used to pay costs associated with federal personnel displaced by self-governance or Title I contracting.

In subsequent years, funds may only be reduced in very limited circumstances: if Congress reduces the amount available from the prior year's appropriation; if there is a directive in the statement of managers which accompanies an appropriation; if the Indian tribe agrees; if there is a change in the amount of pass-through funds; or, if the project contained in the funding agreement has been completed.

(e) Other Resources. If an Indian tribe elects to carry out a compact or funding agreement using federal personnel, supplies, supply sources or other resources that the Secretary has available under procurement contracts, the Secretary is required to acquire and transfer the personnel, supplies or resources to the Indian tribe.

(f) Reimbursement to Indian Health Service. The Indian Health Service is authorized to provide goods and services to tribes on a reimbursable basis. Reimbursements are to be credited to the same or subsequent appropriation account which provided the initial funding. The Secretary is authorized to receive and retain the reimbursed amounts until expended without remitting them to the Treasury.

(g) Prompt Payment Act. This subsection makes the Prompt Payment Act (31 U.S.C. Chapter 39) applicable to the transfer of all funds due to a tribe under a compact or funding agreement. The first annual or semi-annual transfer due under a funding agreement must be made within 10 calendar days of the date the Office of Management and Budget apportions the appropriations for that fiscal year. Under this section, the Secretary is obligated to pay in-

terest to a Self-Governance tribe, as calculated under the Prompt Payment Act, for any late payment under a funding agreement.

(h) Interest or Other Income on Transfers. An Indian tribe may retain interest earned or other income realized on funds transferred under a Compact or funding agreement. Interest earned must not reduce the amount of funds the tribe is entitled to receive during the year the interest was earned or in subsequent years. An Indian tribe may invest funds received in a funding agreement as it wishes, provided it follows the "prudent investment standard", a commonly utilized fiduciary standard, that the Committee believes is sufficiently stringent to ensure that funds are invested wisely and safely yet provide a reasonable yield on investment.

Eligible investments under the prudent investment standard may include the following: (1) cash and cash equivalents (including bank checking accounts, savings accounts, and brokerage account free cash balances that carry a quality rating A1 P1, or AA or higher), (2) money market accounts with an A rating or higher, (3) certificates of deposit where the amounts qualify for insurance ($100,000 or less) or where the issuing bank has delivered a specific assignment, (4) bank repossession certificates where the amounts qualify for insurance ($100,000 or less) or where the issuing bank has delivered a specific assignment, (5) U.S. Government or Agency Securities, (6) commercial paper rated A1 P1 at time of purchase and which cannot exceed 10% of portfolio at time of purchase with any one issuer (short term paper—under 90 days—may be treated as a cash equivalent, (7) auction rate preferred instruments that are issued by substantial issuers, are rated AA or better, and may be utilized with auction maturities of 28 to 90 days, (8) corporate bonds of U.S. corporations that have Moody's, Standard and Poor's, or Fitch's rating of A or equivalent and where no more than 10% of the portfolio at time of purchase is invested in the securities of any one issuer, (9) dollar denominated short term bonds of the G7 Nations or World Bank only if the yields exceed those of U.S. instruments of equivalent maturity and quality, and where no more than 25% of portfolio at time of purchase is invested in this asset category, (10) properly registered short term no-load government or corporate bond mutual funds with a safety rating and average fund quality of A or higher, which demonstrate low volatility, and where no more than 25% of portfolio at time of purchase is invested in any one fund.

(i) Carryover of Funds. All funds paid to an Indian tribe under a compact or funding agreement are "no year" funds and may be spent in the year they are received or in any future fiscal year. Carryover funds are not to reduce the amount of funds that the tribe may receive in subsequent years.

(j) Program Income. All program income (including Medicare/Medicaid) reimbursements earned by an Indian tribe is supplemental to the funding that is included in its funding agreement. The Secretary may not reduce the amount of funds that the Indian tribe may receive under its funding agreement for future fiscal years. The Indian tribe may retain such income and spend it either in the current or future years.

(k) Limitation of Costs. An Indian tribe is not required to continue performance of a Program, function, service, or activity (or

portion thereof) included in a funding agreement if doing so requires more funds than were provided under the funding agreement. If an Indian tribe believes that the amount of funds transferred is not enough to carry out a program, function, service, or activity, (or portion thereof) for the full year, the Indian tribe may so notify the Secretary. If the Secretary does not supply additional funds the tribe may suspend performance of the program, function, service, or activity (or portion thereof) until additional funds are provided.

Section 509. Construction projects

(a) In General. Indian tribes are authorized to conduct construction projects authorized under this section. The tribes are to assume full responsibility for the projects, including responsibility for enforcement and compliance with all relevant federal laws, including the National Historic Preservation Act of 1966 and the National Environmental Policy Act of 1969. A tribe undertaking a construction project must designate a certifying officer to represent the tribe and accept federal court jurisdiction for purposes of the enforcement of federal environmental laws.

(b) Negotiations. This subsection provides that negotiation of construction projects are negotiated pursuant to section 105(m) of the Act and construction project agreements included in the funding agreement as an addendum.

(c) Codes and Standards. The tribe and the IHS must agree to standards and codes for the construction project. The agreement is to conform with nationally accepted standards for comparable projects.

(d) Responsibility for Completion. This subsection provides that the Indian tribe must assume responsibility for the successful completion of the project according to the terms of the construction project agreement.

(e) Funding. This subsection provides that funding of construction projects will be through advance payments, on either an annual or semi-annual basis. Payment amounts will be determined by project schedules, work already completed, and the amount of funds already expended. Flexibility in payment schedules will be maintained by the IHS through contingency funds to take account of exigent circumstances such as weather and supply.

(f) Approval. This subsection allows the Secretary to have at least one opportunity to approve tribal project planning and design documents or significant amendments to the original scope of work before construction. The tribe is to provide at least semiannual progress and financial reports to the Secretary. The Secretary is allowed to conduct semiannual site visits or on another basis if agreed to by the tribe.

(g) Wages. This subsection mirrors section 7(a) of the Indian Self-Determination and Education Assistance Act which incorporates federal Davis-Bacon Act wage protections for workers.

(h) Application of Other Laws. This subsection provides that provisions of the Office of Federal Procurement Policy Act, the Federal Acquisition Regulations, and other federal procurement laws and regulations do not apply to construction projects, unless agreed to by the participating tribe.

Section 510. Federal procurement laws and program regulations

This section provides that unless otherwise agreed to by the parties, compacts and funding agreements are not subject to federal contracting or cooperative agreement laws and regulations (including executive orders) unless those laws expressly apply to Indian tribes. Compacts and funding agreements are also not subject to program regulations that apply to the Secretary's operations.

Section 511. Civil actions

(a) Contract Defined. The Committee intends that Section 110 of Title I of the Act, which grants tribes access to federal district court to challenge a decision by the Secretary, shall apply to this title.

(b) Applicability of Certain Laws. This subsection provides that Department of Interior approval of tribal contracts (25 U.S.C. 81) and section 16 of the Indian Reorganization Act (25 U.S.C. 476) shall not apply to attorney and other professional contracts with Self-Governance tribes.

Section 512. Facilitation

(a) Secretarial Interpretation. This section requires the Secretary to interpret all executive orders, regulations and federal laws in a manner that will facilitate the inclusion of programs, functions, services, or activities, (or portions thereof) and funds associated therewith under Title V, implementation of Title V compacts and funding agreements, and the achievement of tribal health goals and objectives where they are not inconsistent with federal law. This section reinforces the Secretary's obligation not merely to provide health care services to Native American tribes, but to facilitate the efforts of tribes to manage those programs for the maximum benefit of their communities.

(b) Regulation Waiver. An Indian tribe participating in the Self-governance program under title V may seek a waiver of an applicable Indian Self-Determination Act regulation by submitting a written waiver request to the Secretary. The Secretary has 90 days to respond and a failure to act within that period is deemed an approval of the request by operation of law. Action on a waiver request is final for the Department. Denials may be made upon a specific finding that the waiver is prohibited by federal law.

(c) Access to Federal Property. This subsection addresses tribal use of federal buildings, hospitals and other facilities, as well as the transfer to tribes of title to excess personal or real property. At the request of an Indian tribe the Secretary is required to permit the Indian tribe to use government-owned real or personal property under the Secretary's jurisdiction under such terms as the parties may agree to.

The Secretary is required to donate title to personal or real property that is excess to the needs of any federal agency or the General Services Administration as long as the Secretary has determined that the property is appropriate for any purpose for which a compact is authorized, irrespective of whether a tribe is in fact administering a particular program that matches that purpose. For instance, if a tribe is not administering a mental health program under its IHS compact or funding agreement, but is administering

a mental health program under other authority or funding agreement, the Secretary may nonetheless acquire excess or surplus property and donate such property to the tribe so long as the Secretary determines that the tribe will be using the property to administer mental health services.

Title to property furnished by the government or purchased with funds received under a compact or funding agreement vests in the Indian tribe if it so chooses. Such property also remains eligible for replacement, maintenance or improvement on the same terms as if the United States had title to it. Any property that is worth $5,000 or more at the time of a retrocession, withdrawal or reassumption may revert back to the United States at the option of the Secretary.

(d) Matching or Cost-Participation Requirement. Funds transferred under compacts and funding agreements are to be considered non-federal funds for purposes of meeting matching or cost participation requirements under federal or non-federal programs.

(e) State Facilitation. This section encourages and authorizes States to enter agreements with tribes supplementing and facilitating Title V and other federal laws that benefit Indians and Indian tribes, for example, welfare reform. it is designed to provide federal authority so as to remove equal protection objections where states enter into special arrangements with tribes.

The Committee wants to foster enlightened and productive partnerships between state and local governments, on the one hand, and Indian tribes on the other; and, the Committee wants to be sure that states are authorized by the federal government to undertake such initiatives, as a delegation of the federal government's constitutional authority to deal with Indian tribes as political entities, irrespective of any limitations which have from time to time been argued might otherwise exist with respect to state action under either state constitutional provisions or other provisions of the Constitution. Many state and tribal governments have undertaken positive initiatives both in health care issues and in natural resource management, and it is the Committee's strong desire to fully support, authorize and encourage such cooperative efforts.

(f) Rules of Construction. Provisions in this title and in compacts and funding agreements shall be liberally construed and ambiguities decided for the benefit of the Indian tribe participating in the program.

Section 513. Budget request

(a) The President is required to annually identify in his/her budget all funds needed to fully fund all Title V compacts and funding agreements. These funds are to be apportioned to the Indian Health Service and will then be transferred to the Office of Tribal Self-Governance. The IHS may not thereafter reduce the funds a tribe is otherwise entitled to receive whether or not such funds have been apportioned to the Office of Tribal Self-Governance.

The Committee has been made aware that the current system for payment and approval of funding and amendments for annual funding agreements for self-governance demonstration tribes is inefficient and time consuming. In addition, by leaving authority and

responsibility for distributions to Area Offices, there have been reported instances of excessive and unwarranted assertion of authority by Area Offices over self governance tribes. This includes Area Offices retaining shares of funds not authorized to be retained by the tribe's annual funding agreement. The Committee concludes that by requiring a report on self-governance expenditures, and by moving all self-governance funding onto a single line, the Congress will be able to achieve the following ends: more accurately gauge the amount of funding flowing directly to tribes through participation in self governance; generate savings through decreasing the bureaucratic burden on the payment and approval process in the Indian Health Service; expedite the transferal of funding to tribal operating units; and, aid in the implementation of true government-to-government relations and tribal self determination.

(b) The budget must identify the present level of need and any shortfalls in funding for every Indian tribe in the United States that receives services directly from the Secretary, through a Title I contract or in a Title V compact and funding agreement.

Section 514. Reports

(a) Annual Report. The Secretary is required to submit to Congress on January 1 of every year a written report on the Self-Governance program. The report is to include the level of need presently funded or unfunded for every Indian tribe in the United States that receives services directly from the Secretary, through a Title I contract or in a Title V compact and funding agreement. The Secretary may not impose reporting requirements on Indian tribes unless specified in Title V.

(b) Contents. The Secretary's report must identify: (1) the costs and benefits of self-governance; (2) all funds related to the Secretary's provision of services and benefits to self-governance tribes and their members; (3) all funds transferred to self-governance tribes and the corresponding reduction in the federal bureaucracy; (4) the funding formula for individual tribal shares; (5) the amount expended by the Secretary during the preceding fiscal year to carry out inherent federal functions; and (6) contain a description of the method used to determine tribal shares. The Secretary's report must be distributed to Indian tribes for comment no less than 30 days prior to its submission to Congress and include the separate views of Indian tribes.

(c) Report on IHS Funds. This section requires the Secretary to consult with Indian tribes and report, within 180 days after this title is enacted, on funding formulae used to determine tribal shares of funds controlled by IHS. The formulae are to become a part of the annual report to Congress discussed above in Section 514(d). This provision is not intended to relieve HHS from its obligation under Title V to make all funds controlled by the central office, national, headquarters or regional offices available to Indian tribes. This provision is also not intended to require reopening funding formulae that are already being used by HHS to distribute funds to Indian tribes. Any new formulae or revision of existing formulae should be determined only after significant regional and national tribal consultation.

Section 515. Declaimers

(a) No Funding Reduction. This provision states that nothing in Title V shall be interpreted to limit or reduce the funding for any program, project or activity that any other Indian tribe may receive under Title I or other applicable federal laws. A tribe that alleges that a compact or funding agreement violates this section may rely on section 110 of the Act to seek judicial review of the allegation.

(b) Federal Trust and Treaty Responsibilities. This section clarifies that the trust responsibility of the United States to Indian tribes and individual Indians which exists under treaties, Executive Orders, laws and court decisions shall not be reduced by any provision of Title V.

(c) Tribal Employment. This provision excludes Indian tribes carrying out responsibilities under a compact or funding agreement from falling under the definition of "employer" as that term is used in the National Labor Relations Act.

(d) Obligations of the United States. The IHS is prohibited from billing, or requiring Indian tribes from billing, individual Indians who have the economic means to pay for services. For many years the Interior and Related Agencies appropriations bills included language that prohibited the Indian Health Service, without explicit direction from Congress, from billing or charging Indians who have the economic means to pay. In 1997 the language was removed from the appropriation bills and it has not been included since. This section reflects the Committee's intent that the IHS is prohibited from billing Indians for services, and is further prohibited from requiring any Indian tribe to do so.

Section 516. Application of other sections of the Act

(a) This section expressly incorporates a number of provisions from other areas of the Indian Self-Determination and Education Assistance Act into Title V. These sections include: 5(b) (access for three years to tribal records), 6 (setting out penalties that apply if an individual embezzles or otherwise misappropriates funds under Title V); 7 (federal Davis-Bacon Act wage and labor standards and Indian preference requirements); 102(c) and (d) (relating to Federal Tort Claims Act coverage); 104 (relating to the right to use federal personnel to carry out responsibilities in a compact or funding agreement); 105(k) (access to federal supplies); 111 (clarifying that Title V shall have no impact on existing sovereign immunity and the United States' trust responsibility); and section 314 Public Law No. 101–512 (coverage under the Federal Tort Claims Act).

(b) At the request of an Indian tribe, other provisions of Title I of the Indian Self-Determination Act which do not conflict with provisions in Title V may be incorporated into a compact or funding agreement. If incorporation is requested during negotiations it will be considered effective immediately.

Section 517. Regulations

This section gives the Secretary limited authority to promulgate regulations implementing Title V.

(a) In General. The Secretary is required to initiate procedures to negotiate and promulgate regulations necessary to carry out Title V within 90 days of enactment of Title V. The procedures

must be developed under the Federal Advisory Committee Act. The Secretary is required to publish proposed regulations no later than one year after the date of enactment of Title V. The authority to promulgate final regulations under Title V expires 21 months after enactment. The Committee is aware of the success of the Title I negotiated rulemaking and believes that one reason for its success is a similar limitation of rulemaking authority contained in section 107(a) of the Indian Self-Determination Act, which this section is modeled after.

(b) Committee. This provision requires that a negotiated rulemaking committee made up of federal and tribal government members be formed in accordance with the Negotiated Rulemaking Act. A majority of the tribal committee members must be representatives of and must have been nominated by Indian tribes with Title V compacts and funding agreements. The committee will confer with and allow representatives of Indian tribes, inter-tribal consortiums, tribal organizations and individual tribal members to actively participate in the rulemaking process.

(c) Adaptation of Procedures. The negotiated rulemaking procedures may be modified by the Secretary to ensure that the unique context of self-governance and the government-to-government relationship between the United States and Indian tribes is accommodated.

(d) Effect. The effect of Title V shall not be limited if regulations are not published.

(e) Effect of Circulars, Policies, Manuals, Guidances and Rules. Unless an Indian tribe agrees otherwise in a Compact or funding agreement, no agency circulars, policies, manuals, guidances program regulations or rules adopted by the IHS apply to the tribe.

Section 518. Appeals

In any appeal (including civil actions) involving a decision by the Secretary under Title V, the Secretary carries the burden of proof. To satisfy this burden the Secretary must establish by clear and convincing evidence the validity of the grounds for the decision made and that the decision is fully consistent with provisions an policies of Title V.

Section 519. Authorization of appropriations

This section authorizes Congress to appropriate such funds as are necessary to carry out Title V.

The Committee is aware of and concerned with the many lawsuits that have been filed against the United States for failure to pay full contract support costs to tribal contractors under the Act. Amounts appropriated in recent years for contract support have failed to keep pace with the demand as tribes assume greater responsibility for health care services. The result has been the filing of several lawsuits with significant liability for the United States.

At the same time, the Committee is concerned with the moratorium that has been placed on any new or expanded contracts or compacts—effectively frustrating the purpose of the Act and stopping Indian self determination in its tracks. Because of these factors, the amendment in the nature of a substitute contained a provision that lifts the moratorium for new or expanded contracts and

compacts, but conditions the Secretary's ability to enter such agreements on two eventualities: (1) the availability of sufficient appropriations for such new agreements; and (2) a determination by the IHS that the level of contract support cost funding for existing contractors will not be diminished as a result of any new or expanded contract or compact.

Section 601. Demonstration project feasibility

This provision requires an 18 month study to determine the feasibility of creating a Tribal Self-Governance Demonstration Project for other agencies, programs and services in the Department of Health and Human Services.

(a) Study. This subsection authorizes the feasibility study.

(b) Considerations. This subsection requires the Secretary to consider (1) the effects of a Demonstration Project on specific programs and beneficiaries, (2) statutory, regulatory or other impediments, (3) strategies for implementing the Demonstration Project, (4) associated costs or savings, (5) methods to assure Demonstration Project quality and accountability, and (6) such other issues that may be raised during the consultation process.

Report. This subsection provides that the Secretary is to submit a report to Congress on the results of the study, which programs and agencies are feasible to be included in a Demonstration Project, which programs would not require statutory changes or regulatory waivers, a list of legislative recommendations for programs that are feasible but which would require statutory changes, and any separate views of Indian tribes or other entities involved in the consultation process.

The Committee has deferred to the Secretary's request not to provide for a demonstration or pilot project component to the Feasibility Study to determine how to best apply Self-Governance to agencies other than the Indian Health Service within HHS. The Secretary has pledged to work in a cooperative spirit with the Indian tribes to quickly identify those programs outside the IHS that are suitable for Self-Governance. The Committee believes that there are agencies and programs outside of the IHS that should be ready to participate in the Self-Governance program at the conclusion of the study and anticipates the introduction of legislation at that time to authorize such participation.

Section 602. Consultation

(a) Study Protocol. This provision requires the Secretary to consult with Indian tribes to determine a protocol for conducting the study. The protocol shall require that the government-to-government relationship between the United States and the Indian tribes forms the basis for the study, that consultations are jointly conducted by the tribes and the Secretary, and that the consultation process allows for input from Indian tribes and other entities who wish to comment.

(b) Conducting Study. This provision requires that when the Secretary conducts the study, the Secretary is to consult with Indian tribes, states, counties, municipalities, program beneficiaries, and interested public interest groups.

Section 603. Definitions

(a) This subsection is intended to incorporate into Title VI the definitions used in Title V.

(b) This subsection defines "agency" to mean any agency in the Department of Health and Human Services other than the Indian Health Service.

Section 604. Authorization of appropriations

This section authorizes the appropriation of such sums as necessary for fiscal years 2000 and 2001 in order to carry out Title VI.

Section 5. Amendments clarifying civil proceedings.

(a) This provision amends section 102(e)(1) of the Act to clarify that the Secretary has the burden of proof in any civil action pursuant to section 110(a).

(b) The provision provides that the amendment to sections 102(e)(1) set out in subsection (a) shall apply to any proceeding commenced after October 25, 1994.

Section 6. Speedy acquisition of goods and services

This section requires the Secretary to enter into agreements for the acquisition of goods and services for tribes, including pharmaceuticals at the best price and in as fast a manner as is possible, similar to those obtained by agreement by the Veterans Administration.

Section 7. Patient records

This section provides that Indian patient records may be deemed to be federal records under the Federal Records Acts in order to allow tribes to store patient records in the Federal Records Center.

Section 8. Repeals

This section repeals Title III of the Indian Self-Determination and Education Assistance Act which authorizes the Demonstration Project replaced by this Act.

Section 9. Savings provision

This section provides that funds already appropriated for Title III of the Indian Self-Determination and Education Assistance Act shall remain available for use under the new Title V.

Section 10. Effective date

This section provides that the Act shall take effect on the date of enactment.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

The cost estimate for S. 979 as calculated by the Congressional Budget Office is set forth below:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, November 9, 1999.

Hon. BEN NIGHTHORSE CAMPBELL,
Chairman, Committee on Indian Affairs,
U.S. Senate,
Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 979, the Tribal Self-Governance Amendments of 1999.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Dorothy Rosenbaum.

Sincerely,

BARRY B. ANDERSON
(For Dan L. Crippen, Director).

Enclosure.

S. 979—Tribal Self-Governance Amendments of 1999

CBO estimates that implementing S. 979 would cost less than $500,000 in each of fiscal years 2000 through 2004, assuming appropriation of the necessary funds. Because enacting the bill would not affect direct spending or receipts, pay-as-you-go procedures would not apply. The legislation contains no intergovernmental or new private-sector mandates as defined in the Unfunded Mandates Reform Act and would impose no costs on state, local, or tribal governments.

S. 979 would amend the Indian Self-Determination and Education Assistance Act to establish a permanent tribal self-governance program within the Indian Health Service (IHS). Under existing demonstration authority, the IHS and tribes enter into funding agreements whereby a tribe assumes administrative and programmatic duties that were previously performed by the Federal Government. Because the current demonstration authority does not end until 2006, and because the provisions of the new permanent program would not be significantly different from those governing the demonstration program, CBO estimates that establishing a permanent program would have no federal budgetary impact during fiscal years 2000 through 2004. Under the existing demonstration program, the IHS may select 30 new tribes each year to participate. S. 979 would raise that number to 50. Because in recent years fewer than 10 new tribes each year have become eligible to participate, CBO expects that the change in law would have no effect on participation.

S. 979 would authorize appropriations for fiscal years 2000 and 2001 for the IHS to conduct a study and report to the Congress on the feasibility of a demonstration project that would expand self-governance compacts to include programs operated by other agencies of the Department of Health and Human Services (HHS). CBO estimates that this study would cost less than $250,000. In addition, the bill would require the Secretary of HHS to submit an annual report on the implementation of the Indian Self-Determination and Education Assistance Act, with an emphasis on contract support costs. Because the Secretary already prepares this report

each year, CBO estimates that the requirement would not result in additional costs.

S. 979 would allow Indian tribes to store their patient records at Federal Records Centers. CBO expects that very few tribes would take advantage of this option and that increased costs to the Federal Records Centers would be less than $500,000 in each of fiscal years 2000 through 2004.

Finally, S. 979 would give Indian tribes carrying out self-governance contracts the same right as the United States under the Medical Care Recovery Act (42 U.S.C. 2651) to recover from liable third parties the reasonable value of care the tribe provided. The bill also specifies that amounts recovered under that authority would be retained by the tribe (an authority that exists in current law under section 207(a) of the Indian Health Care Improvement Act). CBO assumes that any additional amounts the tribes recover and the related spending of these amounts would not be considered part of the federal budget.

The CBO staff contact is Dorothy Rosenbaum. This estimate was approved by Robert A. Sunshine, Assistant Director for Budget Analysis.

REGULATORY IMPACT STATEMENT

Paragraph 11(b) of rule XXVI of the Standing rules of the Senate requires that each report accompanying a bill evaluate the regulatory paperwork impact that would be incurred in implementing the legislation. The Committee has concluded that enactment of S. 979 will create only de minimis regulatory or paper work burdens.

EXECUTIVE COMMUNICATIONS

At the hearing on S. 979 on July 19, 1999, Mr. Michael Lincoln, Deputy Director of the Indian Health Service (IHS) appeared and testified before the Committee in support of S. 979. The statement of Mr. Lincoln follows:

STATEMENT OF THE INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committee: Good morning. I am Michael E. Lincoln, Deputy Director, Indian Health Service (IHS). Accompanying me today is Paula K. Williams, Director, Office of Tribal Self-Governance, and Douglas Black, Director, Office of Tribal Programs. We are pleased to be here today to discuss S. 979, the "Tribal Self-Governance Amendments of 1999."

The IHS goal is to raise the health status of American Indians and Alaska Natives (AI/ANs) to the highest possible level. The mission is to provide a comprehensive health services delivery system for AI/ANs with opportunity for maximum Tribal involvement in developing and managing programs to meet their health needs. The provision of Federal health services to American Indians and Alaska Natives is based upon a special government-to-government relationship between Indian tribes and the United States, which has been reaffirmed throughout the history of this Nation by all three branches of this Nation's

government. In 1994, the President issued an Executive Memorandum directing all Federal Departments and Agencies to implement policies and procedures for consulting with Indian Tribes on matters that affect Indian people.

The IHS Self-Governance Demonstration Project (SGDP) was authorized in October 1992 pursuant to Public Law 102–573, the Indian Health Amendments of 1992. In May 1993, IHS began its first compact negotiations with tribes under the demonstration authority. Since that time, the Agency has entered into 42 Self-Governance (SG) Compacts and 59 Annual Funding Agreements (AFA) through Fiscal Year (FY) 1998. These compacts transfer approximately $549 million to 216 tribes in Alaska and 43 tribes in the lower 48 states participating in the SGDP. These negotiated agreements transfer the funding associated with programs, functions, services and activities assumed by the tribes, from Area and Headquarters budgets to those tribes.

The 259 tribes participating in this project constitute 46.5% of the federally recognized tribes and they collectively serve over 32% of the total IHS users. This Project has provided Tribal Governments the needed local control of their health programs and allows Tribal leadership to implement aggressive and successful health promotion and disease prevention initiatives which are truly responsive to the health needs of their service population. Local control has also provided more ownership by local leadership which has resulted in significant improvements in the quality and quantity of health services. Tribes have been able to increase the number of physicians and clinic sites to make health care more accessible to the people. Some have implemented special services to address the unique needs of the elderly. The Mississippi Band of Choctaw Indians Health Center's Radiology Department has been awarded the Nashville Area Radiology Technologist of the Year Award for two consecutive years. In addition, their Health Center's Women's Wellness Center and Choctaw Community Integrated Service System has been recognized by the Department of Health and Human Services, Maternal and Children's Health Bureau, as a "model" for State Health Departments nationwide. And, most impressive, tribally operated health facilities are scoring higher in their accreditation reviews than they did under Agency administration. For example, the Chippewa Cree Health Center and laboratory each scored a perfect 100 points and their Chemical Dependency Center scored 98 points in the accreditation review conducted by the Joint Commission on Accreditation of Health Care Organizations.

The Self-Governance Demonstration Project has been a success. We do need to continue to assess the impact of continued transfers of funds upon the Agency's ability to carry out its residual functions and to continue providing direct health services to tribes who choose not to contract

or compact. The Agency is taking steps to downsize and reorganize in order to free up resources for transfer to tribes, but these efforts could be out paced by increased compacting and certain provisions of this bill.

The challenge before the Tribes, Indian health programs, the IHS and the Congress is to retain the applied expertise of the Indian Health Service in core public health functions that are critical to elevating the health status of American Indians/Alaska Natives and reducing the disparity in the health status of AI/ANs compared with the general population. We, who are involved in Indian Health care, must deal with a changing external environment with new demands, new needs, and new priorities. The Indian Health Service supports the spirit and intent of the Tribal Self-Governance Amendments. S. 979 is consistent with our goal of providing maximum participation of tribes in the development and management of Indian health programs.

In the 105th Congress, the Department closely worked with Congress and the tribes on H.R. 1833, the predecessor legislation to S. 979 and H.R. 1167. Agreement was reached on many points, as was reflected in the version of H.R. 1833 that passed the House on October 5, 1998. The Department testified favorably on H.R. 1833 before this Committee after it passed the House and, with a few exceptions, supported the bill. We would like to highlight for you our major concerns with certain provisions contained in S. 979. In fact, some were concerns we raised with H.R. 1833 last year and again appear in S. 979. While these represent our significant concerns, we acknowledge that there has been a great deal of hard work and a spirit of compromise on the part of all parties that brought us this far. In this same manner, we believe that we will continue to move forward.

Proposed sec. 512(b)—Facilitation: regulation waiver

S. 979 appears to have inadvertently dropped the language "promulgated under this act," from Section 512(b)(1), the effect of which is that the applicability of the provision becomes overly broad applying to regulations promulgated by HHS as well as other Departments thereby creating the potential for unforeseen consequences outside of HHS' control. As a result of this omission, we have serious concerns with Section 512(b)(1), particularly in the context of language found in the next paragraph, (b) (2), which specifies that the Secretary shall only deny a waiver if it is otherwise prohibited by Federal law. Taken together, these two provisions are a significant concern.

Title VI, Section 5—Amendments clarifying civil proceedings

Last year, H.R. 1833 contained a de novo standard of judicial review which would have retroactively overruled judicial determinations applying the Administrative Proce-

dures Act (APA) standard of review in ISDA cases. After negotiations with Tribal representatives, the House Committee on Resources and Administration Officials, the de novo provision was removed. We appreciate that this provision has remained out of the current House and Senate bills. However, we continue to have concerns about the remaining section concerning judicial proceedings. As this provision is currently drafted, its impact extends well beyond the scope of self-governance affecting any litigation that is currently on-going between tribes and HHS or the Department of the Interior. It would change the burden of proof in favor of the tribes in the middle of such litigation. This change would be in addition to the change effected by Section 507(d) of the bill, which already increases the Secretary's burden of proof to "clear and convincing evidence" prospectively for litigation involving self-governance funding agreements. It is important that the legislation remain litigation neutral. The entire Section 6 in Title VI contained in S. 979 should be removed.

Title V, Section 516—Application of other sections of the Act

The proposed section 516 of the new Title V seems to make an inadvertent drafting error which makes it unclear whether funding is subject to the availability of appropriations or is an entitlement irrespective of the funding level of appropriations. We believe that this issue is easily resolved and we will work with Committee staff to address this error. We also will continue to work with the tribes and the Authorizing and Appropriations Committee to address the ever-growing contract support funding within the annual appropriations. In doing so, we will work collectively to ensure that funding for contract support costs will not adversely affect funding for other IHS programs, including services delivered to non-contracting and non-compacting tribes.

Title V, Section 505—Funding agreements

Section 505 establishes the scope of IHS programs, services, functions and activities (PFSAs) that are subject to self-governance funding agreements. Last year, Title VI was added to H.R. 1833 to address the Administration's concerns about moving too quickly to include non-IHS PFSAs without first determining whether other Department of Health and Human Services (HHS) programs should be brought within the scope of this self-governance legislation. Hence, Title VI was added to H.R. 1833, and also is included in both S. 979 and H.R. 1167 to authorize a study to asses the feasibility of expanding the scope of this legislation to other HHS programs. We believe that the two provisions of Section 505, (F) and (G), would expand the scope of the PFSAs subject to funding agreements under this legislation to programs outside the IHS, even while the Title VI study is underway. We believe that

before any potential expansion of the scope of self-governance funding agreements is authorized, the study authorized in Title VI should be completed and the results analyzed. We will work with you to make sure that different provisions of the bill work together.

In general, we will be happy to work with the Committee to address any of the concerns we have raised as well as any others that may arise. We note that other Feral Departments may have concerns about S. 979. For example, we have been advised by the Department of the Interior that it has serious concerns regarding the definition of the term "inherent Federal functions", and recommends that the term not be defined in the bill. It is our understanding that the Department of the Interior plans to send a letter to the Committee setting forth its concerns in greater detail.

I want to express my appreciation to the Title V Tribal Workgroup and to commend their cooperative spirit in working with the IHS and other components of the Department in the evolution of S. 979. The version of S. 979 that we are discussing today is the result of many in-depth discussions and a great deal of analysis.

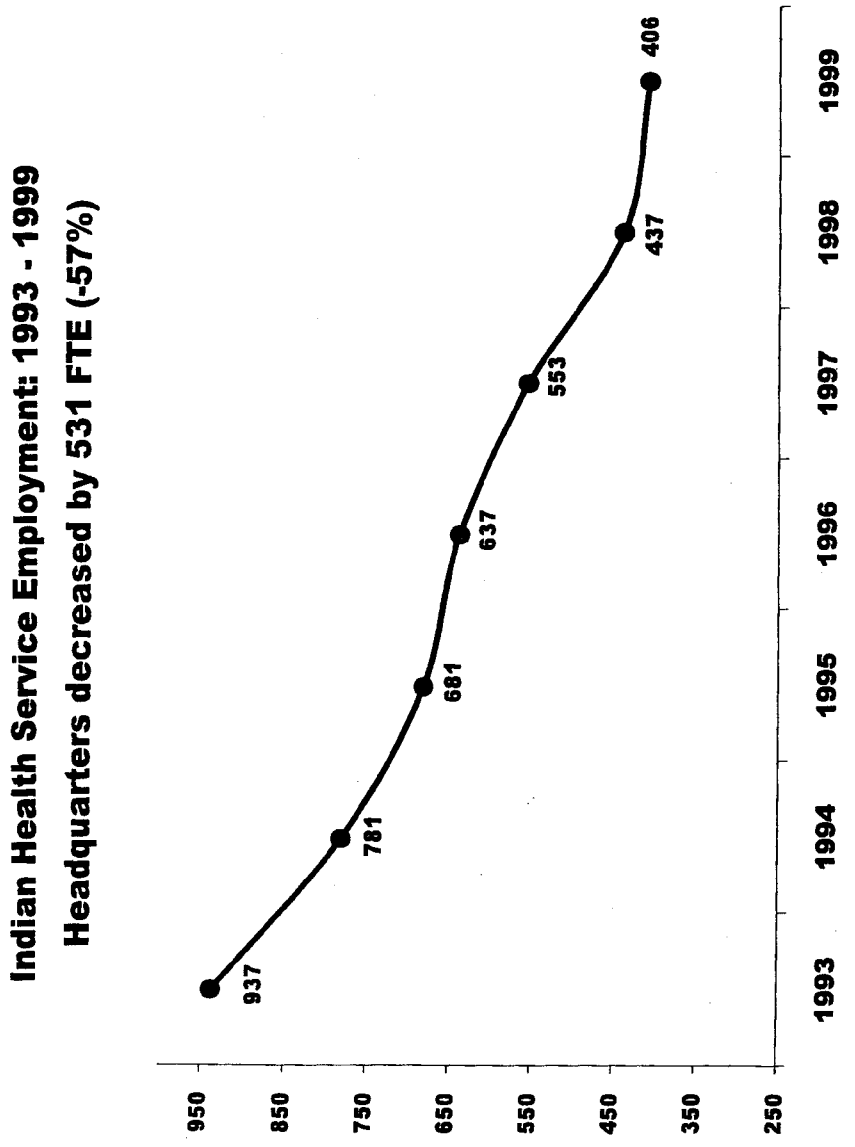
We are pleased to note that the IHS and tribal representatives have successfully negotiated provisions in the bill for tribal assumption of construction projects. The negotiated provisions of the bill authorize a specific process for tribes to elect to carry out construction of health and sanitation facilities as a self-governance activity.

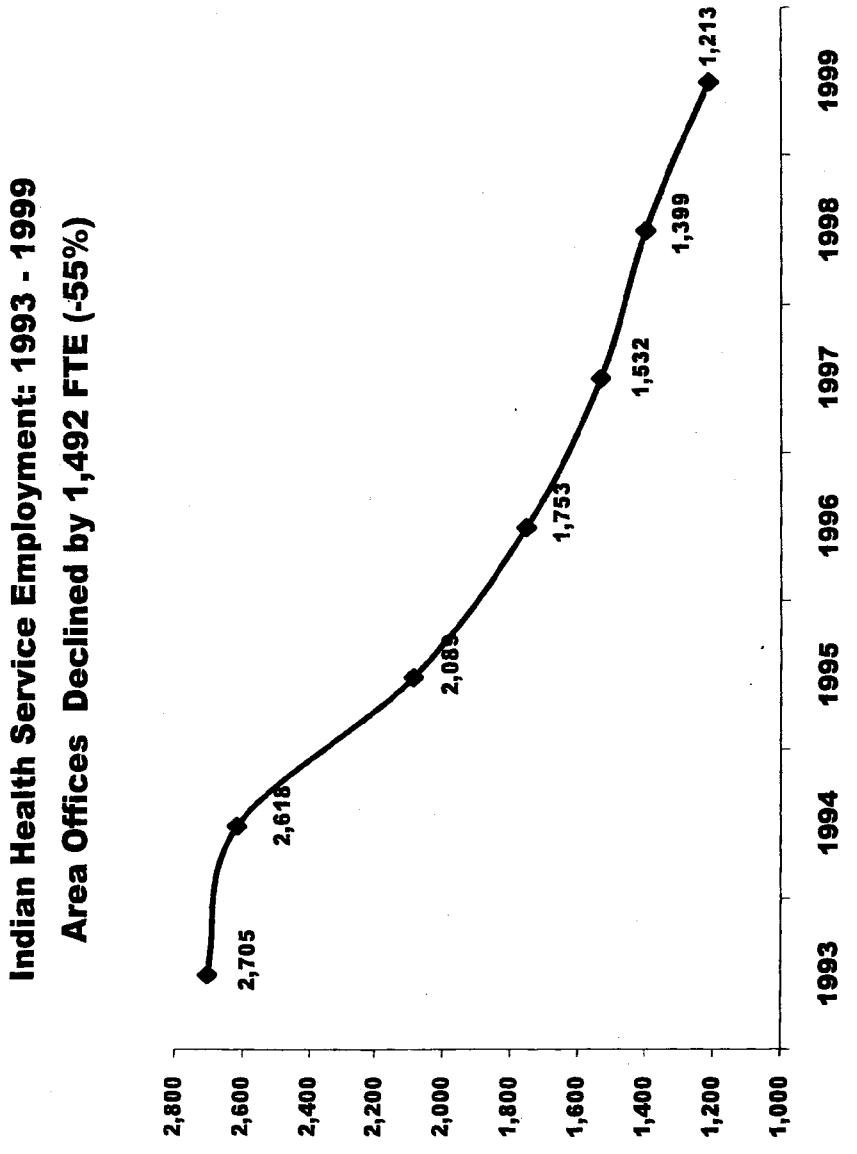
Competitive grant programs such as the Indian Health Professions Scholarships and the Tribal Management Grant Program have been established for specific public purposes. Likewise, the Department and IHS have agency-wide initiatives that address national concerns and are carried out under general grant authorities from general agency funds. All competitive grant programs, including those that support national needs and benefit all Tribes, should be exempted from Tribal shares. We believe that this bill sufficiently addresses our concerns in this area.

In conclusion, we support making self-governance authority permanent within the IHS so long as these changes continue to allow the Department and the IHS to perform its inherent functions and to maintain its trust responsibility to all Tribes. We also support exploring the expansion of self-governance demonstration authority to non-IHS programs of the Department, but only after consultation with all stakeholders and more specific guidance from Congress.

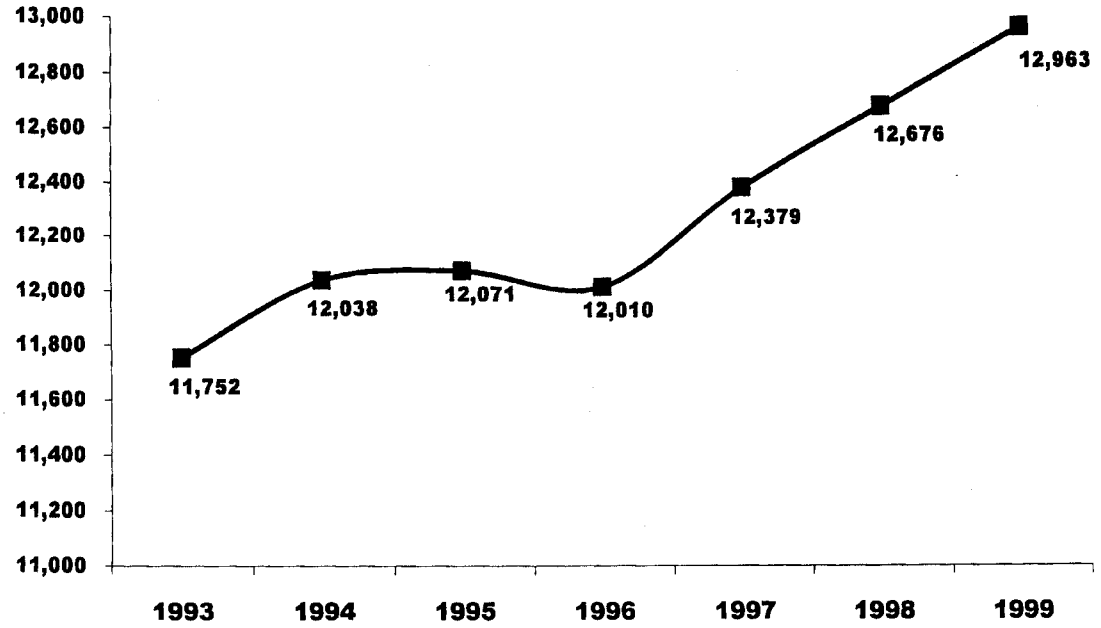
I commend you for your commitment to rights of the Nation's Indian Tribes and to providing them opportunities to administer those federal programs affecting the health and welfare of their people. The Indian Health Service and the Department of Health and Human Services stand ready to work collaboratively with this Committee, the Congress, and the Tribes to ensure that such efforts are successful.

Mr. Chairman, this concludes my statement. We will be pleased to answer any questions that you may have. Thank you.


Indian Health Service Employment: 1993 - 1999
Headquarters decreased by 531 FTE (-57%)
950
850
750
650
550
450
350
250
1993
1994
1995
1996
1997
1998
1999
937
781
681
637
553
437
406


Indian Health Service Employment: 1993 - 1999
Area Offices Declined by 1,492 FTE (-55%)
2,800
2,600
2,400
2,200
2,000
1,800
1,600
1,400
1,200
1,000
1993
1994
1995
1996
1997
1998
1999
2,705
2,618
2,089
1,753
1,532
1,399
1,213

Indian Health Service Employment: 1993 - 1999
Service Units increased by 1,211 FTE (+10%)



IHS FTE: Area, Service Unit, HQ, & Total

	1993	1994	1995	1996	1997	1998	1999
Area Offices	2,705	2,618	2,089	1,753	1,532	1,399	1,213
Service Units	11,752	12,038	12,071	12,010	12,379	12,676	12,963
Headquarters	937	781	681	637	553	437	406
TOTAL	15,441	15,511	14,865	14,422	14,464	14,512	14,582

HEADQUARTERS:

Total percentage decline of 57%

Many function were streamlined, consolidated or reassigned to the field

FTE reductions at Headquarters are a result of combined trends listed below for the Areas

AREAS:

Total percentage decline of 55%.

No Area Office was closed but most downsized substantially.

Total percentage decline of 55%.

FTE reductions are a result of several trends acting together and include:

Transfer of area functions and dollars to tribes under self governance

Reassignment of staff and functions to service units

Reductions due to cuts in administrative funding

SERVICE UNITS:

Federal employment in the Indian Health Service units increased by 10% during a period in which over all Indian Health Service employment decreased.

Reflects agency concentration of effort, resources, manpower in health delivery rather than administration.

CHANGES IN EXISTING LAW

In compliance with subsection 12 of rule XXVI of the Standing Rules of the Senate, changes to existing law made by the bill are required to be set out in the accompanying Committee report. The Committee finds that enactment of S. 979 will result in the following changes in existing law. The matter to be deleted is indicated in brackets **[]** and bold face type. The matter to be inserted is indicated in italic.

1. Section 102(e)(1) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450f(e)(1)) is amended as follows:

(e)(1) With respect to any hearing or appeal conducted pursuant to subsection (b)(3) *or any civil action conducted pursuant to section 110(a)* of this section, the Secretary shall have the burden of proof to establish by clearly demonstrating the validity of the grounds for declining the contract proposal (or portion thereof).

2. Section 105 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450j) is amended as follows:

(k) For purposes of section 201(a) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 481(a)) (relating to Federal sources of supply, including lodging providers, airlines and other transportation providers), a tribal organization carrying out a contract, grant, or cooperative agreement under this subchapter shall be **[**deemed an executive agency**]** *deemed an executive agency and part of the Indian Health Service* when carrying out such contract, grant, or agreement and the employees of the tribal organization shall be eligible to have access to such sources of supply on the same basis as employees of an executive agency have such access. *At the request of an Indian tribe, the Secretary shall enter into an agreement for the acquisition, on behalf of the Indian tribe, of any goods, services, or supplies available to the Secretary from the General Services Administration or other Federal agencies that are not directly available to the Indian tribe under this section or any other Federal law, including acquisitions from prime vendors. All such acquisitions shall be undertaken through the most efficient and speedy means practicable, including electronic ordering arrangements.*

* * * * * * *

(o) At the option of a tribe or tribal organization, patient records may be deemed to be Federal records under the Federal Records Act of 1950 for the limited purposes of making such records eligible for storage by Federal Records Centers to the same extent and in the same manner as other Department of Health and Human Services patient records. Patient records that are deemed to be Federal records under the Federal Records Act of 1950 pursuant to this subsection shall not be considered Federal records for the purposes of chapter 5 of title 5, United States Code.

* * * * * * *

(p)(1) All funds recovered under 42 U.S.C. 2651 associated with health care provided by a tribally-administered facility or program of the Indian Health Service, whether provided before or after the facility's or program's transfer to tribal administration, shall be

credited to the account of the facility or program providing the service and shall be available without fiscal year limitation.

(2) For purposes of 42 U.S.C. 2651, a tribe or tribal organization carrying out a contract, compact, grant or cooperative agreement pursuant to this Act shall be deemed to be the United States and shall have the same right to recover as the United States for the reasonable value of past or future care and treatment provided under such contract, compact, grant, or cooperative agreement. Nothing herein shall be construed to affect a tribe's or tribal organization's right to recover under any other applicable federal, state or tribal law.

3. Section 106 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. § 450j–1) is amended:

(c) The Secretary shall provide an annual report in writing on or before May 15 of each year to the Congress on the implementation of this Act. Such report shall include—

(1) an accounting of the total amounts of funds provided for each program and budget activity for direct program costs and contract support costs of tribal organizations under self-determination;

(2) an accounting of any deficiency of funds needed to provide required contract support costs to all contractors for the current fiscal year;

(3) the indirect costs rate and type of rate for each tribal organization negotiated with the appropriate Secretary;

(4) the direct cost base and type of base from which the indirect cost rate is determined for each tribal organization;

(5) the indirect cost pool amounts and the types of costs included in the indirect costs pools; and

(6) an accounting of any deficiency of funds needed to maintain the preexisting level of services to any tribes affected by contracting activities under this Act, and a statement of the amount of funds needed for transitional purposes to enable contractors to convert from a Federal fiscal year accounting cycle, as authorized by section 105(d).

* * * * * * *

(d)[(c)] Treatment in shortfalls in indirect cost recoveries.

* * * * * * *

(e)[(d)] Liability for indebtedness incurred before fiscal year 1992.

* * * * * * *

(f)[(e)] Limitation on remedies relating to cost disallowances.

* * * * * * *

(g)[(f)] Addition to contract of full amount contractor entitled.

* * * * * * *

(h)[(g)] Indirect costs for contracts for construction projects.

* * * * * * *

(i)[(h)] Indian Health Service and Bureau of Indian Affairs budget consultations.

* * * * * * *

(j)[(i)] Use of funds for matching or cost participation requirements.

* * * * * * *

(k)[(j)] Allowable uses of funds without approval of Secretary.

* * * * * * *

(l)[(k)] Suspension, withholding, or delay in payment of funds.

* * * * * * *

(m)[(l)] Use of program income earned.

* * * * * * *

(n)[(m)] Reduction of administrative and other responsibilities of Secretary; use of savings.

* * * * * * *

(o)[(n)] Rebudgeting by tribal organization.

4. Title III of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450f note) is hereby repealed.

[TITLE III—TRIBAL SELF-GOVERNANCE DEMONSTRATION PROJECT

SEC. 301. The Secretary of the Interior and the Secretary of Health and Human Services (hereafter in this title referred to as the "Secretaries") each shall, for a period not to exceed 18 years following enactment of this title (Oct. 5, 1988), conduct a research and demonstration project to be known as the Tribal Self-Governance Project according to the provisions of this title.

SEC. 302. (a) For each fiscal year, the Secretaries shall select thirty tribes to participate in the demonstration project as follows:

(1) a tribe that successfully completes a Self-Governance Planning Grant, authorized by Conference Report 100–498 to accompany H.J. Res. 395, One Hundredth Congress, first session (Pub. L. 100–202) shall be selected to participate in the demonstration project; and

(2) the Secretaries shall select, in such a manner as to achieve geographic representation, the remaining tribal participants from the pool of qualified applicants. In order to be in the pool of qualified applicants—

(A) the governing body of the tribe shall request participation in the demonstration project;

(B) such tribe shall have operated two or more mature contracts; and

(C) such tribe shall have demonstrated, for the previous three fiscal years, financial stability and financial management capability as evidenced by such tribe having no significant and material audit exceptions in the required annual audit of such tribe's self-determination contracts.

SEC. 303. (a) The Secretaries is (sic) directed to negotiate, and to enter into, an annual written funding agreement with the governing body of a participating tribal government that successfully completes its Self-Governance Planning Grant. Such annual written funding agreement—

(1) shall authorize the tribe to plan, conduct, consolidate, and administer programs, services and functions of the Depart-

ment of the Interior and the Indian Health Service of the Department of Health and Human Services that are otherwise available to Indian tribes or Indians, including but not limited to the Act of April 16, 1934 (48 Stat. 596) (25 U.S.C. 452 et seq.), as amended, and the Act of November 2, 1921 (42 Stat. 208) (25 U.S.C. 13).

(2) subject to the terms of the written agreement authorized by this title, shall authorize the tribe to redesign programs, activities, functions or services and to reallocate funds for such programs, activities, functions or services;

(3) shall not include funds provided pursuant to the Tribally Controlled Community College Assistance Act (Public Law 95–471) (25 U.S.C. 1801 et seq.), for elementary and secondary schools under the Indian School Equalization Formula pursuant to title XI of the Education Amendments of 1978 (Public Law 95–561, as amended) (25 U.S.C. 2001 et seq.), or for either the Flathead Agency Irrigation Division or the Flathead Agency Power Division: *Provided,* That nothing in this section shall affect the contractability of such divisions under section 102 of this Act (25 U.S.C. 450f);

(4) shall specify the services to be provided, the functions to be performed, and the responsibilities of the tribe and the Secretaries pursuant to this agreement;

(5) shall specify the authority of the tribe and the Secretaries, and the procedures to be used, to reallocate funds or modify budget allocations within any project year;

(6) shall, except as provided in paragraphs (1) and (2), provide for payment by the Secretaries to the tribe of funds from one or more programs, services, functions, or activities in an amount equal to that which the tribe would have been eligible to receive under contracts and grants under this Act (Pub. L. 93–638, see Short Title note under section 450 of this title), including direct program costs and indirect costs, and for any funds which are specifically related to the provision by the Secretaries of services and benefits to the tribe and its members: *Provided,* however, That funds for trust services to individual Indians are available under this written agreement only to the extent that the same services which would have been provided by the Secretaries are provided to individual Indians by the tribe:

(7) shall not allow the Secretaries to waive, modify or diminish in any way the trust responsibility of the United States with respect to Indian tribes and individual Indians which exists under treaties, Executive Orders and Acts of Congress;

(8) shall allow for retrocession of programs or portions thereof pursuant to section 105(e) of this Act (25 U.S.C. 450j(e)); and

(9) shall be submitted by the Secretaries ninety days in advance of the proposed effective date of the agreement to each tribe which is served by the agency which is serving the tribe which is a party to the funding agreement and to the Congress for review by the Committee on Indian Affairs of the Senate and the Committee on Natural Resources (now Committee on Resources) of the House of Representatives.

(b) For the year for which, and to the extent to which, funding is provided to a tribe pursuant to this title, such tribe—

(1) shall not be entitled to contract with the Secretaries for such funds under section 102 (25 U.S.C. 450f), except that such tribe shall be eligible for new programs on the same basis as other tribes; and

(2) shall be responsible for the administration of programs, services and activities pursuant to agreements under this title.

(c) At the request of the governing body of the tribe and under the terms of an agreement pursuant to subsectoin (a), the Secretaries shall provide funding to such tribe to implement the agreement.

(d) For the purpose of section 110 of this Act (25 U.S.C. 450m–1) the term "contract" shall also include agreements authorized by this title; except that for the term of the authorized agreements under this title; the provisions of section 2103 of the Revised Statutes of the United States (25 U.S.C. 81), and section 16 of the Act of June 18, 1934 (25 U.S.C. 476), shall not apply to attorney and other professional contracts by participating Indian tribal governments operating under the provisions of this title.

(e) To the extent feasible, the Secretaries shall interpret Federal laws and regulations in a manner that will facilitate the agreements authorized by this title.

(f) To the extent feasible, the Secretaries shall interpret Federal laws and regulations in a manner that will facilitate the inclusion of activities, programs, services, and functions in the agreements authorized by this title.

SEC. 304. The Secretaries shall identify, in the President's annual budget request to the Congress, any funds proposed to be included in the Tribal Self-Governance Project. The use of funds pursuant to this title shall be subject to specific directives or limitations as may be included in applicable appropriations Acts.

SEC. 305. The Secretaries shall submit to the Congress a written report on July 1 and January 1 of each of the five years following the date of enactment of this title (Oct. 5, 1988) on the relative costs and benefits of the Tribal Self-Governance Project. Such report shall be based on mutually determined baseline measurements jointly developed by the Secretaries and participating tribes, and shall separately include the views of the tribes.

SEC. 306. Nothing in this title shall be construed to limit or reduce in any way the services, contracts or funds that any other Indian tribe or tribal organization is eligible to receive under section 102 (25 U.S.C. 450f) or any other applicable Federal law and the provisions of section 110 of this Act (25 U.S.C. 450m-1) shall be available to any tribe or Indian organization which alleges that a funding agreement is in violation of this section.

SEC. 307. For the purpose of providing planning and negotiation grants to the ten tribes added by section 3 of the Tribal Self-Governance Demonstration Project Act to the number of tribes set forth by section 302 of the Act (as in effect before the date of enactment of this section (Dec. 4, 1991)), there is authorized to be appropriated $700,000.

SEC. 308. (a) The Secretary of Health and Human Services, in consultation with the Secretary of the Interior and Indian tribal

governments participating in the demonstration project under this title, shall conduct a study for the purpose of determining the feasibility of extending the demonstration project under this title to the activities, programs, functions, and services of the Indian Health Service. The Secretary shall report the results of such study, together with his recommendations, to the Congress within the 12-month period following the date of the enactment of the Tribal Self-Governance Demonstration Project Act (Dec. 4, 1991).

(b) The Secretary of Health and Human Services may establish within the Indian Health Service an office of self-governance to be responsible for coordinating the activities necessary to carry out the study required under subsection (a).

SEC. 309. The Secretary of the Interior shall conduct a study for the purpose of determining the feasibility of including in the demonstration project under this title those programs and activities excluded under section 303(a)(3). The Secretary of the Interior shall report the results of such study, together with his recommendations, to the Congress within the 12-month period following the date of the enactment of the Tribal Self-Governance Demonstration Project Act (Dec. 4, 1991).

SEC. 310. For the purposes of providing one year planning and negotiations grants to the Indian tribes identified by section 302, with respect to the programs, activities, functions, or services of the Indian Health Service, there are authorized to be appropriated such sums as may be necessary to carry out such purposes. Upon completion of an authorized planning activity or a comparable planning activity by a tribe, the Secretary is authorized to negotiate and implement a Compact of Self-Governance and Annual Funding Agreement with such tribe.]

5. The Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) is amended by adding at the end:

TITLE V—TRIBAL SELF-GOVERNANCE

SEC. 501. DEFINITIONS.

(a) IN GENERAL.—In this title:

(1) CONSTRUCTION PROJECT.—The term "construction project"—

(A) means an organized noncontinuous undertaking to complete a specific set of predetermined objectives for the planning, environmental determination, design, construction, repair, improvement, or expansion of buildings or facilities, as described in a construction project agreement; and

(B) does not include construction program administration and activities described in paragraphs (1) through (3) of section 4(m), that may otherwise be included in a funding agreement under this title.

(2) CONSTRUCTION PROJECT AGREEMENT.—The term "construction project agreement" means a negotiated agreement between the Secretary and an Indian tribe, that at a minimum—

(A) establishes project phase start and completion dates;

(B) defines a specific scope of work and standards by which it will be accomplished;

(C) identifies the responsibilities of the Indian tribe and the Secretary;

(D) addresses environmental considerations;

(E) identifies the owner and operations and maintenance entity of the proposed work;

(F) provides a budget;

(G) provides a payment process; and

(H) establishes the duration of the agreement based on the time necessary to complete the specified scope of work, which may be 1 or more years.

(3) GROSS MISMANAGEMENT.—The term "gross mismanagement" means a significant, clear, and convincing violation of a compact, funding agreement, or regulatory, or statutory requirements applicable to Federal funds transferred to an Indian tribe by a compact or funding agreement that results in a significant reduction of funds available for the programs, services, functions, or activities (or portions thereof) assumed by an Indian tribe

(4) INHERENT FEDERAL FUNCTIONS.—The term "inherent Federal functions' means those Federal functions which cannot legally be delegated to Indian tribes.

(5) INTER-TRIBAL CONSORTIUM.—The term "inter-tribal consortium" means a coalition of 2 or more separate Indian tribes that join together for the purpose of participating in self-governance, including tribal organizations.

(6) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(7) SELF-GOVERNANCE.—The term "self-governance" means the program of self-governance established under section 502.

(8) TRIBAL SHARE.—The term "tribal share" means an Indian tribe's portion of all funds and resources that support secretarial programs, services functions, and activities (or portions thereof) that are not required by the Secretary for performance of inherent Federal functions.

(b) INDIAN TRIBE.—In any case in which an Indian tribe has authorized another Indian tribe, an inter-tribal consortium, or a tribal organization to plan for or carry out programs, services, functions, or activities (or portions thereof) on its behalf under this title, the authorized Indian tribe, inter-tribal consortium, or tribal organization shall have the rights and responsibilities of the authorizing Indian tribe (except as otherwise provided in the authorizing resolution or in this title). In such event, the term "Indian tribe" as used in this title shall include such other authorized Indian tribe, inter-tribal consortium, or tribal organization.

SEC. 502. ESTABLISHMENT.

The Secretary of Health and Human Services shall establish and carry out a program within the Indian Health Service of the Department of Health and Human Services to be known as the "Tribal Self-Governance Program" in accordance with this title.

SEC. 503. SELECTION OF PARTICIPATING INDIAN TRIBES.

(A) CONTINUING PARTICIPATION.—Each Indian tribe that is participating in the Tribal Self-Governance Demonstration Project under title III on the date of enactment of this title may elect to participate in self-governance under this title under existing authority as reflected in tribal resolution.

(b) ADDITIONAL PARTICIPANTS.—

(1) IN GENERAL.—In addition to those Indian tribes participating in self-governance under subsection (a), each year an additional 50 Indian tribes that meet the eligibility criteria specified in subsection (c) shall be entitled to participate in self-governance.

(2) TREATMENT OF CERTAIN INDIAN TRIBES.—

(A) IN GENERAL.—An Indian tribe that has withdraw from participation in an inter-tribal consortium or tribal organization, in whole or in part, shall be entitled to participate in self-governance provided the Indian tribe meets the eligibility criteria specified in subsection (c).

(B) EFFECT OF WITHDRAWAL.—If an Indian tribe has withdrawn from participation in an inter-tribal consortium or tribal organization, that Indian tribe shall be entitled to its tribal share of funds supporting those programs, services, functions, and activities (or portions thereof) that the Indian tribe will be carrying out under the compact and funding agreement of the Indian tribe.

(C) PARTICIPATION IN SELF-GOVERNANCE.—In no event shall the withdrawal of an Indian tribe from an inter-tribal consortium or tribal organization affect the eligibility of the inter-tribal consortium or tribal organization to participate in self-governance.

(c) APPLICANT POOL.—

(1) IN GENERAL.—The qualified applicant pool for self-governance shall consist of each Indian tribe that—

(A) successfully completes the planning phase described in subsection (d);

(b) has requested participation in self-governance by resolution or other official action by the governing body of each Indian tribe to be served; and

(C) has demonstrated, for 3 fiscal years, financial stability and financial management capability.

(2) CRITERIA FOR DETERMINING FINANCIAL STABILITY AND FINANCIAL MANAGEMENT CAPACITY.—For purposes of this subsection, evidence that, during the 3-year period referred to in paragraph (1)(C), an Indian tribe had no uncorrected significant and material audit exceptions in the required annual audit of the Indian tribe's self-determination contracts or self-governance funding agreements with any Federal agency shall be conclusive evidence of the required stability and capability.

(d) PLANNING PHASE.—Each Indian tribe seeking participation in self-governance shall complete a planning phase. The planning phase shall be conducted to the satisfaction of the Indian tribe and shall include—

(1) legal and budgetary research; and

(2) internal tribal government planning and organizational preparation relating to the administration of health care programs.

(e) GRANTS.—Subject to the availability of appropriations, any Indian tribe meeting the requirements of paragraphs (1)(B) and (C) of subsection (c) shall be eligible for grants—

(1) to plan for participating in self-governance; and

(2) to negotiate the terms of participation by the Indian tribe or tribal organization in self-governance, as set forth in a compact and a funding agreement.

(f) RECEIPT OF GRANT NOT REQUIRED.—Receipt of a grant under subsection (e) shall not be a requirement of participation in self-governance.

SEC. 504. COMPACTS.

(a) COMPACT REQUIRED.—The Secretary shall negotiate and enter into a written compact with each Indian tribe participating in self-governance in a manner consistent with the Federal Government's trust responsibility, treaty obligations, and the government-to-government relationship between Indian tribes and the United States.

(b) CONTENTS.—Each compact required under subsection (a) shall set forth the general terms of the government-to-government relationship between the Indian tribe and the Secretary, including such terms as the parties intend shall control year after year. Such compacts may only be amended by mutual agreement of the parties.

(c) EXISTING COMPACTS.—An Indian tribe participating in the Tribal Self-Governance Demonstration Project under title III on the date of enactment of this title shall have the option at any time after the date of enactment of this title to—

(1) retain the Tribal Self-Governance Demonstration Project compact of that Indian tribe (in whole or in part) to the extent that the provisions of that compact are not directly contrary to any express provision of this title; or

(2) instead of retaining a compact or portion thereof under paragraph (1), negotiate a new compact in a manner consistent with the requirements of this title.

(d) TERM AND EFFECTIVE DATE.—The effective date of a compact shall be the date of the approval and execution by the Indian tribe or another date agreed upon by the parties, and shall remain in effect for so long as permitted by Federal law or until terminated by mutual written agreement, retrocession, or reassumption.

SEC. 505. FUNDING AGREEMENTS.

(a) FUNDING AGREEMENT REQUIRED.—The Secretary shall negotiate and enter into a written funding agreement with each Indian tribe participating in self-governance in a manner consistent with the Federal Government's trust responsibility, treaty obligations, and the government-to-government relationship between Indian tribes and the United States.

(b) CONTENTS.—

(1) IN GENERAL.—Each funding agreement required under subsection (a) shall, as determined by the Indian tribe, authorize the Indian tribe to plan, conduct, consolidate, administer, and receive full tribal share funding, including tribal shares of discretionary Indian Health Service competitive grants (excluding congressionally earmarked competitive grants) for all programs, services, functions, and activities (or portions thereof), that are carried out for the benefit of Indians because of their status as Indians without regard to the agency or office of the Indian Health Service (or of such other agency) within which the program, service, function, or activity (or portion thereof) is performed.

(2) INCLUSION OF CERTAIN PROGRAMS, SERVICES, FUNCTIONS, AND ACTIVITIES.—Such programs, services, functions, or activities (or portions thereof) include all programs, services, functions, activities (or portions thereof), including grants (which may be added to a funding agreement after award of such grants), with respect to which Indian tribes or Indians are primary or significant beneficiaries, administered by the Department of Health and Human Services through the Indian Health Service and grants (which may be added to a funding agreement after award of such grants) and all local, field, service unit, area, regional, and central headquarters or national office functions administered under the authority of—

(A) the Act of November 2, 1921 (42 Stat. 208, chapter 115; 25 U.S.C. 13);

(B) the Act of April 16, 1934 (48 Stat. 596, chapter 147; 25 U.S.C. 452 et seq.);

(C) the Act of August 5, 1954 (68 Stat. 674, chapter 658);

(D) the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.);

(E) The Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2401 et seq.);

(F) any other Act of Congress authorizing any agency of the Department of Health and Human Services to administer, carry out, or provide financial assistance to such a program, service, function or activity (or portions thereof) described in this section that is carried out for the benefit of Indians because of their status as Indians; or

(G) any other Act of Congress authorizing such a program, service, function, or activity (or portions thereof) carried out for the benefit of Indians under which appropriations are made available to any agency other than an agency within the Department of Health and Human Services, in any case in which the Secretary administers that program, service, function, or activity (or portion thereof).

(c) INCLUSION IN COMPACT OR FUNDING AGREEMENT.—It shall not be a requirement that an Indian tribe or Indians be identified in the authorizing statute for a program or element of a program to be eligible for inclusion in a compact or funding agreement under this title.

(d) FUNDING AGREEMENT TERMS.—Each funding agreement under this title shall set forth—

(1) terms that generally identify the programs, services, functions, and activities (or portions thereof) to be performed or administered; and

(2) for the items identified in paragraph (1)—

(A) the general budget category assigned;

(B) the funds to be provided, including those funds to be provided on a recurring basis;

(C) the time and method of transfer of the funds;

(D) the responsibilities of the Secretary; and

(E) any other provision with respect to which the Indian tribe and the Secretary agree.

(e) SUBSEQUENT FUNDING AGREEMENTS.—Absent notification from an Indian tribe that is withdrawing or retroceding the oper-

ation of 1 or more programs, services, functions, or activities (or portions thereof) identified in a funding agreement, or unless otherwise agreed to by the parties, each funding agreement shall remain in full force and effect until a subsequent funding agreement is executed, and the terms of the subsequent funding agreement shall be retroactive to the end of the term of the preceding funding agreement.

(f) EXISTING FUNDING AGREEMENTS.—Each Indian tribe participating in the Tribal Self-Governance Demonstration Project established under title III on the date of enactment of this title shall have the option at any time thereafter to—

(1) retain the Tribal Self-Governance Demonstration Project funding agreement of that Indian tribe (in whole or in part) to the extent that the provisions of that funding agreement are not directly contrary to any express provision of this title; or

(2) instead of retaining a funding agreement or portion thereof under paragraph (1), negotiate a new funding agreement in a manner consistent with the requirements of this title.

(g) STABLE BASE FUNDING.—At the option of an Indian tribe, a funding agreement may provide for a stable base budget specifying the recurring funds (including, for purposes of this provision, funds available under section 106(a)) to be transferred to such Indian tribe, for such period as may be specified in the funding agreement, subject to annual adjustment only to reflect changes in congressional appropriations by sub-sub activity excluding earmarks.

SEC. 506. GENERAL PROVISIONS.

(a) APPLICABILITY.—The provisions of this section shall apply to compacts and funding agreements negotiated under this title and an Indian tribe may, at its option, include provisions that reflect such requirements in a compact or funding agreement.

(b) CONFLICTS OF INTEREST.—Indian tribes participating in self-governance under this title shall ensure that internal measures are in place to address conflicts of interest in the administration of self-governance programs, services, functions, or activities (or portions thereof).

(c) AUDITS.—

(1) SINGLE AGENCY AUDIT ACT.—The provisions of chapter 75 of title 31, United States Code, requiring a single agency audit report shall apply to funding agreements under this title.

(2) COST PRINCIPLES.—An Indian tribe shall apply cost principles under the applicable Office of Management and Budget Circular, except as modified by section 106, or by any exemptions to applicable Office of Management and Budget Circulars subsequently granted by the Office of Management and Budget. No other audit or accounting standards shall be required by the Secretary. Any claim by the Federal Government against the Indian tribe relating to funds received under a funding agreement based on any audit under this subsection shall be subject to the provisions of section 106(f).

(d) RECORDS.—

(1) IN GENERAL.—Unless an Indian tribe specifies otherwise in the compact or funding agreement, records of the Indian tribe shall not be considered Federal records for purposes of chapter 5 of title 5, United States Code.

(2) RECORDKEEPING SYSTEM.—The Indian tribe shall maintain a recordkeeping system, and, after 30 days advance notice, provide the Secretary with reasonable access to such records to enable the Department of Health and Human Services to meet its minimum legal recordkeeping system requirements under sections 3101 through 3106 of title 44, United States Code.

(e) REDESIGN AND CONSOLIDATION.—An Indian tribe may redesign or consolidate programs, services, functions, and activities (or portions thereof) included in a funding agreement under section 505 and reallocate or redirect funds for such programs, services, functions, and activities (or portions thereof) in any manner which the Indian tribe deems to be in the best interest of the health and welfare of the Indian community being served, only if the redesign or consolidation does not have the effect of denying eligibility for services to population groups otherwise eligible to be served under Federal law.

(f) RETROCESSION.—An Indian tribe may retrocede, fully or partially, to the Secretary programs, services, functions, or activities (or portions thereof) included in the compact or funding agreement. Unless the Indian tribe rescinds the request for retrocession, such retrocession will become effective within the timeframe specified by the parties in the compact of funding agreement. In the absence of such a specification, such retrocession shall become effective on—

(1) the earlier of—

(A) 1 year after the date of submission of such request; or

(B) the date on which the funding agreement expires; or

(2) such date as may be mutually agreed upon by the Secretary and the Indian tribe.

(g) WITHDRAWAL.—

(1) PROCESS.—

(A) IN GENERAL.—An Indian tribe may fully or partially withdraw from a participating inter-tribal consortium or tribal organization its share of any program, function, service, or activity (or portions thereof) included in a compact of funding agreement.

(B) EFFECTIVE DATE.—The withdrawal referred to in subparagraph (A) shall become effective within the timeframe specified in the resolution which authorizes transfer to the participating tribal organization or inter-tribal consortium. In the absence of a specific timeframe set forth in the resolution, such withdrawal shall become effective on—

(i) the earlier of—

(I) 1 year after the date of submission of such request; or

(II) the date on which the funding agreement expires; or

(ii) such date as may be mutually agreed upon by the Secretary, the withdrawing Indian tribe, and the participating tribal organization or inter-tribal consortium that has signed the compact or funding agreement on behalf of the withdrawing Indian tribe, inter-tribal consortium, or tribal organization.

(2) DISTRIBUTION OF FUNDS.—When an Indian tribe or tribal organization eligible to enter into a self-determination contract under title I or a compact or funding agreement under this title fully or partially withdraws from a participating inter-tribal consortium or tribal organization—

(A) the withdrawing Indian tribe or tribal organization shall be entitled to its tribal share of funds supporting those programs, services, functions or activities (or portions thereof) that the Indian tribe will be carrying out under its own self-determination contract or compact and funding agreement (calculated on the same basis as the funds were initially allocated in the funding agreement of the inter-tribal consortium or tribal organization); and

(B) the funds referred to in subparagraph (A) shall be transferred from the funding agreement of the inter-tribal consortium or tribal organization, on the condition that the provisions of sections 102 and 105(i), as appropriate, shall apply to that withdrawing Indian tribe.

(3) REGAINING MATURE CONTRACT STATUS.—If an Indian tribe elects to operate all or some programs, services, functions, or activities (or portions thereof) carried out under a compact or funding agreement under this title through a self-determination contract under title I, at the option of the Indian tribe, the resulting self-determination contract shall be a mature self-determination contract.

(h) NONDUPLICATION.—For the period for which, and to the extent to which, funding is provided under this title or under the compact of funding agreement, the Indian tribe shall not be entitled to contract with the Secretary for such funds under section 102, except that such Indian tribe shall be eligible for new programs on the same basis as other Indian tribes.

SEC. 507. PROVISIONS RELATING TO THE SECRETARY.

(a) MANDATORY PROVISIONS.—

(1) HEALTH STATUS REPORTS.—Compacts or funding agreements negotiated between the Secretary and an Indian tribe shall include a provision that requires the Indian tribe to report on health status and service delivery—

(A) to the extent such data is not otherwise available to the Secretary and specific funds for this purpose are provided by the Secretary under the funding agreement; and

(B) if such reporting shall impose minimal burdens on the participating Indian tribe and such requirements are promulgated under section 517.

(2) REASSUMPTION.—

(A) IN GENERAL.—Compacts or funding agreements negotiated between the Secretary and an Indian tribe shall include a provision authorizing the Secretary to reassume operation of a program, service, function, or activity (or portions thereof) and associated funding if there is a specific funding relative to that program, service, function, or activity (or portion thereof) of—

(i) imminent endangerment of the public health caused by an act or omission of the Indian tribe, and

the imminent endangerment arises out of a failure to carry out the compact or funding agreement; or

(ii) gross mismanagement with respect to funds transferred to a tribe by a compact or funding agreement, as determined by the Secretary in consultation with the Inspector General, as appropriate.

(B) PROHIBITION.—The Secretary shall not reassume operation of a program, service, function, or activity (or portions thereof) unless—

(i) the Secretary has first provided written notice and a hearing on the record to the Indian tribe; and

(ii) the Indian tribe has not taken corrective action to remedy the imminent endangerment to public health or gross mismanagement.

(C) EXCEPTION.—

(i) IN GENERAL.—Notwithstanding subparagraph (B), the Secretary may, upon written notification to the Indian tribe, immediately reassume operation of a program, service, function, or activity (or portion thereof) if—

(I) the Secretary makes a finding of imminent substantial and irreparable endangerment of the public health caused by an act or omission of the Indian tribe; and

(II) the endangerment arises out of a failure to carry out the compact or funding agreement.

(ii) REASSUMPTION.—If the Secretary reassumes operation of a program, service, function, or activity (or portion thereof) under this subparagraph, the Secretary shall provide the Indian tribe with a hearing on the record not later than 10 days after such reassumption.

(D) HEARINGS.—In any hearing or appeal involving a decision to reassume operation of a program, service, function, or activity (or portion thereof), the Secretary shall have the burden of proof of demonstrating by clear and convincing evidence the validity of the grounds for the reassumption.

(b) FINAL OFFER.—In the event the Secretary and a participating Indian tribe are unable to agree, in whole or in part, on the terms of a compact or funding agreement (including funding levels), the Indian tribe may submit a final offer to the Secretary. Not more than 45 days after such submission, or within a longer time agreed upon by the Indian tribe, the Secretary shall review and make a determination with respect to such offer. In the absence of a timely rejection of the offer, in whole or in part, made in compliance with subsection (c), the offer shall be deemed agreed to by the Secretary.

(c) REJECTION OF FINAL OFFERS.—

(1) IN GENERAL.—If the Secretary rejects an offer made under subsection (b)(or 1 or more provisions or funding levels in such offer), the Secretary shall provide—

(A) a timely written notification to the Indian tribe that contains a specific finding that clearly demonstrates, or that is supported by a controlling legal authority, that—

(i) the amount of funds proposed in the final offer exceeds the applicable funding level to which the Indian tribe is entitled under this title;

(ii) the program, function, service, or activity (or portion thereof) that is the subject of the final offer is an inherent Federal function that cannot legally be delegated to an Indian tribe;

(iii) the Indian tribe cannot carry out the program, function, service, or activity (or portion thereof) in a manner that would not result in significant danger or risk to the public health; or

(iv) the Indian tribe is not eligible to participate in self-governance under section 503;

(B) technical assistance to overcome the objections stated in the notification required by subparagraph (A);

(C) the Indian tribe with a hearing on the record with the right to engage in full discovery relevant to any issue raised in the matter and the opportunity for appeal on the objections raised, except that the Indian tribe may, in lieu of filing such appeal, directly proceed to initiate an action in a Federal district court pursuant to section 110(a); and

(D) the Indian tribe with the option of entering into the severable portions of a final proposed compact of funding agreement, or provision thereof, (including a lesser funding amount, if any), that the Secretary did not reject, subject to any additional alterations necessary to conform the compact or funding agreement to the severed provisions.

(2) EFFECT OF EXERCISING CERTAIN OPTION.—If an Indian tribe exercises the option specified in paragraph (1)(D), that Indian tribe shall retain the right to appeal the Secretary's rejection under this section, and subparagraphs (A), (B), and (C) of that paragraph shall only apply to that portion of the proposed final compact, funding agreement, or provision thereof that was rejected by the Secretary.

(d) BURDEN OF PROOF.—With respect to any hearing or appeal or civil action conducted pursuant to this section, the Secretary shall have the burden of demonstrating by clear and convincing evidence the validity of the grounds for rejecting the offer (or a provision thereof) made under subsection (b).

(e) GOOD FAITH.—In the negotiation of compacts and funding agreements the Secretary shall at all times negotiate in good faith to maximize implementation of the self-governance policy. The Secretary shall carry out this title in a manner that maximizes the policy of tribal self-governance, in a manner consistent with the purposes specified in section 3 of the Tribal Self-Governance Amendments of 1999.

(f) SAVINGS.—To the extent that programs, functions, services, or activities (or portions thereof) carried out by Indian tribes under this title reduce the administrative or other responsibilities of the Secretary with respect to the operation of Indian programs and result in savings that have not otherwise been included in the amount of tribal shares and other funds determined under section 508(c), the Secretary shall make such savings available to the Indian tribes, inter-tribal consortia, or tribal organizations for the provi-

sion of additional services to program beneficiaries in a manner equitable to directly served, contracted, and compacted programs.

(g) TRUST RESPONSIBILITY.—The Secretary is prohibited from waving, modifying, or diminishing in any way the trust responsibility of the United States with respect to Indian tribes and individual Indians that exists under treaties, Executive orders, other laws, or court decisions.

(h) DECISIONMAKER.—A decision that constitutes final agency action and relates to an appeal within the Department of Health and Human Services conducted under subsection (c) shall be made either—

(1) by an official of the Department who holds a position at a higher organizational level within the Department than the level of the departmental agency in which the decision that is the subject of the appeal was made; or

(2) by an administrative judge.

SEC. 508. TRANSFER OF FUNDS.

(a) IN GENERAL.—Pursuant to the terms of any compact or funding agreement entered into under this title, the Secretary shall transfer to the Indian tribe all funds provided for in the funding agreement, pursuant to subsection (c), and provide funding for periods covered by joint resolution adopted by Congress making continuing appropriations, to the extent permitted by such resolutions. In any instance where a funding agreement requires an annual transfer of funding to be made at the beginning of a fiscal year, or requires semiannual or other periodic transfers of funding to be made commencing at the beginning of a fiscal year, the first such transfer shall be made not later than 10 days after the apportionment of such funds by the Office of Management and Budget to the Department, unless the funding agreement provides otherwise.

(b) MULTIYEAR FUNDING.—The Secretary is authorized and may employ, upon tribal request, multiyear funding agreements. References in this title to funding agreements shall include such multiyear funding agreements.

(c) AMOUNT OF FUNDING.—The Secretary shall provide funds under a funding agreement under this title in an amount equal to the amount that the Indian tribe would have been entitled to receive under self-determination contracts under this Act, including amounts for direct program costs specified under section 106(a)(1) and amounts for contract support costs specified under section 106(a)(2), (3), (5), and (6), including any funds that are specifically or functionally related to the provision by the Secretary of services and benefits to the Indian tribe or its members, all without regard to the organizational level within the Department where such functions are carried out.

(d) PROHIBITIONS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary is expressly prohibited from—

(A) failing or refusing to transfer to an Indian tribe is full share of any central, headquarters, regional, area, or service unit office or other funds due under this Act, except as required by Federal law;

(B) withholding portions of such funds for transfer over a period of years; and

(C) reducing the amount of funds required herein—

(i) to make funding available for self-governance monitoring or administration by the Secretary;

(ii) in subsequent years, except pursuant to—

(I) a reduction in appropriations from the previous fiscal year for the program or function to be included in a compact or funding agreement;

(II) a congressional directive in legislation or accompanying report;

(III) a tribal authorization;

(IV) a change in the amount of pass-through funds subject to the terms of the funding agreement; or

(V) completion of a project, activity, or program for which such funds were provided;

(iii) to pay for Federal functions, including Federal pay costs. Federal employee retirement benefits, automated data processing, technical assistance, and monitoring of activities under this Act; or

(iv) to pay for costs of Federal personnel displaced by self-determination contracts under this Act or self-governance;

(2) EXCEPTION.—The funds described in paragraph (1)(C) may be increased by the Secretary if necessary to carry out this Act or as provided in section 105(c)(2).

(e) OTHER RESOURCES.—In the event an Indian tribe elects to carry out a compact or funding agreement with the use of Federal personnel, Federal supplies (including supplies available from Federal warehouse facilities), Federal supply sources (including lodging, airline transportation, and other means of transportation including the use of interagency motor pool vehicles) or other Federal resources (including supplies, services, and resources available to the Secretary under any procurement contracts in which the Department is eligible to participate), the Secretary shall acquire and transfer such personnel, supplies, or resources to the Indian tribe.

(f) REIMBURSEMENT TO INDIAN HEALTH SERVICE.—With respect to functions transferred by the Indian Health Service to an Indian tribe, the Indian Health Service is authorized to provide goods and services to the Indian tribe, on a reimbursable basis, including payment in advance with subsequent adjustment. The reimbursements received from those goods and services, along with the funds received from the Indian tribe pursuant to this title, may be credited to the same or subsequent appropriation account which provided the funding, such amounts to remain available until expended.

(g) PROMPT PAYMENT ACT.—Chapter 39 of title 31, United States Code, shall apply to the transfer of funds due under a compact or funding agreement authorized under this title.

(h) INTEREST OR OTHER INCOME ON TRANSFERS.—An Indian tribe is entitled to retain interest earned on any funds paid under a compact or funding agreement to carry out governmental or health purposes and such interest shall not diminish the amount of funds, the Indian tribe is authorized to receive under its funding agreement in the year the interest is earned or in any subsequent fiscal year.

Funds transferred under this title shall be managed using the prudent investment standard.

(i) CARRYOVER OF FUNDS.—All funds paid to an Indian tribe in accordance with a compact or funding agreement shall remain available until expended. In the event that an Indian tribe elects to carry over funding from 1 year to the next, such carryover shall not diminish the amount of funds the Indian tribe is authorized to receive under its funding agreement in that or any subsequent fiscal year.

(j) PROGRAM INCOME.—All medicare, medicaid, or other program income earned by an Indian tribe shall be treated as supplemental funding to that negotiated in the funding agreement. The Indian tribe may retain all such income and expend such funds in the current year or in future years except to the extent that the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) provides otherwise for medicare and medicaid receipts. Such funds shall not result in any offset or reduction in the amount of funds the Indian tribe is authorized to receive under its funding agreement in the year the program income is received or for any subsequent fiscal year.

(k) LIMITATION OF COSTS.—All Indian tribe shall not be obligated to continue performance that requires an expenditure of funds in excess of the amount of funds transferred under a compact or funding agreement. If at any time the Indian tribe has reason to believe that the total amount provided for a specific activity in the compact or funding agreement is insufficient the Indian tribe shall provide reasonable notice of such insufficiency to the Secretary. If the Secretary does not increase the amount of funds transferred under the funding agreement, the Indian tribe may suspend performance of the activity until such time as additional funds are transferred.

SEC. 509. CONSTRUCTION PROJECTS.

(a) IN GENERAL.—Indian tribes participating in tribal self-governance may carry out construction projects under this title if they elect to assume all Federal responsibilities under the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.), the National Historic Preservation Act (16 U.S.C. 470 et seq.), and related provisions of law that would apply if the Secretary were to undertake a construction project, by adopting a resolution—

(1) designating or certifying officer to represent the Indian tribe and to assume the status of a responsible Federal official under such laws; and

(2) accepting the jurisdiction of the Federal court for the purposes of enforcement of the responsibilities of the responsible Federal official under such environmental laws.

(b) NEGOTIATIONS.—Construction project proposals shall be negotiated pursuant to the statutory process in section 105(m) and resulting construction project agreements shall be incorporated into funding agreements as addenda.

(c) CODES AND STANDARDS.—The Indian tribe and the Secretary shall agree upon and specify appropriate building codes and architectural and engineering standards (including health and safety) which shall be in conformity with nationally recognized standards for comparable projects.

(d) RESPONSIBILITY FOR COMPLETION.—the Indian tribe shall assume responsibility for the successful completion of the construction project in accordance with the negotiated construction project agreement.

(e) FUNDING.—Funding for construction projects carried out under this title shall be included in funding agreements as annual advance payments, with semiannual payments at the option of the Indian tribe. Annual advance and semiannual payment amounts shall be determined based on mutually agreeable project schedules reflecting work to be accomplished within the advance payment period, work accomplished and funds expended in previous payment periods, and the total prior payments. The Secretary shall include associated project contingency funds with each advance payment installment. The Indian tribe shall be responsible for the management of the contingency funds included in funding agreements.

(f) APPROVAL.—The Secretary shall have at least 1 opportunity to approve project planning and design documents prepared by the Indian tribe in advance of construction of the facilities specified in the scope of work for each negotiated construction project agreement or amendment thereof which results in a significant change in the original scope of work. The Indian tribe shall provide the Secretary with project progress and financial reports not less than semiannually. The Secretary may conduct onsite project oversight visits semiannually or on an alternate schedule agreed to by the Secretary and the Indian tribe.

(g) WAGES.—All laborers and mechanics employed by contractors and subcontractors in the construction, alteration, or repair, including painting or decorating of a building or other facilities in connection with construction projects undertaken by self-governance Indian tribes under this Act, shall be paid wages at not less than those prevailing wages on similar construction in the locality as determined by the Indian tribe.

(h) APPLICATION OF OTHER LAW.—Unless otherwise agreed to by the Indian tribe, no provision of the Office of Federal Procurement Policy Act, the Federal Acquisition Regulations issued pursuant thereto, or any other law or regulation pertaining to Federal procurement (including Executive orders) shall apply to any construction project conducted under this title.

SEC. 510. FEDERAL PROCUREMENT LAWS AND REGULATIONS.

Notwithstanding any other provision of law, unless expressly agreed to by the participating Indian tribe, the compacts and funding agreements entered into under this title shall not be subject to Federal contracting or cooperative agreement laws and regulations (including Executive orders and the regulations relating to procurement issued by the Secretary), except to the extent that such laws expressly apply to Indian tribes.

SEC. 511. CIVIL ACTIONS.

(a) CONTRACT DEFINED.—For the purposes of section 110, the term "contract" shall include compacts and funding agreements entered into under this title.

(b) APPLICABILITY OF CERTAIN LAWS.—Section 2103 of the Revised Statutes (25 U.S.C. 81) and section 16 of the Act of June 18, 1934 (48 Stat. 987; chapter 576; 25 U.S.C. 476), shall not apply to attor-

ney and other professional contracts entered into by Indian tribes participating in self-governance under this title.

(c) REFERENCES.—All references in this Act to section 1 of the Act of June 26, 1936 (49 Stat. 1967; chapter 831) are hereby deemed to include the first section of the Act of July 3, 1952 (66 Stat. 323, chapter 549; 25 U.S.C. 82a).

SEC. 512. FACILITATION.

(a) SECRETARIAL INTERPRETATION.—Except as otherwise provided by law, the Secretary shall interpret all Federal laws, Executive orders and regulations in a manner that will facilitate—

(1) the inclusion of programs, services, functions, and activities (or portions thereof) and funds associated therewith, in the agreements entered into under this section;

(2) the implementation of compacts and funding agreements entered into under this title; and

(3) the achievement of tribal health goals and objectives.

(b) REGULATION WAIVER.—

(1) IN GENERAL.—An Indian tribe may submit a written request to waive application of a regulation promulgated under section 517 or the authorities specified in section 505(b) for a compact or funding agreement entered into with the Indian Health Service under this title, to the Secretary identifying the applicable Federal regulation sought to be waived and the basis for the request.

(2) APPROVAL.—Not later than 90 days after receipt by the Secretary of a written request by an Indian tribe to waive application of a regulation for a compact or funding agreement entered into under this title, the Secretary shall either approve or deny the requested waiver in writing. A denial may be made only upon a specific finding by the Secretary that identified language in the regulation may not be waived because such waiver is prohibited by Federal law. A failure to approve or deny a waiver request not later than 90 days after receipt shall be deemed an approval of such request. The Secretary's decision shall be final for the Department.

(c) ACCESS TO FEDERAL PROPERTY.—In connection with any compact or funding agreement executed pursuant to this title or an agreement negotiated under the Tribal Self-Governance Demonstration Project established under title III, as in effect before the enactment of the Tribal Self-Governance Amendments of 1999, upon the request of an Indian tribe, the Secretary—

(1) shall permit an Indian tribe to use existing school buildings, hospitals, and other facilities and all equipment therein or appertaining thereto and other personal property owned by the government within the Secretary's jurisdiction under such terms and conditions as may be agreed upon by the Secretary and the Indian tribe for their use and maintenance;

(2) may donate to an Indian tribe title to any personal or real property found to be excess to the needs of any agency of the Department, or the General Services Administration, except that—

(A) subject to the provisions of subparagraph (B), title to property and equipment furnished by the Federal Government for use in the performance of the compact or funding agreement or purchased with funds under any compact or

funding agreement shall, unless otherwise requested by the Indian tribe, vest in the appropriate Indian tribe;

(B) if property described in subparagraph (A) has a value in excess of $5,000 at the time of retrocession, withdrawal, or reassumption, at the option of the Secretary upon the retrocession, withdrawal, or reassumption, title to such property and equipment shall revert to the Department of Health and Human Services; and

(C) all property referred to in subparagraph (A) shall remain eligible for replacement, maintenance, and improvement on the same basis as if title to such property were vested in the United States; and

(3) shall acquire excess or surplus Government personal or real property for donation to an Indian tribe if the Secretary determines the property is appropriate for use by the Indian tribe for any purpose for which a compact or funding agreement is authorized under this title.

(d) MATCHING OR COST-PARTICIPATION REQUIREMENT.—All funds provided under compacts, funding agreements, or grants made pursuant to this Act, shall be treated as non-Federal funds for purposes of meeting matching or cost participation requirements under any other Federal or non-Federal program.

(e) STATE FACILITATION.—States are hereby authorized and encouraged to enact legislation, and to enter into agreements with Indian tribes to facilitate and supplement the initiatives, programs, and policies authorized by this title and other Federal laws benefitting Indians and Indian tribes.

(f) RULES OF CONSTRUCTION.—Each provision of this title and each provision of a compact or funding agreement shall be liberally construed for the benefit of the Indian tribe participating in self-governance and any ambiguity shall be resolved in favor of the Indian tribe.

SEC. 513. BUDGET REQUEST.

(a) IN GENERAL.—

(1) IN GENERAL.—The President shall identify in the annual budget request submitted to Congress under section 1105 of title 31, United States Code, all funds necessary to fully fund all funding agreements authorized under this title, including funds specifically identified to fund tribal base budgets. All funds so appropriated shall be apportioned to the Indian Health Service. Such funds shall be provided to the Office of Tribal Self-Governance which shall be responsible for distribution of all funds provided under section 505.

(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to authorize the Indian Health Service to reduce the amount of funds that a self-governance tribe is otherwise entitled to receive under its funding agreement or other applicable law, whether or not such funds are apportioned to the Office of Tribal Self-Governance under this section.

(b) PRESENT FUNDING; SHORTFALLS.—In such budget request, the President shall identify the level of need presently funded and any shortfall in funding (including direct program and contract support costs) for each Indian tribe, either directly by the Secretary of

Health and Human Services, under self-determination contracts, or under compacts and funding agreements authorized under this title.

SEC. 514. REPORTS.

(a) ANNUAL REPORT.—

(1) IN GENERAL.—Not later than January 1 of each year after the date of enactment of the Tribal Self-Governance Amendments of 1999, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Resources of the House of Representatives a written report regarding the administration of this title.

(2) ANALYSIS.—The report under paragraph (1) shall include a detailed analysis of the level of need being presently funded or unfunded for each Indian tribe, either directly by the Secretary, under self-determination contracts under title I, or under compact the level of need by being presently funded or unfunded for each Indian tribe, either directly by the Secretary, under self-determination contract under title I, or under compacts and funding agreements authorized under this Act. In compiling reports pursuant to this section, the Secretary may not impose any reporting requirements on participating Indian tribes or tribal organizations, not otherwise provided in this Act.

(b) CONTENTS.—The report under subsection (a) shall—

(1) be compiled from information contained in funding agreements, annual audit reports, and data of the Secretary regarding the disposition of Federal funds; and

(2) identify—

(A) the relative costs and benefits of self-governance;

(B) with particularity, all funds that are specifically or functionally related to the provision by the Secretary of services and benefits to self-governance Indian tribes and their members;

(C) the funds transferred to each self-governance Indian tribe and the corresponding reduction in the Federal bureaucracy;

(D) the funding formula for individual tribal shares of all headquarters funds, together with the comments of affected Indian tribes or tribal organizations, developed under subsection (c); and

(E) amounts expended in the preceding fiscal year to carry out inherent Federal functions, including an identification of those functions by type and location;

(3) contain a description of the method or methods (or any revisions thereof) used to determine the individual tribal share of funds controlled by all components of the Indian Health Service (including funds assessed by any other Federal agency) for inclusion in self-governance compacts or funding agreements;

(4) before being submitted to Congress, be distributed to the Indian tribes for comment (with a comment period of no less than 30 days, beginning on the date of distribution); and

(5) include the separate views and comments of the Indian tribes or tribal organizations.

(c) REPORT ON FUND DISTRIBUTION METHOD.—Not later than 180 days after the date of enactment of the Tribal Self-Governance

Amendments of 1999, the Secretary shall, after consultation with Indian tribes, submit a written report to the Committee on Resources of the House of Representatives and the Committee on Indian Affairs of the Senate which describes the method or methods used to determine the individual tribal share of funds controlled by all components of the Indian Health Service (including funds assessed by any other Federal agency) for inclusion in self-governance compacts or funding agreements.

SEC. 515. DISCLAIMERS.

(a) NO FUNDING REDUCTION.—Nothing in this title shall be construed to limit or reduce in any way the funding for any program, project, or activity serving an Indian tribe under this or other applicable Federal law. Any Indian tribe that alleges that a compact or funding agreement is in violation of this section may apply the provisions of section 110.

(b) FEDERAL TRUST AND TREATY RESPONSIBILITIES.—Nothing in this Act shall be construed to diminish in any way the trust responsibility of the United States to Indian tribes and individual Indians that exists under treaties, Executive orders, or other laws and court decisions.

(c) TRIBAL EMPLOYMENT.—For purposes of section 2(2) of the Act of July 5, 1935 (49 Stat. 450, chapter 372) (commonly known as the 'National Labor Relations Act'), an Indian tribe carrying out a self-determination contract, compact, annual funding agreement, grant, or cooperative agreement under this Act shall not be considered an employer.

(d) OBLIGATIONS OF THE UNITED STATES.—The Indian Health Service under this Act shall neither bill nor charge those Indians who may have the economic means to pay for services, nor require any Indian tribe to do so.

SEC. 516. APPLICATION OF OTHER SECTIONS OF THE ACT.

(a) MANDATORY APPLICATION.—All provisions of sections 5(b), 6, 7, 102 (c) and (d), 104, 105 (k) and (l), 106 (a) through (k), and 111 of this Act and section 314 of Public Law 101–512 (coverage under chapter 171 of title 28, United States Code, commonly known as the 'Federal Tort Claims Act'), to the extent not in conflict with this title, shall apply to compacts and funding agreements authorized by this title.

(b) DISCRETIONARY APPLICATION.—At the request of a participating Indian tribe, any other provision of title I, to the extent such provision is not in conflict with this title, shall be made a part of a funding agreement or compact entered into under this title. The Secretary is obligated to include such provision at the option of the participating Indian tribe or tribes. If such provision is incorporated it shall have the same force and effect as if it were set out in full in this title. In the event an Indian tribe requests such incorporation at the negotiation stage of a compact or funding agreement, such incorporation shall be deemed effective immediately and shall control the negotiation and resulting compact and funding agreement.

SEC. 517. REGULATIONS.

(a) IN GENERAL.—

(1) PROMULGATION.—Not later than 90 days after the date of enactment of the Tribal Self-Governance Amendments of 1999,

the Secretary shall initiate procedures under subchapter III of chapter 5 of title 5, United States Code, to negotiate and promulgate such regulations as are necessary to carry out this title.

(2) PUBLICATION OF PROPOSED REGULATIONS.—Proposed regulations to implement this title shall be published in the Federal Register by the Secretary no later than 1 year after the date of enactment of the Tribal Self-Governance Amendments of 1999.

(3) EXPIRATION OF AUTHORITY.—The authority to promulgate regulations under paragraph (1) shall expire 21 months after the date of enactment of the Tribal Self-Governance Amendments of 1999.

(b) COMMITTEE.—

(1) IN GENERAL.—A negotiated rulemaking committee established pursuant to section 565 of title 5, United States Code, to carry out this section shall have as its members only Federal and tribal government representatives,, a majority of whom shall be nominated by and be representatives of Indian tribes with funding agreements under this Act.

(2) REQUIREMENTS.—The committee shall confer with, and accommodate participation by, representatives of Indian tribes, inter-tribal consortia, tribal organizations, and individual tribal members.

(c) ADAPTATION OF PROCEDURES.—The Secretary of Health and Human Services shall adopt the negotiated rulemaking procedures to the unique context of self-governance and the government-to-government relationship between the United States and Indian tribes.

(d) EFFECT.—The lack of promulgated regulations shall not limit the effect of this title.

(e) EFFECT OF CIRCULARS, POLICIES, MANUALS, GUIDANCES, AND RULES.—Unless expressly agreed to by the participating Indian tribe in the compact or funding agreement, the participating Indian tribe shall not be subject to any agency circular, policy, manual, guidance, program regulation or rule adopted by the Indian Health Service, except for the eligibility provisions of section 105(g) and regulations promulgated under section 517.

SEC. 518. APPEALS.

In any appeal (including civil actions) involving decisions made by the Secretary under this title, the Secretary shall have the burden of proof of demonstrating by clear and convincing evidence—

(1) the validity of the grounds for the decision made; and

(2) that the decision is fully consistent with provisions and policies of this title.

SEC. 519. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out this title.

(b) ASSUMPTION OF NEW OR EXPANDED PROGRAMS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, in fiscal year 2000 the Secretary may enter into contracts, compacts or annual funding agreements with an Indian tribe or tribal organization to operate a new or expanded program, service, function or activity of the Indian Health Service pursuant

to the Indian Self-Determination and Education Assistance Act, P.L. 93–638, as amended (25 U.S.C. 450 et seq.) only if—

(A) and to the extent sufficient contract support costs are appropriated and are specifically earmarked for the assumption of new or expanded programs, functions, services or activities; and

(B) the Indian Health Service determines that the percentage of contract support costs provided to existing contractors will not be reduced as a result of the assumption of any new or expanded programs, functions, services or activities under this title.

(2) Nothing in this section shall be construed to affect the allocation of funds other than contract support cost funds.

2. The Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) is amended by adding at the end the following:

TITLE VI—TRIBAL SELF-GOVERNANCE—DEPARTMENT OF HEALTH AND HUMAN SERVICES

SEC. 601. DEFINITIONS.

(a) IN GENERAL.—In this title, the Secretary may apply the definitions contained in title V.

(b) OTHER DEFINITIONS.—In this title:

(1) AGENCY.—The term "agency" means any agency or other organizational unit of the Department of Health and Human Services, other than the Indian Health Service.

(2) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

SEC. 602. DEMONSTRATION PROJECT FEASIBILITY.

(a) STUDY.—The Secretary shall conduct a study to determine the feasibility of a tribal self-governance demonstration project for appropriate programs, services, functions, and activities (or portions thereof) of the agency.

(b) CONSIDERATIONS.—In conducting the study, the Secretary shall consider—

(1) the probable effects on specific programs and program beneficiaries of such a demonstration project;

(2) statutory, regulatory, or other impediments to implementation of such a demonstration project;

(3) strategies for implementing such a demonstration project;

(4) probable costs or savings associated with such a demonstration project;

(5) methods to assure quality and accountability in such a demonstration project; and

(6) such other issues that may be determined by the Secretary or developed through consultation pursuant to section 603.

(c) REPORT.—Not later than 18 months after the date of enactment of this title, the Secretary shall submit a report to the Committee on Indian Affairs of the Senate an the Committee on Resources of the House of Representatives. The report shall contain—

(1) the results of the study under this section;

(2) a list of programs, services, functions, and activities (or portions thereof) within each agency with respect to which it

would be feasible to include in a tribal self-governance demonstration project;

(3) a list of programs, services, functions, and activities (or portions thereof) included in the list provided pursuant to paragraph (2) that could be included in a tribal self-governance demonstration project without amending statutes, or waiving regulations that the Secretary may not waive;

(4) a list of legislative actions required in order to include those programs, services, functions, and activities (or portions thereof) included in the list provided pursuant to paragraph (2) but not included in the list provided pursuant to paragraph (3) in a tribal self-governance demonstration project; and

(5) any separate views of tribes and other entities consulted pursuant to section 603 related to the information provided pursuant to paragraphs (1) through (4).

SEC. 603. CONSULTATION.

(a) STUDY PROTOCOL.—

(1) CONSULTATION WITH INDIAN TRIBES.—The Secretary shall consult with Indian tribes to determine a protocol for consultation under subsection (b) prior to consultation under such subsection with the other entities described in such subsection.

(2) REQUIREMENTS FOR PROTOCOL.—The protocol shall require, at a minimum, that—

(A) the government-to-government relationship with Indian tribes forms the basis for the consultation process;

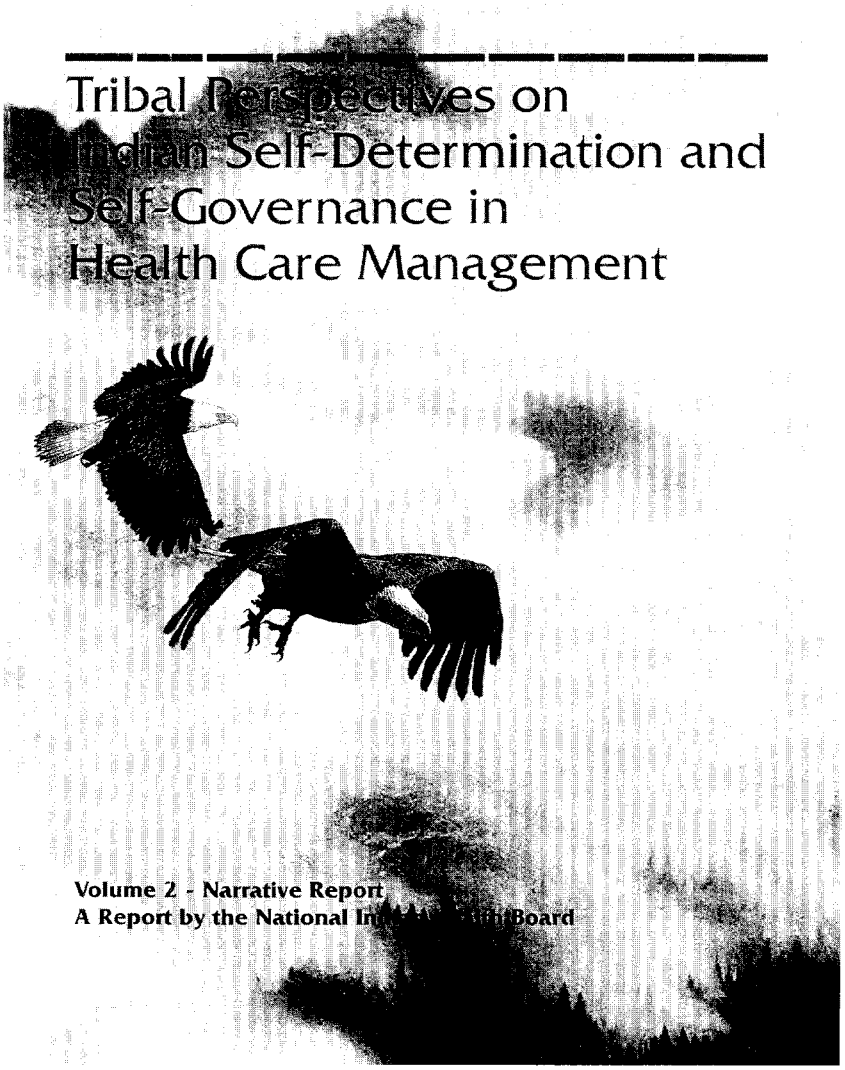
(B) the Indian tribes and the Secretary jointly conduct the consultations required by this section; and

(C) the consultation process allows for separate and direct recommendations from the Indian tribes and other entities described in subsection (b).

(b) CONDUCTING STUDY.—In conducting the study under this title, the Secretary shall consult with Indian tribes, State, counties, municipalities, program beneficiaries, and interested public interest groups, and may consult with other entities as appropriate.

SEC. 604 AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated for fiscal years 2000 and 2001 such sums as may be necessary to carry out this title. Such sums shall remain available until expended.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A Report by the National In

NATIONAL INDIAN HEALTH BOARD MEMBERS, ALTERNATES, and DELEGATES DURING THE COMPLETION OF THIS PROJECT

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Muriel Segundo
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The National Indian Health Board (NIHB) is a non-profit organization representing all federally-recognized tribes in the United States in advocating for the improvement of health care delivery. NIHB members and alternates represent each of the 12 Indian Health Service Areas, and are generally elected at-large by tribal governmental officials within each Area. NIHB was founded by tribal leaders in 1972 to ensure that the treaty commitments promised to our ancestors are upheld in all matters related to health and human services. The project "Empowering Tribes to Participate in the Development of National Health Policy" was funded by the Department of Health and Human Services Administration for Native Americans grant number 90NA1792/01 and the Indian Health Service Cooperative Agreement number ISU 000694-04-11. The project included the research used to produce this report, as well as evaluation and improvement of NIHB's performance in its mission and enhancement of NIHB's ability to communicate with tribes. For additional information or copies contact the National Indian Health Board, 1385 S. Colorado Boulevard, Suite A-707, Denver, CO 80222, (303) 759-3075, fax: (303) 759-3674. Project completed 1998.

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CHAPTER 1

INTRODUCTION AND BACKGROUND

PURPOSE OF PROJECT

It has been 25 years since the federal policy of Indian self-determination was first conceptualized in the form that was ultimately enacted into P.L. 93-638, the Indian Self-Determination Act, in 1975. Since that time, there have been amendments to the law and self-governance demonstration projects have begun. Through both self-determination contracting and self-governance compacting, tribes have options to withdraw shares of Area Offices and Headquarters Offices of the Indian Health Service (IHS). During this time there have been many other changes in the Indian health care system, including federal budget reductions, re-design of the system under the guidance of the Indian Health Design Team (IHDT), re-organization of the federal government, changes in health care financing, and the addition of newly recognized tribes.

It is difficult to distinguish the impacts of these changes from one another. At least partially for this reason, there has never been a broad national assessment of the impacts of tribal control of health care delivery systems. This project provides such an assessment. While it is admittedly a first step, the assessment this project provides is the result of information gathered on the effects of tribal control from those in the most appropriate position to evaluate the impacts: the tribes themselves.

In the absence of quantitative information, the concerns of those trying, for whatever reason, to protect the status quo have led to beliefs that when tribes withdraw their shares, they are hurting other tribes; that the quality of care declines and prevention programs are eliminated when tribes assume control of health care delivery systems; and that health care professionals do not want to work for tribes. Are these myths or reality? Are there "winners" and "losers" among tribes with different types of health care delivery systems?

The purpose of this study is to explore these issues from a tribal perspective and to gather the evidence to confirm or deny these fears and myths. This report includes a financial analysis, as well as an assessment of the changes in services and facilities, management changes and challenges, and the impacts on quality of care. This study also considers the opportunities and barriers to contracting and compacting, the issue of tribal sovereignty, future trends, and recommendations from tribal leaders.

This report is organized into three volumes. Volume 1 is the executive summary. Volume 2 is the narrative report. Volume 3 contains charts and graphs of the supporting data for Volume 2.

Every federally-recognized tribe was encouraged to participate in this study. A total of 210 tribes and tribal organizations participated in the study, representing more than 38 percent of the 554 federally-recognized tribes. While the level of participation

varies from Area to Area, the overall participation in this study is greater than in any other published report.

HISTORY OF SELF-DETERMINATION AND SELF-GOVERNANCE POLICIES

The roots of self-determination and self-governance policies lie in the desires of many tribes to deliver federal Indian programs and services to their own people, in the historical desire of Congress that tribes become self-sufficient, and in a desire on the part of the Nixon presidential administration that a policy of Indian self-determination replace the earlier policy which focussed on terminating the federal responsibility towards Indian tribes. The congruence of these forces led to P.L. 93-638, the "Indian Self-Determination and Education Assistance Act of 1975."[1] This law allows tribes to develop their own governmental capacities by directing the Departments of Interior (DOI) and of Health and Human Services (DHHS), upon the request of any tribe, to enter into self-determination contracts with tribal organizations for planning, conducting, and administering programs provided by the federal government for the benefit of Indians. In the ensuing development and refinement of the self-determination and self-governance policies, changes typically occurred as responses to implementation within the DOI, but eventually impacted both Interior and DHHS policy and procedures. Advances in the scope of control available to tribes often developed under self-governance, and were subsequently extended to self-determination contracts.

Development of the initial self-determination contracting process of the Act, know known as "Title I", was very slow. The Bureau of Indian Affairs (BIA) retained ultimate control and made budget allocation decisions under Title I. The contracting process as implemented in the early years was very burdensome, and many tribal leaders remained unsatisfied with the self-determination policy overall. Some tribal leaders objected that the purposes of the Act were not being carried out in practice. Other tribal leaders worried that contracting for programs would lead to a hidden type of termination,[2] or "termination by appropriation."[3]

Problems surrounding implementation of self-determination came to a head in late 1987, when allegations of extreme waste and mismanagement in the federal Indian bureaucracy became a topic of national attention.[4] In response to the allegations, the Interior and Related Agencies Appropriations Subcommittee of the House of Representatives held an oversight hearing in November of 1987.

During the oversight hearing, DOI officials proposed that the funds appropriated to the BIA should be turned over to the tribes, and the tribes could manage their own affairs. This proposal resonated with a more meaningful self-determination policy as advocated

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[1] P.L. 93-638, 88 Stat. 2203, 25 U.S.C. §§ 450-458 (as amended) ("Self-Determination Act").
[2] Indian Self-Determination and Education Assistance Act Implementation, Hearings before the United States Senate Select Committee on Indian Affairs, 95th Congress, 1st Session, on Implementation of Public Law 93-638 (1977)
[3] Put roughly, the fear is that when tribes take over responsibility to administer programs and the sole remaining activity of the federal government is funding for the programs, it would be very easy for the federal government to attempt to absolve itself of any further responsibility for the tribes, and to cut funding.
[4] This national media attention was largely due to a series of articles in the *Arizona Republic*, a newspaper located in Phoenix, Arizona. The series, "Fraud in Indian Country," ran in the Fall of 1987.

by several tribal leaders at the time. By mid-December 1987, tribal representatives had met with the DOI and other top officials, and ten tribes had agreed to voluntarily test the proposed new "self-governance" program.

But fears of termination via the self-determination/self-governance process, as had been expressed earlier by some tribal leaders, were heightened when DOI, through then-Commissioner of Indian Affairs Ross Swimmer, came out with its proposal for the self-governance program in December 1987: Section 209 of the Self-Determination Act Amendments. Section 209 provided for a direct transfer of funds currently contracted by tribes, with a waiver of the trust responsibility of the United States for any programs assumed by the tribes. The proposal of Section 209 came as a surprise to tribes, because there had been no prior consultation with tribes prior to doing so. Tribes were not willing to jeopardize their trust and treaty relationships with the United States so easily.

The less than straightforward approach adopted by the DOI when it proposed Section 209 was met with unanimous opposition by tribal leaders nationwide. The tribes that had been working with the United States to develop a self-governance program made a counterproposal to Section 209, designed to ensure that the federal government maintained its trust responsibility. The tribal proposal, the "Tribal Self-Governance Demonstration Project," became Title III of the Self-Determination Act when the Indian Self-Determination and Education Assistance Act Amendments of 1988[5] was passed. Under Title III, self-governance compacting would be tested within the Department of Interior, with the participation of 20 tribes that were to be selected by the Secretary of Interior.[6] Title III also contains provisions clearly protecting the trust and treaty relationship between the United States and tribes, thereby alleviating the main concerns over Section 209.

Title III paved the way for major changes in the manner in which tribes could administer federal programs they choose to assume. The 1988 Amendments contained provisions reinforcing the right of tribes to recover the direct and indirect costs of contracting, so that services would not be diminished as a result of a tribal decision to contract. Under Title III tribes may redesign programs and reallocate funds among programs with virtually no federal approval or supervision, while under Title I tribes must receive approval from the Agency prior to redesigning programs or reallocating funds.[7]

Congress also used the 1988 Amendments to address the need for streamlining the contracting process, by amending the Self-Determination Act to increase tribal participation in federal Indian programs. The Secretaries at DOI and DHHS were directed to consult with tribes when they drafted regulations to implement the amendments.

Implementation of the Self-Governance Demonstration Project got off to a sluggish start within the BIA. While the BIA treated self-governance as an administrative

[5] P.L. 100-472, 102 Stat. 2285.
[6] Title III of the Indian Self-Determination and Education Assistance Act, as added by the 1988 amendments, P.L. 100-472, 25 U.S.C. § 450f note.
[7] It should be noted that, before a tribe may enter into a self-governance compact, it must first successfully complete three years of tribal management under self-determination contracts. 25 U.S.C. § 458bb(c)(3).

nuisance, congressional support for the policy remained strong, particularly within the Interior and Related Agencies Appropriations Subcommittee in the House of Representatives. At the request of tribes, Congress provided funds in 1991 for the establishment of an Office of Self-Governance within DOI's Office of the Secretary.

Congressional support for the Demonstration Project continued in 1991. Funding for 1992 was increased by $2 million to cover self-governance planning, negotiations, implementation and shortfall expenses, as well as for the continuation of the Self-Governance Communication and Education initiative administered by the Lummi Nation. Through the Tribal Self Governance Demonstration Project Act of 1991[8] Congress directed the Indian Health Service to initiate self-governance budget research and agency planning activities with the 17 tribes that had existing compacts with the DOI. Management of the research from the tribal perspective was undertaken for the most part by the Cherokee Nation of Oklahoma, but all 17 tribes participated in the IHS planning process and negotiations. P.L. 102-184 also expanded the Demonstration Project within DOI to include 30 tribes, and the Demonstration Project was extended to include 30 tribes within IHS in 1992.[9]

The next major developmental steps in the self-determination/self-governance policy came when President Clinton signed P.L. 103-413 in October 1994. Title I of this legislation was called the Indian Self-Determination Contract Reform Act. It was a result of congressional dissatisfaction with the failure of the DOI and DHHS to develop satisfactory regulations implementing the 1988 amendments intended to increase tribal participation in the management of federal Indian programs. In Title I of the 1994 Act, Congress imposed a negotiated rulemaking process on the Secretaries of DOI and DHHS. For the first time, this process gave tribes a significant role in the development of federal regulations to implement contracting reforms. The results of this negotiated rulemaking, which involved 48 tribal representatives[10], were joint final regulations for the awarding of contracts and grants under the Self-Determination Act published in the Federal Register on June 24, 1996.[11] Another important effect of the 1994 amendments was that a number of advantages previously available only to self-governance compacting tribes, like the availability of tribal shares, were extended to self-determination contracting tribes.

Title II of the 1994 Amendments was the Tribal Self-Governance Act, which eventually became Title IV of the Self Governance Act. In this Act, Congress expressed its satisfaction with the BIA Self-Governance Demonstration Project, and Self-Governance was made a permanent program within the Department of Interior. The Secretary of Interior was authorized to select up to 20 new tribes per year for participation in self-governance.[12] In order to ensure tribes a direct role in promulgating the regulations for implementation of the self-governance program within the DOI, the law provided that if a majority of self-governance tribes so requested, the Secretary shall initiate negotiated rulemaking with the affected tribes and that a majority of the negotiated

[8] P.L. 102-184, 105 Stat. 1278.
[9] Indian Health Amendments of 1992, P.L. 102-573, 106 Stat. 4590.
[10] Three of the four co-chairs of the Negotiated Rulemaking Committee were tribal representatives and members of the National Indian Health Board Executive Board: Julia Davis, Ed Mouss, and Buford Rolin.
[11] 61 Fed. Reg. 32482, June 24, 1996
[12] 25 U.S.C. § 458bb

rulemaking committee shall be representatives of such tribes.[13] Title II also provided for participation of all non-BIA Interior programs in self-governance, and for the establishment of programmatic targets to transfer programs to tribes. The Act re-emphasized that there was no intent on the part of Congress to diminish the federal trust responsibility to Indians or Indian tribes.[14]

Technical amendments bills furthered the development of the self-governance program in 1996. P.L. 104-109[15] allowed, at tribal choice, any provision of Title I to be incorporated into either a Title III or Title IV self-governance compact or funding agreement. The FY 1997 Omnibus Appropriations Bill, signed by President Clinton on September 30, 1996, provided appropriations for DOI and allowed for up to 50 new tribes per year to be selected to join DOI's self-governance program.

Recent developments in self-determination/self-governance policy continue to center around self-governance. As a result of what was primarily an initiative driven by self-governance tribes, a Title V has been drafted for the Self-Determination Act. This draft would make self-governance a permanent program in IHS. On June 7, 1997, Representative George Miller of California introduced H.R. 1833, the Tribal Self-Governance Amendments of 1997. If enacted, the bill in its current form would allow for all tribes currently participating in the Demonstration Project to be grandfathered into a permanent Self-Governance Program, if they so choose. It would also allow for up to 50 new tribes to join the program per year. The bill would also allow, but not require, the Secretary of DHHS to negotiate demonstration self-governance projects with tribes for the operation non-IHS programs within the Department. The Senate has scheduled hearings on Title V for the spring of 1998, and a version comparable to H.R. 1833 will likely be introduced at about the same time.

[13] 25 U.S.C. § 458gg.
[14] 25 U.S.C. § 458ff(b).
[15] 110 Stat. 776.

CHAPTER 2

RESEARCH APPROACH AND METHODS

This study includes four different types of research: (1) a review of previous studies; (2) a financial analysis; (3) a survey of tribes; and (4) an analysis of training needs. The survey of tribes was the most critical element of the study, since it provided the tribal perspectives necessary to accomplish the goal of the study: evaluating the impacts of tribal choices in health care from a tribal perspective. Because this survey presents a tribal perspective, it gives equal weight to every federally-recognized tribe regardless of the number of members enrolled, the amount of the IHS budget allocated to the tribe, or the number of facilities serving the tribe.

An Advisory Committee was formed to help guide the development of the tribal survey and to review draft reports. Every Area Health Board and all members of the National Indian Health Board were invited to participate in the Advisory Committee or to designate a person to represent them on the Advisory Committee. After the initial formation of the Advisory Committee, additional members were solicited to assure that all Areas and all types of tribes were represented. A list of Advisory Committee members is provided at the beginning of this report. Advisory Committee meetings were held by teleconference.

REVIEW OF PREVIOUS STUDIES

The search for previous studies included internal documents prepared by or for the Indian Health Service, as well as journals and other published literature. Reports and articles were reviewed to determine whether any information was pertinent to this study. Very little research has been done on this subject and most sources are based on very limited personal observations and anecdotal information, rather than a quantitative analysis. A narrative summary is provided in Chapter 3, *Review of Previous Studies.*

FINANCIAL ANALYSIS

Financial data were gathered from published sources and from the Department of Health and Human Services (DHHS) Financial Reporting System. Data from this system for the period from FY 1993 through FY 1997 were used for the core analysis in this report. This system retrieves data directly from the departmental accounting system used to manage the financial expenditures of the IHS. The system only reports expenditures, not income, budgets or allowances. Thus, revenues from Medicare and Medicaid are reported as "expenditures against collections."

The budget structure was reviewed for each fiscal year. Tables were developed for each Area and Headquarters for each year (see Volume 3). Because the budget structure changes in each of the years in this study, the format was designed to assure consistency across fiscal years.

Trend analysis required estimates of population growth and inflation. IHS estimates of service population and the medical component of the Consumer Price Index (CPI) were used to develop adjusted per capita expenditure figures.

Other sources of information used in this analysis include financial data gathered directly from Area Offices and Title III compact information provided by the Budget Office at IHS.

A more complete discussion of methods, definitions and limitations is provided in this volume in Chapter 4, *IHS Financial Trends During Self-Governance (Title III) Compacting, FY93 to FY 97.*

SURVEY OF TRIBES

Two surveys were conducted, one of tribal leaders and one of tribal health directors. The questionnaire used to survey tribal leaders was intended to be brief and policy-oriented. The health directors questionnaire was longer and requested more detailed, quantitative information.

Questionnaires

The development of both questionnaires involved the Advisory Committee in detailed discussions of the intent and wording of each question. Questions were designed to be answered quickly and with a minimum of research or consultation. The Advisory Committee intended to make the questions clear, relevant, and without bias.

Quality Assurance Pilot Study

Before development of the final survey questions, a pilot study was conducted to determine whether questions about the quality of care could produce information that could be used as a basis for comparison between Tribal and IHS facilities. This pilot study, "Quality Measurement in Indian Health Facilities"[16] involved telephone interviews with quality assurance coordinators from a representative cross-section of Indian health facilities. The pilot study demonstrated that specific, quantitative data on quality indicators would not be comparable between Indian health facilities in a national survey at this time.[17] Even when facilities measured the same indicators, such as the rate of eye exams for diabetics, they used different approaches to calculate their measurements. Also facilities generally could not retrieve data that were old enough to make "before-and-after" comparisons to evaluate whether the quality of care had changed after a tribe assumed management of a program. As a result of the pilot study, questions about the quality of care in the final surveys were formulated to measure qualitative information on a variety of quality indicators, from the perspective of the tribal leaders and tribal health

[16] A full report of the pilot study is contained in Volume 3 of this report.

[17] The pilot study thus reiterated the need for uniform, reliable measures of health, as advocated for and addressed by the Baseline Measures Workgroup.

directors, who often must use these data on quality to make decisions relating to health care services.

Tribal Leader Questionnaire

The tribal leader questionnaire includes two pages of short answer and open-ended questions about health programs, economic impacts, factors affecting the choice of health care delivery systems, and tribal sovereignty. A third page of questions was not directly related to this study, but rather was designed to provide guidance to the National Indian Health Board. The results of those questions are not included in this report.

Health Director Questionnaire

The health director questionnaire has 13 pages of questions. The questionnaire includes a service profile and description of population served that was used to help classify tribes into the categories of contracting, compacting, and direct service. The survey instrument asks about changes in programs and services, quality, and management during the period from 1993 to 1997. It also includes questions about recruitment and retention and training needs. This questionnaire also seeks tribal perspectives on their respective IHS Area Offices.

For the Alaska and California Areas, some of the questions in both questionnaires were tailored to fit the local circumstances. In most instances, this involved using the term "tribal organization" in addition to "tribe." For the tribal leader survey in Alaska, different categories were used to describe the primary method of health care.

Both questionnaires were "field tested" on individuals who were expected to participate in the survey.

Survey Distribution and Follow-up

Tribal Leader Mailing List

Mailing lists were obtained from the IHS. Those on the IHS Tribal Leaders Mailing List received the tribal leaders questionnaire. This included every federally-recognized tribe. While there are 554 federally-recognized tribes, the list includes 587 people. In addition to the tribal chairmen, the list includes the chief executive officers of multi-tribal organizations that contract or compact on behalf of tribes. In the rare instance in which both a tribal leader and a leader of a multi-tribal organization representing the same tribe responded to the questionnaire, this may seem like duplication in responses that could give more weight to those tribes. However, the leaders of small tribes often have different perspectives than the leaders of regional multi-tribal organizations. Furthermore, the multi-tribal organization response is counted a single time while the organization may represented a dozen or more tribes.

Health Director Mailing List

The health directors questionnaire was sent to every person on the IHS health directors mailing list. This list is arranged by IHS Area and facility, rather than tribe. Thus, some tribes that operate more than one facility received more than one health directors survey form. However, no tribe returned more than one completed health director survey form. Tribes that do not operate any facilities and do not have a designated health director are not included on this list. For tribes that did not have a health director, a second letter was sent to the tribal leader who was asked to give the health director survey form to the Service Unit Director or another individual selected by the tribal leader to answer the questions on behalf of their tribe.

Follow-up Activities to Increase Rate of Return of Questionnaires

While the mailing lists were considered to be comprehensive, there was concern that tribal leaders and health directors may be too busy to answer the questionnaires. Several approaches were used to ensure a sufficient rate of return to make the survey valid. These included the following:

A postcard reminder was sent to each questionnaire recipient approximately two weeks after the questionnaire was mailed.

An incentive was offered for early return of questionnaires. Tribes that returned both the tribal leader survey and the health director survey by a specified deadline were eligible for a drawing. Prizes for the drawing were free registration for one person from each Area for the National Indian Health Board's Annual Consumer Conference. The grand prize included roundtrip airfare to the conference.

To raise awareness and to motivate people to participate, the Project Coordinator traveled extensively to promote the project. The project and the questionnaires were discussed at meetings in nearly every Area, as well as national meetings and workshops at the National Indian Health Board's Annual Consumer Conference.

In each Area, except Navajo, Phoenix, and Tucson, an organization (usually the Area Health Board) was subcontracted to make personal contact with questionnaire recipients and to assist them in filling out the questionnaires. Compensation in this subcontract was structured to reward results. A weekly report was sent via FAX each Friday to each subcontractor so that they could track the results of their efforts.

For Navajo and Tucson Areas, the NIHB staff telephoned and Faxed the survey questionnaire recipients to encourage them to return the completed questionnaires.

These extensive efforts to assure the participation of every tribe in this study resulted in 210 tribes participating by returning either the tribal leaders questionnaire or the health directors questionnaire or both. This represents approximately 38 percent of the 554 federally-recognized tribes.

Equal Weight for Every Federally-Recognized Tribe

Although an estimated 38 percent of federally-recognized tribes participated in this study, this does not imply that the study is representative of 38 percent of the American

Indian and Alaska Native people. The study included both some of the largest tribes in the country and some of the smallest. No attempt was made to calculate the number of people whose lives were affected by the changes in health care described in this report. Because this survey presents a tribal perspective, it gives equal weight to every federally-recognized tribe regardless of the number of members enrolled or the amount of the IHS budget allocated to the tribe or the number of facilities serving the tribe.

Definition of Terms

To make the study meaningful, it was necessary to classify tribes as receiving their health care by "contracting," "compacting," or "IHS direct services." Such classification is difficult because most tribes have a mix of administrative approaches for receiving services. Most tribes have contracts for community-based services, such as Community Health Representative programs, even when most of their clinical services are provided directly by the IHS. While most of the IHS-funded hospitals in the Alaska Area are operated by tribes, in the other Areas there are few tribally-operated hospitals. This means that tribes with compacts may not be compacting all Service Unit functions.

The following definitions were used to classify tribes and survey respondents in this study:

Compacting tribes: Every tribe that has a negotiated Title III self-governance compact with the IHS, regardless of the types of services included in that compact.

Contracting tribes: Tribes that do not have a Title III compact with the IHS and that operate at least one outpatient medical clinic through a Title I contract under P.L. 93-638.

IHS direct service tribes: Tribes that do not have a Title III compact with the IHS and do not operate any outpatient medical clinics. These tribes may operate other health services under Title I contracts, such as outreach workers, alcohol and mental health services, and community health nursing. These tribes may receive outpatient medical services from an IHS-operated clinic or they may have services purchased from the private sector.

The sources of information used for assigning these classification include both IHS reports and information provided on the health director survey. There is a wide range of services provided under different administrative arrangements for each classification.

Tribal leaders were asked, "What is the primary method of health care delivery for your Tribe?" For tribes outside of Alaska, they were asked to check either IHS direct service, contracting, or compacting. Their choice did not always correspond to the classification that this study created for tribes. For example, leaders of two large tribes with compacts indicated checked "IHS direct service" because their tribal members receive most of their clinical services through local IHS-operated hospitals.

The analysis of quality of care information from the surveys uses the tribal leaders' answers about the primary method of health care rather than the classifications used elsewhere in this study, if there is a difference between the two. This is because the

quality issues, such as waiting time, probably apply most appropriately to the facilities where tribal members receive most of their health care.

It may seem confusing that some data are analyzed using the study classifications and some are analyzed using the tribal leader self-classification of the primary method of health care delivery. The tribal leader self-classifications can only be applied to the tribal leader surveys. They cannot be applied to the health director survey responses because health directors were not asked this question. Also, the tribal leader self-classifications cannot be applied to the part of the mailing lists for which there was no response. Hence, it is not possible to compare the sample to the population on the basis of tribal leader self-classification.

Since there are many advantages to using the study classifications, one might ask, why use tribal leader self-classifications for any of the analysis? The first reason is that this is a study about tribal perceptions and the tribal leader self-classifications reflect those perceptions. More importantly, however, for some questions the tribal leaders may think they are evaluating a different aspect of the system than the study classification implies.

For some questions, it is helpful to analyze the information in relation to the size of the tribe. For this reason, tribes were divided into three size categories: small, medium and large. The source of information on size was a question on the health director survey asking the total user population as defined by the IHS for 1996. Responses were arranged according to size, and then divided into three groups with roughly the same number of tribes in each group. This resulted in the following definitions:

Small: Tribe or facility with a 1996 user population less than 1,000.

Medium: Tribe or facility with a 1996 user population from 1,000 to 4,000.

Large: Tribe or facility with a 1996 user population greater than 4,000.

Among those that responded to the health directors survey, the range in user population was 60 to 117,000. The user population of half the tribes was less than 2,000.

Because there were so few responses from some Areas, several Areas were combined in the analysis of some of the data:

Southwest: includes the Albuquerque, Navajo, Phoenix, and Tucson Areas.

North: includes the Billings and Bemidji Areas.

Analysis of Survey Data

Survey results were coded and data were entered into a computer database. For each question, frequencies of answers were generated. Where there was insufficient response to questions, the data were eliminated from the study. Responses to questions were cross-tabulated, usually either by type of tribe or by Area. Tables were prepared using frequencies and percentages. These tables are available in a Volume 3. The

information was analyzed, and relevant information was combined into summary tables that are included in this report.

Most findings are presented using percentages. The comparisons by types of tribes are given as percentages based upon numbers of tribes in each category, not numbers of Native American people served. While the findings from this study present numbers to describe groups of tribes and trends, no statistical analysis has been done that would support statements about cause and effect. However, the findings often suggest striking relationships in the data.

The results of this survey are presented in five chapters of this volume, with more detailed supporting documentation in the corresponding sections in Volume 3. Survey results may be found in the Volume 2 narrative in the following chapters: Chapter 5, *Changes in Services and Facilities*; Chapter 6, *Management Changes and Challenges*; Chapter 7, *Changes in Quality of Care*; Chapter 8, *Opportunities and Barriers*; and Chapter 9, *Tribal Sovereignty and the Future.*

Description of the Survey Sample [18]

The survey was intended to elicit representation from tribes in each IHS Area. In addition, it was important to have representation from IHS direct service, contracting, compacting tribes. In this section, there is a description of the types of tribes in the survey, a general description of the tribes responding from each Area, and summary information. To make the comparisons between the population and the sample, every tribe in the IHS tribal leaders list was categorized as IHS direct service, contracting or compacting using the definitions given above and data provided by IHS. The description of the sample is summarized in Figure 2.1.

IHS Direct Service Tribes

There were 146 tribes on the tribal leader mailing list that were categorized as IHS direct service tribes. This is 25 percent of the tribes on the list. Tribal leaders from IHS direct service tribes returned 40 questionnaires, for a 27 percent rate of return. This represents 23 percent of the total tribal leader questionnaires returned, which is very close to the 25 percent of the mailing list that was used.

Health directors from IHS direct service tribes returned 21 questionnaires, which reflects about 10 percent of the total tribes in this category. However, IHS direct service tribes are less likely to have health directors than other types of tribes. The health director mailing list was only 239, which is only 41 percent of the tribal leader list. While tribal leaders for IHS direct service tribes were asked to pass the health director survey to an IHS Service Unit Director or another person if they did not have a health director, this rarely happened. There is no representation of health directors from IHS direct service

[18] The people who respond to the survey are considered a "sample" of the population. It is important to estimate whether or not the sample actually represents the population. A sample is considered more representative if a higher the percentage of people respond. It is also more representative if the sample has the same characteristics as the general population.

tribes in several Areas where there is little or no IHS direct service, including Alaska, Bemidji, California and Nashville. Unfortunately, no health director surveys were returned from IHS direct service tribes in the Albuquerque Area where 23 of the 25 tribes are classified as IHS direct service.

The IHS direct service category used in this study is based upon information obtained about the provision of outpatient medical care. However, information obtained from the health directors surveys shows that tribes in this category do manage a number of programs. Among these tribes, 95 percent were contracting for outreach workers (Community Health Representatives), 86 percent were contracting for alcoholism services, 36 percent were contracting for mental health services, 33 percent were contracting for emergency medical services (EMS), 32 percent were contracting for Community Health Nursing (CHN), 23 percent were contracting dental care and 18 percent were managing Contract Health Services (CHS). One tribe was receiving most of its services from another tribe that was compacting. Some of the tribes in this category were primarily purchasing services rather than receiving them from an IHS facility, including 27 percent that received hospital care and 14 percent that received outpatient care through purchased services.

When tribal leaders from the study category of IHS direct service tribes were asked how their tribal members receive *most* of their services, 75 percent replied IHS direct service. However, 18 percent replied contracting, 5 percent replied compacting, and 3 percent replied private insurance.

Figure 2.1

Samples for Tribal LeaderSurvey & Health Director Survey by Area and Type of Tribe

Areas	*Tribal Leader Survey*			*Health Director Survey*		*Number of Surveys Received*				
	Number of Tribes	Number of Responses	Percentage of Response	Number of Responses	Percentage of Responses	Tribal Leaders Only	Health Directors Only	Both Types Survey	Total	Percent of Tribes
Aberdeen	19	9	47%	10	53%	1	2	8	11	58%
Alaska	237	81	34%	6	3%	80	5	1	86	36%
Albuquerque	25	4	16%	2	8%	4	2	0	6	24%
Bemidji	35	6	17%	12	34%	3	9	3	15	43%
Billings	9	4	44%	6	67%	1	3	3	7	78%
California	100	22	22%	4	4%	21	3	1	25	25%
Nashville	28	9	32%	9	32%	4	4	5	13	46%
Navajo	2	2	100%	1	50%	1	0	1	2	100%
Oklahoma	41	15	37%	5	12%	13	3	2	18	44%
Phoenix	37	8	22%	6	16%	4	2	4	10	27%
Portland	42	10	24%	9	21%	7	6	3	16	38%
Tucson	2	1	50%	1	50%	0	0	1	1	50%
Total	**577**	**171**	**30%**	**71**	**12%**	**139**	**39**	**32**	**210**	**36%**
								Based on 554 Tribes:		38%
Types of Tribe										
IHS Direct Service	146	40	27%	21	14%	26	7	14	47	32%
Contracting	176	36	20%	31	18%	25	20	11	56	32%
Compacting	255	95	37%	19	7%	88	12	7	107	42%
Total	**577**	**171**	**30%**	**71**	**12%**	**139**	**39**	**32**	**210**	**36%**

Contracting Tribes

There were 176 tribes on the tribal leader mailing list that were categorized as contracting tribes. This is 30 percent of the tribes on the list. Tribal leaders from contracting tribes returned 36 questionnaires, for a 20 percent rate of return. This represents 21 percent of the total tribal leader questionnaires returned, which is considerably less than the 30 percent of the mailing list that was used. Thus contracting tribes are statistically under-represented in the tribal leader survey.

Health directors from contracting tribes returned 31 questionnaires, which is a 29 percent rate of return on those mailed. This represents 18 percent of the contracting tribes. There are no contracting tribes in the Billings, Navajo or Tucson Areas, so these Areas are not represented among the health directors of contracting tribes. Also there were no questionnaires returned from health directors of contracting tribes in Alaska or Oklahoma, but there are very few contracting tribes in these two Areas.

The contracting category used in this study is based upon information obtained about the provision of outpatient medical care. However, information obtained from the health directors surveys shows that 37 percent of these tribes have sanitation and environmental services provided directly by the IHS. Also, 20 percent of the tribes report that the Service Unit functions are provided directly by IHS, and 17 percent have their Contract Health Services managed by IHS.

The health directors survey shows that many contracting tribes are purchasing services from the private sector. Half the tribes are purchasing their hospital services, 40 percent are purchasing optometry, 37 percent are purchasing emergency medical services, 23 percent are purchasing dental care, and 20 percent are purchasing pharmaceuticals.

When tribal leaders from the study category of contracting tribes were asked how their tribal members receive most of their services, 80 percent of those who responded answered contracting. However, 20 percent said IHS direct services. This is probably because those tribes provided ambulatory medical service, but IHS provided the hospital services including emergency rooms and some outpatient services.

Compacting Tribes

There were 255 tribes and tribal organizations on the tribal leader mailing list that were categorized as compacting tribes. This is 44 percent of the tribes on the list. Tribal leaders from compacting tribes returned 95 questionnaires, for a 37 percent rate of return. This represents 56 percent of the total tribal leader questionnaires returned, which is considerably more than the 45 percent of the mailing list. Thus compacting tribes are statistically over-represented in the tribal leader survey.

Tribal leader surveys were received from compacting tribes from all of the Areas that have compacting tribes except California. There are no compacting tribes in the Aberdeen, Albuquerque, Navajo and Tucson Areas, and currently only two in California.

The vast majority of the tribal leader questionnaires in the compacting category that were returned were from Alaska. This is actually fairly representative of the whole. The tribal leader mailing list had 223 compacting tribes and tribal organizations in Alaska out of a total of 255, or 87 percent. At the same time, the Alaska tribal leaders returned 78 of the 95 questionnaires received from compacting tribes, or 82 percent. While the Alaska compact covers most Alaska Native villages, the tribal leader list includes both the village chiefs and the chief executive officers of the regional non-profit Native health organizations. While the village chiefs often represent the viewpoint of the very small and isolated communities, the regional non-profit corporations have the broader perspective of large health care delivery systems.

Health director surveys were returned by 19 compacting tribes and tribal organizations. In general, the Alaska Native villages do not have health directors. So, the Alaska response is generally from the regional non-profit Native health corporations which are much fewer in number than tribes. For the health director survey, the 6 Alaska questionnaires returned is 32 percent of all health directors in the compacting sample. However, those 6 organizations probably serve about half the villages in Alaska. So the level of representation is much greater than it would appear from the numbers.

Altogether the rate of return of health director surveys was 41 percent for compacting tribes, which is greater than the other categories. For the health director survey, 80 percent of compacting tribes in the Bemidji Area are represented, 67 percent from the Nashville Area are represented, and 60 percent from the Portland Area are represented. While the response rates from these Areas were especially high, there were responses from all Areas with compacting tribes except California.

According to the health director survey, compacting tribes received their services in a variety of ways. Over 75 percent of the tribes provided outpatient medical care (95 percent), dental care (89 percent), alcoholism services (89 percent), Contract Health Services (84 percent) and pharmacy (79 percent) under their compacts. However, IHS directly provided sanitation and environmental health for 47 percent and Service Unit functions for 32 percent. Many of the compacting tribes purchased services such as hospital (68 percent), optometry (37 percent), audiology (37 percent) and emergency medical services (32 percent).

When tribal leaders from the study category of compacting tribes outside of Alaska were asked how their tribal members receive *most* of their services, 17 responded. Of these, 76 percent answered compacting. However, 12 percent said IHS direct services and 12 percent said contracting. This is probably because those tribes had compacts for a limited number of services, but IHS provided the hospital services including emergency rooms and some outpatient services.

> Among the 78 tribal leaders from Alaska whose tribes were classified as compacting tribes, 20 percent reported that 100 percent of their services were provided through the compact, 21 percent said that their services were mostly provided by compact, 16 percent said that it was an equal mix of compact and IHS direct service, 20 percent said that most health care came

from IHS direct services, and 25 percent reported 100 percent IHS direct services. One Alaska tribal leader explained it this way:
It all depends on where our tribal members reside. Those members living near the compacting hospital go there, while those living elsewhere go to the IHS direct hospital.

Sample Distribution by Area

Aberdeen

There are 19 tribes in the Aberdeen Area, of which 15 were classified as IHS direct service and 4 as contracting tribes. A total of 11 tribes participated in the study, or 58 percent. Among these, 8 tribes returned both the tribal leader questionnaire and the health director questionnaire, while one returned only the tribal leader questionnaire and 2 returned only the health director questionnaire. According to the health director survey, the number of tribal members living on or near the reservation for participating tribes ranged from 375 to 14,000 with a median[19] of 2,500 and an average of 4,500. Tribal employment ranged from 50 to 510 with a median of 180 and an average of 226. The number of tribal employees working in health care ranged from 30 to 100, with a median of 45 and an average of 51. The number of tribal members working in health care ranged from 18 to 400, with a median of 47 and an average of 90.

Alaska

The situation in Alaska is unique within the Indian Health Service. Since the beginning of self-determination there have been 12 regional non-profit corporations that correspond in geographic region to the 12 profit-making corporations formed under the Alaska Native Claims Settlement Act. Historically, these regional non-profit corporations have contracted or compacted health services on behalf of the villages within their regions. All of the regional non-profit corporations and most of the villages in Alaska have entered into a single, statewide compact. The compact covers almost all native health services in Alaska, except for the Alaska Native Medical Center in Anchorage. Several villages close to Anchorage receive direct services from this IHS hospital, and several villages have decided to contract directly with the IHS. Thus, there are 237 Alaska Native Villages and tribal organizations in the Alaska Area, of which 233 were classified as compacting, 10 as contracting tribes, and 4 as IHS direct service.

A total of 86 tribes or tribal organizations from Alaska participated in the study, or 36 percent of the potential 237 individuals who could have returned questionnaires. Among these, 1 tribal organization returned both the tribal leader questionnaire and the health director questionnaire. In addition, 80 returned only the tribal leader questionnaire, representing leaders at the village level. Altogether 6 health directors returned the health director questionnaires, all representing regional non-profit corporations, with an equal mix of large and small corporations. Thus, 50 percent of the regional non-profits were represented and those in turn probably represent about 50 percent of the villages.

[19] Median is the point at which half are larger and half are smaller.

According to the health director survey, employment for regional non-profit Native health corporations ranged from 60 to 600 with a median of 244 and an average of 296. The number of tribal employees working in health care ranged from 28 to 446, with a median of 188 and an average of 215. The number of tribal members working in health care ranged from 13 to 185 with a median of 49 and an average of 68.

Albuquerque

There are 25 tribes in the Albuquerque Area, of which 23 were classified as IHS direct service and 2 as contracting tribes. A total of 4 tribes participated in the study, or 16 percent. None of the tribes returned both the tribal leader questionnaire and the health director questionnaire. The tribal leader questionnaire was returned by 4 tribes and 2 others returned the health director questionnaire. All of the responses were from IHS direct service tribes. The reason for the low rate of response may be that the tribes are less involved in the management of their health care than in many other Areas and therefore less comfortable responding to questions about it. Because of the low rate of response, the information from this Area is combined with three other Areas to form a category called *Southwest* for much of the analysis in this report.

Bemidji

There are 35 tribes and tribal organizations in the Bemidji Area, of which 14 were classified as IHS direct service, 16 as contracting tribes, and 5 as compacting tribes. A total of 15 tribes participated in the study, or 43 percent. Among these, 3 tribes returned both the tribal leader questionnaire and the health director questionnaire, while 3 returned only the tribal leader questionnaire and 9 returned only the health director questionnaire. According to the health director survey, the number of tribal members living on or near the reservation for participating tribes ranged from 300 to 10,000 with a median of 1,200 and an average of 3,328. Tribal employment ranged from 293 to 4,000, with a median of 1,500 and an average of 1,751. The number of tribal employees working in health care ranged from 20 to 260, with a median of 60 and an average of 86. The number of tribal members working in health care ranged from 5 to 150, with a median of 18 and an average of 41.

Billings

There are 9 tribes in the Billings Area, of which 7 were classified as IHS direct service and 2 as compacting tribes. A total of 7 tribes participated in the study, or 78 percent. Both types of tribes were represented proportionally. Among these, 3 tribes returned both the tribal leader questionnaire and the health director questionnaire, while 1 returned only the tribal leader questionnaire and 3 returned only the health director questionnaire. According to the health director survey, the number of tribal members living on or near the reservation for participating tribes ranged from 450 to 2,900, with an average of 1,675. Tribal employment ranged from 200 to 350, with a median of 241 and an average of 264. The number of tribal employees working in health care ranged from

42 to 110, with a median of 85 and an average of 79. The number of tribal members working in health care ranged from 80 to 106, with an average of 93. Because there were only 4 health director questionnaires, the responses from the Billings Area were combined with the Bemidji Area to form a new category called *North* for the analysis and summary of some of the data.

California

The California Area has a history and health care delivery structure that is somewhat unique in the Indian Health Service. Funding for tribal health programs began in 1969 with a demonstration project called the California Rural Indian Health Program. The California Area IHS Office was established in 1977. From the beginning, health care has been delivered to tribes through consortia under contracts.

There are 100 tribes and tribal organizations in the California Area, of which 98 were classified as contracting tribes and 2 as compacting tribes. A total of 25 tribes participated in the study, or 25 percent. Only 1 tribe returned both the tribal leader questionnaire and the health director questionnaire, while 21 returned only the tribal leader questionnaire and 3 returned only the health director questionnaire. According to the health director survey, the number of tribal members living on or near the reservation for participating tribes ranged from 36 to 4,000, with a median of 1,500 and an average of 2,042. Tribal employment ranged from 23 to 500, with a median of 30 and an average of 184. The number of tribal employees working in health care ranged from 16 to 158, with a median of 20 and an average of 65. The number of tribal members working in health care ranged from 1 to 75, with a median of 50 and an average of 42.

Nashville

There are 28 tribes in the Nashville Area, of which 9 were classified as IHS direct service, 16 as contracting, and 3 as compacting tribes. A total of 13 tribes participated in the study, or 46 percent. All types of tribes were represented. Among these, 5 tribes returned both the tribal leader questionnaire and the health director questionnaire, while 4 returned only the tribal leader questionnaire and 4 returned only the health director questionnaire. According to the health director survey, the number of tribal members living on or near the reservation for participating tribes ranged from 165 to 2,100, with a median of 425 and an average of 771. Tribal employment ranged from 7 to 5,000, with a median of 120 and an average of 683. The number of tribal employees working in health care ranged from 2 to 129, with a median of 19 and an average of 8. The number of tribal members working in health care ranged from 2 to 375, with a median of 14 and an average of 71.

Navajo

The Navajo Area has 2 tribes, both of which are classified as IHS direct service. Both tribes participated in this study. One tribe provided both types of questionnaires, while the other tribe submitted only the tribal leader questionnaire. Because of the small

numbers, the tribes from the Navajo Area were combined with tribes from three other Areas to create a group called *Southwest* for the analysis and reporting of most of the data in this study.

Oklahoma

There are 41 tribes and tribal organizations in the Oklahoma Area, of which 32 were classified as IHS direct service, 2 as contracting, and 7 as compacting tribes. A total of 18 tribes participated in the study, or 44 percent. All types of tribes were represented. Among these, 2 tribes returned both the tribal leader questionnaire and the health director questionnaire, while 13 returned only the tribal leader questionnaire and 3 returned only the health director questionnaire. According to the health director survey, the number of tribal members living on or near the reservation for participating tribes ranged from 125 to 92,000, with a median of 400 and an average of 18,855. Tribal employment ranged from 27 to 1,800, with a median of 75 and an average of 408. The number of tribal employees working in health care ranged from 2 to 756, with a median of 3 and an average of 155. The number of tribal members working in health care ranged from 5 to 600, with a median of 10 and an average of 205.

Phoenix

There are 37 tribes in the Phoenix Area, of which 27 were classified as IHS direct service, 7 as contracting, and 3 as compacting tribes. A total of 10 tribes participated in the study, or 27 percent. All types of tribes were represented. Among these, 4 tribes returned both the tribal leader questionnaire and the health director questionnaire, while 4 returned only the tribal leader questionnaire and 2 returned only the health director questionnaire. Because of the low rate of response, the information from this Area is combined with three other Areas to form a category called *Southwest* for much of the analysis in this report.

Portland

There are 42 tribes in the Portland Area, of which 11 were classified as IHS direct service, 21 as contracting, and 10 as compacting tribes. A total of 16 tribes participated in the study, or 38 percent. All types of tribes were represented. Among these, 3 tribes returned both the tribal leader questionnaire and the health director questionnaire, while 7 returned only the tribal leader questionnaire and 6 returned only the health director questionnaire. According to the health director survey, the number of tribal members living on or near the reservation for participating tribes ranged from 190 to 3,000, with a median of 650 and an average of 1,144. Tribal employment ranged from 4 to 1,300, with a median of 150 and an average of 332. The number of tribal employees working in health care ranged from 8 to 200, with a median of 36 and an average of 67. The number of tribal members working in health care ranged from 4 to 75, with a median of 15 and an average of 32.

Tucson

There are 2 tribes in the Tucson Area. Both are classified as IHS direct service tribes; however, one tribe receives most of its health care through a managed care plan purchased by the IHS for tribal members. Only one tribe participated in the study, submitting both types of questionnaires. This tribe was combined with tribes from the Albuquerque, Phoenix, and Navajo Areas to form a group called *Southwest* for most aspects of this study.

Summary

A total of 210 tribes and tribal organizations participated in this study. This represents 36 percent of the 587 tribes and tribal organizations that received questionnaires. It is about 38 percent of the 554 federally-recognized tribes. Every Area was represented in the study. The rate of participation by tribes within the Areas ranges from 24 to 100 percent.

For the tribal leader survey, 171 questionnaires were returned. This is 29 percent of the total 587 mailed and 31 percent of the 554 federally-recognized tribes. Tribal leaders from every Area participated, with a response rate ranging from 16 to 100 percent by Area. Tribal leaders from every type of tribe participated, with 40 from IHS direct service tribes, 36 from contracting tribes, and 95 from compacting tribes.

The health director survey was sent to 256 people in 239 organizations. A total of 71 questionnaires were received representing 30 percent of the organizations. Every Area was represented, with response rates ranging from 15 to 100 percent. Health director questionnaires were received from 21 IHS direct service tribes, 31 contracting tribes and 19 compacting tribes.

Overall, the survey sample appears to be representative of the whole. Where the numbers are low, Areas have been combined into larger groups for some types of analysis.

ASSESSMENT OF TRAINING NEEDS AND OPPORTUNITIES

The assessment of training needs and opportunities drew upon previous reports, information from the health directors survey, and telephone interviews with a variety of sources.

The telephone interviews were conducted with over 40 individuals in order to identify the types of training or technical assistance provided for Indian health, and who provides it. The 13 types of training listed in the health directors survey were also included in the telephone survey. While the health directors survey intended to identify training needs of, and resources used by, tribes, the telephone survey tried to identify the types of training that were already being provided.

The telephone survey started with a list of IHS Area Offices, tribal colleges, Area Health Boards, universities, and private firms. Each organization was asked whether they provided specific types of training. If they did not provide the training, they were asked to name other organizations that might provide the training. The organizations named were then contacted and the same telephone interview was conducted with them. To the extent possible, organizations were asked to provide training catalogs, advertisements or other written descriptions of courses.

All of this information was analyzed to determine unmet training needs. This information is incorporated into Chapter 8, *Opportunities and Barriers*.

CHAPTER 3

REVIEW OF PREVIOUS STUDIES

INTRODUCTION

Very little research has been conducted and even less has been published about the effects of tribal contracting and compacting on Indian health. A search of computerized bibliographic sources produced less than a half dozen items in the published literature. Several reports have been written that had limited distribution and generally are not available to the public. Internal documents prepared by the Indian Health Service (IHS) offer some data and observations that are relevant to contracting and compacting, although they are usually reported in a different context.[20] Much of the published literature provides negative views of tribal contracting and compacting, but it does not provide data to support those views.

JOURNAL ARTICLES

In 1996, the *American Journal of Public Health* published an editorial by Joseph G. Jorgenson, University of California-Irvine, and an article by Stephen J. Kunitz, University of Rochester School of Medicine, that explored their opinions about the effects of contracting and compacting on Indian health. Both men viewed contracting and compacting in the context of government policies of termination. Jorgenson did not distinguish compacting and contracting from federal downsizing efforts.

Jorgenson asserted that: "Among the approximately 275 tribal, 200 Native Alaska villages, and 11 Native Alaska regional corporations, I know of four that have been successful" (p. 1363). However, it is not clear how he assessed all these organizations to arrive at his conclusion, because he provides no data to support this assertion.

Kunitz makes a number of statements without providing any data to substantiate his claims. For example, he asserts that tribally operated programs are more expensive than programs operated by the Indian Health Service (p. 1464). He bases this observation on the assumption that "The Indian Health Service has benefited from economies of scale, which are unlikely to be achieved when individual tribes contract for services" (p. 1468). He does not consider the alternative possibility that tribes may be able to achieve greater economies of scale from business practices like purchasing through prime vendor contracts rather than the IHS warehouse system. Also, he does not question whether the federal bureaucracy may create diseconomies of scale.

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[20] For example, the yearly budget justification report prepared by the Department of Health and Human Services to support the IHS budget request has, in recent years, included an anecdotal account of advances reported by tribes operating under the IHS Office of Self Governance. *See, e.g.*, Indian Health Service, Department of Health and Human Services Fiscal Year 1998: Justification of Estimates for Appropriations Committees, 103-107 (1997).

Furthermore, Kunitz concludes that when tribes take control of health care systems, they place less emphasis on public health and prevention programs. Again, there is no data to support this assertion. He states:

> Thus, while some very important preventable problems remain, it is clear that, overall, the Indian Health Service has contributed significantly to the improvement of Indian health. The question is whether it will be able to continue to do so, or whether the new health care delivery systems that are replacing it will be similarly successful. It seems unlikely that they will, for the increasing costs of care in the face of stagnant budgets will probably mean that clinical functions will be protected as best they can while public health and prevention programs are retrenched. (p. 1471)

Kunitz cites no research investigating whether tribes that manage health care delivery systems place greater or lesser emphasis on prevention than the Indian Health Service.

Citing former IHS Director Emory Johnson as his source, Kunitz states that "while contracting is supposed to be a matter of choice for tribal governments, they are being forced to do it or risk losing what services they have" (p. 1470). No evidence is provided to support this assertion. This suggests a need for research to determine whether elected tribal officials believe that their sovereignty and their right to choose the type of management of their health care delivery system is being respected by the IHS.

Kunitz's article sparked a strong reaction across the country among those involved daily in American Indian and Alaska Native health care. The article was cause for concern because it provided a published justification for detractors from tribal management of health care provision, thus giving an air of legitimacy to his unfounded conclusions and projections.

Everett R. Rhoades, MD, who served as Director of the IHS from 1982 to 1993, provided his assessment of contracting and compacting in an article entitled, "Reflections on a Decade as the Director of the IHS" published in *The IHS Primary Care Provider* in January 1997. While Rhoades provided leadership for the IHS during a critical time for implementing self-determination and self-governance policies, he reveals his lack of support for these policies: "It is hard to see how the interests of Indian people will be served by 'balkanization' of this magnificent program" (p. 4). He further states:

> . . .I'm not so sure that those advocates of self-governance realize that they cannot have true self-government without forfeiture of the federal trust responsibility. Perhaps that is what is desired, but it should be called by its correct name, termination. (p. 4)

This article provides an historic perspective from the leadership of the IHS, but the legal conclusion drawn by Rhoades regarding the interplay between self-governance and the federal trust responsibility towards American Indians and Alaska Natives is not substantiated.

Rhoades published an editorial, "Changing Paradigms and Their Effect on American Indian and Alaska Native Health," in the *Annals of Epidemiology* (1997) in which he stated:

> One result beginning to be discerned is the threatened disintegration of the extensive and previously successful public health infrastructure of the Indian Health Service (IHS). This 'balkanization', accompanied by continued downsizing of the federal government, almost surely will result in program losses for a number of tribes.

Again, no supporting evidence is provided.

In another issue of *The IHS Primary Care Provider* (February 1997), Wesley Picciotti, Director, IHS Clinical Support Center, writes a brief article on "Compacting and CSC Services." He states:

> Indeed, it has been our observation that clinicians in the field have little or no knowledge that 'compacting' is taking place or what it might mean to them; generally they have not been involved in the process.

Picciotti further states that the Clinical Support Center will no longer sponsor continuing education activities at facilities where compacting has occurred unless tribes restore their shares of CSC funding.

Rodney L. Brod and Ronald Ladue, published an article on a survey of urban Indians that makes some references to tribal contracting. The article, "Political Mobilization and Conflict among Western Urban and Reservation Indian Health Service Programs," published in the *American Indian Culture and Research Journal* (1989), recounts the funding conflicts in the Billings Area of the Indian Health Service. Brod and Ladue offer the following data on tribal contracting:

> Although the service population from 1980 through 1985 represented a 20 percent increase, the total IHS budgets for the Billings area during those same years showed a 34 percent increase, reflecting the general push for improved facilities and greater tribal self-determination . . .These 638 contract dollars amounted to only 1.2 percent of the total Billings area IHS budget in the first year (1980), but have increased to 9.5 percent of the 1985 budget. (p. 181)

Quoting a report by the Office of Technology Assessment, Brod and Ladue state:

> Thus, tribes in the Billings area have not yet taken over the vast majority of responsibilities, partly due to 'the IHS position that the administration and support responsibilities of IHS headquarters and area offices usually are not contractible, because such functions are difficult to associate with specific tribes.' (p. 181)

While this article was written in 1989, the Indian Self-Determination Contract Reform Act of 1994 provided for a negotiated rule making process that resulted in the Final Rule (25

CFR Part 900) being published on June 24, 1996. Under the current regulations, significantly more of Headquarters and Area Office functions are clearly contractible than were thought to be contractible in 1989.

REPORTS

One of the few reports evaluating the impact of the Indian Self-Determination Act was written in 1984. A joint effort of the National Indian Health Board and American Indian Technical Services, the project evaluated the status of implementation of P.L. 93-638 with an emphasis on information and technical assistance provided to tribes leading to their decisions about the management of their health care delivery systems. The final report, *Evaluation Report: The Indian Health Service's Implementation of the Indian Self-Determination Process*, was published by the IHS on April 20, 1984. Acknowledging the limitations of the study, the authors wrote:

> While this project has been a necessary first step in the evaluation process, its scope needs to be extended, since IHS has a responsibility to assure the quality and availability of services delivered to all Indian people under the auspices of the IHS, whether delivered directly or under tribal contract. (p. 106)

The study provided a definition of successful outcomes of the Indian self-determination process that is still relevant today:

> Exemplary programs are characterized as those that provide better health care opportunities than had been previously provided by IHS or that meet tribal needs. The manner in which this is achieved includes the assumption of small IHS responsibilities, the full takeover of IHS facilities and services, and the establishment of services where none existed before. (p. iv)

This report also identified some barriers to contracting that existed in 1984 and may still exist today:

> Reasons given by tribes for not wanting to contract include the administrative burdens that must be assumed in contracting and the fact that indirect costs are not adequately covered. Tribes who were generally satisfied with the IHS delivery of services also expressed that they are less interested in contracting these services. (p. iv)

In 1986 the General Accounting Office (GAO) published a report for the U. S. Senate Select Committee on Indian Affairs called, "Indian Health Service: Contracting for Health Services Under the Indian Self-Determination Act." The report is based upon interviews with 12 contracting tribes and 4 IHS Area Offices, as well as a survey of all federally-recognized tribes. This study found that 7 of the 12 contracting tribes interviewed and 65 to 78 percent of the survey respondents said that "they have little if any say in the health care to be delivered or the funding of their contracts" (p. 4). These tribes "did not believe that self-determination was being achieved under Public Law 93-638" (p. 24). In that survey, 72 percent of the tribes and tribal organizations said that IHS

funding was inadequate for contracting the services (p. 27). Among the tribes that were not contracting at that time, 44 to 79 percent expecting to be contracting within 5 years (p. 29). Lack of both direct and indirect funding was the major reason that tribes were not increasing the levels of their contracting, according to the GAO report.

In 1987, the Northwest Portland Area Indian Health Board (NPAIHB) conducted a study that showed that even if tribes included all typical indirect costs in their indirect cost rate and obtained full recovery, they would not receive the full costs of operating an Indian health program in parity with the government's operation of the program. This study was used to help shape the 1988 Amendments to the Indian Self-Determination Act, to include a provision for contract support costs as direct costs that tribes incurred in contracting programs that were not covered by indirect rates and were not required by the federal government.

A more recent report, written by James M. Sizemore, CPA, and published as a joint effort of the Northwest Portland Area Indian Health Board and the Affiliated Tribes of Northwest Indians in May 1997, is the second edition of *Determining the True Cost of Contracting Federal Programs for Indian Tribes*. Sizemore found that indirect cost rates among the Northwest tribes had increased primarily due to increasing federal standards for such things as administrative procedures and facilities accessibility for disabled persons, and the failure of some agencies to pay their respective share of indirect costs. He also found that tribes had different indirect cost rates which he attributes to both tribal objectives and the negotiation process:

> Not all federal negotiators view negotiations as having the same goal. Some work to negotiate the lowest possible rate – others the fairest possible rate. (p. 24)

Over time, the study shows, tribes have developed the financial systems, experience and administrative capacity to negotiate rates that more fully cover their costs. However, Sizemore found that:

> Tribes are still being required to divert services dollars to pay indirect costs due to shortfalls in contract support funds in both BIA and IHS. This remains a disincentive to many tribes to contracting more programs. (p. 39)

One reason that Congress does not appropriate the necessary funding to cover contract support costs, according to Sizemore, is that the IHS does not submit the required reports to Congress on time. He attributes this to the fact that the agency does not have a single full-time position dedicated to the task of collecting the data and preparing the reports.

After the 1988 Amendments were passed, the IHS established an Indian Self-Determination (ISD) Fund to help offset the costs to tribes of starting to contract. IHS policy provided that tribes would receive this funding on a "first-come-first-served" basis until the ISD Fund was exhausted. Sizemore reported that in January 1997 the ISD Fund was funded at $7.5 million, while tribes had requested $36 million over this amount. As more tribes assume more programs, the demand for the ISD Fund is expected to be $75 million in 1998, according to Sizemore.

While Sizemore concludes that without adequate ISD funding "there is little incentive for tribal governments to assume the responsibility to deliver services," he also finds that many tribes have chosen to operate IHS programs (p. 64). The significance of this issue is placed into context with this statement:

> The option to contract to operate federal programs means the relationships change. The federal government changes from delivering services to delivering resources. Tribal governments assume the responsibility to deliver services, with reliance on the federal resources. Indian people come to rely on their own tribal government for services, instead of the federal government. (pp. i-ii)

While this report considers only one aspect of resource issues based on data from only one IHS Area, it provides an extremely thorough, thoughtful and well-documented account that has broad implications for the entire Indian health system.

One of the major goals of the Clinton presidential administration was a restructuring of the national health care system, and as a result many changes occurred at the national level. The effects of many of these changes were seen in Indian country. The Henry J. Kaiser Family Foundation sponsored a forum in November 1996 to consider the major changes in the structure and context of Indian health services. They published a volume, *A Forum on the Implications of Changes in the Health Care Environment for Native American Health Care,* that includes four articles as well as a summary of the forum proceedings.

The first article in the Kaiser volume, "Overview: Current and Evolving Realities of Health Care to Reservation and Urban American Indians" by Jo Ann Kauffman, Emory Johnson, and Joe Jacobs, provides historic, demographic and health status information, as well as a description of the health care delivery system. They cite examples of contracting and compacting successes:

> Many tribes, such as the Couer d'Alene in Idaho or the Salish-Kootenai in Montana have discovered vast improvements in the health options for their tribal members by administering their own programs. (p. 43)

They also acknowledge the systemic changes resulting from contracting and compacting:

> The IHS has discovered, however, that the overall impact of increased contracting and compacting (combined with FTE reductions) is forcing an inevitable redesign of the total IHS agency to remain functional and to protect the interests of those tribes not involved in contracting or compacting for services.

The authors conclude that balancing these divergent objectives is a critical concern for the future of Indian health.

The second article in the Kaiser volume is "Factors Affecting Tribal Choice of Health Care Organizations" by Mim Dixon, Judith K. Bush, and Pamela E. Iron. This

article presents the findings of interviews with tribal leaders, tribal health directors, IHS Area Directors, and Area health planning staff for a representative cross-section of nine tribes in four different IHS Areas. Based on these interviews, Dixon *et al* present a model explaining how tribes make decisions about health care systems. The model explains that tribal decisions involve the legal, historical, and political contexts of tribes. Different tribal organizations have different processes of decision-making. Basic beliefs guide decision-making. Decisions are also affected by choices available to tribes, perceived outcomes, planning and negotiating. This model reveals a much more complex process involved in tribal decisions than is normally inferred.

The authors found that tribal leaders were well versed in the advantages and disadvantages of IHS direct services and tribally operated services, including quality of care, financial and management issues, and community development. However, they found vast differences in philosophy between tribes:

> With the negotiated rulemaking for the Indian Self-Determination Act reducing the differences between contracting and compacting, the choice tends to be more philosophical than based on specific criteria. Those who are already compacting see it as a natural progression in self-determination and self-governance. Those who are not compacting are more concerned about the effect of compacting on the delivery of direct IHS services, particularly those provided to their Tribe. . . leaders of non-compacting tribes view self-governance as an experiment which could lead to termination. They say 'the U.S. government is getting off the hook' on its trust responsibilities and that other Tribes are engaged in 'a money grabbing scheme.' However, even the leaders of non-compacting Tribes acknowledge the advantages of flexibility and a higher degree of integration of services from the annual funding agreement approach. (p. 70)

The interviews revealed basic beliefs that guide tribal choices including the desire for quality care and holistic solutions. While the health care of tribal members is a high priority for most tribal leaders, the leaders understand long term decision-making very well and must balance many other factors with the need for health care. A high value placed on maintaining the federal trust responsibility is one factor that often influences such long-term decisions.

With regard to training and technical assistance, the authors report that "the nearly unanimous recommendations from those interviewed for this study are to use existing Tribal organizations and to deliver services as close to the Tribes as feasible" (p.86).

Another article in the Kaiser volume is specifically about training needs. "Management Development Needs in Native American Health Care" by Jay Noren, David Kindig and Audrey Sprenger of the University of Wisconsin-Madison reports the results of a survey of 33 Indian health sites, including 18 operated by IHS, 11 tribally operated, and 4 combined operations. They found the greatest management training priorities to be: (1) managed care trends and effect on programs, particularly Contract Health Services; (2) Board and manager education for effective, collaborative relationships and communication; (3) continuous quality improvement; (4) creating customer orientation in

services delivery and assessing customer satisfaction; and (5) management of conflict among staff.

The University of Wisconsin study identified barriers to training, including cost and funding, time away from work, lack of staff back-up during absences, and child care. One recommendation was that training must be concise and accessible from a local perspective, i.e. three-day training within a regional location. While the study does not specifically address issues related to contracting and compacting, the authors report that "[c]ompacting or contracting by the tribe, as well as the recruitment and retention of professional staff, were also repeatedly noted" (p. 142).

A project funded by the Kaiser Family Foundation but not yet published is "Case Studies of Managed Care in Indian Health" by Mim Dixon. Two of the four case studies presented by Dixon involve successful tribally-operated health programs. Chief Andrew Isaac Health Center (CAIHC) in Fairbanks, Alaska, is operated under compact by the Tanana Chiefs Conference. CAIHC has achieved significant cost savings by using prime vendor contracts rather than the IHS warehouse system. For example, the cost of nursing supplies was reduced from $200,000 per year to $60,000 per year. CAIHC has also been effective at negotiating discount contracts with Contract Health Service providers and instituting case management that has improved quality of care while still reducing costs.

Another of the case studies involved the Mashantucket Pequot Tribal Nation in Connecticut. The Tribe owns, funds and administers a managed care Health Plan that serves employees and Tribal members. The Pequot Pharmaceutical Network (PRxN) is a tribally-owned enterprise that makes money on managed care.

Both of these case studies provide detailed examples of highly sophisticated, high quality, cost-effective programs providing a greater range of services than would otherwise have been provided through IHS direct service. In both cases, the tribes have maintained control over their health care systems while forming partnerships with the private sector.

Concerns about the ability to monitor changes in quality of care in Indian health programs led to the formation of the Baseline Measures Workgroup, comprised of both tribal and IHS representatives charged with developing recommendations for core data sets for compacting tribes. *The Baseline Measures Workgroup Final Report*, published in 1996, offers recommendations for measures applicable to health promotion, health protection, preventive services, access, resource management and utilization and strategies for the community's health. The recommendations suggest sources for data, but no standards were developed for the analysis of data that would make the measures consistent, comparable between tribes, or easy to aggregate to present a regional or national assessment. The workgroup endorsed the principle that tribes have a right to negotiate the measures they will use.

IHS Internal Documents on Training Needs

Four documents discussing management training issues were written between 1986 and 1997 by and for the Indian Health Service (IHS). Generally, the earlier reports focus on management development and employee training needs with specific recommendations for the IHS to institute policies and procedures for employee development.

The 1986 study[21] was an internal report that recommended the development and maintenance of a single, uniform, centrally owned fundamental policy and procedure manual dealing with training and development, as essential to promoting consistency throughout the Indian Health Service. The report states, "At a minimum, different approaches to the content and design of policy and procedure manuals for training and development are needed for personnel servicing staff, training directors, supervisors and managers, and employees." The Indian Health Service Policy Manual was updated to address this need but significant gaps still exist.

The 1990 report[22] provides 11 recommendations that include: allocating a percentage of the IHS Area's budget to training; the establishment of regional training centers; and creation of an office that would be the Agency focal point of the planning, development, and coordination of executive, mid-level, and staff training.

The 1992 Medical Faculty Advocacy study[23] focuses on this special program wherein Indian Health Service worked directly with allopathic and osteopathic schools of medicine to increase the awareness medical students, residents, medical faculty members and administrators of the unique career opportunities offered by the Agency. The 8 recommendations contained in this report urged the IHS to re-activate the program, to expand the scope of the project, and to promote stronger local alliances.

The Nottingham report[24] is a broader study assessing the Agency from a business perspective with recommendations specific to customer improvement and system enhancements.

The IHS has also produced documents that summarize discussion groups (roundtables) convened over the years. These subject specific sessions (for example, managed care and Indian health) included experts from various disciplines to provide guidance and direction to the Agency and for use by tribal governments. Most of these reports include recommendations on training or technical assistance needs for that particular topic.

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[21] *Report to the Director: The Operations and Management of Training and Development in the Indian Health Service*, April 1986 by the Subcommittee of the Council of the Associate and Area Directors Standing Committee on Training.
[22] *Assurance of Quality in IHS Administration: The Final Report of the Human Resource Development Work Group*, September 1990 by Office of Health Program Research and Development, Tucson, AZ.
[23] *Medical Faculty Advocacy Program*, June 1992 by Americans for Indian Opportunity.
[24] *International Management Project at the Indian Health Service*, June 1996 by Nottingham Trent University Business School, Nottingham, England.

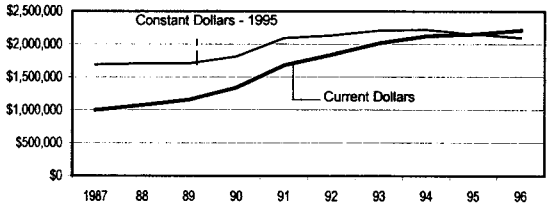
Data Sources

On an annual basis, the IHS Division of Program Statistics publishes two reports that provide data on morbidity, mortality, and health system data: *Trends in Indian Health*; and *Regional Differences in Indian Health*. The data in these reports are derived from a variety of sources, including vital statistics reported by the National Center for Health Statistics (NCHS), and Indian Health Service internal data systems, which include the Patient Care Component (PCC) of the Resource and Patient Management System (RPMS), the Monthly Inpatient Services Report, the Ambulatory Patient Care System, the Chemical Dependency Management Information System, the IHS Nutrition and Dietetics Program Activity Reporting System, and other internal data sources.

The most recent publication, 1996 *Trends in Indian Health*, was published in 1997. Many of the tables and graphs in this report contain longitudinal information starting as early as 1973, and because some of the graphs in the health system data section distinguish tribally-operated facilities from IHS direct facilities, providing some data for comparison as the number of tribally-managed health programs has increased over the past few years.

Figure 3.1, taken from *Trends* Chart 1.6, shows the IHS budget from 1987 to 1996 giving both the actual dollars appropriated by Congress (current dollars) and the inflation-adjusted purchasing power of those dollars (constant dollars - 1995). While there has been a small growth in appropriations each year, it has not been sufficient to compensate for general inflation. Furthermore, inflation in the medical sector has exceeded general inflation as a pattern over these years. The result in inflation-adjusted dollars has been a relatively flat budget since 1991. During this same period there has been a growth in the population to be served. The combination of inflation and population growth likely have resulted in less health care spending per person over the past six years. In terms of unmet need, then, the overall picture appears to be getting worse despite some budget increases.

Figure 3.1
Trend in Indian Health Service Budget



The Indian Health Service budget (appropriations and collections) has increased 121-percent from FY 1987 to FY 1996. However, in constant 1995 dollars, the budget has only increased 24-percent.

(Source: Chart 1.6 1996 Trends in Indian Health, IHS)

The 1996 *Trends* report contains data that illustrate the magnitude of the increases in contracting and compacting activities over time. For example, contracts have grown from $130.7 million in 1981 to $297.5 million in 1995, while grants and compacts grew from $12.1 million to $335 million during that same period (Figure 3.2). The grants and compacts category includes IHS scholarships and loans. In FY1995, contracts under P.L. 93-638 accounted for 38 percent of the total contracted and compacted dollars, while grants and compacts accounted for 47 percent (*Trends* Chart 5.2).

Figure 3.2
IHS Tribal Health Contract and Grant/Compact Awards
FY 1975 - 1995

Fiscal Year	*Total*	*Contracts*	*Grants/Compacts*
1995	$632.5	$297.5	$335.0
1994	$762.0	$648.1	$114.5
1993	$551.4	$491.5	$59.9
1992	$562.5	$511.6	$50.9
1991	$450.2	$410.1	$40.1
1990	$348.1	$320.7	$27.4
1989	$330.1	$306.6	$23.5
1988	$230.3	$217.2	$13.1
1987	$210.7	$200.9	$9.8
1986	$209.1	$199.0	$10.1
1985	$234.0	$218.1	$15.9
1984	$194.0	$177.5	$16.5
1983	$157.7	$143.1	$14.6
1982	$141.1	$126.5	$14.6
1981	$142.8	$130.7	$12.1
1980	$121.9		
1979	$74.0		
1978	$70.1		
1977	$57.9		
1976	$32.6		
1975	$17.4		

Source: Table 5.1 1996 Trends in Indian Health, IHS

Data from the *Trends* report show that tribally-managed health care programs are keeping pace with their IHS counterparts, in terms of facility accreditation, which is an indicator of the overall quality of care in a health facility. According to 1996 *Trends* data, 100 percent of both tribally-operated and IHS-operated hospitals were accredited by JCAHO as of January 1, 1996 (Figure 3.3). In addition, both IHS direct services and tribally-operated services showed declines in the number of hospital admissions and the average daily hospital patient load from 1987 to 1994, and these declines were parallel in magnitude for both types of services (Figures 3.4 and 3.5). These trends are consistent with trends in the overall U.S. health care system to improve the quality of care by increasing the efficient use of services by decreasing inpatient care in favor of more efficient and less expensive ambulatory care.

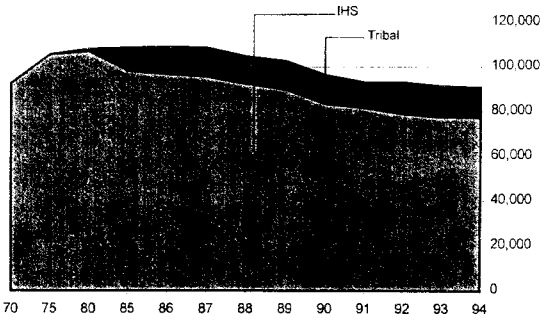
Figure 3.3
Accreditation Status of Hospitals, Health Centers, and Regional Youth Treatment Centers, January 1,1996

Type of Facility	Total	ccredited	Not Accredited	Percent Accredited
IHS Hospitals	38	38	0	100%
Tribal Hospitals	[2] 11	11	0	100%
IHS Eligible Health Centers	57	57	0	100%
Regional Youth Treatment Cente	9	6 [4]	0	67%

[1] Accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAH
[2] Excludes health centers not eligible for accreditation survey and those under Tribal managem pursuant to P.L. 93-638.
[3] Provide alcohol and substance abuse treatment.
[4] Includes 3 facilities accredited by JCAHO and 3 facilities accredited by the Commission on Accreditation of Rehabilitation Facilities.

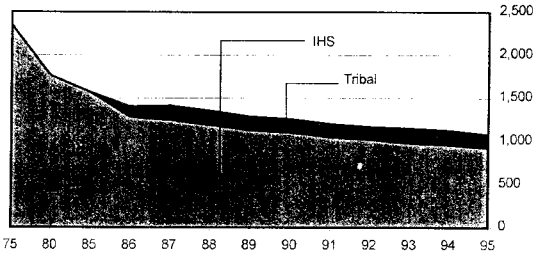
Source: Table 1.7, 1996 Trends in Indian Health, IHS.

Figure 3.4
Number of Hospital Admissions, IHS and Tribal Direct and Contract General Hospitals



(Source: Chart 5.4, 1996 Trends in Indian Health, IHS)

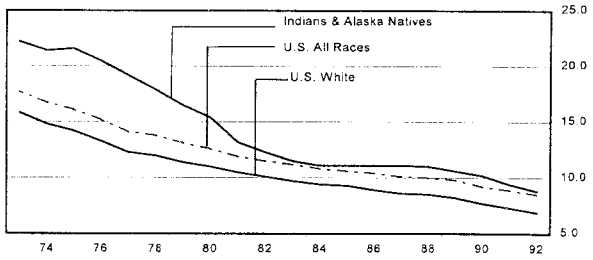
Figure 3.5
Average Daily Hospital Patient Load, IHS and Tribal Direct and Contract General Hospitals



(Source: Chart 5.5, 1996 Trends in Indian Health, IHS)

The 1996 *Trends* report contains extensive data on trends in morbidity and mortality for the overall Indian health care system, but does not distinguish between IHS operated and Tribally-operated sites in its charts and graphs. However, despite the dramatic increase in Tribal contracting since 1981 and compacting since 1993, the overall health status of American Indians and Alaska Natives has steadily improved on a number of indicators as illustrated in Figures 3.6, 3.7, and 3.8.

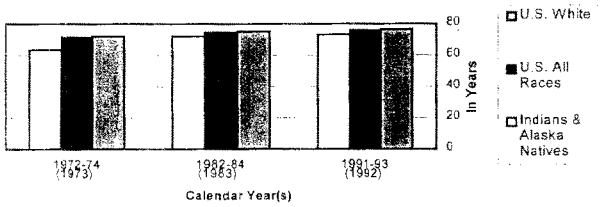
Figure 3.6
Infant Mortality Rates



The infant mortality rate for American Indians and Alaska Natives dropped from 22.2 infant deaths per 1,000 live births in 1972-1974 to 8.8 in 1991-1993, a decrease of 60 percent. The U.S. All Races and White populations, rates for 1992 were 8.5 and 6.9, respectively.

Source: Chart 3.7, 1996 Trends in Indian Health, IHS.

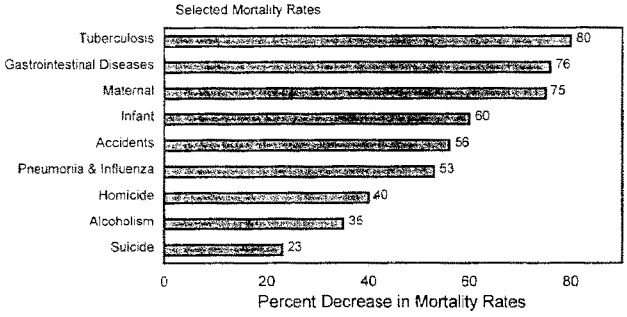
Figure 3.7
Life Expectancy at Birth



Life Expectancy at birth for American Indians and Alaska Natives in 1972-74 was nearly 8 yeas less than the life expectancy of the U.S. All Races and White populations in 1973. For 1991-93 versus 1992, the gap with U.S. All Races population has narrowed to 2.6 years and with the White population to 3.3 years.

Source: Chart 4.37, 1996 Trends in Indian Health, IHS.

Figure 3.8
Indian Health Service Program Accomplishments Since 1973



*Alcoholism rate decrease since 1980

Source: Chart 4.40, 1996 Trends in Indian Health, IHS.

Another source of data on the quality of care in Indian health is the IHS Diabetes Program's yearly Diabetes Audit. Every year, the IHS Diabetes Program collects data on an number of process and outcome indicators of the quality of diabetes care, through a systematic audit of a sample of charts from both IHS and tribal facilities throughout the country. Although the results of this audit do not distinguish IHS from tribal facility data, overall the data show consistent improvements over time in the quality of care delivered to patients with diabetes. This data set is the only existing, comprehensive database of quality of care information in Indian health that provides standardized, comparable results. Unfortunately, the data do not provide comparisons between IHS and tribal facilities.

Overall, the existing data on the quality of care in Indian health facilities shows no trends towards worsening quality, and several indicators show that the quality of care in Indian health is improving. At the same time, tribal compacting and contracting of health facilities has increased dramatically, despite the lack of resources for health services. However, more data are needed to specifically compare the quality of care in tribally-managed health programs with IHS direct facilities, to see if differences in quality of care do indeed exist, as some authors have asserted.

CHAPTER 4

IHS FINANCIAL TRENDS DURING SELF-GOVERNANCE (TITLE III) COMPACTING FY 93 TO FY 97

by David Mather, Dr.P.H.

INTRODUCTION

The purpose of this financial analysis is to help understand the impact of tribal choices in health care delivery upon the financial resources available to tribes and the IHS. The analysis is designed to help separate the financial effects of Title III self-governance compacting and expanded Title I contracting from other changes in the operational and financial environment of the IHS.

In FY 1992, the IHS became involved in planning with tribes for expanded opportunities for self-determination as part of the Self-Governance Demonstration Project authorized by Congress in P.L. 100-472, P.L. 102-537, P.L. 102-184, and the amendments to P.L. 93-638. Late in FY 1993, the first self-governance compacts were awarded to 6 tribes. These compacts included "tribal share" resources that had previously been expended by IHS Headquarters or Area Offices.

While implementing Title III, the IHS has also been responding to executive initiatives to restructure and reduce the size of the administrative components of the agency. The Indian Health Design Team (IHDT), described as the first attempt in 40 years to change the overall structure of the IHS, was formed by the Director of the IHS in January 1995. The final report of the IHDT, issued in November 1995,[25] recommended a restructuring and downsizing of IHS Headquarters and a redesign of Area Offices. The fundamental focus of the agency administrative structure should change, according to the IHDT, from "directing and controlling" to "supporting" the field programs, whether operated by IHS or by tribes.

Thus the IHS has been faced with multiple directives regarding the role of Headquarters and the Area Offices in carrying out the mission of the agency. Many of these directives interact with and support the general financial objective of self-governance which allows tribal health care providers access to the resources of Headquarters and Area Offices to improve health care to their members. These "tribal share" resources are supposed to come from the reduction or elimination of services from Areas or Headquarters. It has been unclear if the agency has been successful in accomplishing the required internal reallocation of resources.

There is a wide variation in the amount of contracting and compacting by tribes across the IHS Areas. This has made it difficult to assess whether the changes in Headquarters and the Area Offices forced by self-governance compacting and expanded

[25] DHHS, *Design for a New IHS: Recommendation of the Indian Health Design Team*, Final Report, November, 1995.

Title I contracting are adversely affecting the ability of these offices to provide essential support to IHS direct service tribes and tribal contractors operating P.L. 93-638 programs under Title I without the benefit of "tribal shares."

Research Questions

This financial analysis reviewed both appropriation and expenditure financial data for Headquarters and for each Area Office for the past five years (FY 93-FY 97).

The data were obtained from the agency from several sources. Data were analyzed to provide estimates of the following impacts and changes:

Estimation of the impacts of inflation and service population growth.

Estimation of the amount of Title I contracting and self-governance compacting for each Area Office.

Estimation of the changes in expenditures by IHS Service Units that are not tribally operated, as reported by each Area Office.

Estimation of the changes in the level of direct federal expenditures for the administrative costs associated with IHS Headquarters and each Area Office.

METHODS

In addition to the published sources of financial data cited in this report, financial data were gathered directly from IHS records using several separate financial data reporting instruments developed from three separate IHS financial data bases.

DHHS Financial Reporting System

Comprehensive financial data for the entire IHS were gathered from the Department of Health and Human Services (DHHS) Financial Reporting System for the fiscal years FY 93 to FY 97.

Data were originally requested for six full fiscal years beginning in FY 92 to provide a baseline for IHS expenditures prior to any self-governance compacting. The DHHS Financial Services Financial Reporting System maintains historical financial data online for only 5 years. During FY 93, only 6 tribal self-governance compacts were awarded, and these awards were not completed until the last quarter of the fiscal year. The amount of funds transferred in self-governance compacts during FY 93 was not material to the overall trend analysis.

A data collection instrument was developed in consultation with the IHS Budget & Accounting Analyst, Systems Review and Analysis Branch of the Division of Financial Management. An initial data extraction was completed for one fiscal year for the entire

IHS. The collection instrument was reviewed and revised to provide the needed data at a summary level possible while maintaining accuracy.

The budget structure was reviewed for each fiscal year and all expenditures for each Area Office location (accounting point) and Headquarters were extracted by sub-sub-activity code and by cost center. Budget structure has changed for each of the fiscal years in the trend analysis, so the format was designed separately for each fiscal year budget, in order to assure consistency in categorization across fiscal years and valid trend analysis. Information was also summarized to provide the maximum information regarding trends in self-governance compact funding and in funding to IHS directly operated programs.

Expenditures are reported for allowance, by sub-sub-activity codes and by accounting point (location) codes. Expenditures for multi-year allowances such as Medicare and Medicaid, Indian Health Facilities, etc., were summed across all applicable allowance years.

Expenditures were reported for all tribally operated sub-sub-activities (50-99) and reported in column 4 as a tribally operated program expense. Expenditures for all IHS operated sub-sub-activities (00-49) were further reported by cost center, in order to determine what proportion of these funds was expended by Headquarters, by Area Offices, or by directly operated IHS Service Units.

Cost centers for IHS directly operated hospitals, health centers, and contract care were summed to represent IHS direct service programs. All cost center expenditures incorrectly coded (usually due to an invalid cost center) were reviewed to determine if the appropriate coding could be inferred from the location code or by sub-sub-activity. If possible, the data were recoded (and footnoted) to the correct code. Expenditures for Headquarters, Headquarters West, and each Area are reported for each fiscal year from FY 93 to FY 97 in Volume III of this report.

All expenditures were adjusted to eliminate the facilities appropriation for construction of new sanitation projects or health facilities (allowance 290). Thus, trend data were not distorted by large, one-time capital expenditures.

Area Office Financial Management Systems

Financial data were requested directly from each of the Area Offices to cross validate and assist in interpreting the data received from the DHHS Financial Reporting System. This also provided information on certain categories of funds that could not be extracted from the DHHS Financial Reporting System due to the budget structure of the system.

A data survey instrument was designed. It was pre-tested on two Area Offices and revised to eliminate data that could not be accurately reported by Areas. A letter was sent to each Area Director requesting cooperation with the study. Two or more telephone conversations were held directly with Chief Financial Officers (CFOs) or other assigned financial management staff in each Area Office. Completed responses were received

from 5 Area Offices. Several other Area Offices responded by indicating that the data were not available. No response was received from 3 Area Offices. The responses were utilized to cross validate the data received from the DHHS Financial Reporting Systems and to highlight areas where the structure of the DHHS Financial Reporting System data limited the analysis.

Title III Resource Tables and Alaska Area Compact Funding Records

Detailed financial data on Title III compacts were obtained from the Office of Management Support, Division of Financial Management of the IHS. These data contained comprehensive records of all expenditures by the IHS in FY 97 to Title III compacts. These data were supplemented with data from the Alaska Area Office which was provided by co-signers on the Alaska Tribal Health Compact. Data were adjusted to delete sanitation and health facilities construction funding from the Title III compact totals.

Data Limitations

During the collection and analysis of the data, several limitations were discovered in the financial reports from the IHS accounting and budgeting systems. These limited the usefulness of the analysis and the conclusions. In general, the data provided for FY 93 and FY 97 is much more complete and consistent than the data provided for the intermediate years. Some of the inaccuracies in the data were caused by a series of changes in the IHS budgeting and accounting system that were implemented to allow the agency to account for Title III self-governance compacts. These changes in the IHS budget structure and financial reporting system were not implemented consistently across the 5 years of the analysis, nor have they been implemented consistently across the 12 Area Offices of the IHS.

In FY 93 and FY 94, all self-governance compacts were initially managed through the Office of Self-Governance at Headquarters. Funds for the self-governance compacts were withdrawn from Area Office accounts and expensed directly into self-governance compacts at Headquarters. This creates the appearance that Area Offices with high activity by self-governance tribes are actually losing funding when in fact these funds are merely being transferred and expensed against Headquarters accounting points.

During FY 94 and FY 95, the funds for Title III self-governance compacts (from many allowances) were grouped together to provide information on overall levels of Title III compacting. This was not completed in a consistent manner across all Areas, making the data from different Areas difficult to compare. Additionally, the ability to track trends in the contract support or other specific sub-sub-activities was lost as these funds were accounted for differently in different fiscal years.

Data reported on the expenditures of revenue from third party resources were very incomplete, and should be interpreted with great care. The IHS accounting system is relatively accurate in reporting the expenditures by direct IHS facilities from third party resources. But it substantially under-reports the collection and expenditures by all tribal health providers of these resources.

Tribal health providers in non-federal facilities, or operating programs with Urban Indian funding, or authorized under the Medicaid Demonstration Project, collect substantial portions of their Medicaid revenue directly from the states. All tribal providers collect and expend payments from private third party providers directly. These payments that do not go through the IHS are not accounted for by the IHS financial management system. It is highly likely that there is great variability among Areas[26] on the amounts of third party revenue available to tribal contractors and compactors that are not recorded in the IHS accounting system.

Population Growth

The impact of population growth on the per capita IHS expenditure for services was computed by using IHS estimates of growth in the service population by Area as reported in *IHS Trends in Indian Health, 1996*.

Two measures of the IHS service population were available. The IHS "active user" population is the number of eligible AI/AN individual who have used the I/T/U system in the past three years. This user count is take from the IHS system and has been subject to some tribal criticism due to data transfer problems from tribal registration systems. In addition, this system does not reflect the true "demand" on the I/T/U system because eligible AI/AN in many Areas are prevented from using the system due to barriers caused by Inadequate funding.

The IHS "service population," used in this report, is estimated by the IHS from the 1990 U.S. Census age, race and gender files. Population projections are developed by the IHS using standard demographic techniques and information from the 1984-1993 vital events files.

Inflation

IHS faces numerous built-in inflationary factors, in addition to beneficiary population growth. Congressionally appropriated Pay Act increases, within-grade increases, changes in incentive pay structure for Commissioned Corps personnel, increased costs of purchased drugs, supplies and other materials, increases in rent and utilities, cost of technological improvements to maintain standards of care, and increases in the costs of purchased medical services all contribute to the inflationary costs of the IHS.

Several measures were considered for indexing IHS expenditures to inflation. Congressionally appropriated amounts for pay increases were considered, but they under-represent the inflation factor on federal wages. They do not account for grade or within grade salary increases awarded for seniority and for increase in incentive

[26] For example, there are no federal facilities in the California Area, so no Medicaid or Medicare revenue is reported as expended by tribal health programs in the DHHS financial system.

payments for physicians or other health professionals. In addition, tribal contractors are increasingly relying on private sector employees to replace federal employees lost to retirement or transfer. These employees must be recruited and retained with wage increases consistent with increases in the general medical sector. The general Consumer Price Index (CPI) and the CPI wage index were also considered. However, inflation in the medical services component has significantly outpaced growth in the overall index or the wage sector of the CPI in the last two decades.

The medical care component of the CPI was considered to be the most accurate indicator of inflationary pressure experienced by the IHS and tribal providers. Thus, the medical care component of the CPI was used to adjust for inflation in this study.

RESULTS

Appropriations for the Indian Health Service

Unlike most major federal health programs, the budget of the IHS (which is funded primarily under the authority of the Synder Act) is treated as a discretionary program in the federal budget process. Congress often appropriates fewer resources than needed. American Indians and Alaska Natives who use the IHS system must bear the impact of any shortfalls in these appropriations through longer waiting times for care, limited services, older medical technology, outdated facilities, elimination of health programs, and overall reductions in the level of health care services provided by the Indian Health Service and tribal health care systems.

During the past five years, the budget appropriations for the IHS grew very slowly with increases of between 1 and 3 percent per year (see Figure 4.1). Although these increases may have been comparable to or slightly in excess of many federal discretionary programs during this period, they were less than the increases provided to the major federal health care entitlement programs. Medicaid averaged over 10 percent growth per year for the period 1992 to 1996, over 4 times the levels of growth in the IHS budget over the same period.[27]

This trend is not new. The IHS has been struggling to keep pace with the growth in the cost of health care and the rising number of IHS beneficiaries for the past two decades. A report issued by the Department of Health and Human Services in 1986, entitled "*Bridging the Gap: Report on the Task Force on Parity of Indian Health Services,*" found that expenditures per capita by IHS declined from 75 percent of national expenditure levels in 1975 to less than 69 percent in 1986. In the subsequent decade, this gap widened. In the FY 99 budget submission to the DHHS, the Agency cites the Health Care Financing Administration publication entitled *Health Care Financing Review,* which indicates that IHS appropriations in FY 97 were less than 34 percent of the per capita expenditure for the civilian US population.

[27] Health Care Financing Administration, MB, OMM, DM, Medicaid -Vendor, Medical Assistance and Administrative Payments for FY 87-96.

Figure 4.1

INDIAN HEALTH SERVICE APPROPRIATIONS (FY 94-FY 98) *(dollars in thousands)*					
Health Program	**FY 94**	**FY 95**	**FY 96**	**FY 97**	**FY 98***
Hosp/Clinics	$799,574	$823,866	$852,435	$890,824	$906,801
Dental Services	$53,151	$57,518	$59,680	$62,783	$65,517
Mental Health	$35,272	$36,448	$37,561	$38,341	$39,279
Alcohol/Subt.Ab.	$87,617	$91,352	$91,666	$91,482	$91,782
Contract Health Serv.	$349,848	$362,564	$365,099	$368,325	$337,375
Public Health Nursing	$22,187	$23,505	$24,311	$26,676	$28,198
Health Education	$7,919	$8,244	$8,421	$8,632	$8,932
Community Health Reps	$43,010	$43,955	$43,958	$43,973	$44,312
AK Immunizations	$1,348	$1,328	$1,328	$1,328	$1,328
Urban Health	$22,834	$23,349	$23,360	$24,768	$25,288
Health Professions	$27,406	$28,044	$26,271	$26,270	$26,720
Tribal Management	$5,285	$5,348	$2,348	$2,348	$2,348
Direct Operations	$49,471	$49,709	$49,260	$48,709	$47,386
Self-Governance	$4,980	$9,090	$9,104	$9,090	$9,106
Contract Support Costs	$136,186	$145,460	$153,040	$160,720	$168,702
Total Services	$1,646,088	$1,709,780	$1,747,342	$1,806,269	$1,841,074
Total Facilities	$296,980	$253,282	$238,958	$247,731	$257,538
Total Appropriations	$1,943,068	$1,963,062	$1,986,800	$2,054,000	$2,098,612
Increase in Appropriation	+3.7%	+1.0%	+1.2%	+3.4%	+2.2%
Population Growth	+3.2%	+2.8%	+2.2%	+2.3%	+2.3%
Inflation (Medical CPI)	+4.9%	+5.1%	+4.1%	+3.4%	+3.4%

Impact of Population Growth and Inflation

The increases in IHS appropriations have not kept pace with the inflationary costs of health care. Although inflation the medical sector has slowed from the double digit pace of the late 1980s, health care still remains one of the most inflationary sectors of the economy. Premiums paid by employers for health care increased an average of 5 percent annually throughout the first half of the decade. The medical component of the Consumer Price Index also shows increases of between 3-5 percent per year during the past 5 years.

The IHS health program has experienced significant additional growth due to increased population of Alaska Natives and American Indians. During the period from 1993 to 1994, the IHS service population[28] increased generally between two and three percent each year due to natural population growth and the addition of newly recognized tribes with eligibility for IHS services.

[28] *Trends in Indian Health, 1996*, Indian Health Service.

Figure 4.2 shows the changes in the per capita IHS appropriations (Services and Facilities) for the years 1993 to 1998. This information is illustrated in the graph in Figure 4.3. Without adjusting for inflation (the bars), the amount provided to the IHS per capita (bars) has remained virtually constant over the six year period. When the amount is adjusted for inflation (the line), a marked decline is noted in the per capita amount available from IHS appropriations to provide health care to IHS beneficiaries.

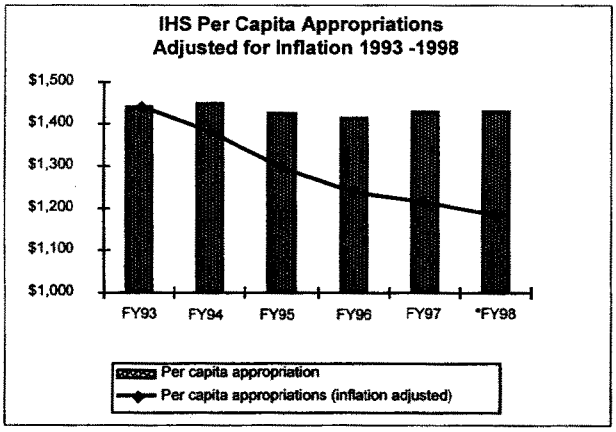
Figure 4.2

IHS PER CAPITA APPROPRIATIONS (FY 93 - FY 98)
(dollars in thousands)

Year	Appropri-ations	Population	% Pop. growth from 93	Per Capita	Medical CPI	% CPI growth from 93	Adjusted Per Capita
FY93	$1,874,351	1,299,415	-	$1,442	199	-	$1,442
FY94	$1,943,068	1,340,666	+ 3.2%	$1,449	208	+ 4.9%	$1,382
FY95	$1,963,062	1,376,692	+ 5.9%	$1,426	218	+10.0%	$1,297
FY96	$1,986,800	1,405,437	+ 8.2%	$1,414	227	+14.1%	$1,239
FY97	$2,054,000	1,435,529	+10.5%	$1,430	233	+17.5%	$1,217
FY98	$2,098,612	1,466,354	+12.8%	$1,431	240	+20.9%	$1,183

*Includes all directly appropriated dollars including construction funds. Excludes third party collections from Medicare and Medicaid and private insurance.

Figure 4.3



*FY 98 CPI estimated based on CPI data to 11/97 extrapolated to 3/98.

Scope of Title III Compacting in the IHS

During this period of generally declining resources, the Self-Governance Demonstration Project was authorized by Congress in P.L. 100-472, P.L. 102-537, and P.L. 102-184, as amendments to P.L. 93-638. The IHS began planning with selected tribes for self-governance compacts in FY 92, and awarded self-governance compacts to six tribes in the last quarter of FY 93. For the first time, these compacts included about $5 million of "tribal share" resources, which had previously been expended by IHS Headquarters or Area Offices in support of the health services provided to the tribes.

By 1997, this effort had expanded to include over 239 tribes[29] and over $423 million in funds, including about $48.3 million in "tribal share"[30] funding from Headquarters and the Area Offices. As Table 4.4 illustrates, self-governance compacts under Title III are very unevenly distributed across the Area Offices of the Indian Health Service. Several Areas, including Aberdeen, Albuquerque, Navajo, and Tucson have no Title III compacts, while the Alaska Area has over 95 percent of its tribes served under a Title III compact for at least some portion of their primary care services.[31] In addition, each tribe involved in compacting has negotiated the Programs/Functions/Services/ Activities (P/F/S/As) to be included in its Title III agreement,[32] which has resulted in additional variation in the amount of funds available to the tribes as "tribal shares" across the agency.

Because of the variability in the amount of "tribal share" resources made available to Title III tribes across Area Offices, it is difficult to generalize regarding the impact Title III has had on Area Offices across the agency.

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[29] Includes 206 tribes in the Alaska Tribal Health Compact (ATHC) which are members of 15 separate regional tribal health organizations that directly participate in the ATHC.
[30] These funds are normally labeled "non-recurring" to the tribe but are generally recurring to the Agency.
[31] Alaska is a good example of the difficulty in categorizing tribes as direct service or Title III. Virtually every larger tribe in Alaska has, or is a member of a consortium that has, a Title III compact. The Alaska Native Medical Center, however, is still operated by the IHS and serves as the principle referral center for the entire state and as the primary care facility for Anchorage and many surrounding communities.
[32] For example, the Alaska Area Office in FY 98 has been impacted the greatest, with compacting by 206 tribes of the ATHC. However, the tribes voluntarily left $13.8 million (more than the total $11.6 million taken in "tribal shares" by the Alaska tribes) in tribal share resources at the Area Office to continue support of selected programs.

Figure 4.4

Total Funding in Tribal Self-Governance Compacts FY 97
(dollars in thousands)

Area Office	Number SG Tribes	Program/SU Base Funding	Area Office Tribal Shares	Headquarters Tribal Shares	Total Funding
Aberdeen	0	$0	$0	$0	$0
Alaska	216	$173,809,470	$10,747,235	$6,941,683	$191,498,388
Albuquerque	0	$0	$0	$0	$0
Bemidji	5	$12,274,880	$1,594,386	$988,874	$14,858,140
Billings	2	$19,435,739	$1,859,302	$1,877,843	$23,172,884
California	2	$7,421,505	$660,558	$416,784	$8,498,847
Nashville	2	$12,344,217	$1,403,131	$564,249	$14,311,597
Navajo	0	$0	$0	$0	$0
Oklahoma City	8	$97,142,564	$4,317,573	$9,705,952	$111,166,089
Phoenix	3	$6,220,981	$227,408	$2,358,659	$8,807,048
Portland	11	$29,548,577	$2,987,484	$1,663,908	$34,199,969
Tucson	0	$0	$0	$0	$0
Total	249	$358,197,933	$23,797,077	$24,517,952	$406,512,962
Percentage		88.1%	5.9%	6.0%	100.0%

Source :IHS Compact Summary

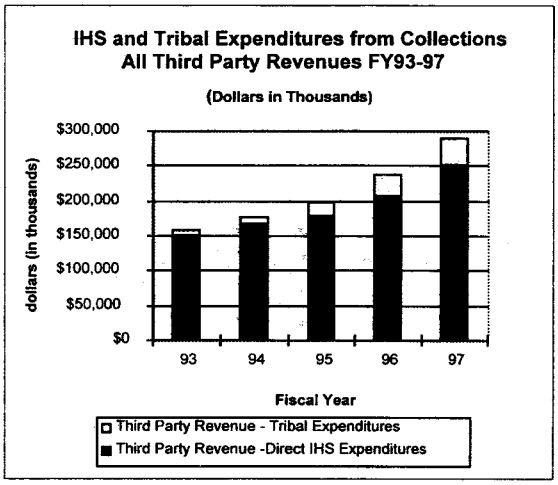
Alternate Resources - Medicaid, Medicare, and Private Insurance

To cope with less than adequate levels of congressional appropriations, the IHS and the tribes that operate health programs have been forced to rely increasingly on alternate resources. Revenue from Medicaid, Medicare, and private insurance is becoming an increasingly important source of revenue to maintain services.[33]

From FY 93 to FY 97, third party revenue as reported by the IHS accounting system increased over 80 percent from about $159 million in FY 93 to over $290 million in FY 97, as illustrated in Figure 4.5.

[33] In the DHHS financial data system, all revenues are actually shown as expenditures. Thus the term "expenditure" is used in this report. The terms "expenditure against third party revenue" and "expenditures against collections" are more precise terminology, since the system only reports expenditures and not income.

Figure 4.5



Includes all expenditures from all allowances for Medicaid and Medicare, private insurance, and Federal Medical Cost Recovery Act. Tribal expenditures include both Title I and Title III expenditures.

Reported expenditures of self-generated revenue by directly operated IHS programs accounted for most of the increase (almost $100 million). IHS directly-operated programs generate the majority of third party revenue reported throughout the IHS system. This is because IHS continues to operate the majority of IHS hospitals and all the larger medical centers, which deliver more expensive services and therefore generate larger amounts of third party revenue. Tribal health programs, although starting from a much smaller base, increased revenue from Medicaid and Medicare at a much faster rate. Reported tribal health program expenditures of Medicare and Medicaid resources increased from about $10.5 million in FY 93 to almost $40 million in FY 97, for an increase of almost 400 percent.

The self-generated revenue reported by tribes is significantly under- reported in the IHS accounting system, since this item includes only Medicare and Medicaid revenue. Payments for Medicaid and Medicare are only captured if collected under the authority of P.L. 94-437 through the IHS/HCFA negotiated encounter rate. Collections of Medicaid from the four large tribal facilities operating under the authority of the Medicaid Demonstration Project are paid directly to the facility by the states, and are not included in the total reported by the IHS. Many tribes also collect payments from state Medicaid programs for services provided outside IHS facilities through programs and employees that are enrolled through normal state Medicaid provider enrollment processes. These

payments are normally made directly by states to tribal providers, effectively bypassing the IHS accounting system.

Additionally, revenue received by tribes from private insurance is paid directly to tribes and not recorded in the IHS accounting system.

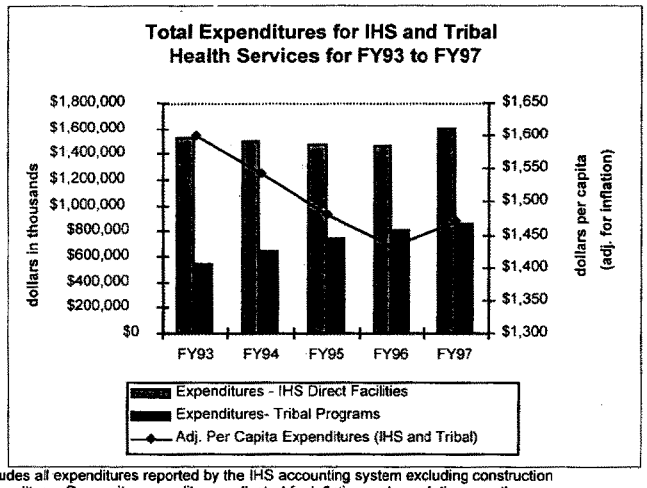
Total Expenditures Reported By IHS and Tribal Health Providers

Total expenditures reported by all IHS and tribal health providers continued to grow over the five year period. Almost all of the growth in total expenditures was in the tribal health system, as tribes continued to assume control of an increasingly larger portion of the IHS health delivery system. Expenditures for IHS direct services increased for the first time in FY 97, as a result of collections from third party revenue.

Despite the substantial increase in self-generated revenue for all IHS and tribal health providers, the total per capita expenditures when adjusted for inflation remained in a downward trend for the period from FY 93-96 (see Figure 4.6). There was a modest increase in adjusted per capita expenditures in FY 97. This is attributable to a large increase in Medicaid revenue from an adjustment in the IHS/HCFA negotiated encounter rate. The average rate paid by Medicaid for both inpatient and outpatient care was increased by over 50 percent.[34] The increase was granted in recognition of the inadequate increases that had been negotiated in the late 1980s and early 1990s, when inflationary costs in medical care were approaching 10 percent annually. Although the IHS has maintained that Medicaid continues to under-reimburse the costs incurred in providing care, it is unlikely that an increase of this magnitude will be repeated.

[34] Inpatient rates rose from $487 per day to $736 per day (and from $570 to $930 per day in Alaska).

Figure 4.6



Includes all expenditures reported by the IHS accounting system excluding construction
Expenditures Per capita expenditures adjusted for inflation and population growth.

Changes in Expenditures at Headquarters and Area Offices

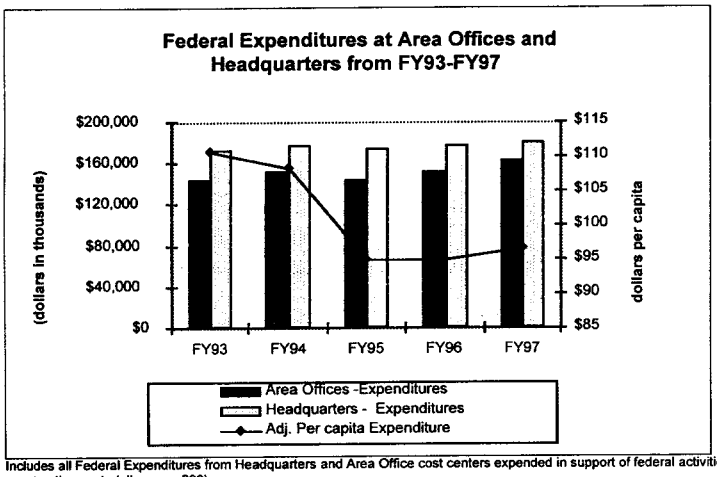
Since the advent of self-governance compacting, overall expenditures at IHS Headquarters and all Area Offices have remained relatively constant. When adjustments are made for inflation and population growth, the adjusted amount of yearly per capita funding available to support Headquarters and Area operations has declined from about $111 to about $97 over the five year period from FY 93 to FY 97.

Some expenditures currently reported to Headquarters do not directly support headquarters operations and will not decline with continued downsizing of Headquarters. For example, Indian Health Service Scholarships for Indian students from across the country are supported from Headquarters. Some Contract Health Service funding that is spent at the Service Unit level is included in Headquarters accounting, such as the Contract Health Emergency Fund (CHEF) expenditures.

Declines in the expenditures at the Area Offices and Headquarters are not at the levels expected, considering the transfer of "tribal shares" totaling $48 million (Figure 4.4) from these levels of the agency to tribally-operated Title III programs. However, reductions in force and reassignments of personnel actually require substantial resources to complete during the transition period. Any savings in operational costs that can be

achieved through these activities cannot be expected to accrue until one or two years after the actual reorganization or reduction in the size of the agency.

Figure 4.7



Includes all Federal Expenditures from Headquarters and Area Office cost centers expended in support of federal activities except construction costs (allowance 290)

Continued declines should be expected in both the total Area Offices and Headquarters expenditures over the next two to three years, as savings from staffing reduction and reassignments made in FY 96 and FY 97 begin to accrue to these levels of the agency. This should accelerate in FY 2000 and beyond, when the reductions currently planned at Headquarters for FY 98 and 99 start to result in actual savings.

Figure 4.8

Federal Expenditures in Support of Area Offices
FY 93 and FY 97
dollars in thousands

Area Office	# Title III Tribes	FY 93 Area Office (AO Expend. only)	FY97 Area Office (AO Expend. only)	Change in Area Expenditures
Aberdeen	0	$14,186	$20,400	43.8%
Alaska	207	$28,808	$19,377	-32.7%
Albuquerque	0	$12,804	$9,265	-27.6%
Bemidji	5	$8,422	$7,327	-13.0%
Billings	2	$8,682	$8,803	1.4%
California	2	$7,112	$5,673	-20.2%
Nashville	2	$7,310	$6,339	-13.3%
Navajo	0	$28,808	$37,811	31.3%
Oklahoma City	8	$27,713	$37,697	36.0%
Phoenix	3	$14,403	$13,559	-5.9%
Portland*	11	$12,324	$9,224	-25.2%
Tucson	0	$8,636	$6,133	-29.0%
Total	240	$156,386	$155,075	-0.8%

All amounts exclude new construction expenditures, *Portland Area is FY 94 data, because FY 93 data is not available.

There is a great deal of variation, however, in changes in federal expenditures at Area Offices. Although it would be expected that relative growth or decline in federal expenditures at individual Area Offices would be directly related to the amount of Title III compacting activity in the Areas, this factor explains little of the variation. Although expenditures in support of Area Office functions have continued to increase in some of the Areas with little Title III activity, the Tucson and Albuquerque Areas are notable exceptions. These two Area Offices, which have no Title III compacts, appear to have continued to reduce overall expenditures and to provide additional resources to the directly-operated IHS programs. As expected, declines in expenditures at Area Offices are also evident in Areas such as Alaska and Portland, which have relatively high participation by tribes in self-governance compacting and self-determination contracting. On the other hand, the Oklahoma Area, which has a high rate of Title III compacting, shows a growth in expenditures at the Area Office.[35]

Area Office expenditures also show significant variation across Areas and across fiscal years. These variations may be explained by many factors, including the size of the Area and variations in Area Office budgeting and accounting practices. Trends across fiscal years in the same Area can show variation due to changes in internal accounting practices over the time period.

[35] Expenditure data on the Oklahoma Area appear inconsistent across fiscal years, so the apparent increase could be an artifact of the financial reporting system.

Trends in Total Expenditures by Areas

In general, there is a wide variation in structure and spending patterns across the Areas of the IHS. The size of the service population varies from approximately 28,000 beneficiaries in the smallest Area (Tucson) to over 300,000 in the largest Area (Oklahoma).

Health care expenditures per capita also vary substantially between the Areas, from about $3,300 per capita in the Alaska Area to only $800 per capita in the California Area, not adjusted for inflation. These differences reflect historical resource allocation patterns, current levels of need, differences in costs of care, dependence on IHS as a primary care resource by eligible IHS beneficiaries, and a host of other factors. One factor that may explain a large part of this difference is that the DHHS Financial Data System used for this analysis does not report Medicaid and Medicare expenditures for California, while there is a significant amount of these sources in the Alaska totals.[36] An IHS survey on the scope of services provided in 1993, found that the level of need met by the agency ranged from 31 percent in the California Area to roughly 70 percent in the Aberdeen and Tucson Areas.[37]

This section of the report summarizes, for each of the IHS Areas, the changes in resources after self-governance started in 1993. The impact of population growth and inflation for each Area is also evaluated. More detailed information is presented Volume 3.

Terminology

Terminology can sometimes be confusing. The following definitions will help clarify the meaning of the terms used in this section:

Area: (example: "Aberdeen Area") This includes all expenditures recorded in the DHHS financial reporting system for all tribes and administrative services within that Area. This includes IHS funding, as well as Medicaid and Medicare when collected through the IHS. It includes the items defined below as Area Office cost center, Federal Direct Expenditures, and Tribal Health Program Expenditures. It only includes operational costs, not expenditures for new construction for water and sewer or health facilities.

Area Office or ***Area Office cost center***: (example: "Aberdeen Area Office" or "Aberdeen Area Office cost center") The cost center includes federal expenditures for the Area Office that are not allocated to Service Units or tribal health programs. It only includes operational costs, not expenditures for new construction for water and sewer or health facilities.

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[36] The FY 97 Medicaid and Medicare expenditures in Alaska exceeded $47 million.
[37] Neale, John F. DDS, MPH, Health Services Inventory of the Indian Health Service (internal IHS document).

Federal Direct Expenditures: (labels on bars in figures) These are expenditures for IHS direct services, including the Area Office cost center. This figure includes both IHS appropriations and third party collections. It only includes operational costs, not expenditures for new construction for water and sewer or health facilities.

Tribal Health Program Expenditures: (labels on bar in figures) These are expenditures of federal money for tribally-operated programs under both Title I contracting and Title III compacting. This amount includes program funds, indirect costs, and tribal shares. It also includes any Medicaid or Medicare paid to the tribes through the IHS. It does not include private insurance collections or contributions from tribes. It only includes operational costs, not expenditures for new construction for water and sewer or health facilities.

Adjusted per capita expenditure: (lines in the figures) These are total expenditures for the Area, both federal direct expenditures and tribal expenditures, that are adjusted for inflation and divided by the service population. This amount includes the Area Office cost center. It only includes operational costs, not expenditures for new construction for water and sewer or health facilities. Adjusted per capita expenditures are used to identify trends. Adjusted per capita expenditures represent the purchasing power of federal expenditures each year in dollars equivalent to the base year. The base year for all Areas except Portland is the 1993 Fiscal Year. For the Portland Area, the base year is FY 1994.

Per capita expenditure: These are total expenditures divided by the service population. Per capita expenditures are not adjusted for inflation. Per capita expenditures are used to compare between Areas using the same fiscal years. Figure 4.9 shows the service population for each Area for 1993 and 1997.

Figure 4.9

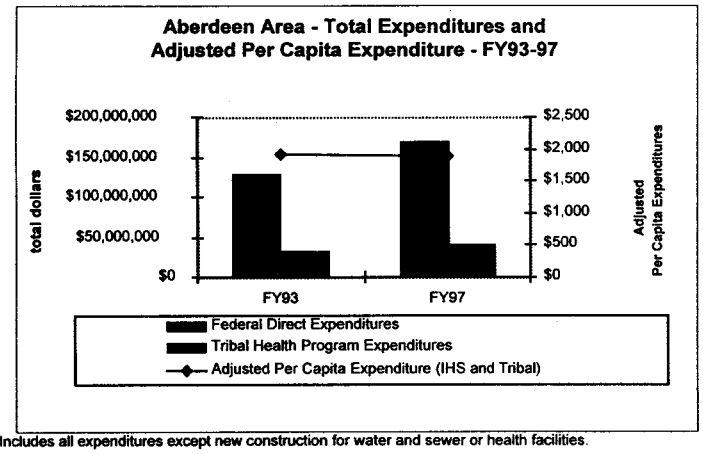
IHS SERVICE POPULATION BY AREA FOR 1993 AND 1997

Area Office	1993 Service Population	1997 Service Population
Aberdeen	85,454	94,204
Alaska	93,390	103,209
Albuquerque	72,117	78,686
Bemidji	65,412	79,427
Billings	50,564	55,178
California	113,448	123,208
Nashville	56,062	72,836
Navajo	195,118	213,831
Oklahoma City	277,268	298,499
Phoenix	128,524	139,993
Portland	136,180	147,887
Tucson	25,878	27,571
Total	1,299,415	1,434,529

Source :IHS Regional Differences, 1996 and IHS Office of Statistics

Aberdeen Area

Figure 4.10



Includes all expenditures except new construction for water and sewer or health facilities.

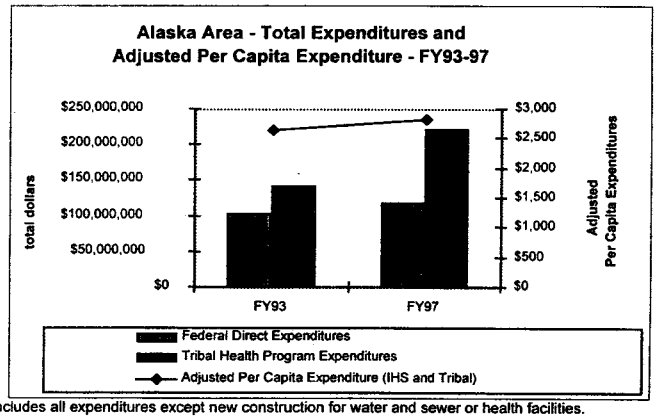
Expenditures in the Aberdeen Area increased from $163 million in FY 93 to $210 million in FY 97 (these totals reflect the combination of Federal Direct Expenditures and Tribal Health Program Expenditures in the Figure above), reflecting an increase of almost 29 percent in funding. In addition to the small mandatories and routine increases available to all Areas, Aberdeen received additional staffing funds as directed by Congress for the new hospital in Pine Ridge, South Dakota, and new health centers in Wayne, South Dakota, and Belmont, North Dakota. The Aberdeen Area also increased collections from third party resources by over 100 percent during this period, from less than $15 million in 1993 to over $31 million in 1997.

Aberdeen had no tribes compacting under the authority of Title III. Federal expenditures in support of the Aberdeen Area Office cost center continued to increase faster than increases in the Area budget. The Area Office grew from about $14.2 million to $20.4 million, or an increase of about 44 percent.

Per capita expenditures increased in the Aberdeen Area from $1,910 to $2,226. When adjusted for inflation, the per capita expenditures in Aberdeen over the 5 year period decreased by less than 1 percent.

Alaska Area

Figure 4.11



Includes all expenditures except new construction for water and sewer or health facilities.

The Alaska Area expenditures grew from $245 million in FY 93 to $340 million in FY 97 (these totals reflect the combination of Federal Direct Expenditures and Tribal Health Program Expenditures in the Figure above), an increase of almost 39 percent in funding over the period. Much of this unusually large increase is attributable to new funds directed by Congress to staff the new Alaska Native Medical Center (ANMC),

which is the statewide tertiary care center located in Anchorage, and the Kotzebue hospital. Alaska also increased collections from third party resources substantially during this period, from less than $28 million in 1993 to over $52 million in 1997.[38] New revenue from Title III compacting in the Area (Headquarters tribal shares) accounted for only about $6.9 million, or 7 percent of the increase in funding from FY 93 to FY 97.

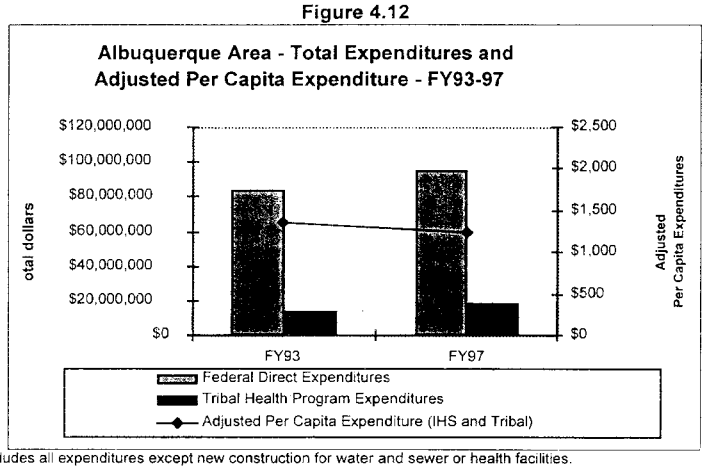
Virtually all tribes in Alaska compact under the authority of Title III. Federal expenditures in support of the Alaska Area Office cost center decreased substantially over the period, dropping from almost $29 million in 1992 to $19.3 million in 1997. This amounts to a 33 percent decrease.

Per capita annual expenditures increased in the Alaska Area over the five year period, from $2,626 to $3,300. When adjusted for inflation, the per capita expenditures in Alaska increased over the entire 5 year period by about 7 percent.

[38] This amount reflects only the Medicaid and Medicare collections received through the IHS. Two of the HCFA Demonstration projects are in the Alaska Area.

Albuquerque Area

Figure 4.12



Includes all expenditures except new construction for water and sewer or health facilities.

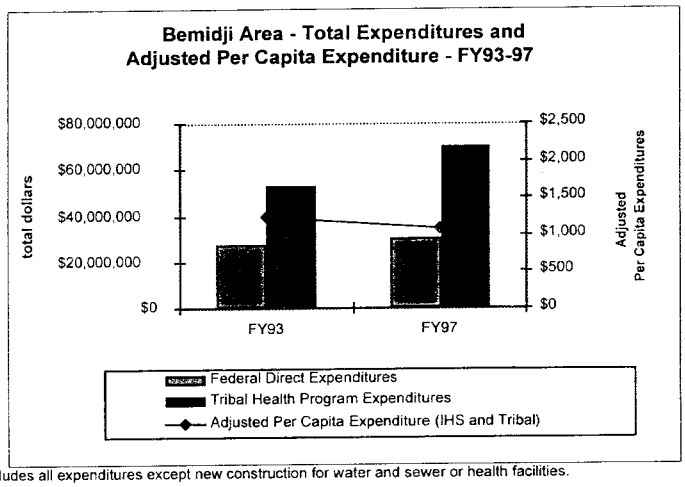
The Albuquerque Area increased expenditures from $97 million in FY 93 to $113 million in FY 97 (these totals reflect the combination of Federal Direct Expenditures and Tribal Health Program Expenditures in the Figure above), an increase of 16 percent over the period. Albuquerque had limited increases in expenditures from IHS appropriations. The expenditures against collections from third party resources increased by over 100 percent, from $9 million in 1993 to over $18.3 million in 1997.

The Albuquerque Area had no tribes compacting under the authority of Title III. However, federal expenditures in support of the Albuquerque Area Office cost center still declined substantially: from $12.8 million in FY 93 to $9.3 million in FY 97, a decrease of about 29 percent.

Per capita expenditures increased slightly in the Albuquerque Area, from $1,357 to $1,447. When adjusted for inflation, the per capita expenditures in the Albuquerque Area decreased about 9 percent over the 5 year period.

Bemidji Area

Figure 4.13



Includes all expenditures except new construction for water and sewer or health facilities.

Bemidji Area expenditures grew from $80.8 million in FY 93 to $101 million in FY 97 (these totals reflect the combination of Federal Direct Expenditures and Tribal Health Program Expenditures in the Figure above), resulting in an increase in funding of almost 25 percent over the period. The Bemidji Area also increased collections from third party resources substantially during period, from less than $5 million in 1993 to over $30 million in 1997.[39]

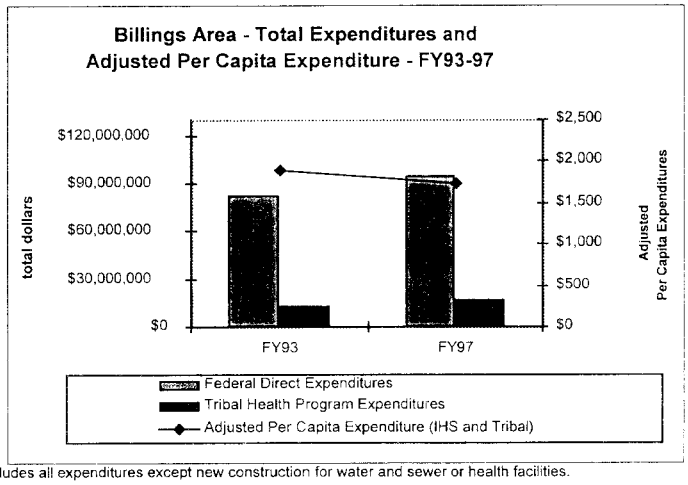
Bemidji had five tribes compacting under the authority of Title III. Federal expenditures in support of the Bemidji Area Office cost center dropped from $8.4 million to about $7.4 million over the period.

Per capita expenditures rose less in the Bemidji Area was less than for the IHS overall, from $1,235 in 1993 to $1,272 in 1997. When adjusted for inflation, the per capita expenditures decreased by 14 percent. This greater than average decrease is attributable primarily to a large increase in the service population in the Bemidji Area. Where most Areas experienced a natural population growth of between 6 and 10 percent during the period, Bemidji experienced a 21 percent population increase, primarily due to the addition of newly-recognized tribes.

[39] Over half of the increase in Medicaid and Medicare collections in the Bemidji Area is from tribal health providers in FY 97. This may have been caused by tribal health providers beginning to collect Medicaid and Medicare revenue under the authority provided by the MOA between HCFA and IHS, which was finalized in early 1997.

Billings Area

Figure 4.14



Includes all expenditures except new construction for water and sewer or health facilities.

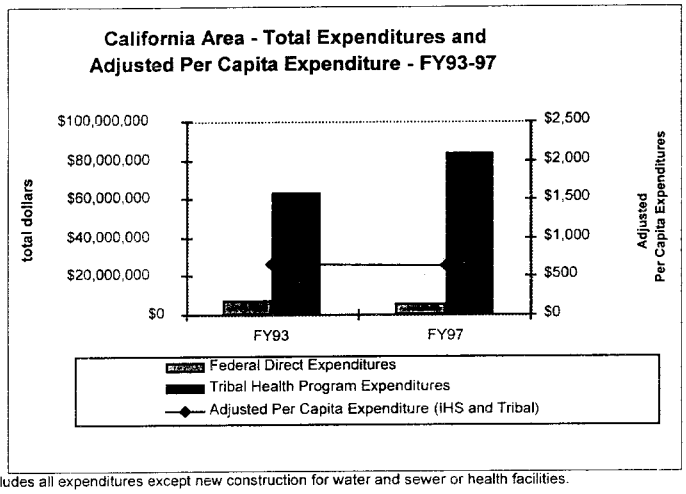
Expenditures in the Billings Area, with a service population of about 55,000, increased from $95.9 million in FY 93 to $112.7 million in FY 97 (these totals reflect the combination of Federal Direct Expenditures and Tribal Health Program Expenditures in the Figure above). This was an increase of almost 18 percent in funding over the period. The Billings Area received some direct appropriations to provide staffing and support for three facilities in Montana: a new hospital at the Crow Reservation and new health centers at Fort Belknap and Hayes. As in other Areas, much of the total increase was the result of collections from third party resources. These increased by 125 percent during period, from about $9 million in 1993 to about $20.6 million in 1997.

The Billings Area has two tribes compacting under the authority of Title III. Federal expenditures in support of the Billings Area Office cost center first increased and then dropped slightly over the period.

Per capita expenditures increased slightly in the Billings Area, from $1,896 to $2,042. When adjusted for inflation, the per capita expenditures in the Billings Area decreased over the five year period by about 8 percent.

California Area

Figure 4.15



Includes all expenditures except new construction for water and sewer or health facilities.

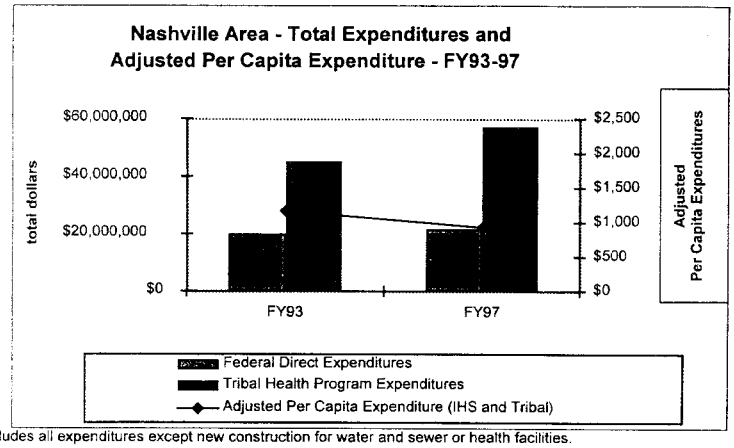
The California Area, serving about 120,000 beneficiaries, has the lowest reported expenditure level per capita of any Area Office in the IHS. Per capita expenditures in the California Area rose from $648 in 1993 to $745 in 1997. When the per capita expenditures are adjusted for inflation, however, amount decreased by about 2 percent.

Total IHS expenditures for the California Area grew from $70.8 million in FY 93 to $90.1 million in FY 97 (these totals reflect the combination of Federal Direct Expenditures and Tribal Health Program Expenditures in the Figure above), or an increase of about 27 percent over the period. With no IHS directly-operated facilities and few federally-owned tribally-operated facilities in the California Area, these figures do not include third party revenue for any year in the period. As noted previously in the report, most tribal providers collect substantial amounts of third party revenue directly and do not report expenditures through the IHS financial management system. Thus, the total under-represents the actual expenditures.

California has two tribes compacting under the authority of Title III. Federal expenditures in support of the California Area Office cost center have declined significantly, from about $7.1 million in FY 93 to $5.6 million in FY 97. This is a decrease of about 26 percent.

Nashville Area

Figure 4.16



Includes all expenditures except new construction for water and sewer or health facilities.

The Nashville Area expenditures grew from $65.2 million in FY 93 to $79.1 million FY 97 (these totals reflect the combination of Federal Direct Expenditures and Tribal Health Program Expenditures in the Figure above), an increase of almost 21 percent over the period. The figures for the Nashville Area show the lowest levels of collections of third party revenue of any Area except California. DHHS figures indicate a growth in this revenue of about $1.4 million over the period, from less than $2 million in 1993 to about $3.3 million in 1997. Because this Area has only one IHS directly-operated facility, expenditures against third party collections may be substantially under reported in the IHS financial management system.

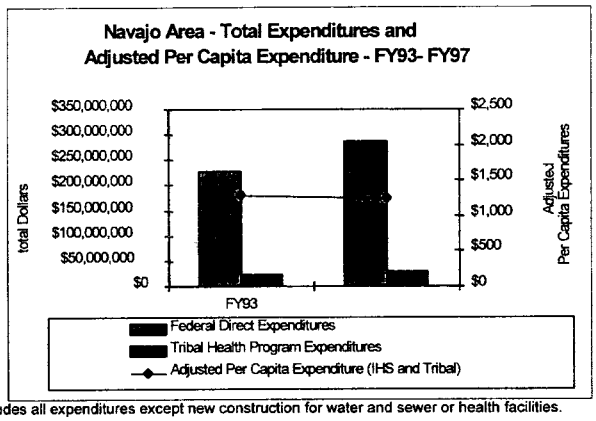
The Nashville Area, with two tribes compacting under the authority of Title III, experienced reductions in expenditures from the Area Office cost center. The Area Office budget declined by about $1 million, from $7.3 million in FY 93 to $6.4 million in FY 97.

Nashville was the only Area to experience a decline in per capita expenditures prior to adjusting for inflation. The unadjusted per capita expenditure went from $1,164 in FY 93 to $1,087 in FY 97. This greater than average decrease is attributable primarily to the large growth in the service population in the Nashville Area. While most Areas experienced a natural population growth of between 6 and 10 percent during the period, Nashville experienced a population increase of almost 30 percent, primarily due to the addition of newly recognized tribes.

Inflation-adjusted per capita expenditures in the Nashville decreased more than per capita expenditures did in any other Area Office, from $1,164 in 1993 to $926 in 1997, or almost 25 percent. Like California, per capita expenditures in the Nashville Area are probably significantly understated in the DHHS financial reporting system due to the treatment of third party revenue by tribal contractors.

Navajo Area

Figure 4.17



Includes all expenditures except new construction for water and sewer or health facilities.

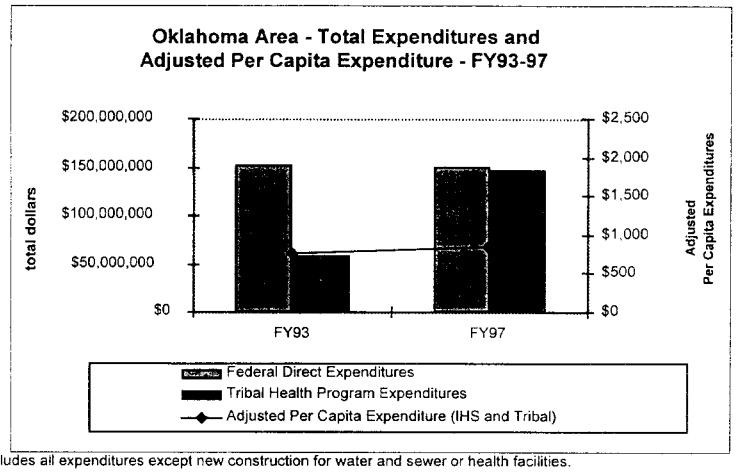
The Navajo Area expenditures grew from $245 million in FY 93 to $313 million in FY 97 (these totals reflect the combination of Federal Direct Expenditures and Tribal Health Program Expenditures in the Figure above), an increase of almost 27 percent. The Navajo Area also relied substantially on increased collections from third party resources. Expenditures against these resources increased by over 56 percent, from less than $48 million in FY 1993 to over $75 million in FY 1997.

The Navajo Area had no tribes compacting under the authority of Title III. Federal expenditures in support of the Navajo Area Office cost center continued to increase faster than increases in the Area budget, from about $28.8 million to $37.8 million from FY 93 to FY 97. This was an increase of about 31 percent.

Unadjusted per capita expenditures increased slightly in the Navajo Area, from $1,288 to $1,463. When adjusted for inflation, however, the purchasing power in the Navajo Area decreased over the 5 year period by about 3 percent.

Oklahoma Area

Figure 4.18



Includes all expenditures except new construction for water and sewer or health facilities.

The Oklahoma Area, with a service population of about 298,000, is the largest Area in the IHS. Expenditures grew from $211 million in FY 93 to $297 million in FY 97 (these totals reflect the combination of Federal Direct Expenditures and Tribal Health Program Expenditures in the Figure above), an increase of almost 40 percent. In addition to relying on the small mandatory and routine increases available to all Areas, Oklahoma received directly appropriated funds for additional staffing for the new facilities constructed in the Area. Oklahoma also received an additional $9.7 million in tribal share resources for the Area. This represented about 11 percent of the total increase in revenue received by the Area. Collections from third party resources in the Oklahoma Area increased by over 100 percent, from less than $16 million in FY 1993 to over $32 million in FY 1997.

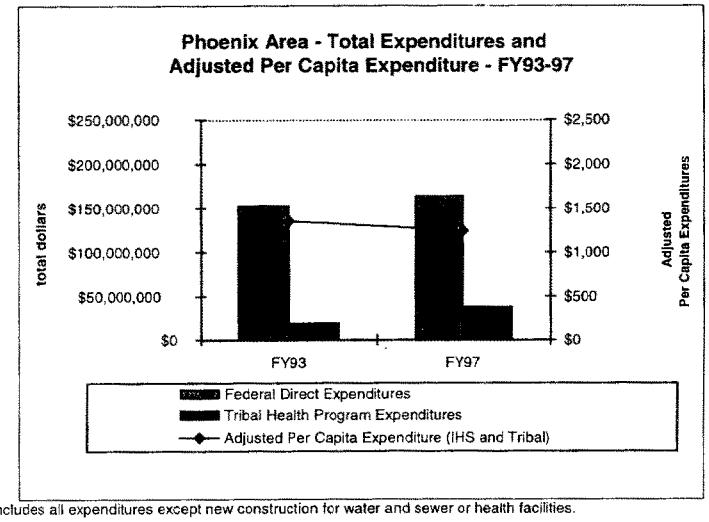
Oklahoma is second to Alaska in the amount of Area resources in Title III compacts. However, federal expenditures for the Oklahoma Area Office cost center appeared to increase during the period of this study, from about $27.7 million to $37.7 million, or about 36 percent.[40]

[40] Expenditures to the Oklahoma Area Office cost center appear to vary more than expected across fiscal years. This might be caused by the way Supply Service (central warehouse) expenditures are coded, which could distort this analysis.

Unadjusted per capita expenditures increased slightly in the Oklahoma Area, from $761 to $997. Adjusted for inflation, the per capita expenditures in the Oklahoma Area increased over the 5 year period by about 11 percent.

Phoenix Area

Figure 4.19



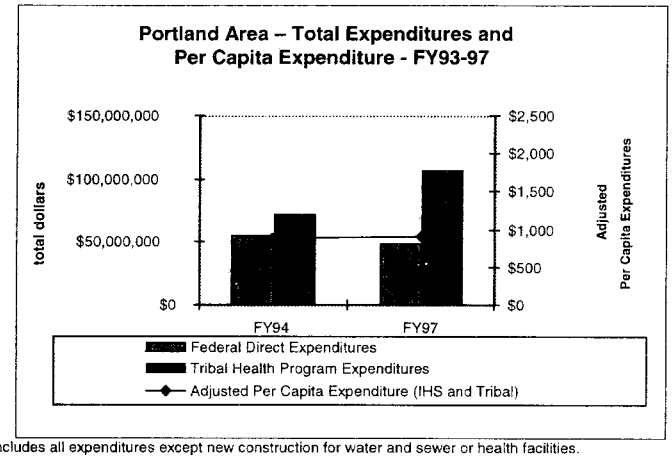
Includes all expenditures except new construction for water and sewer or health facilities.

The Phoenix Area expenditures grew from $174 million in FY 93 to $203 million in FY 97 (these totals reflect the combination of Federal Direct Expenditures and Tribal Health Program Expenditures in the Figure above), an increase of almost 17 percent. Phoenix Area collections from third parties increased from less than $20.5 million in FY 1993 to over $34 million in FY 1997.

Phoenix has less than 6 percent of the Area Office resources under Title III compacts. Federal expenditures for the Area Office cost center were reduced by about 7 percent.

Portland Area

Figure 4.20



Includes all expenditures except new construction for water and sewer or health facilities.

The Portland Area has a service population of 148,000 beneficiaries. The Area expenditures grew from $127 million in FY 94[41] to $156 million in FY 97 (these totals reflect the combination of Federal Direct Expenditures and Tribal Health Program Expenditures in the Figure above), an increase of almost 23 percent over the period.

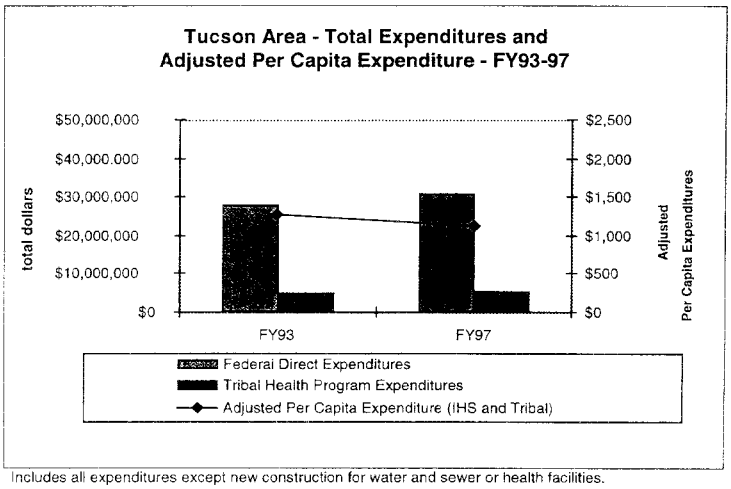
The Area has 11 tribes compacting under the authority of Title III. Federal expenditures for the Portland Area Office cost center decreased substantially over the period, dropping from almost $12.3 million in FY 94 to $9.2 million in FY 97. This is a decease in expenditures of about 25 percent.

Unadjusted per capita operational expenditures increased slightly in the Portland Area, from $917 to $1,055 per capita from FY 94 to FY 97. When adjusted for inflation, purchasing power in the Portland Area decreased over the 4 year period by about 2 percent.

[41] Accurate data from the DHHS financial reporting system was not available for the Portland Area for FY 93.

Tucson Area

Figure 4.21



Includes all expenditures except new construction for water and sewer or health facilities.

The Tucson Area is the smallest Area in the IHS, with only two tribes and a service population of 28,000 beneficiaries. The Tucson Area expenditures grew from $32.8 million in FY 93 to $36.5 million in FY 97 (these totals reflect the combination of Federal Direct Expenditures and Tribal Health Program Expenditures in the Figure above), an increase of almost 11 percent. The Area received no congressionally-directed appropriations for new programs or facilities. Tucson Area collections from third party resources grew by almost 100 percent during the period, from less than $2.6 million in FY 1993 to over $5.1 million in FY 1997.

No tribes in the Area compacted under the authority of Title III. Federal expenditures in support of the Area Office cost center, however, still decreased from about $8.4 million in FY 93 to $6.1 million in FY 97, a reduction of about 38 percent.

Unadjusted per capita operational expenditures increased slightly in the Tucson Area, from $1,270 to $1,325. When adjusted for inflation, however, the purchasing power in the Tucson Area decreased over the 5 year period, by about 11 percent.

DISCUSSION

There has been some growth in expenditures across the IHS and tribal health system. But expenditures have not grown enough to allow the agency and tribes to keep ahead of population growth and inflation.

Directly appropriated funds are a shrinking portion of the revenue available to the IHS and tribes for provision of health services. Significant increases in directly appropriated funds have only been provided to tribes or the IHS when specifically earmarked by Congress, usually to open and staff newly constructed facilities.

Although the growth of revenue from third party revenue sources has been substantial, the IHS and tribal health providers appear to have exhausted much of the potential for continued growth from these sources. Increased efficiencies in the billing process for both tribal and IHS providers have brought one-time gains. In FY 96, a large increase (averaging over 50 percent) in the negotiated IHS/HCFA encounter rates for Medicaid was provided to make up for historical deficiencies in the rate. This increase was of a magnitude unlikely to be repeated in future years.

Managed care also is beginning to impact the ability of the I/T/U providers to expand revenue from private insurance and Medicaid. Employer-purchased health plans from private sector managed care organizations have little incentive to include I/T/U providers. P.L. 95-437 requires "fee for service" insurance to cover the cost of care provided in I/T/U facilities, but the law does not require managed care plans to waive the large co-insurance and deductibles which American Indians and Alaska Natives (AI/AN) must pay when the I/T/U providers are "out of plan." Medicaid is undergoing major changes as many states are enrolling an increasing number of Medicaid beneficiaries in managed care programs.[42] Medicaid managed care programs differ significantly from state to state. In some states, these programs have enrolled Medicaid-eligible AI/AN in capitated plans completely outside the I/T/U system. Other states have allowed AI/AN to remain in a "fee for service" plan in the I/T/U system, or provided payment to the I/T/U providers for "out of plan" services.

Changes in Medicaid created by welfare reform, as enacted in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, are now being implemented by the states. The de-coupling of Medicaid from cash assistance payments removes a major incentive for IHS beneficiaries to enroll in Medicaid. The impact of this change on enrollment levels of AI/AN in the Medicaid program is expected to be substantial, especially for children. Children usually require only preventative health care and this provides little incentive for their parents to enroll them in Medicaid when they are receiving services through an Indian health program. Decreased Medicaid enrollment levels will reduce the revenue available in the I/T/U health system. This, in turn, could increase utilization of IHS and tribal facilities, as AI/AN are unable to use Medicaid to purchase medical care in the private sector.

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[42] Rosenbaum, Sara, J.D. Zuveka, Ann, D.P.A., *Integrating Indian Health Programs into Medicaid Managed Care Systems:* A roundtable sponsored by the Indian Health Center and the Center for Health Policy Research of the George Washington University. 1996.

CONCLUSIONS

Population growth and inflation have continued to erode the capacity to meet the need of American Indians and Alaska Natives. Although it has affected all Areas, the impact of population growth on per capita expenditures has been greatest in the Nashville and Bemidji Areas, which have added substantial numbers of beneficiaries due to newly recognized tribes in addition to natural population growth. Increasingly, tribes and the IHS have relied on revenue collected from third parties to close the fiscal gap necessary to maintain service levels in IHS or tribal operated health programs.

Stimulated by Title III and other initiatives, the IHS has begun the process of downsizing the Area Offices and Headquarters. In general, reductions in expenditures at both levels have not been significant during the period covered in this study. Cost savings from reorganizations and reductions will continue to accrue in Headquarters in the coming years, as the impact of the past reductions and the currently planned reductions becomes more apparent.

Area Offices have responded in a very diverse manner to the pressures to downsize and reallocate resources to field health programs. As expected, some Areas with a large proportion of resources in Title III agreements (like Portland and Alaska) have dramatically reduced the resources expended directly from the Area Office. So have some Area Offices with no Title III agreements (Tucson and Albuquerque). In addition, several Areas with large direct IHS components have continued to expand federal expenditures for the Area Office (Aberdeen and Navajo). On the other hand, the Oklahoma Area Office, with the second largest proportion of Title III agreements, has also continued to substantially expand expenditures from the Area Office. There is no evidence that funding has been shifted from the Areas with little of no compacting to Areas with more compacting.

There have been differences in the growth of total revenue expended by all direct and tribal programs in the Areas. In general, the growth can be explained by several factors including: differences in the growth in collection of self-generated revenue (and differences in reporting collections of self-generated revenue), directed congressional appropriations to support the operation and staffing of newly constructed IHS (replacement) facilities, and the transfer of resources under Title III (and to a much lesser extent Title I) from Headquarters to the Areas.

Over the next five years these shifts in the financing environment, may stimulate more tribes to choose the increased flexibility of Title III compacting. The flexibility and control over local health resources may be necessary for tribes to respond to the accelerating pace of change in the Indian Health Service and the general health care environment.

CHAPTER 5

CHANGES IN SERVICES AND FACILITIES

INTRODUCTION

One way to evaluate changes in the Indian health system the past 3-4 years is to measure the growth and/or loss of services and facilities. The health directors survey asked respondents to list any new health programs that were started or significantly expanded, any health programs that were eliminated or significantly reduced, facilities that were opened or expanded, and any facilities that were closed or reduced since 1993.

The purpose of these questions was to gather objective data indicating whether tribes and tribal members experienced improvements or deterioration at the most basic level of delivery of services: the availability of facilities and programs to provide the services. Further, the information was used to test the hypothesis put forward by Kunitz (1996) that when tribes take control of health care systems, they place less emphasis on public health and prevention programs.

POPULATION GROWTH AS A FACTOR

Demands on Services from Population Growth

Many Indian health programs have had to expand to accommodate population growth. Nearly 70 percent of the tribes represented in the health director survey reported that their user or service population changed significantly since 1993. A tribe in the Aberdeen Area reported a population increase at an average rate of 35 percent per year since 1993, with a 1996-97 increase of 47 percent. In the Phoenix Area, a tribe reported that patient registration had increased from 750 to over 1300.

Reasons Cited for Population Growth

In their comments, health directors cited different reasons for population growth. A tribe in the Nashville Area said that their service population had tripled because of increased community awareness of the health programs. One tribe explained their population increased due to the following causes:

> Added more homes to the Reservation and HUD bought more homes in town. Tribal members moved off reservation and other Indians moved in. Increased life expectancy. More births. More prenatal care.

Another tribal health director had the following explanation:

> Tribal constitution was amended lowering blood [quantum] requirements [for Tribal membership]. To date this has resulted in an increase of approximately 1900 CHS eligible, without an increase in resources.

Several tribes offered explanations like these for the population growth related to economic development:

> Numbers have increased by approximately 25%-30%. [Tribal] members have returned to the reservation due to improved employment availability and living conditions.

> Population increase due to the opening of the Casino. Patients returning to area. Within the last six years, continual patient visits increase - 30,918 in FY92 to 43,042 in FY97.

While economic development is usually regarded as positive, the growth in population is not necessarily off-set by growth in third party income.

Responses to Population Growth

Federal funding for IHS has not kept pace with these types of population increases. Some tribes have found it very difficult to respond to the increased demand for services, as explained by the health director of this IHS direct service tribe:

> New programs and expansion are virtually impossible, we barely maintain the status quo for lack of funding, population increases, etc.

At the same time, other tribes have managed to add new programs and services.

CHANGES IN PROGRAMS AND SERVICES

New and Expanded Programs and Services

Percentage of Tribes Adding or Expanding Programs

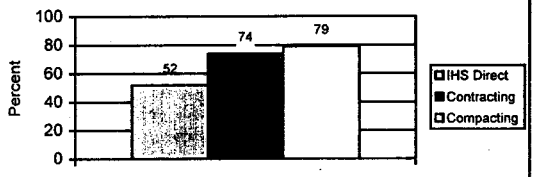
A majority of the tribes in every category added or expanded programs or services, including 50 percent of IHS-direct service tribes, 77 percent of contracting tribes and 70 percent of compacting tribes. Tribally-operated programs added more types of services than did IHS direct service programs. Two or more new programs were added by 41 percent of IHS direct service tribes, 67 percent of contracting tribes and 58 percent of compacting tribes.

Average Number of New Programs per Tribe

The number and scope of new programs is dramatic. For the 71 tribes represented in the health directors survey, there were 241 new programs added or

significantly expanded. This is an average of 2.3 new programs per tribe. The average for IHS direct service tribes in the study is 1.5 new programs. For contracting tribes, the average is 2 per tribe. And for compacting tribes, the average is almost 4 per tribe.

Figure 5.1
Percent of Tribes Adding New Programs by Type of Tribe



Source: Health Director Survey

Some tribes have made extraordinary gains, as expressed by these health directors:

> Overall health care program services have significantly expanded since Self-Governance.
>
> We became a self-governance tribe in the first year of demonstration so new and expanded programs and services are too numerous to list. Improvement has been significant.
>
> We have increased the level of services/benefits in all programs. Most dramatic has been in the area of CHS where significant preventive services are now being funded due to savings in this area.

To test the hypothesis that larger tribes were more able to add or expand programs than smaller tribes, the tribes in the study were divided into three nearly equal groups by size of user population. There were 21 tribes in the small category (less than 1000 users) and they averaged about 1 new program per tribe. The 23 tribes in the medium category (1000 to 4000 users) averaged nearly 3.75 per tribe. And the large category (over 4000 users) had 23 tribes that averaged 2.3 new programs per tribe. It seems that the medium-sized tribes added or expanded the most.

Types of Programs Added or Expanded

The following list of new services illustrates the breadth and sophistication of new programs offered by one contracting tribe:

Intense breast & cervical cancer screening, prenatal services, gastroenterology clinic (on site), endocrinology clinic (on-site), respite care, audiology services (on-site), Women's Health Case Management, Community Health Nursing function expansion, data system expansion, Psychology/Licensed Counselor Services (on-site), Medical Laboratory services (on-site) expansion, expansion of home glucose monitoring program, addition of full-time Nutrition Technician services, School Health expansion.

To analyze the data, new programs were grouped into 36 different categories. The top ten categories of new programs added, for all tribes in the study, were:

Women's Health Care (including mammography, culposcopy, gynecology, obstetrics, and prenatal care) – expanded by 25 percent of tribes

Ear, Eye, Nose and Throat (including audiology, optometry, ophthalmology, laser surgery) – expanded by 25 percent of tribes.

Mental Health – expanded by 23 percent of tribes.

Dental Care (including dentistry, oral surgery, pediatric dentistry, and orthodontics) – expanded by 20 percent of tribes.

Increased Medical Staffing (including primary care physicians and midlevel practitioners) – expanded by 18 percent of tribes.

Diabetes Care (including Diabetes Clinics and Renal Clinics, but not including dialysis) – started or expanded by 17 percent of tribes (this percentage would increase significantly if other categories were combined, such as dialysis, podiatry, ophthalmology, case management, nutrition, patient education, prevention, etc.).

Administration (adding a health director, expanding billing, medical records, quality assurance, continuing education) – 17 percent of tribes.

Prevention (community-based programs such as injury prevention, tobacco cessation, fitness programs, fitness centers, and community screening) – 15 percent of tribes.

Alcohol Treatment (including Alcohol and Other Drugs) – 15 percent of tribes.

Contract Health Services (CHS) – 15 percent of tribes.

Among these top ten categories, there were some differences between IHS direct service programs and tribally-operated programs. None of the IHS direct service programs in the study reported an increased medical staffing, while 26 percent of tribally-operated programs were able to expand their primary care staff. The leading new program for IHS direct service was diabetes care, with 29 percent of the tribes receiving new or expanded programs, compared to 12 percent of tribally-operated programs. In all the other top ten categories, the tribally-operated programs exceeded IHS direct service programs in the addition or expansion of services.

Figure 5.2
Top 10 Programs Added by Type of Tribe

Program	IHS Direct	Tribally-Operated
Eye, Ear, Nose, Throat	14%	30%
Women's Health	19%	28%
Mental Health	14%	26%
Increased Staffing	0%	26%
Dental	10%	24%
Administration	5%	22%
Prevention	5%	20%
Alcohol Treatment	5%	20%
Contract Health Services	10%	18%
Diabetes Care	29%	12%

Source: Health Director Survey

Comparison of Clinical Services with Community Based Programs, Auxiliary Services and Prevention

For further analysis, the 36 categories were grouped in several ways to examine what types of services are being added or expanded. Those services classified as clinical were only included in the Clinical Services category. However, the other services were grouped in different ways to allow for different types of comparison with the clinical category. Some non-clinical categories of services belonged in more than one group and so they were counted more than once. Because of the duplication, these non-clinical groups should not be compared with each other, but only with the Clinical Services category. Below is the definition of each group by type of service:

Clinical Services: Contract Health Services (CHS), diabetes care, dialysis, elder care, expanded hours, increased medical staffing, laboratory, more medical specialties, pharmacy, and radiology.

Auxiliary Services: case management; ear, eye, nose and throat; physical therapy and occupational therapy, and podiatry.

Community-based Programs: community health nursing (CHN), Community Health Representatives (CHRs), Emergency Medical Services (EMS), environmental health, home health, occupational health, prevention, school nursing, and transportation.

Prevention Services: alcohol treatment, mental health, case management, community health nursing, diabetes care, HIV/AIDS, immunizations, nutrition, patient education, prevention, school nursing, and women's health care.

These groupings apply broad definitions. For example, women's health care is placed in prevention because most of the added services involve cancer prevention

through mammography, cervical cancer screening, and early intervention. Mental health is regarded as prevention because it prevents suicide, child abuse and other domestic violence. Similarly, alcohol treatment is considered prevention because alcohol abuse is so closely related to a number of diseases and injuries.

Using these groupings, the IHS direct service tribes that added or expanded their programs in the past three years can be compared to the tribally-operated programs that added or expanded their services. The results are shown in Figure 5.3.

Figure 5.3

Types of Services Added or Significantly Expanded For Tribes that Added One or More Programs

	IHS Direct (n = 11)	Tribally-Operated (n = 38)
Clinical Services	173%	155%
Community-based Programs	82%	76%
Auxiliary Services	64%	53%
Prevention Services	191%	195%

Source: Health Director Survey

As the numbers in Figure 5.3 suggest, when programs are added the priorities are very similar between IHS direct services and tribally-operated programs. Both have made prevention services (in the broadest definition) the highest priority, with clinical services being the second priority.

Because the tribally-operated programs tended to expand more than the IHS direct service programs, tribes that contracted or compacted benefited more from new and expanded services in the past three years. This is illustrated in Figure 5.4 which compares all tribes in the study that returned the health directors survey.

Figure 5.4

Types of Services Added or Significantly Expanded For All Tribes in the Study

	IHS Direct (n = 21)	Tribally-Operated (n = 50)
Clinical Services	90%	118%
Community-based Programs	43%	58%
Auxiliary Services	33%	40%
Prevention Services	100%	148%

Source: Health Director Survey

Emphasis on Prevention in New and Expanded Programs and Services

As Figure 5.4 indicates, in the past 3 years tribes that operated their own programs added more services of every type than IHS direct service tribes, but the greatest difference was in prevention services. A large portion of the difference in

broadly defined prevention services is the alcohol treatment and mental health components. While 19 percent of IHS direct service tribes had new or expanded programs of alcohol treatment and/or mental health services, 48 percent of tribally-operated programs expanded in these areas.

A health director of an IHS direct service tribe that has identified the need for diabetes prevention stated, "Prevention screening funds are given to CDC then tribes are required to compete for those funds from CDC." He felt his tribe was at a disadvantage because they had no grant writers. His conclusion was that "IHS needs to provide prevention funds." A tribal leader from an IHS direct service tribe in the Phoenix Area stated:

> . . . Indian Health Service concentrates on treatment instead of prevention. If IHS conducts preventive activities, it is usually more secondary in nature. Very little is primary prevention.

Contrary to the hypothesis put forth by Kunitz, the IHS tends to choose clinical services for program expansion more often than tribaliy-operated programs. Further, tribes place more emphasis on prevention than clinical services when adding new programs, although Kunitz predicted the opposite. This point is illustrated even more clearly when considering all tribes in the study, rather than just those who added at least one program.

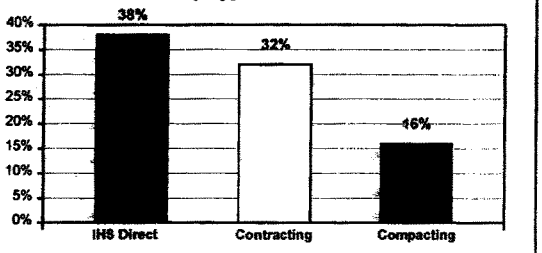
Programs Eliminated or Significantly Reduced

The health directors survey asked for a list of programs that had been eliminated or significantly reduced since 1993 and the reasons for that change, in order to determine whether such an effect had occurred.

Percentage of Tribes Eliminating or Reducing Programs

The response to this question suggests that significant program reductions affected about one-third of the survey respondents. IHS direct service tribes were more likely to have programs eliminated than contracting and compacting tribes were to have eliminated them (38 percent, 32 percent, and 16 percent, respectively).

Figure 5.5
Percent of Tribes Eliminating Programs by Type of Tribe



Source: Health Director Survey

Percentage of Tribes Eliminating More than One Program

When IHS direct service tribes reduced programs they were more likely to reduce or eliminate only one program, while tribally-operated health services were more likely to eliminate more than one program. The study shows that 10 percent of IHS direct service tribes lost more than one program in the past three years, while 16 percent of contracting tribes and 5 percent of compacting tribes eliminated more than one program.

Reasons for Program Reduction or Elimination

The reasons programs were reduced or eliminated are related to funding shortages in 67 percent of the cases for IHS direct service tribes and 65 percent of contracting tribes, but funding shortage was not cited as a reason by compacting tribes. Altogether funding shortages accounted for the elimination or significant reduction of 33 programs, experienced by 11 of the 71 tribes in this study, including 5 IHS direct service tribes and 6 contracting tribes.

Rather than funding shortages, staff shortages and space limitation were the reasons that compacting tribes reduced or eliminated programs. Staff shortages were cited by 25 percent of IHS direct service tribes, 11 percent of contracting tribes and 67 percent of compacting tribes as a reason for reducing or eliminating programs. A health director from Alaska provided this example of a program eliminated due to staff shortages in a remote area:

> Quality review conducted, dentist found to be performing way below standards. Dentist chose to terminate contract. We have to drive over 200+ miles to see a dentist.

In this case, the program was eliminated to improve the quality of care.

For nearly one-fourth of the programs that were eliminated by contracting tribes, the reason was that the tribe decided to re-program funds to higher priority areas. One health director described the process this way:

> Nothing was really eliminated, but [we performed] lots of reorganization and streamlining for efficiency and expansion through creative funding and maximization of resources.

Other tribes did eliminate programs in the process of reorganizing.

One important activity in reorganization may be the elimination of duplicative services. This in turn leads to the elimination of programs, as was cited by some IHS direct service tribes.

Types of Programs Reduced or Eliminated

The types of programs reduced or eliminated fell into 14 categories. The top categories of programs to be eliminated or reduced were:

Ear, Eye, Nose and Throat – 15 percent of tribes
Mental Health – 12 percent of tribes
Alcohol and Substance Abuse – 12 percent of tribes
Prevention and Health Education – 12 percent of tribes
Administration – 6 percent of tribes (all of which were contracting tribes)
Medical Staff – 6 percent of tribes
Community Health Nursing – 6 percent of tribes

All other categories of programs had only one program reduced or eliminated, comprising 3 percent of the tribes in the study.

The highest category for reduction or elimination was Ear, Eye, Nose and Throat, which includes optometry. The reduction in this category is explained by a health director of an IHS direct service tribe:

> Our Tribal adult eye program has been decreased due to lack of adequate funding. IHS has never funded a Adult Optometry program. Youth are IHS's priority. In prior years the Tribe has assisted adults, diabetics and unemployed members. Because of limited resources the Tribe has limited eyeglass purchases to members with no income. Funding is needed for adult optometry needs.

Since optometry is also one of the categories in which most programs were added, it seems that eyeglasses are a benefit that fluctuates with the availability of resources.

Comparison of Clinical Services with Community-Based Programs, Auxiliary Services and Prevention

Using the same groupings as used with added and expanded programs, the services eliminated or significantly reduced were grouped for further analysis. The purpose of this analysis was to test the hypothesis that when tribes had to reduce or eliminate programs they would be less likely than the IHS to reduce clinical services and more likely to reduce prevention programs. The data from the 71 tribes in this study suggests that the opposite is true.

Figure 5.6

Types of Programs Eliminated or Significantly Reduced For Tribes that Reduced One or More Program

	IHS Direct (n = 8)	Tribally-Operated (n = 13)
Clinical Services	13%	15%
Community-based Programs	13%	31%
Auxiliary Services	38%	23%
Prevention Services	75%	31%

Source: Health Director Survey

Both the IHS direct service programs and the tribally-operated programs that reduced services only reduced clinical services in 13-15 percent of the tribes. However IHS was more likely to reduce prevention programs, as these were reduced by 75 percent of the tribes that eliminated services compared to 31 percent of the tribally-operated programs that eliminated services. Most of the IHS reduction in prevention services was in alcohol treatment and mental health categories: 63 percent of the IHS program reduction was in these areas, compared to 23 percent of the tribally-operated programs. Even if one compares all the other prevention programs without including alcohol and mental health, the IHS reductions were still greater than the tribally-operated programs (13 percent compared to 8 percent).

While tribally-operated health care systems tended to preserve prevention programs, they were more likely to reduce community-based programs. The types of community-based services eliminated or reduced by tribally-operated programs included community health nursing, Community Health Representatives (CHRs), Emergency Medical Services (EMS), and occupational health. One of these, community health nursing, is also included in the broadly-defined prevention grouping.

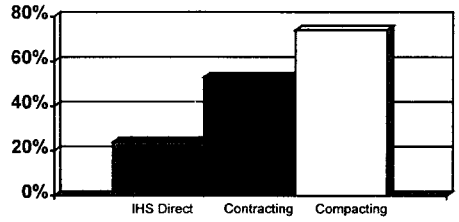
CHANGES IN FACILITIES

New or Expanded Facilities

Percentage of Tribes with New Facilities

About half of the 70 tribes in this study that returned health director surveys reported that they had built at least one new facility or significantly enlarged an existing facility. This included 24 percent of IHS direct service programs, 53 percent of contracting tribes and 74 percent of compacting tribes.

Figure 5.7
Tribes with New Facilities



Source: Health Director Survey

Tribes with More than One New Facility

Among the IHS direct service tribes, 10 percent added two new facilities, but none added more than two. For contracting tribes, 7 percent added two facilities, 7 percent added three facilities and 3 percent added five or more facilities. Compacting tribes in the study added more facilities per tribe, including 11 percent that added two facilities, 5 percent added three facilities, 5 percent added four facilities and 5 percent added five or more facilities.

Types of New Facilities

Health centers accounted for 57 percent of the facilities built since 1993. Health centers in this study are ambulatory care facilities that provide physician services. Among tribes that built new facilities, 74 percent built health centers.

For IHS direct service tribes, the new facilities were dialysis centers (44 percent), health centers (33 percent), or health aide clinics (22 percent). Contracting tribes built health centers (54 percent), behavioral health facilities (8 percent), community centers offering such services as elders programs and day care (8 percent), health aide clinics (2 percent) and other types of buildings (25 percent). Among compacting tribes, the new facilities included health centers (68 percent), office buildings (16 percent), behavioral health facilities (4 percent), training centers (4 percent) and other buildings (8 percent).

Facilities Closed

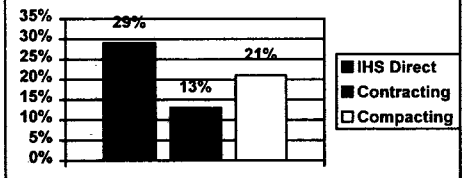
Percentage of Tribes Affected by Facility Closures

About 20 percent of the tribes participating in the health directors survey reported closing facilities. A total of 20 facilities were closed that had served 14 tribes. The IHS direct service delivery had a higher percentage of tribes with closed facilities, 29 percent compared to 13 percent for contracting tribes and 21 percent for compacting tribes.

Types of Facilities Closed

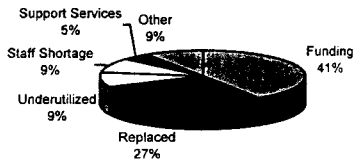
Fourteen of the 20 facilities that were closed, or 70 percent, were ambulatory care facilities. Other types of facilities that were closed (with one in each category) were a hospital, an office building, a behavioral health center, a community center, and a training center.

Figure 5.8
Tribes that Closed Facilities



Source: Health Director Survey

Figure 5.9
Reasons that Facilities were Closed



Source: Health Director Survey

Reasons for Facilities Closing

Less than half of these facilities were closed due to lack of funding. The IHS direct service tribes cited funding shortages as a reason for closing facilities more often than contracting and compacting tribes (75 percent compared to 29 percent and 20 percent, respectively).

About 30 percent of the facilities were replaced with newer facilities. All of the ambulatory clinics that were closed by contracting tribes were replaced with new facilities, including one tribe that replaced four different clinics. However, only 17 percent of the IHS direct services facilities and 25 percent of the compacting facilities that were closed were replaced. For example, an old Air Force base hospital that was "deteriorating and not close to the major Tribal population base" was closed and replaced with a "new comprehensive Health Center" built by the tribe.

Other reasons for closing facilities were underutilization (10 percent), staff shortages (10 percent), and lack of support services (10 percent). In one case, the IHS closed a hospital that had an average daily patient load less than 15 and the tribe has been fighting to keep the emergency room open because there is no replacement facility.

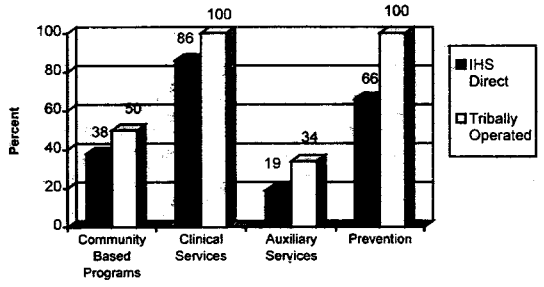
SUMMARY

Overall, in the past three years there have been more gains than losses in programs in every type of service and in every type of tribe. If one subtracts the number of programs eliminated or significantly reduced from the number of new and expanded programs, the net gain is substantial. When the net gain is divided by the number of tribes in the study, the results indicate that among IHS direct service tribes 86 percent

have more clinical services, 66 percent have more prevention programs, 38 percent have more community based programs, and 19 percent have more auxiliary services.

The gains are even more impressive for tribally-operated health care systems. Of these tribes, an average of 50 percent have more community-based programs, 100 percent have at least one new clinical service and 14 percent have more than one, 34 percent have more auxiliary services, and 100 percent have at least one new prevention program with 68 percent having more than one additional prevention program.

Figure 5.10
Net Gains in Programs By Type of Tribe

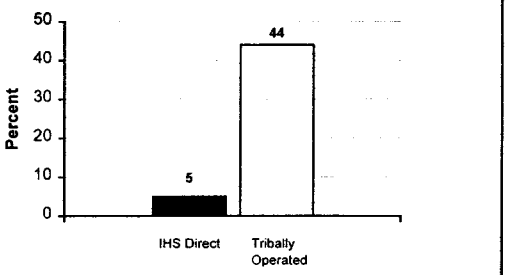


Source: Health Director Survey

The contrast between tribally-operated programs and IHS programs is even more striking when one considers facilities. For contracting and compacting tribes, 12 facilities were closed and 49 new facilities were added for a net gain of 37 facilities. When this is averaged across the 50 contracting and compacting tribes participating in this study, there was a new facility for nearly three-quarters of the tribes. Because some tribes built more than one new facility, the gains actually affected 44 percent of the tribes.

IHS direct service tribes, on the other hand, did not experience these same gains in facilities. For the IHS direct service tribes in the study there were 9 new facilities and 8 closed facilities for a net gain of one facility. This indicates that only 5 percent of the 21 tribes in this category experienced a gain. If one looks only at ambulatory care facilities, there was a net loss of one clinic. This indicates that about 5 percent of the IHS direct service tribes experienced a net loss in ambulatory care facilities.

Figure 5.11
Net Gains in Facilities by Type of Tribe



Source: Health Director Survey

Of course, these are averages and not every tribe fits this profile. Those that close programs for financial reasons may not be adding programs. Clearly, some tribes feel that their services and facilities have suffered due to a combination of problems, as expressed by these two tribes that receive IHS direct services :

> The IHS is funded at approximately 50%[43] of need. The facility was built in 1936 and is seriously outdated, under funded, understaffed, and lacks capacity to implement new and enhanced programs. In the past, the local IHS has survived by being bailed out of deficit when the inadequate resources are exceeded. Now that Area and headquarter reserves are being eliminated to accommodate compacting and contracting tribes, we are being impacted. Also, additional functions and responsibilities are being downloaded from HQ to the Area Office and Service Unit with no additional resources to support them. This is creating additional workload and overload of local resources.

> At our IHS facilities, Hospitals and Clinics have had to lay off people due to the lack of funds. Yet we continue to serve more people at this facility.

Most tribes in the study, even those that have seen dramatic improvements, feel that there are many more health care improvements needed and that this requires greater funding by Congress.

[43] Actually, the degree of underfunding may be a lot worse. It is generally agreed that per capita expenditure for health care in the United States is roughly $3,600 per year. Per capita expenditures for urban and reservation-based American Indians and Alaska Natives through IHS, on the other hand, is roughly $1,200 per year. The implication is that IHS is actually funded at a level much closer to 33% when considering the entire Indian and Alaska Native population in the United States.

This study suggests that in the era of self-determination and self-governance there are more tribes experiencing improved health care than those with deteriorating health care. Furthermore, there are more winners than losers in every type of tribe: IHS direct service tribes, contracting tribes and compacting tribes. What is most remarkable is that these gains have happened in an era when the federal budget has not kept pace with inflation and there is government downsizing.

CHAPTER 6

MANAGEMENT CHANGES AND CHALLENGES

INTRODUCTION

One possible explanation for the gains in services and facilities described in Chapter 4 is that contracting and compacting have improved the management of Indian health services for those tribes that have chosen to utilize these methods for delivery of their health care.[44] There are several ways that tribes can improve management to obtain the resources to expand services and improve their facilities. These include increasing income from non-IHS sources, reducing expenditures, and redesigning systems to reflect tribal priorities. This section explores how tribes have used various strategies, comparing IHS direct service tribes with those operating their own health programs.

In addition to financial management, all Indian health facilities face the problem of recruiting and retaining health professionals. Fear has been expressed that health professionals will be less likely to work for tribes than to work for the federal government. The health director survey sought information on recruitment and retention that is presented in this section of the report.

The source for most of the information in this chapter is the health directors survey. Some of the questions were open-ended, which resulted in a broad range of answers, but may have created undercounting in some categories since a respondent may not have thought to list an item that another tribe listed. Respondents were reluctant to answer some types of questions and when the response rate was too low, the information was not included in the analysis because it was unlikely to be representative of the tribes. Occasionally, the information is included with an indication of the number of tribes responding.

This chapter is organized first to consider management changes, including more efficient management practices, third party billing, and income from other sources. Then information from the survey about recruitment and retention of health professionals is presented. Finally, the level of reassumption and retrocession of services is discussed as an indicator of tribal success, or failure, in managing health services.

MANAGEMENT EFFICIENCIES

Percentage of Tribes Reporting Management Changes

When asked to describe any management changes that have created efficiencies in the delivery of services to tribal members since 1993, the health directors of contracting tribes cited more examples than any other type of tribe. Less than two-thirds

[44] There may be other explanations as well and these alternative hypotheses are discussed in Chapter 8.

of the IHS direct service tribes and compacting tribes cited any changes, compared to 83 percent of the contracting tribes. This may be an indicator that when tribes first take over the management of Indian health programs, they are more likely to make management changes. After three years of refining management practices, when the tribes are eligible for compacting, there are probably fewer changes to be made. The management focus of compacting tribes might be to continue to improve effective practices like third party collections and purchasing from the private sector.

Types of Management Changes Reported

Nearly 20 percent of the contracting tribes in the study implemented new computer systems and/or financial management systems. For example, a Nashville Area tribe reported that it had "[p]urchased an automated billing package from the private sector, [and is] now able to bill electronically. Upgraded patient data management system through IHS." Only 5 percent of the compacting tribes and none of the IHS direct service tribes reported this change. Perhaps associated with computer systems, 10 percent of contracting tribes and 5 percent of compacting tribes hired more technical specialists. None of the IHS direct service programs reported this management change.

There were two areas of changes that were reported only by contracting tribes. These were initiating some form of quality improvement program (QA, TQM, CQI, or JCAHO accreditation) and choosing to eliminate some programs or facilities that were perceived as low priority or under-used.

Compacting tribes were more likely to report reorganization to create fewer supervisory positions (11 percent), compared to contracting tribes (3 percent) and IHS direct service tribes (none). However, IHS direct service tribes reported shifting responsibility to the local level (14 percent) more often than contracting tribes (10 percent) and compacting tribes (5 percent).[45] A health director for an IHS direct service tribe explained that some of the unwelcome changes in the IHS had produced positive changes in management:

> Due to congressional action, (i.e., FTE reduction, restructuring, etc), more authority and responsibilities are being delegated to the service unit level. This is empowering employees to take ownership in the organization, which results in managing care.

Contracting more services with the private sector was cited by 11 percent of the compacting tribes, 5 percent of contracting tribes, and 3 percent of IHS direct service tribes. Improved management of the Contract Health Services (CHS) program was listed by 5 percent of both IHS direct service and compacting tribes, but no contracting tribes.

[45] While the tribes who manage their own programs apparently did not think to report it, contracting and compacting inherently shift responsibility to the local level by allowing tribal control of programs previously controlled by the federal government.

Purchasing Methods

A management tool often used to reduce costs is to seek purchasing alternatives that offer the best possible prices. Purchasing and procurement programs that do not consider multiple options may overlook possible savings associated with using a different vendor or purchasing method. To find out whether tribes are able to realize such benefits when they take over their own programs, health directors were asked about specific purchasing methods.

IHS direct service tribes were more likely to use only one method of purchasing (25 percent) compared to contracting tribes (7 percent) and compacting tribes (14 percent). Because compacting tribes were more likely to use more than two purchasing methods (32 percent) compared to other tribes (20 percent), they have higher percentages of using as many types of purchasing as are available.

Prime vendor contracts are used by 74 percent of the compacting tribes, compared to 53 percent of contracting tribes and 48 percent of IHS direct service tribes. Other types of discount contracts and cooperatives were used by 53 percent of compacting tribes, 47 percent of contracting tribes, and 29 percent of IHS direct service tribes. Altogether, about 40 percent of the tribes used IHS warehouses and 50 percent used GSA rates, with compacting tribes utilizing these methods more frequently than other tribes.

NON-IHS SOURCES OF HEALTH CARE FUNDING

Third Party Billing

In general, tribally-operated programs appear to be doing a better job of third party billing than IHS direct services. Health directors were asked to estimate the percentage of their total health care funding derived from Medicaid and Medicare (M/M) and other third party resources. The reliability of this reporting is questionable, since many tribes are reluctant to disclose this type of information.

Percentage of Tribes Reporting No Third Party Collections

Among the 17 IHS direct service tribes reporting, 8 said they had no M/M collections and 9 said they had no private insurance collections (47 and 52 percent, respectively). By comparison, 6 of the 25 contracting tribes reported no M/M and 5 reported no private insurance collections (24 and 20 percent respectively). Among the 19 compacting tribes reporting, 2 said they had no M/M and 5 reported no private insurance collections (11 and 16 percent, respectively).

Percentage of Health Care Budget from Third Party Collections

The maximum percentage of health care budget derived from M/M collections was 29 percent for IHS direct service tribes, 30 percent for contracting tribes, and 33 percent

for compacting tribes in this study. The median was 2 percent for IHS direct service tribes, 4 percent for contracting tribes, and 8 percent for compacting tribes.

For private insurance, the maximum reported was 5 percent for IHS direct service, 21 percent for contracting, and 53 percent for compacting tribes. The median was 0 for IHS direct service, 3 percent for contractors, and 5 percent for compactors.

Third Party Collections as a Source of Funding for New Facilities

Third Party collections were an important source of funding for new facilities. It was a source of funding for 43 percent of the new facilities constructed by IHS direct service tribes, 33 percent of facilities constructed by contracting tribes, and 10 percent of facilities built by compacting tribes. The fact that compacting tribes were less likely to use third party collections for facilities construction reflects greater tribal contributions to cover construction costs.

Management Changes to Improve Third Party Collections

Improved third party collections was listed as a management change by 16 percent of the contracting tribes and 10 percent of the other tribes. A Nashville Area health director described the changes for their tribe:

> The creation of an alternate resource specialist position has allowed for our ability to maximize 3rd party payment for off-site provider care before we resort to utilizing/expending CHS dollars.

Improving third party collections generally requires a managerial commitment of resources for billing department personnel as well as computer systems.

Income from Serving Non-Beneficiaries

One strategy for increasing third party collections is to serve non-beneficiaries. For most tribes in this study, fewer than 10 percent of their health care consumers are non-beneficiaries. It is notable that those who serve higher rates of non-beneficiaries tend to be tribally-operated. This approach is not always welcome, as indicated by the leader of a California tribe who stated:

> The Native before was the primary reason for Indian clinics; now they are open to all, and again Indians are of least importance.

In some cases, there is not a significant non-beneficiary population living nearby to serve. Serving non-beneficiaries is more prevalent among contracting tribes. Nearly a quarter of contracting tribes had more than 10 percent of their customers who were non-beneficiaries, compared to 16 percent of compacting tribes and 9 percent of IHS direct service tribes.

Funding from Tribes and Other Sources

Sources of Funding for New Facilities

The study shows that tribes contributed to the financing of new health care facilities for 29 percent of the new facilities built for IHS direct service tribes, 62 percent of new facilities for contracting tribes, and 75 percent of new facilities for compacting tribes. Compacting tribes were not only able to receive more tribal funding for new facilities, but they also received more IHS funding. IHS contributed to 40 percent of new facilities built for compacting tribes, 24 percent of facilities built for contracting tribes, and 14 percent of facilities built for IHS direct service tribes.

In addition to more tribal and IHS funds, tribally-operated programs took advantage of other sources of new facilities financing that were not used to construct IHS direct-service facilities. These include monies from the Department of Housing and Urban Development (HUD), other non-IHS federal sources, and bonds. A tribal health director explained how they solved a problem with a facility that "was declared 'condemned' by IHS," but IHS did not have funds to replace. The Tribe built a new facility using a grant from the HUD Community Development Block Grant (CDBG) program and carry over funds from previous contracts with IHS. For other tribes, some of these sources of funding were used for buildings to house administration or elders programs, rather than medical services.

Another source of capital funding reported by two tribally-operated facilities was philanthropy, or grants from foundations and charities. State funding for facilities construction was reported by only one tribe, which was operated by IHS direct service.

In general, IHS direct service tribes relied on a single source of funding for construction or expansion of outpatient clinics. Among compacting tribes, 76 percent relied on one source of funding and 24 percent used two sources of funding. Contracting tribes used more strategies with only 57 percent relying on one source of funding, 36 percent using two sources, and 7 percent combining three or more sources.

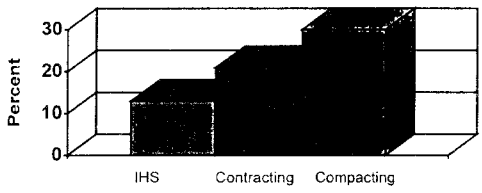
Tribal Contribution to Health Care Operating Budgets

The study suggests that tribes were more likely to supplement operating costs for health services when they were tribally managed. Health directors were asked to estimate the percentage of funding for their health care that came from tribal contributions. Among the 17 IHS direct service tribes, only 4 reported tribal contributions (24 percent), ranging from 2 percent to 10 percent of their health care budgets. Of the 25 contracting tribes reporting, 11 had tribal contributions (44 percent), with 4 tribes contributing 19 to 45 percent of their health care budgets. For the most part, the Alaska non-profit regional corporations do not receive tribal subsidies. However, among the other 13 compacting tribes, 5 reported tribal subsidies (38 percent), ranging from 2 to 15 percent of their health care budgets.

Summary of Non-IHS Sources of Funding for Operating Expenses

Altogether the average non-IHS funding for IHS direct service tribes was 13 percent of the health care budget, compared to 21 percent for contracting tribes and 30 percent for compacting tribes.

Figure 6.1
Percentage of Health Care Budget from non-IHS Sources



Source: Health Director Survey

Flexibility and Leveraging IHS Funding

An important benefit of compacting is that it gives tribes flexibility in how they manage their programs. This flexibility applies to combining funding sources. The health director of one tribal organization offered this explanation:

> Compacting has allowed our tribal health consortium to redirect dollars and combine with other funding sources for maximization of resources.

To explore the impact of such flexibility, health directors were asked, "Have you been able to use IHS funding to bring in additional dollars from other sources for health care services for your Tribe?" Answering "yes" to this question were 41 percent of IHS direct service tribes, 46 percent of contracting tribes, and 63 percent of compacting tribes. Thus, compacting tribes were much more able to use funds from IHS to gain access to other funds for which they might not otherwise have been eligible. As one health director from Alaska explained, "We actively solicit other funding, using IHS dollars as a match."

There were no questions in this study about gaming and other sources of economic development that would create the potential for tribes to contribute to the operating and capital budgets of their health care programs. However, it can be assumed that wealthier tribes are more able to contribute to the health care of their

members. Also, no correlation has been made between tribal wealth and the choice of IHS direct service, contracting or compacting.

RECRUITMENT AND RETENTION

Problems Recruiting Health Care Professionals

Percentage of Tribes Reporting Recruitment Problems

Tribal health directors were asked if they had any problems recruiting 18 different types of health care professionals in the past 3 years. Only tribes that had these positions were used in calculating the percentages that had problems recruiting. If there were fewer than three tribes with positions in a category, these positions were dropped from the comparison. This resulted in six positions for comparison: physician, midlevel practitioners (physician assistants and nurse practitioners), dentists, registered nurses, public health nurses and pharmacists. The percentages of tribes who indicated that they had recruiting difficulties in each of these categories are summarized in Figure 6.2.

Figure 6.2

Recruitment Problems by Type of Health Care Professional

	Percent of Tribes Reporting Problems	
	IHS Direct	Tribally- Operated
Physicians	67%	75%
Midlevel Practitioners	25%	40%
Dentists	67%	50%
Registered Nurses	25%	18%
Public Health Nurses	50%	14%
Pharmacists	50%	33%

Source: Health Director Survey

As Figure 6.2 indicates, tribally-operated programs had more difficulty than IHS direct service programs in recruiting physicians and midlevel practitioners, although the difference between IHS direct service tribes and compacting tribes in recruiting physicians was only 8 percent. The tribally-operated programs had less difficulty recruiting dentists, registered nurses, public health nurses and pharmacists.

Factors Contributing to Recruiting Problems

Tribes were asked to list the factors contributing to recruiting problems. Two Aberdeen Area tribes offered these descriptions:

> Isolation, work load, inadequate schools. Lack of C.E.U.'s , lack of cultural events for families, distance to cities for shopping, weather, and teen violence.
>
> Lack of housing. Pay is not competitive. Facilities are outdated, dilapidated, and poorly equipped. Weekend and after hour calls are demanding. Heavy workload. Community criticism and lack of community support and respect for health care providers.

And these comments came from a Billings Area tribe:

> Isolation. Pay back for some and not all positions. Have husband and wife that are both professionals, but only have one position available.

A Bemidji Area tribe added these considerations:

> Recruiting Family Practice is a problem - a lot of competition with large groups who can offer more, i.e., signing bonuses, profit sharing. Also we are sometimes considered not "Indian" enough - too modern for those who still think we live in teepees. And we do need more space - the clinic is crowded.

Measuring Retention

Health directors were asked to give the number of positions in each of 18 categories and the number of vacancies for each type of position in the past 3 years. A turnover rate was calculated by dividing the number of vacancies by the number of positions. A relatively low rate of response to these questions may create distortions in the results. However, if there were fewer than five tribes of each type of tribe for a category, that category was dropped from further analysis. This resulted in a description of turnover rates for the following 3 health professions: physician, dentist, and pharmacist.

The low rate of response notwithstanding, the results show that IHS direct service tribes had a lower turnover rates for physicians (9 percent) compared to other tribes (40 percent for contracting tribes and 39 percent for compacting tribes). For dentists, the IHS direct service tribes reported a 12 percent turnover, compared to 20 percent for contracting tribes and 10 percent for compacting tribes. The rate of turnover for pharmacists was 59 percent for IHS direct service tribes, 11 percent for contracting tribes and 5 percent for compacting tribes. It should be noted that the rate of turnover for administrators in tribally-operated programs was quite low –there were only 2 reported vacancies out of 52 reported positions in 12 tribes during the past three years.

When asked about the average length of time a medical provider works for their health facilities, the number of years cited was very similar for IHS direct service tribes and tribally-operated programs. The range for IHS-managed programs was 1-15 years, while the range for tribally-operated programs was 1-20 years. The average for IHS-managed programs was 4.8 years, compared to 4 years for tribally-operated programs. However, the median (with half more and half less) was 3 years for both IHS direct

service and tribally-operated programs. It should be noted that some tribes are relatively new to management of physicians, so they have had less time to establish a track record of retention. As the health director of a compacting tribe explained, because the tribe had "acquired many of its medical providers since 1993, it is not possible to calculate a valid average."

Salaries for Physicians

A comparison of reported salaries for board certified Family Practice physicians shows a great range in salaries. For IHS direct facilities (with only 3 tribes reporting), the range was $65,000 to $120,000 with an average salary of $95,000. For tribally-operated programs (with 30 reporting), the range was $40,000 to $175,000 with an average salary of $98,220. It should be noted that the high end of the range for tribally-operated programs was for a program with one physician and a 17-month vacancy, which could indicate that the salary was based on *locum tenens* (temporary) physician fees, which are much higher than salaries for permanent positions. None of the other programs paid more than $120,000.

A Bemidji Area health director felt that tribes could save on physician salaries by acquiring physicians through intergovernmental agreements:

> Tribes are having to pay $30-$50 thousand more to hire the same person than what it would cost the Tribe if the person was Commissioned Corps or Civil Service. Tribes should be allowed to offer Commissioned Corps, Civil Service or Tribal hire as options. The FTE ceiling does not allow tribes any options unless the Tribe has a Corps or Civil Service vacancy.

Benefits offered to employees may vary greatly among employers, affecting the total cost of compensation. The intent of the question was to obtain a general indication of whether it was more expensive for tribes to hire doctors than for the federal government to do so. In general, it appears that there are no major differences.

Improving Recruitment and Retention

When asked to describe any innovation their tribes had found successful in improving the recruitment and retention of health care professionals, health directors cited a number of creative approaches. Here are some examples:

> Tribal orientation. Orientation/participation in health initiatives. Presentation to Legislative Council.
>
> Access to community peers. Conferencing using teleconferencing, consulting using our tele-med equipment.
>
> Currently producing a video about our community and surrounding attractions.

Working with the local hospitals to jointly recruit physicians.

Continuity in administration. Attaining JCAHO [accreditation] which clarifies governance function which keeps tribal politics out of health care.

Established Traditional Medicine program which assists in retention.

These ideas came from all types of tribes.

Health directors were asked whether any of seven different approaches would be helpful in recruitment and retention of health care professionals. In general, the IHS direct service tribes were more enthusiastic about the ideas than the tribally-operated programs. The percentage of those who answered the question that thought these were good ideas is given in Figure 6.3 by type of tribe.

Figure 6.3

Percentage of Tribes by Type that Responded that Approaches Would Be Helpful in Recruitment and Retention

	IHS Direct	Contracting	Compacting
Training for professionals at local extensions of university	100%	63%	68%
Scholarships for professional training for Native Americans	63%	73%	79%
Loan pay-back and other incentives to recruit professionals	90%	80%	84%
An organized, inter-Tribal recruitment system	76%	77%	53%
Better pay for professionals	100%	77%	68%
Housing	90%	60%	42%
Community social support for professionals	86%	60%	47%

Source: Health Director Survey

As these numbers indicate, the top priorities for IHS direct service tribes are better pay, more local training, housing, and incentives such as loan payback. For contracting tribes, the top priorities are an organized inter-tribal recruitment system, as well as better pay and incentives such as loan payback. Compacting tribes place the highest priorities on loan payback and other incentives, as well as scholarships for Native Americans.

When the response to these ideas is analyzed by Area, there is a lot of variation between the IHS Areas, as shown in Figure 6.4. For example, there is a greater need for housing in Aberdeen than the other Areas. "On-site visits are helpful because of our extreme isolation," said an Aberdeen Area health director, "we are aware of housing needs for professionals - until housing funds can be found this will remain a problem." In Portland, there is already a organized inter-tribal recruitment system and the 78 percent positive response rate seems to indicate support for continuation of this idea.

Figure 6.4

Percentage of Tribes by Area That Responded That Approaches Would Be Helpful in Recruitment and Rentention

	Aberdeen	Alaska	California	Nashville	North	Oklahoma	Portland	Southwest
Training for professionals at local extensions of university	90%	67%	100%	67%	75%	60%	100%	50%
Scholarships for professional training for Native Americans	100%	100%	100%	67%	75%	80%	89%	60%
Loan pay-back and other incentives to recruit professionals	100%	83%	100%	67%	75%	80%	100%	60%
An organized, inter-Tribal recruitment system	70%	67%	100%	67%	75%	80%	78%	50%
Better pay for professionals	100%	83%	100%	67%	75%	60%	89%	60%
Housing	100%	67%	40%	33%	75%	60%	78%	40%
Community social support for professionals	100%	50%	40%	33%	69%	60%	88%	50%

Source: Health Director Survey

RETROCESSION AND REASSUMPTION OF SERVICES

Indian Self-Determination Act regulations allow for tribes to decide to have the IHS reassume the management of any program that the tribe has contracted or compacted ("retrocession") and for the Secretary to take back control over programs in certain extreme circumstances ("reassumption"). Overall, tribal management has been successful as measured by the number of programs for which tribes have assumed management and then later turned them back to the federal government to manage. Only 3 of the 70 tribes represented in the health directors survey, about 4 percent, have reported giving programs back to the IHS to manage. These include one compacting tribe and two contracting tribes.

One example that was cited was a youth residential treatment program. The Tribe was forced to turn the program back to IHS because a "regulation definition changed to say that IHS could not distribute the funds to programs." Another tribal organization turned back two programs, women's health care and health aide training. The reason for giving back the women's health care program is that it served a predominantly urban population at the expense of the rural tribal members. The health aide training program was eliminated due to lack of money and insufficient practicum sites. The third tribe did not cite reasons for turning back contract health and environmental health programs.

SUMMARY

The data from this study suggests a pattern that is likely to continue to emerge in tribally-operated systems. As tribes take over management of health programs under P.L. 93-638 contracts, they appear anxious to make changes in management to increase income from third party sources and to create efficiencies by acquiring new computers

and re-organizing services. Initially, they are more likely to use a shotgun approach, trying several different strategies to achieve management objectives. However, as they get more experience they learn what works best for them and they keep the most effective approaches and abandon the other strategies. At first, contracting tribes increase their administrative staffing to improve such areas as quality assurance, purchasing and planning. Later they may see a need to streamline their administration staffing. After three years of contracting, when they become eligible for compacting, their management systems are largely in place. Thus, compacting tribes are making fewer management changes and using fewer strategies to achieve their objectives than are the contracting tribes.

Another pattern that emerges from the information in this study is that tribes are more likely to use income from economic enterprises to support health care services and to build new facilities when tribes are operating the health care programs under contract or compact. It is not clear whether tribes with successful economic enterprises are more likely to be contracting or compacting health programs than tribes with a more limited economic base and less management experience. Just as we are unable to answer the question, "Which came first, the chicken or the egg?", there is no information in this study that allows us to answer the question, "Do tribes invest in health care because they feel a greater ownership in the programs they are operating themselves, or do tribes that operate health care programs invest in them because they also have successful economic enterprises that create the capacity to do so?"

One of the more surprising findings is that IHS funding for new or expanded facilities appears to benefit compacting tribes more than either IHS direct service tribes or contracting tribes. This likely reflects the high percentage of contracting tribes from the California Area that have had difficulty obtaining funding for new facilities. There may be other explanations, as well. Perhaps compacting tribes, because they already have managed their own programs for at least three years under contract, have had plans for facilities in place longer than other tribes. Perhaps compacting tribes are more effective at lobbying Congress and/or influencing IHS. Or perhaps they have the greatest need for new facilities and that is part of what motivated them to begin tribal management. Further investigation would be necessary to determine the true reasons.

This study suggests that tribes are very capable of managing their own health care programs. "We are capable of making our own decisions," said the director of one tribally-operated program. Others echoed this sentiment with an endorsement for self-determination and self-governance:

> PL 93-638 and all amendments have greatly enhanced our ability to assist our tribal members in leading healthy productive lives.
>
> Increased funding, more flexibility, less paperwork, less bureaucracy, all in all compacting has been very positive for our tribe.

About 4 percent of the tribes in the study that have assumed management of programs have later turned them back to the federal government. In the rare instances in which this has happened, the reasons are usually related to regulations, insufficient budgets or geographic issues rather than inability to manage the programs.

While some might be concerned that health care professionals will not want to work for tribes, this concern is not borne out by the survey data. Tribes report fewer problems recruiting health care professionals than the IHS direct service programs. This may be because tribes have more strategies available to them than the federal government offers.

Overall, it appears that tribally-operated programs have been successful in increasing services and improving facilities by implementing a variety of management approaches including making trade-offs to eliminate some services and start others, creating greater efficiencies that result in more expendable dollars, improving billing for third party resources to increase income, deriving income from serving non-beneficiaries, using IHS funding to bring in additional dollars from other sources, and making contributions from the tribe's profitable economic enterprises to operating and capital budgets for health programs.

CHAPTER 7

IMPACT ON THE QUALITY OF CARE

Yvette Roubideaux, M.D., M.P.H.

INTRODUCTION

The survey of tribal leaders and health directors included questions to assess the impact of self-determination and self-governance activities on the quality of care in Indian health programs. For years the Indian Health Service has measured quality internally using a variety of indicators, but there have been no studies that measure the quality of care from the perspective of tribal leaders in Indian health. Since elected tribal leaders and health directors often make key decisions related to health care services for their tribes, their perspective on the quality of care delivered to their community members is very important. Their perspective is often a key factor in the tribe's decision whether to remain under IHS direct service or to enter into contracts or compacts to manage their own health care services.

Measuring the quality of care in Indian health is a very complicated process. It involves defining what is meant by quality, from what perspective, and choosing what objective measures to use to demonstrate quality. Indian health programs vary greatly in terms of size, type of facility, priorities, health problems in the community, and the capacity to actually measure quality. The project team anticipated problems in availability, accuracy and comparability of data gathered in a national survey from such a diverse group of health care facilities. These concerns were confirmed during the pilot study, "Quality Measurement in Indian Health Facilities,"[46] which revealed that there was great variability in the availability of data on quality from Indian health facilities. When available, these data were often qualified as potentially inaccurate, and were not always comparable with data from other facilities.

Therefore, the project team's original plan to collect quantitative data on the quality of care in Indian health facilities was revised given the limitations on time and resources and the inherent difficulties in measuring quality in Indian health facilities. The project team realized that tribal leaders and health directors must still use these data to make key decisions on health care issues for their communities. So the project team decided to gather information on the quality of care from the perspective of the tribal leaders and health directors, and to ask for their qualitative comments on a number of indicators of quality. The answers to these questions were analyzed to determine how tribal leaders and health directors view the quality of care delivered to their communities through their health care systems. These answers were compared for the different types of health care delivery systems (IHS direct, contract, compact) present in Indian country. This study was intended to be a "first look" at the quality of care in Indian health care systems from the perspective of tribal leaders and health directors. Descriptive information

[46] The full report of the pilot study is available in Volume 3 of this report.

gathered in the survey may be used to generate hypotheses and further studies to clarify the results.

METHODS

The study design and methods are explained in detail in an earlier section of this report. In brief, two survey instruments were developed to assess the impact of the self-determination and self-governance activities in Indian country from the tribal perspective: one survey of elected tribal leaders; and one survey of health directors. Several questions were included in each survey to identify changes in the quality of care from the tribal perspective.

In the tribal leader survey, 577 surveys were mailed to an elected tribal leader as appropriate for each tribe. The survey included four major questions related to the quality of care delivered to members of that particular tribe:

1. Changes in health care provided to tribe in the past 3 to 4 years.
2. Awareness of summaries of health care quality from facilities/programs that serve the tribe.
3. Time spent on health care issues by the tribal leader.
4. Importance of bringing together the traditional language, beliefs, and healing practices with the health care system.

The project team analyzed the answers to each of these questions and compared the results for tribal leaders from different IHS Areas and from the different types of health care delivery systems.

In the health director survey, 256 surveys were mailed to the designated tribal health director for each tribe where appropriate. The survey included seven major questions intended to assess the quality of care in the Indian health programs serving each tribe in greater detail than in the tribal leader survey:

1. Accreditation status of facilities/programs serving the tribe.
2. Overall assessment of the changes in the quality of care since 1993.
3. Qualitative information on selected quality indicators.
4. Accuracy of data used for quality measurement.
5. The role of elected tribal leaders in quality assurance activities.
6. QA Coordinator: time and training for QA.
7. Orientation of providers on cultural beliefs/traditional healing.

The project team analyzed the answers to each of these questions and compared the results for health directors from different IHS Areas and from different types of health care delivery systems.

The surveys were mailed to the tribal leaders and health directors, and several reminders were sent to increase the response rate and ensure representation from all of the IHS Areas. The identities of the respondents were kept confidential, and were not reported as a part of the results. Comparisons were planned between tribal leaders and

health directors from the same tribe, but the number of matching surveys was too low to provide useful results. The results of the questions in each survey were analyzed and are presented here in a descriptive fashion.

RESULTS

Tribal Leader Survey

Response Rate/Sample Characteristics

Of the 577 surveys mailed to tribal leaders, 171 surveys were completed, resulting in a response rate of 30 percent. All of the IHS Areas were represented, and the response rate for each Area ranged from 16 percent in the Albuquerque Area to 100 percent in the Navajo Area, with most Area response rates in the 20-40 percent range.

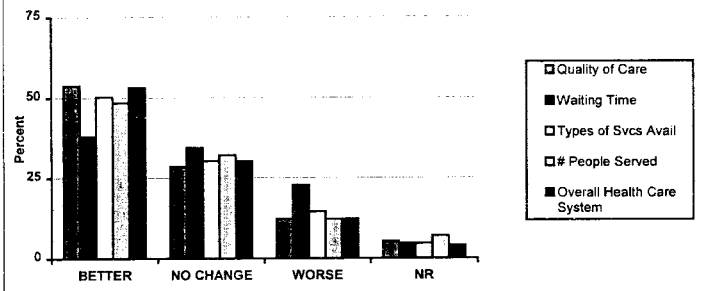
The tribal leaders were asked to define the method of health care delivery for their tribe/tribal organization from their perspective. The question initially was designed to give the tribal leader three basic choices: IHS direct service, contracting, and compacting. However, the Advisory Committee for the project noted that this distinction was unclear for many tribes that utilize a number of services from each of the different categories listed above. So the question was redesigned to account for these differences by asking the tribal leader to choose the *primary* method of health care delivery for their tribe. The question was also modified for the Alaska tribes who, despite being generally regarded as compacting tribes, may utilize IHS direct services such as the Alaska Native Medical Center. In general, the response rate by type of health care delivery system was relatively representative of the actual proportions of these types of health care delivery systems currently in Indian health.

While analyzing the surveys, the project team noticed that a small number of tribal leaders indicated that the primary method of health care delivery for their tribe was different from the method most commonly identified by the IHS or by others familiar with the Indian health system. For example, one tribal leader identified the primary method to be IHS direct service, when most of the services, except for the hospital, were compacted. Even though the tribe is commonly known as a "compacting" tribe, the tribal leader identified the "primary" method of health care delivery as IHS direct services most likely because the large IHS direct hospital serving this tribe was a major source of care for the tribe. The project team considered reclassifying these cases where the tribal leader chose a primary method of health care delivery different from what was expected, but recognized that the tribal leader's perception of the quality of care may in part depend on his or her perspective on the type of health care delivery system serving the tribe, whether or not this perception was consistent with others working in Indian health. Therefore, the project team decided to use the tribal leader's answers in the analysis, in order to remain internally consistent with the concept that these answers represent the perspectives of the tribal leaders, not the project team or others working in Indian health.

Changes in Health Care Provided to Tribe in the Past 3-4 Years

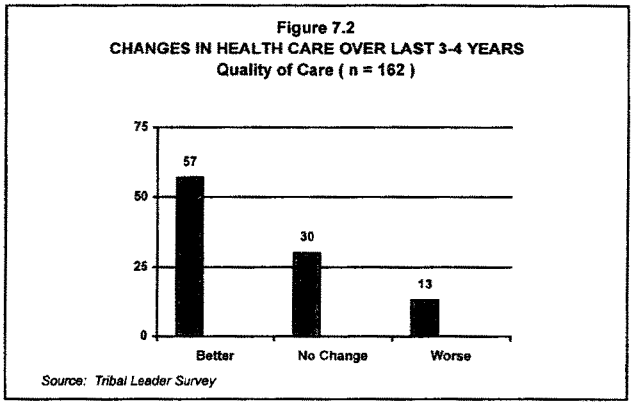
The tribal leaders were asked for their impression of the changes in health care in the past 3-4 years for five major indicators: quality of care, waiting time, types of services available, number of people served, and the overall health care system. The respondents were asked to qualitatively rate their impression of each indicator in the past 3-4 years as "better", "worse", or "no change." The answers to these questions are summarized in Figure 7.1.

Figure 7.1
CHANGES IN HEALTH CARE OVER LAST 3-4 YEARS
Indicators - Summary (n = 171)

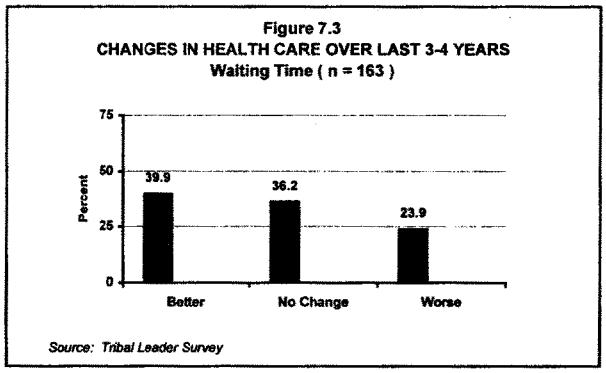


Source: Tribal Leader Survey

For the overall sample, most tribal leaders rated the changes in these indicators over the past 3-4 years as "better." For example, 57 percent of the tribal leaders responding rated the quality of care as "better" in the last 3-4 years, 30 percent rated the quality of care as "no change", and only 13 percent rated the quality care as worse (Figure 7.2).



The responses to the other indicators (waiting times, types of services available, number of people served, overall health care system) showed a similar pattern of being rated more commonly as "better." However, for the indicator waiting times, the relative proportion of "no change" and "worse" answers was higher than for the other indicators (Figure 7.3).



When the data were analyzed by Area, the majority of tribal leaders representing all Areas but California rated the quality of care as "better." The majority of tribal leaders in California rated the changes in quality of care as "no change" (Figure 7.4).

Figure 7.4
Changes in Health Care over last 3-4 years
Quality of Care by Area
(number responding in each category)
(n = 162)

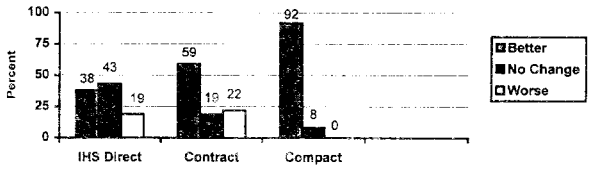
AREA	Better	No Change	Worse	NR	Total
Aberdeen	4	4	1	0	9
Alaska	45	26	7	3	81
Albuquerque	0	2	2	0	4
Bemidji	5	0	1	0	6
Billings	2	1	1	0	4
California	5	10	6	1	22
Nashville	5	2	0	2	9
Navajo	1	1	0	0	2
Oklahoma	9	2	2	2	15
Phoenix	6	1	1	0	8
Portland	9	0	0	1	10
Tucson	1	0	0	0	1

Source. Tribal Leader Survey

When the responses were analyzed by type of health care delivery system selected by the tribal leader, some interesting differences were noted between the categories IHS direct service and contracting/compacting (Figure 7.5). For all Areas except Alaska, most of the contracting (59 percent), and almost all of the compacting (92 percent) tribal leaders indicated that the quality of care was "better", while the tribal leaders who selected IHS direct service selected "no change" as their most common response.

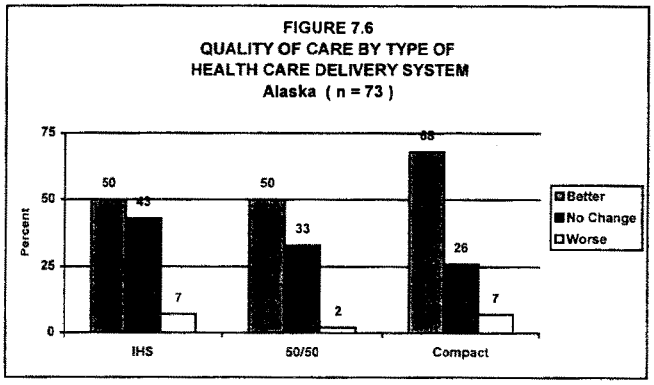
Figure 7.5
QUALITY OF CARE BY TYPE OF HEALTH CARE DELIVERY SYSTEM

All Areas except Alaska (n = 82)

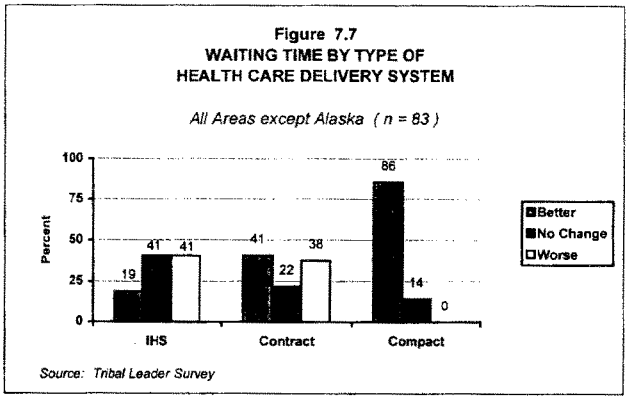


Source: Tribal Leader Survey

For the Alaska Area, tribal leaders who identified their primary method of health care delivery as "mostly compacting" and "100 percent compacting" tended to rate the quality of care as "better" more often than those tribal leaders who indicated higher contributions of IHS direct services (Figure 7.6).



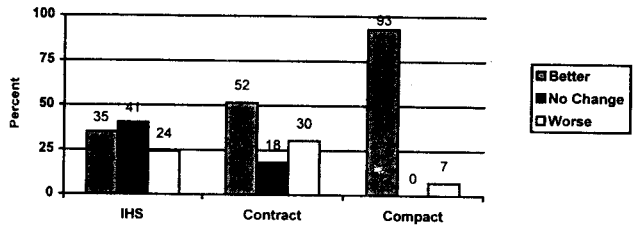
Similar patterns of response were seen for the other indicators when analyzed by type of health care delivery system. Tribal leaders representing compacting tribes more commonly rated each of the other quality indicators (waiting times, types of services, number of people served, overall health care system) as "better." For example, 86 percent of tribal leaders representing compacting tribes rated the indicator waiting time as "better", compared to only 19 percent of the tribal leaders representing IHS direct service tribes, and 41 percent of the tribal leaders representing contracting tribes (Figure 7.7).



In addition, 86 to 93 percent of tribal leaders representing compacting tribes also rated the other indicators as "better" (Figures 7.8, 7.9, and 7.10). The tribal leaders representing IHS direct and contracting tribes only rated these indicators as "better" 35 to 58 percent of the time.

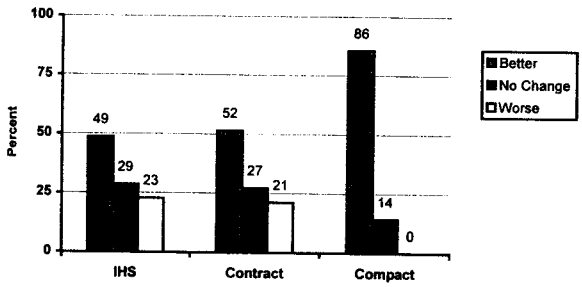
Figure 7.8
TYPES OF SERVICES AVAILABLE
BY TYPE OF HEALTH CARE DELIVERY SYSTEM

All Areas except Alaska (n = 84)



Source: Tribal Leaders Survey

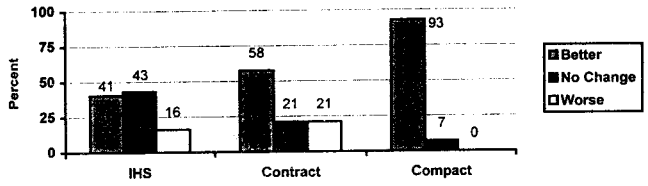
Figure 7.9
NUMBER OF PEOPLE SERVED
BY TYPE OF HEALTH CARE DELIVERY SYSTEM
All Areas except Alaska (n = 82)



Source: Tribal Leader Survey

Figure 7.10
OVERALL HEALTH CARE SYSTEM
BY TYPE OF HEALTH CARE DELIVERY SYSTEM

All Areas except Alaska (n = 84)

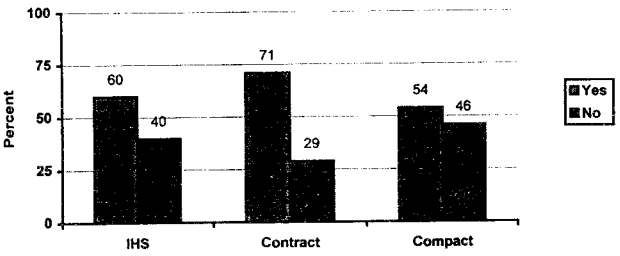


Awareness of Summaries of Health Care Quality

For the overall sample, 63 percent of the tribal leaders responding were aware of summaries of health care quality from facilities/programs that serve their tribe. When the responses were analyzed by type of health care delivery system, the highest level of awareness was indicated by contracting tribes (71 percent) in all Areas except Alaska, and by compacting tribes in Alaska (81 percent) (Figures 7.11 and 7.12).

Figure 7.11
AWARE OF SUMMARIES OF HEALTH CARE QUALITY
BY TYPE OF HEALTH CARE DELIVERY SYSTEM

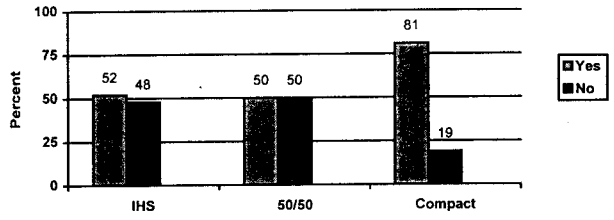
All Areas except Alaska (n = 79)



Source: Tribal Leader Survey

Figure 7.12
AWARE OF SUMMARIES OF HEALTH CARE QUALITY
BY TYPE OF HEALTH CARE DELIVERY SYSTEM

Alaska (n = 74)

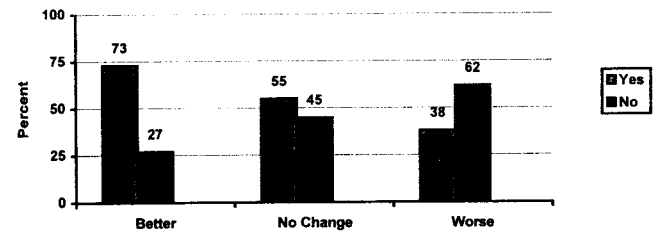


Source: Tribal Leader Survey

In addition, for the overall sample, the tribal leaders who rated the quality of care as "better" tended to be more aware of summaries of health care quality from the facilities/programs serving their tribes than those tribal leaders who rated the quality of care as "no change" or "worse" (Figure 7.13).

Figure 7.13
AWARE OF SUMMARIES OF HEALTH CARE QUALITY
BY CHANGES IN HEALTH CARE: QUALITY OF CARE

Overall Sample (n = 156)



Source: Tribal Leader Survey

Time Spent on Health Care Issues by the Tribal Leader

Among the tribal leaders who responded to this survey, 64 percent indicated that they spend time on health care issues "weekly." An additional 23 percent spend time on health care issues "monthly," and only 14 percent of the tribal leaders responding

ndicated that they spent time on health care issues "quarterly" or "yearly" combined. Further analysis of these responses by Area and type of health care delivery system was imited by the low response rate for this question (43 percent).

Importance of Bringing Together Traditional Language, Beliefs, and Healing Practices with the Health Care System

Of the overall sample, 66 percent indicated that the concept of bringing together traditional language, beliefs, and health practices with the health care system was important to the health of their tribal members. The results of this question will be compared to the question in the health director survey on whether health care providers are oriented on the traditional beliefs and healing practices of the tribe(s) they serve. The combination of these two questions begins to address the issue of cultural competency in Indian health programs, by determining the need for a particular service from the tribal perspective, and by measuring whether the health care system provides that service.

Health Director Survey

Response Rate/Sample Characteristics

Of the 256 surveys mailed to health directors, 70 surveys were completed, resulting in a 27 percent response rate. The response rate by Area ranged from 11 percent for the Oklahoma Area to 59 percent for the Aberdeen Area.

The study classifications of types of health care delivery systems were used to analyze the health director surveys. The response rate by type of health care delivery system was relatively representative of the actual distribution of IHS direct, contracting, and compacting tribes.

Accreditation Status of Facilities/Programs Serving the Tribe

The 70 tribal health directors who responded to the survey represented 115 facilities in their health care delivery systems combined, including 8 hospitals, 73 clinics, and 34 other facilities, such as treatment centers, dental clinics, and outreach programs. All of the 8 hospitals and 60 percent of the 73 ambulatory clinics listed were accredited. The 10 IHS clinics were accredited by Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the 13 contract and 21 compact clinics were accredited by a mix of JCAHO, the Health Care Financing Administration (HCFA), and state accreditation (Figure 7.14).

Figure 7.14
Accreditation Status of Facilities

Hospitals and Clinics

Overall	(n = 81) # Listed	# Accred	% Accred
Hospital	8	8	100
Ambulatory Clinic	73	44	60
Total	81	52	64

By Facility

Accrediting Agency	(n = 52) Hospital #	%	Clinic #	%
JCAHO	8	100%	27	61%
HCFA	n/a		9	20%
State	n/a		8	18%
Overall	8	100%	44	100%

Hospital Accreditation Status By Type of Health Care Delivery System

Health Care Delivery System	(n = 8) Total Hospital #	Accreditation Status (JCAHO)
IHS Direct	7	7
Contract	0	0
Compact	1	1

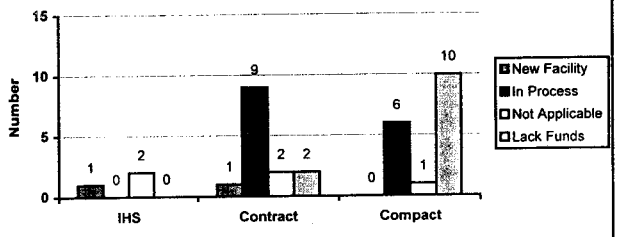
Clinic Accreditation Status By Type of Health Care Delivery System

Health Care Delivery System	(n = 44) Total Clinic #	Accreditation Status JCAHO	HCFA	State
IHS Direct	10	10	0	0
Contract	13	3	4	6
Compact	21	14	5	2

The health directors were asked to record the reasons that their facilities were not accredited. Most of the facilities were either preparing for accreditation or lacked the funds to pursue accreditation. These two reasons were most commonly cited by health directors representing contracting and compacting tribes (Figure 7.15).

Figure 7.15
REASONS NOT ACCREDITED

By Type of HCDS (n = 34)



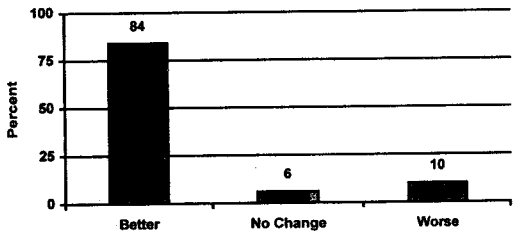
Source: Health Director Survey

Overall Assessment of the Changes in the Quality of Care since 1993

Health directors also were asked to assess the overall quality of care since 1993. The overall quality of care has gotten "better" according to 84 percent (Figure 7.16).

Figure 7.16
OVERALL QUALITY OF CARE SINCE 1993

Overall Sample (n = 69)

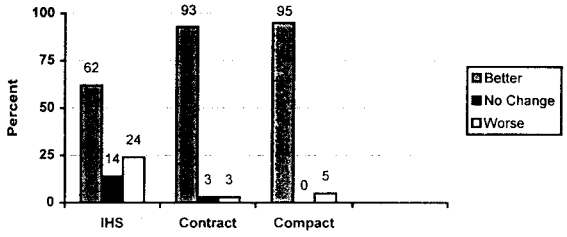


Source: Health Director Survey

This trend was also present in the analysis by Area. In addition, when the data were reviewed by type of health care delivery system, more health directors representing contract and compacting tribes tended to report that the quality of care has gotten "better" compared to tribal health directors representing IHS direct services tribes (Figure 7.17).

Figure 7.17
OVERALL QUALITY OF CARE SINCE 1993

By Type of Health Care Delivery System (n = 69)



Source: Health Director Survey

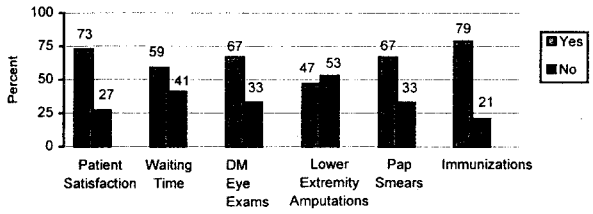
In addition, the largest proportion of "worse" answers was from health directors representing primarily IHS direct services.

Information on Selected Quality Indicators

Health directors were asked if their facilities measured specific quality indicators. Then they were asked to give a qualitative assessment of the results of these indicators over the past 3 years. The six indicators were: patient satisfaction, waiting times, diabetic eye exams, lower extremity amputations, pap smears, and immunizations. The majority of the health directors reported that their health care delivery systems did measure all of the indicators except lower extremity amputations, which was measured by only 47 percent. The proportion measuring the other five indicators ranged from 59 percent (waiting times) to 79 percent (immunizations) (Figure 7.18).

Figure 7.18
QUALITY INDICATORS

Do you Measure? Overall Sample (n = 70)

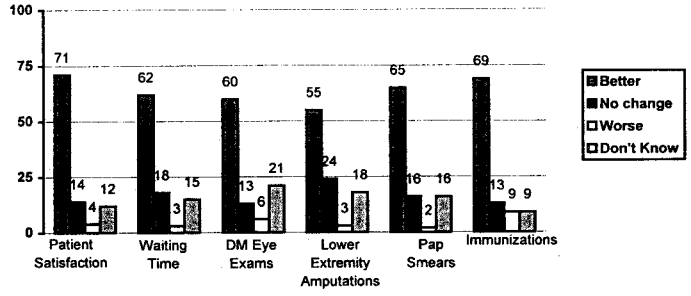


Source: Health Director Survey

Over half of the health directors reported that the results of these indicators over the past three years were mostly "better" (55 - 71 percent), with few reporting "no change" (13 - 24 percent), and even fewer reporting that the indicators were "worse" (2 - 9 percent) (Figure 7.19). The same trends were evident in the sample when the data were analyzed by Area and by type of health care delivery system. No clear differences were seen between IHS, contract, and compact facilities, as the health directors representing tribes with each type of health care delivery system rated these indicators most commonly as "better" in the same proportions as they rated them in the overall sample.

Figure 7.19
QUALITY INDICATORS

Results over the past 3 years - Overall Sample (n = 70)



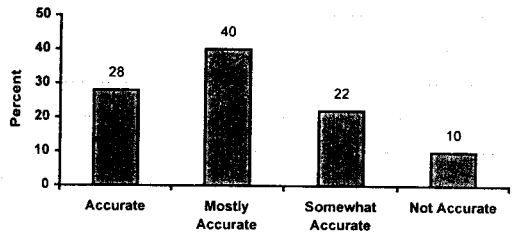
Source: Health Director Survey

Accuracy of Data Used for Quality Measurement

The health directors were asked to assess the accuracy of their data used for quality measurement. Two thirds of the sample thought that their data were "accurate" or "mostly accurate", while about one third of the sample thought that the data were "somewhat accurate" or "not accurate" (Figure 7.20). There were no major differences in these numbers by Area or by type of health care delivery system.

Figure 7.20
ACCURACY OF DATA FOR QA/QM

Overall Sample (n = 60)



Source: Health Director Survey

The Role of Elected Tribal Leaders in Quality Assurance Activities

Of the health directors reporting, 59 percent said that elected tribal leaders were involved in quality assurance activities in their health care delivery systems. Of those involved, there were very small differences when the data were analyzed by Area and by tribe. The types of involvement of elected tribal leaders most commonly reported included "reports to the Board" (77 percent), "training for the Board" (44 percent), and QA Committee membership (26 percent).

QA Coordinator: Time and Training for QA

Most (65 percent) of the health directors reported that their Quality Assurance (QA) Coordinator spent less than 30 percent of their time on QA activities, and only 14 percent had QA Coordinators who spent 100 percent of their time on QA. The QA Coordinators received a variety of training on QA, including continuing education courses (70 percent) and JCAHO training (46 percent) as the most common types of training attended. There were no differences in these answers by Area or type of health care delivery system. Incomplete information prevented the project team from analyzing these data based on facility size, which may have explained some of the differences noted in the answers to this question.

Orientation of Providers on Cultural Beliefs/Traditional Healing

In this survey, health directors were asked if they orient their providers on the cultural beliefs and traditional healing practices of the tribe. Only 4 percent indicated that they do provide this type of orientation. In the tribal leader survey, 96 percent thought that it was "very important" or "somewhat important" or bring together traditional language, beliefs, and healing practices with the health care system for their tribe. It

should be noted that, for the most part, this question was answered by tribal leaders and health directors from different tribes. However, the large difference in the results for each question does suggest that even though these tribal leaders think there is a need for culturally competent care, very few facilities actually provide this type of orientation to make sure that health care providers understand the cultural beliefs and traditional healing practices of the tribal members in their communities.

CONCLUSIONS

This is the first large scale study that specifically asks tribal leaders and health directors about their perceptions of the quality of care in the health systems that serve their tribes. Even though the results of this study are not generalizable due to the relatively low response rate, the results, in a descriptive fashion, do show some clear trends in the quality of care from the tribal perspective.

The most striking finding from this portion of the survey is the tribal perception of the changes in the overall quality of care in Indian health over the past 3 - 4 years. A majority (53 percent) of the tribal leaders thought that the quality of care is "better," and an even greater proportion of health directors chose this response (84 percent). In addition, of the tribal leaders and health directors who responded that the quality of care is "better", proportionally more respondents were from tribally managed programs than from IHS programs. And although few respondents thought that the quality of care is "worse", most of these responses were from tribes served by IHS health programs. The tribal leaders and health directors also thought that the other indicators of quality listed in the survey (waiting times, types of services, number of people served, and overall health care system) were "better" over the past 3-4 years, with compacting tribal leaders and health directors again more commonly rating the quality indicators as "better." Overall, from the perspective of tribal leaders and health directors in this survey, the quality of care, as defined overall and by a number of indicators, is getting better in Indian health. And tribal leaders and tribal health directors representing compacting tribes more commonly rated each of the quality indicators as "better" compared to the IHS and contracting tribes.

The tribal leaders and health directors in this sample represented health programs that were well equipped to measure quality. All of the hospitals, and many of the clinics serving these tribes were accredited or in the process of being accredited. The only limitation on accreditation seemed to be a lack of resources as a common response. It is likely that this would be more common in smaller facilities, regardless of whether they were IHS or tribally managed, but there were insufficient responses to facility size and type in this survey to further analyze this question. Even though most of the Quality Assurance (QA) Coordinators from these facilities spent less than 30 percent of their time on QA activities, most facilities did measure the specific indicators listed in the survey. And two thirds of the respondents thought that their data were accurate or mostly accurate.

The tribal leaders and health directors in this sample had a high level of involvement in the QA activities of the health facilities serving their tribes. Most of the tribal leaders (86 percent) reported spending time "weekly" or "monthly" on health care

issues, and the majority (63 percent) were aware of health care summaries from the facilities that serve their tribe. Interestingly, tribal leaders who rated the quality of care as "better" tended to be more aware of these summaries. The majority of health directors (60 percent) reported that elected tribal officials were involved in QA activities, with reports to the Board being the most common type of involvement.

Even though the tribal leaders and health directors thought that the overall quality of care is getting better, an interesting disparity was found in the answers to a particular question regarding whether the care delivered in Indian health programs is culturally competent. Despite 96 percent of tribal leaders believing that it is "very important" or "somewhat important" to bring together traditional language, beliefs, and health practices with the health care system for their tribe, only 4 percent of health directors indicated that they actually orient new providers on the traditional beliefs and healing practices of their tribes. It should be noted that the answers predominantly represent the opinions of tribal leaders and health directors from different tribes. Still, a disparity between the need for culturally competent care and the efforts by the health facilities to address this need is clear. Since there were no clear differences between IHS or tribally managed programs in the answers to these questions, this appears to be an area for improvement for all types of Indian health programs.

Overall, this survey shows that from the tribal perspective, the quality of care in Indian health is getting better, and very few respondents thought that it is getting worse. These data contradict the assertions of various authors in the literature who claim that the reorganization and move towards tribally-managed health programs has led to a decline in the quality of care. At least in this descriptive survey, a large number of tribal leaders and health directors disagree with those assertions. Even though the results of this study are mostly qualitative, they still represent valid perceptions of quality based on defined indicators and available data. Further studies are needed to help quantify the changes in quality in Indian health, and to address the problems with measuring quality on a national, comparative basis. In addition, the tribal perspective represents only one important perspective on the quality of care; more studies are also needed to assess the perception of Indian patients on the quality of care. As more data are gathered, tribes will be able to make better decisions as they increasingly choose to manage their own health care systems.

CHAPTER 8

OPPORTUNITIES AND BARRIERS

The focus of this chapter is the factors that may lead a tribe to choose or not choose a particular type of management for its health care delivery. Tribes make these choices by analyzing various factors which may be either opportunities or barriers from their own particular standpoints. Opportunities are the incentives that encourage tribes to make a particular choice. As tribes consider their choices, they are likely to evaluate the opportunities that each choice provides. Sometimes tribes would like to choose an option, but there are barriers or obstacles making that choice less feasible or less desirable. Barriers are the disincentives that discourage tribes from making a particular choice. The same factor could be viewed as both an opportunity and a barrier. For example, locally available training in health careers can facilitate the employment of tribal members, and thus training can be an opportunity in that it can increase tribal employment and economic development through the tribal management of health care. However, lack of training could serve as a barrier to tribal management of health care if few tribal members have the necessary management and health professions training.

The preceding chapters have described net gains in services and facilities, changes in management, and impacts on quality of care. For each of these, there have been improvements for all types of tribes in the past three years, but the largest improvements have been associated with tribally-operated programs. If the type of health care delivery a tribe has chosen means the tribe will enjoy similar improvements, these gains may be seen as opportunities. This chapter begins with a discussion on whether the gains identified in the previous chapters are a result of contracting and compacting, or whether there could be other factors at work that are having a more positive outcome for tribally-operated programs than for IHS direct service programs. This distinction is important because it helps to define the extent and limits of the opportunities provided by contracting and compacting.

Next, the chapter summarizes some of the factors that tribal leaders and health directors identified as influencing their decision-making. Since the fundamental principle of Indian self-determination is that tribes can chose how they want their health care system to be managed, the factors that tribes consider important in their decisions provide guidance for effective policymaking. Public policies contain a mix of incentives and disincentives that help to shape tribal decisions about contracting and compacting health services. The information in this chapter provides feedback from tribes about the mix contained in current policies.

Some barriers to contracting and compacting are not naturally occurring results of the type of management, but rather exist separate from how the management type works. The chapter includes a discussion of barriers to contracting and compacting that are created by Congress. It also considers health care employment opportunities and barriers, including training for tribal members. Finally, the chapter concludes by identifying changes that could be made in order to encourage more tribal management of health programs.

INTEPERTING THE SURVEY RESULTS TO IDENTIFY OPPORTUNITIES

Chapters 5, 6, and 7 of this study have provided descriptions of changes in services, facilities, management and quality of care. A striking pattern has been established for nearly every indicator: while all types of tribes have experienced improvements in the past three years, tribally-operated programs appear to have made the greatest gains. Furthermore, there is a relatively consistent pattern that compacting tribes perceive the greatest improvements, followed by contracting tribes, with IHS direct service tribes perceiving the least improvements.

On the surface, one might conclude that contracting and compacting are responsible for the positive changes that have been documented in this study. However, the study does not undertake any statistical tests to correlate the type of management system and the positive changes that have been described. In order to determine whether any cause and effect relationship exists between the type of management and any improvements, the sample size and distribution would have to be tightly controlled and mathematical calculations would have to be performed on the resulting data. Instead of attempting to mathematically establish such causal connections, a decision was made that this study should be broader in scope and should give every tribe an opportunity to participate. The statistical rigor necessary to infer causal relationships was sacrificed in order to ensure that as many tribal opinions as possible could be gathered, and in hopes that a groundwork for further studies in many areas could be created.

One explanation for the gains perceived by tribes that manage their own health care systems is that contracting and compacting have improved the management of Indian health services for those tribes that have chosen to utilize these methods for delivery of their health care. Many of the tribal leaders and health directors from compacting tribes believe that compacting has been responsible for the improvements that they have observed. They have offered comments such as the following:

> Because of Self-Governance our health care has improved drastically.
>
> Overall, Self governance has enabled the Tribe to expand and begin new programs and services, remodel facilities, and purchase needed equipment.

The direct benefits of compacting include greater flexibility in management and the ability to move funding for tribal shares to the local level. The combination of these two benefits may be responsible for the documented improvements. But there also may be other factors at work at the same time to improve the opportunities for compacting tribes to be successful.

One factor that this study was unable to explore fully is the increase in funding from non-IHS sources, including Medicaid and tribal contributions. This study does suggest that tribally-operated programs are doing better than IHS at billing third parties, including Medicaid. However, the opportunity to access these resources may result from state and federal policies that favor tribes in certain states. For example, some states may have policies that increase eligibility for Medicaid and payment for benefits among

IHS beneficiaries. Another potential source of funding may be tribal income from non-health sources. The availability of such resources varies greatly. For example, some tribes are unable or choose not to develop substantial income from gaming, for geographic, legal, or moral reasons. These tribes may have more limited economic development opportunities, which in turn limits the amount of money that the tribes can contribute to their health programs. It is possible that many of the compacting tribes in this study are located in states where policies are more favorable than the states in which the IHS direct service tribes are located, and thus may have more resources available to them to supplement the funding they receive through IHS.

Another factor that should be considered as having an impact on the form of management is the legal limit on the number of compacting tribes. Because the number of tribes that may enter into compacts each year was limited and the eligibility requirement included successful contracting experience, there was competition among the most experienced tribes for the limited number of Self-Governance Demonstration Project compacts. The tribes that sought the opportunity to become part of the Self-Governance Demonstration Project may have already had more resources than other tribes before they received this designation. The tribes that were selected for the Demonstration Project would thus be the tribes most likely to succeed. Thus, it may not be the compacting process that is responsible for the success of these tribes. Rather, the most successful tribes may have been selected for compacting. If all tribes that want to compact were given the opportunity to do so, there could very well be a greater range of outcomes.

Because the ISD Fund is limited and tribes are placed on a waiting list to receive funding as it becomes available, those who entered into contracts earlier are more likely to be receiving the ISD funding than those who entered into contracts later. Those who entered into contracts earlier are also more likely to be selected for the Self-Governance Demonstration Project. Similarly, the IHS new facilities priority list has a waiting time of 10-15 years. Tribes that identified the need for new facilities when they were contracting could be reaping the rewards of new facilities funding as compacting tribes. Thus, compacting tribes may have access to resources as a result of their earlier contracting experiences rather than as a result of the self-governance compacting arrangement.

The intent of this discussion is to caution that conclusions from this study must be drawn very carefully. It is reasonable to conclude that tribes are capable of managing their own programs. Furthermore, this study demonstrates the success of those managers working to provide health care for their tribal members under contracting and compacting. It suggests that, on the whole, the contracting and compacting tribes in this study have demonstrated gains that exceed the IHS direct service tribes. This does not, however, imply that all tribes who have chosen to continue with direct delivery of their health care by IHS would benefit from another choice.

REASONS FOR CHOOSING TYPE OF HEALTH CARE SYSTEM

Explanation of Classification Used to Analyze Reasons for Choosing Type of Health Care System

The health care delivery systems that serve American Indians and Alaska Natives involve a combination of management of different programs. While this study has attempted to classify tribes into three categories – IHS direct service, contracting and compacting – each category includes a range of approaches. Although a particular tribe may be called a "compacting" tribe for this study, its members may actually receive their health care services from programs managed by any of the type of management. The description of the sample by type of tribe in Chapter 2, *Research Approaches and Methods*, more fully describes this variation.

When tribal leaders were asked, "What is the primary method of health care delivery for your Tribe?", over 75 percent gave the same category as the study classification. In Alaska, the question was asked differently. Even though most tribes in Alaska are included in the statewide compact, tribal leaders selected from the following range of options: 100 percent compacting (20 percent), mostly compacting (21 percent), 50/50 mix of compacting and IHS direct service (16 percent), mostly IHS direct service (20 percent), and 100 percent IHS direct service (25 percent). Because of the variation, for some tribes in the study, between what tribal leaders identified as the primary method of health care delivery for their tribe and the study classification, the tribal leader description of the primary method of health care delivery was used in the analysis of the follow-up question, "Why has your Tribe chosen this form of health care delivery?" Since the question was asked differently for the Alaska Area, the following analysis treats Alaska individually wherever necessary.

Figure 8.1
Comparision of Study Classification of Tribes
With Tribal Leader Self-Classification

Percentage of those Answering by Study Classification

Study Classification	IHS Direct Service	Contracting	Compacting	Total
IHS Direct Service (n = 39)	**77%**	18%	5%	100%
Contracting (n = 31)	19%	**81%**	0%	100%
Compacting (n = 17)	12%	12%	**76%**	100%
Total (n = 87)	44%	39%	17%	

Reasons for Choosing Health Care System

Reasons Cited by Leaders of IHS Direct Service Tribes

Leaders of tribes outside of Alaska cited three main reasons for choosing IHS direct service. Nearly a quarter of these tribal leaders cited historical reasons, such as:

this is the way care has always been provided; they are satisfied; or they are reluctant to change because of future uncertainties. Another quarter of these tribal leaders cited economic reasons, such as: too little funding for tribes to assume services; level of resources is not sufficient to make contracting a viable option. For some, it was a combination of these factors, as expressed by these tribal leaders from the Bemidji and Oklahoma Areas:

> The current system is what exists and there is a reluctance to change because of funding uncertainties.

> Elders are accustomed to direct services and do not like changes. They worry about funding not being adequate for their care if all tribes compact or contract their own services. Budgets are too small to cover all services, especially labs and diagnostic equipment. This is not necessarily our choice.

About 18 percent of these tribal leaders said that they had no choice. Some stated that they had no control over these decisions and this was the only option available. The following statements from tribal leaders from the Oklahoma and Billings Areas express this attitude:

> This is not a choice. The way services are delivered is defined by the federal government. There are two federally recognized tribes on the reservation, however the federal government prefers to deal with one. The funding is based upon reservation needs rather than tribal needs. Most times, the reservation needs reflect the needs of the BIA and IHS and not the tribe.

> We do not have any choice. Despite being a federally recognized tribe, Congress and the BIA dictate that other entities make all the decisions.

Some tribal leaders indicated that they had no choice because they were limited by location, geography, and/or access to services.

Another 5 percent indicated that there were not enough qualified people at the local level to assume management of health programs. A tribal leader from the Phoenix Area expressed this concern:

> The Tribe does not feel it has the capacity to assume management of the health care systems at this time. Although we are in the 3rd phase of the Tribal Management Grant toward that goal.

Three of the 38 tribal leaders in this group cited political reasons, such as federal responsibility or treaty obligations. An Aberdeen Area tribal leader offered this reason for choosing IHS direct service:

> Health care is a treaty obligation. Contracting is viewed as termination of the federal Government's responsibility.

Only 2 of the tribal leaders cited quality of care or better health care services as a reason to choose IHS direct service. For most tribes, the decision about how to receive their health care services involves many factors beyond just quality of care. As one tribal leader from the Aberdeen Area painstakingly explained:

> IHS had the potential to be one of the best models for National Managed Care, if Congress funded the agency at 100% of need. Historically this under funded agency has strived to provide needed comprehensive care while functioning under an ever diminishing budget and restricted mission statement. Large tribes find it difficult to understand why the Federal Government is trying to force us to contract an over burdened, crippled system, with a diminishing budget, thus assuming a responsibility we feel is a "Trust Responsibility" belonging to the Federal Government, as we are the first fiduciary responsibility of the United States government. The ... Tribe does not have any monies to help supplement health care. Our population is rapidly increasing (1966-97) - we show 47.1% increase in population growth). Add unfunded Congressional mandates (special pay costs, cost of living allowances, background checks, drug testing), and medical inflation of 8.4%, all of which must be absorbed within direct patient care dollars. IHS budgeting formulas do not include population increase. Tribal Organizations are contracting and compacting further reducing the amount of money available to long standing treaty tribes. Realistically, only one pot of Federal dollars exists for Indian health care. When executive order and state recognized tribes demand the same rights as land based long standing treaty tribes, the amount of funds available are diminished. Lack of adequate Contract Support and long delays in receiving Contract support money is another reason we choose not to contract additional functions, programs, or activities, or compact our health care delivery system.

A health director from the Aberdeen Area provided a further rationale for not moving into compacting:

> Compacting is viewed as an Urban enterprise, they want 'quick fixes' [which have] no cultural relevance - Compacting tribes have not looked far enough into the future or fail to recognize the potential pit falls. Lack of respect for non-compacting tribes; everything we come up with for rights or reasons are adapted for their use.

Among the 31 Alaska tribal leaders who said that the primary method of health care for their tribe or tribal organization was 100 percent or mostly IHS direct service, the reason cited most frequently was historical (35 percent). However, 13 percent said that they had no choice, citing the limitations of location, geography and access to services, or that they were not eligible to compact. Two of the respondents gave economic reasons related to too little funding. Only 1 tribal leader cited tribal control over health care systems or tribal sovereignty.

Altogether, the leaders of tribes in the study with IHS direct services explained their reasons for this in terms of barriers to other choices: no other option, historical

circumstances, too little funding to contract, locally limited staffing, ineligibility to compact. Only 4 of the 69 tribal leaders in this group cited opportunities, including the exercise of tribal sovereignty and federal responsibility. This suggests that if the barriers were reduced or eliminated, some of these tribes might make different decisions, although others are making a firm stance for principles that reach beyond health care.

Reasons Cited by Leaders of Contracting Tribes

This group was comprised of 34 tribal leaders, all from outside of Alaska. A large portion (61 percent) of this group was tribes from California. For historic reasons, California tribes have not had the option to choose IHS direct service. Indian health care in that Area started with contracting. From the beginning, the small tribes and rancherias in California have often organized into consortia that have contracted with IHS. While there is representation from other Areas in this group, the influence of historical circumstances in California are apparent.

The leading reason, across the country, for contracting was historical (26 percent), followed by no choice (21 percent). The lack of choice in the arrangement as it has worked out in California is not necessarily perceived as a barrier by tribes that are more satisfied with the consortium concept, as expressed in this comment from a tribal leader:

> We do not have IHS Hospitals in California; that is why we contract with IHS. Tribes in California are small so it is more effective to join a consortium.

The lack of choice has other implications, however, as expressed by these tribal leaders from California:

> Past council and administration have not explored or wanted to pursue other forms of health care.

> The Tribe is at the beginning of its Governmental infrastructure. This is where we are today.

Among all contracting tribes in the country, those that felt they had no choice included 9 percent for whom this was the only option available, 9 percent who stated they were limited by location and access to services, and 3 percent who said they were not eligible to compact. Other barriers cited were limited local staffing (3 percent) and too little funding (6 percent). All of these are expressed in the following statements by California tribal leaders:

> When our people were newly recognized this health care was already in place. At present we do not have the organizational skills to take on this important program.

> The Tribe participates in a consortium with five other tribes to deliver health care. The Tribe selected this form of service because our funds alone would not be sufficient to provide maximum benefit to the members.

Some tribes view contracting as a middle ground, or compromise, between IHS direct service and compacting. A tribal leader says their tribe chose contracting so that they can:

> have the ultimate say in how to operate our programs and still utilize the Area Office for expert technical assistance.

For some tribes, this middle ground may mean they are gaining management experience in contracting before moving into compacting.

Tribal leaders cited a number of opportunities provided by contracting, including the opportunities to exercise tribal sovereignty and control (18 percent), to maximize funding (18 percent), to improve quality of care (12 percent), to obtain more flexibility to meet the needs of the people (9 percent) and community and/or economic development (3 percent). A tribal leader from California cited several benefits of contracting as reasons for the tribe to contract:

> To allow tribal input into health delivery system and develop programs which meeting unique health care needs of tribe. To maximize the resources available which are necessary (although not always satisfactory) due to historic under-funding of health care services to California tribes.

A tribal leader from the Portland Area explained how contracting enabled the tribe to improve accessibility to services:

> We are located 200 miles from the nearest service unit and 300 miles from the Area office. We have experienced many problems when the [IHS] service unit provided health care and strict compliance to health care priorities.

Tribal control allowed this tribe to improve access to health care for tribal members by purchasing services locally.

Overall, the majority of the contracting tribes sample are from California and tend to feel that their choices are limited because of their historical circumstances, size, and funding. Most other contracting tribes see contracting as a positive choice that provides more tribal control over health systems and more resources to improve services.

Reasons Cited by Leaders of Compacting Tribes in the 48 Contiguous States

Leaders from 15 compacting tribes outside of Alaska participated in the study. While one expressed historical reasons for this choice, none said that they had no choice. The reasons they cited for compacting all related to opportunities. Tribal leaders from the Nashville, Oklahoma, and Phoenix Areas offered these reasons:

> We feel that we can deliver health care more effectively and efficiently.

> Improved, expanded, and accessible services to [Tribal] members and the Indian population residing in our areas. Strengthening the government to government relationship with the U.S. Redesigning services to meet local needs. Focus on Wellness as well as direct care.

> Because our Tribe has always known we would be better managers of health care delivery to our people than IHS. Thus, compacting our health care improved at least 100%.

The opportunity to exercise tribal sovereignty and control over the health care system was cited by 53 percent of compacting tribal leaders as a reason for the decision to compact. More flexibility to meet the needs of their people was the reason given by 40 percent of this group. Tribal leaders from the Nashville and Oklahoma Areas explained:

> [Compacting] allows us the flexibility to better utilize our dollars where needed. We have been able to expand our services and provide quality care for our patients. The funded amount is still extremely low to meet the needs of our patients.

> Self-Governance was chosen because it allows for more freedom in deciding how health care dollars will be spent, less time is spent in dealing with the Area Office and it is closer to a true government to government relationship.

Improving the quality of care and providing better health services were cited by 33 percent as reasons for compacting. Only one of the tribal leaders in this group stated that obtaining more funding was the reason for compacting.

Reasons Cited by Leaders of Compacting Tribes from Alaska

There were 32 tribal leaders from Alaska who said that their health care was 100 percent or mostly compacting. Among these tribal leaders, the picture is more complex. This group includes both the chief executive officer of a regional non-profit Native health corporation that provides the health care services under the statewide Alaska compact and the chiefs of villages that are served by various regional corporations. While some of the villages are very satisfied with their health care system, others are seeking to withdraw from the compact and to contract services from the IHS, either through subregional multi-tribal organizations or at the village level.

Those tribal leaders that support the existing system of regional corporations within the statewide compact offer comments regarding the management efficiencies and the quality of care within an integrated regional system:

> Our regional health corporation has 25 years of experience and extensive years in contracting federal and state dollars. They have the human resources and administrative capabilities that small villages do not have.

> In our region, [the regional corporation] is compacting the health care delivery system, and is working out beyond our expectations. The problems that the patients had are gradually being improved. Native people in our region have a say in how the health care delivery system should be.
>
> 1) Compacting through tribal consortium is a practical approach, i.e. economy of scale. 2) Insufficient Tribal administration capacity to run our own programs.
>
> Compacting reflects the unique tribal cooperation that has developed in Alaska to assure that all AK Natives have access to a comprehensive, integrated, tribally controlled health care delivery system.
>
> Because of the vast location of our small communities, most of our health services are provided on a consortium basis. It is too expensive to travel and the population of each community is too small to address each village by itself.
>
> [The statewide compact] has been in place and taking over our own health care in the village requires training and additional funds we could not get from IHS. We were better off compacting with a larger organization.
>
> People feel this would give them more sovereignty over health care and local programs (health). In reality, most people here have not taken the time to get involved in our current health care system and do not realize how much local power have already have.

Those who want to withdraw from the existing system cite local control and the desire to have more funding at the village level, as the following range of comments reveals:

> We are currently making efforts to use "Self-Determination" as a community. We would like more control as to how funds are spent which are allocated for our tribe.
>
> As stated previously the tribe wanted local (tribal) control and management. By withdrawing from the Regional Health Consortium, we felt we could eliminate the middleman and provide more quality and quantity of services.
>
> To ensure that we receive our share of funds and services for our village. Currently we get what is given, not what is negotiable from our behalf.
>
> Until our Tribe looked into the health care, in the past two years, our services were terrible. Without spending anymore money, we have improved our Doctor, Hospital and prescriptions 100%. Our regional non-profit has been wasting money and having huge carryovers.
>
> They are all thieves all the way to Congress and we are unable to get any money at all for anything.

> At this point, working with the [regional corporation] seems to be working all right. However, it is our interest to eventually see direct health dollars administered out of our Tribe.

Those who are satisfied with the existing system tend to cite the opportunities associated with compacting, such as maximizing funding (28 percent) and improving quality of care (13 percent), as the reasons they choose to compact. The limitations of local staffing are cited by 9 percent, and location and geography by 6 percent, as reasons for joining the regional corporation network of services. The villages that would like to withdraw from the compact cite barriers to contracting including historical circumstances (13 percent), only option available (13 percent), and too little funding (6 percent). Altogether 31 percent of the respondents, including both those who are happy with the compact and those who are unhappy, wrote about political issues of tribal sovereignty, local control and federal responsibility.

Summary of Reasons for Choosing Health Care Management Approaches

Some Tribes See Their Choices as More Limited than the Law Allows

While a basic premise of this study is that P.L. 93-638, as amended, gives tribes a choice of IHS direct service or tribal management, many tribal leaders felt that historic circumstances have limited their choices. Approximately one-fourth of the tribal leaders outside of Alaska from IHS direct service tribes and contracting tribes said that historic reasons dictated the form of health care management for their tribes. Within Alaska, historical reasons for the management of health care were cited by 35 percent of the tribal leaders who said that their health care was 100 percent or mostly IHS direct service, by 8 percent who said it was 50/50, and by 13 percent who said it was 100 percent to mostly compacts.

A surprising number of tribal leaders felt that they had no choice in the management of their health care systems, including 18 percent of IHS direct service tribes outside of Alaska and 13 percent of IHS direct service tribes inside Alaska, as well as 21 percent of contracting tribes nationwide. Compacting tribes believe they have exercised a choice, as none of the tribal leaders of compacting tribes outside Alaska said they had no choice. However, within Alaska 19 percent of the tribal leaders said they had no choice.

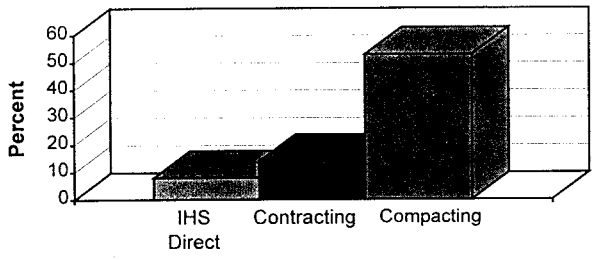
Barriers and Opportunities Related to Choice of Health Care Management

The reasons that IHS direct service tribes chose that form of management related primarily to barriers to tribal management, such as too little funding and lack of local management expertise. For compacting tribes the choice was more often related to opportunities. Compacting tribes saw more opportunities to improve the management of services through greater flexibility (40 percent), than did contracting tribes (9 percent) and IHS direct service tribes (none). Compacting tribes also saw more opportunities to improve quality of care (33 percent), than contracting tribes (12 percent) and IHS direct service tribes (5 percent).

Political Reasons for Choice of Health Care Delivery System

Political reasons were cited less often by IHS direct service tribes (8 percent), than contracting tribes (18 percent) or compacting tribes (53 percent). The reason cited most often by compacting tribes was a political one, specifically the exercise of tribal sovereignty and control (53 percent).

Figure 8.2
Tribes Citing Political Reasons for Choice of Health Care System



Source: Tribal Leader Survey

BARRIERS CREATED BY CONGRESS: LAWS AND APPROPRIATIONS

While the overall lack of federal funding for Indian health care has been identified as a barrier for some Tribes to enter into contracts to manage health care, it has been an incentive for other Tribes to increase funding at the local level by redirecting tribal shares from the Area Office and Headquarters Offices of the IHS to tribally-managed programs.

In addition to overall funding for Indian health, there are two specific categories of Congressional action that serve as barriers to tribal choice: the legal limitations on the number of tribes that can enter into compacts, and funding for contract support costs.

Legal Limits on the Number of Compacting Tribes

While the Indian Health Care Improvement Act Amendments of October 29, 1992,[47] extended the Tribal Self-Governance Demonstration Project to the Department of Health and Human Services, it allowed only 30 tribes per year to enter into annual

[47] P.L. 102-573.

funding agreements with the IHS to deliver services. Because there is a single statewide compact for the Alaska Area, there have been no limitations on the number of Tribes in Alaska that can join the compact and approximately 95 percent have chosen to participate. However, for the other 11 Areas of the IHS, there were altogether only 32 tribes in 1997 with compacts according to the information obtained for this study.

Legislation creating the Self-Governance Demonstration Project requires that tribes contract successfully for 3 years to become eligible for compacting. Considering that 176 tribes and tribal organizations have been identified by this study as contracting to manage outpatient medical services, it is likely that many of those have at least 3 years of experience successfully managing programs. While there were no questions in the surveys of tribal leaders or health directors addressing this barrier to tribal choice, it is readily apparent as a barrier imposed legislatively and administratively.

Contract Support Costs

Federal law provides that tribes will receive contract support funding so that the programs operated by the tribes do not have to be reduced to cover administrative costs. According to the Indian Self Determination Act, funding is supposed to be available for additional costs associated with contracting, beyond the cost of provision of health care. These additional costs are called "contract support costs." The IHS has created an Indian Self-Determination (ISD) Fund to help cover the costs to tribes of assuming new programs that were not included in the government's cost to operate these programs. These include both start-up costs, such as purchasing new computer hardware and software, and recurring costs, such as long distance telephone charges, postage and training. ISD funds can also be used for personnel related expenses, such as unemployment taxes, workers' compensation, and retirement benefits on direct program salaries. However, Congress has not appropriated sufficient funding for the ISD Fund and many tribes do not receive the amounts they request.

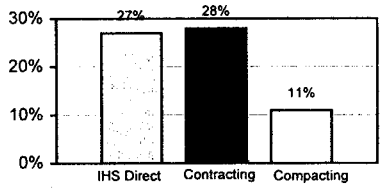
This fact is reflected in the health director survey. One question in the survey asked, "Is your Tribe receiving full funding for direct and indirect contract support costs?" A strong majority of the tribes answered, "No," including 73 percent of IHS direct service tribes, 73 percent of contracting tribes, and 63 percent of compacting tribes. Health directors were asked to estimate the shortfall in contract support cost funding for their tribes. For compacting tribes, these estimates ranged from $12,000 to $3 million with an average of $728,000 and a median of $300,000. For contracting tribes, the estimated shortfall ranged from $5,000 to $3.2 million with an average of $577,000 and a median of $200,000. Tribes classified in the study as IHS direct service tribes reported their estimated shortfall ranged from $2,300 to $300,000 with an average of $84,500 and a median of $66,700.

According to the Health Directors Survey, the lack of Indian Self-Determination (ISD) contract support funding was preventing tribes from contracting or compacting. The Health Director of an Aberdeen Area tribe explained it this way:

If we were to contract, it would take 3-5 years to get contract support dollars and as previously mentioned, the Tribe does not have operating capital to wait that long.

Lack of contract support funding was regarded as a barrier to contracting or compacting for 27 percent of the IHS direct service tribes, 28 percent of contracting tribes, and 11 percent of compacting tribes. Since those classified as compacting tribes were already compacting some services, the proper interpretation of the data for compacting tribes must be that the lack of contract support cost funding is acting as a barrier to contracting or compacting services other than those already compacted or contracted.

Figure 8.3
Lack of Contract Support Funding As a Barrier to Contracting and Compacting



Source: Health Director Survey

INDIAN HEALTH SERVICE ADMINISTRATION

There has been more contracting and compacting for health care in some Areas of the Indian Health Service than in others. Some of this is due to historic circumstances. For example, there are more tribes that are recently recognized by the federal government in the Nashville, California, and Bemidji Areas. Rather than building IHS hospitals for these recently recognized tribes, there was often a decision to purchase services and/or to contract with tribes to operate their own services.

But, even in places where there has been a well-developed IHS infrastructure, there have been differences between Areas in the rates of contracting and compacting. For example, tribes in Alaska have historically been among the national leaders in contracting and then compacting. At the same time, contracting and compacting have been very limited in the Aberdeen and Albuquerque Areas.

Contracting and compacting can lead tribes to withdraw shares (funding for their proportional amount of services) of the Area Office, which in turn would result in fewer Area Office jobs. One could assume that this would create an incentive for Area Offices to discourage tribes from contracting and compacting. A question in this study was

whether tribes perceived their IHS Area Offices as encouraging or discouraging contracting and compacting. Several questions were asked about the Area Offices in the Health Directors survey:

Do you believe the staff size of the Area Office is too big, too small or about right?
Does the Area Office consult with your Tribe prior to negotiating with other tribes in the Area?
Have you received the information you need from the Area Office for making decisions regarding health care delivery?
Does the training and technical assistance provided by the Area Office meet your needs?
How would you describe the Area Office with regard to contracting – encouraging, discouraging, or neutral?
How would you describe the Area Office with regard to compacting – encouraging, discouraging, or neutral?

Recognizing that some Areas had a very low response rate in the health directors study, which may make the answers to these questions not representative of all tribes in the Area, the responses within each Area are presented below.

Perceptions of IHS Area Offices

Aberdeen

With regard to contracting, 60 percent of the tribes saw the Area Office as neutral, 30 percent thought it was encouraging, and 10 percent saw it as discouraging. For compacting, 80 percent of the tribes regarded the Area Office as neutral, 10 percent as encouraging, and 10 percent as discouraging. Half the tribes thought the Area Office was too large, 30 percent thought it was about the right size, and 10 percent thought it was too small. One health director said that "further reductions would slow down the contracting process and T.A. provided."

Most of the tribes (60 percent) said that the Area Office never consults with them prior to negotiating with other tribes in the Area. While 30 percent said the Area Office sometimes consults with them, none of the tribes said that the Area Office always consults with them. Tribes feel that they are getting the information they need from the Area Office for making decisions regarding health care delivery sometimes (70 percent) or always (30 percent). The training and technical assistance provided by the Aberdeen Area Office meets the needs of tribes sometimes (90 percent) or always (10 percent).

Alaska

Most tribes in Alaska are included in the statewide compact, which has already resulted in considerable downsizing of the Area Office. All of the respondents thought the size of the Area Office was about right. Most Alaska Native villages receive their health care through inter-tribal regional non-profit corporations. However, some of the villages have been interested in withdrawing some of the services provided by the regional health corporations and operating them under P.L. 93-638 contracts at the

village or subregional level. The question about the Area office attitude towards contracting thus has a different connotation in Alaska than in most other Areas. In this case, contracting is perceived as withdrawing from the statewide compact rather than moving from IHS direct service to tribally-operated. The responses to this question showed that 67 percent of the Health Directors thought the Area Office was neutral toward contracting, 17 percent thought it was discouraging, and 17 percent thought it was encouraging. About a third of the Health Directors thought the Area Office always consulted with their tribe prior to negotiating with other tribes in the Area. Half thought this happened sometimes, and 17 percent said it never happened. With regard to compacting, 67 percent thought the Alaska Area office was encouraging and the remaining 33 percent thought it was neutral.

One-third of the health directors said that they always received the information they needed from the Area Office for making decisions regarding health care delivery. The other two-thirds said they sometimes received this information. To some extent, the regional non-profits have engaged in activities that might otherwise have been provided by the Area Office. One tribal leader provided this description:

> [The regional corporation] provides educational training for those that are interested in any health care field. I am very impressed with our health aide training. [The regional corporation] also provides technical assistance to their Board of Directors and staff. [The regional corporation's] administrative staff keeps us informed on all issues concerning health and education.

Training and technical assistance provided by the Alaska Area Office meets the tribal needs sometimes for two-thirds of the respondents and always for one other respondent.

Albuquerque

Only two Health Directors from the Albuquerque Area responded to this study. They both said that the Area Office was encouraging about contracting and neutral about compacting. One said that the Area Office was too big and the other thought it was about right. One said that the Area Office sometimes consults the Tribe prior to negotiating with other tribes in the Area, and the other said the Area Office never consults the Tribe. One says they always get from the Area Office the information needed to make decisions regarding health care delivery, and the other says they sometimes get the information needed. The training and technical assistance provided by the Area Office meets the needs of one sometimes and the other never. The health director of the dissatisfied tribe characterized the training as "usually outdated - usually poor presenters."

Bemidji

With regard to contracting, 64 percent of the tribes thought the Area Office was encouraging, 27 percent thought it was discouraging, and none felt it was neutral. As for compacting, 45 percent thought the Area Office was encouraging, 27 percent said it was discouraging, and 9 percent viewed it as neutral. One health director stated: "our Area

Office has pursued the goals of self-determination for Indian tribes with a conviction not shared by most other Area Offices." While 64 percent of the tribes thought the size of the Area Office was about right, 27 percent thought it was too big and 9 percent thought it was too small. According to this study, the Area Office consults with 64 percent of tribes sometimes, 18 percent always, and 9 percent never, prior to negotiating with other tribes in the Area. Most tribes feel that they get the information they need always (36 percent) or sometimes (45 percent) for decision-making regarding their health care delivery system. Only one tribe said they never get this type of information.

About half the tribes feel that the training and technical assistance provided by the Area Office sometimes meets their needs, while 27 percent say it always meets their needs and 9 percent say it never meets their needs. One health director offered this comment about training and technical assistance: "Area staff have paternalistic attitude, have non-Indian view point." Another respondent felt that the IHS staff "cannot meet the needs of the changing environment of health care." However, another health director said, "Technical Assistance/support is excellent. Training needs are not always provided at Area Office level. Must attend IHS Headquarters Training Session."

Billings

Only three of the tribes answered questions about the Area Office attitudes toward contracting and compacting. They were evenly split on contracting between "encouraging," "discouraging," and "neutral." Two of the tribes thought the Area Office discouraged compacting and one thought it was neutral. With regard to the size of the Area Office five tribes responded, with 80 percent saying it was too big and 20 percent saying it was too small. Tribes said that the Area Office never (75 percent) or sometimes (25 percent) consults with them prior to negotiating with other tribes in the Area. All of the tribes that responded to the question said that the Area Office sometimes provides information they need for making decisions regarding health care delivery. The training and technical assistance provided by the Area Office sometimes meets the needs for 75 percent of the tribes and never meets the needs for 25 percent of the tribes responding.

California

All of the tribes or rancherias in California receive their health services through contracts with inter-tribal organizations, with the exception of two compacts. All of the tribal organizations that answered the question saw the Area Office as neutral toward compacting. One Health Director observed that:

> There has been a change in the behavior of the Area Office in regards to Title I & III. In the past, much resistance to Title I and little continuity in the contracts specifically in the Area Office. With a new leader. . ., the behavior has changed and appears to be much more tribal program oriented.

The size of the California Area Office is too big according to 60 percent of the health directors and about right according to 40 percent. Half the tribal organizations said that the Area Office never consults with them prior to negotiating with other tribal

organizations in the Area. The other half were evenly divided between "always" and "sometimes." Health Directors said they receive the information they need from the Area Office for making decisions regarding health care delivery sometimes (60 percent) or always (40 percent). Training and technical assistance provided by the Area Office meets their needs always (40 percent) or sometimes (40 percent), with only 20 percent "never."

Nashville

A majority of the tribes in the Nashville Area (56 percent) describe the Area Office as encouraging toward contracting, but the same percentage say it is discouraging to compacting. With regard to contracting, 11 percent say the Area Office is discouraging and 33 percent call it neutral. With compacting, 22 percent say the Area Office is encouraging and 11 percent say it is neutral. There is unanimous agreement among the tribes that the Area Office is too big. A majority of the tribes (56 percent) say that the Area Office never consults with them prior to negotiating with other tribes in the Area. Another 33 percent say the Area Office sometimes consults. Most of the tribes (89 percent) say that they sometimes receive the information they need from the Area Office for making decisions regarding health care delivery, while this information is always provided to 11 percent of the tribes. Training and technical assistance provided by the Area Office meets 67 percent of the tribes' needs sometimes, 11 percent always and 11 percent never.

Navajo

The Navajo Nation did not participate in the health director study. The health director from another tribe in the Navajo Area did return a questionnaire and the results of that one participant are reported here. The tribe feels that the Area Office is encouraging about contracting and compacting. They feel that the Area Office is about the right size. The Area Office sometimes consults with them prior to negotiating with other tribes in the Area and always provides the information they need to make decisions regarding health care delivery. The training and technical assistance provided by the Area Office sometimes meets their needs.

Oklahoma

Among tribes in the Oklahoma Area participating in this study, 40 percent believe that the Area Office is discouraging to contracting and compacting, 40 percent believe that it is neutral and 20 percent believe that it is encouraging. "We were told we could not succeed," stated one tribal health director, "but we have improved to health status of our members 100 fold. IHS is trying to protect jobs." Most of the tribes (80 percent) think that the Area Office is too big, but 20 percent think it is about right. All of the tribes that responded to the question said that the Area Office sometimes consults with them prior to negotiating with other tribes in the Area. Three-fourths of those who responded to the question said that they sometimes received information they needed from the Area Office for making decisions regarding health care, and one fourth said they never receive the

needed information. Training and technical assistance provided by the Area Office always meets the needs of 40 percent of the tribes, never meets the needs of 40 percent of the tribes and sometimes meets the needs of 20 percent of the tribes.

Phoenix

The Phoenix Area tribes participating in the study were equally divided on whether the Area Office is encouraging or neutral on contracting. They were also equally divided on whether the Area Office is encouraging, discouraging or neutral on compacting. A health director stated that the "Area Office tends to be pushing compacting, but wanting tribes to fail at the same time. They make remarks about the tribes taking over the jobs..."

All of the tribes felt that the Area Office is too big. Two-thirds of the tribes say that the Area Office never consults with them, and one-third says it sometimes consults with them, prior to negotiating with other tribes in the Area. Two-thirds say that they sometimes receive the information they need to make decisions about health care delivery. The other third is evenly divided between those who always get the information they need and those who never get the information they need. One tribal health director complained, "we find we must ask the question the right way for an answer. . . At present IHS offers no suggestions and ways of doing anything." The training and technical assistance provided by the Area Office meets the needs of half the tribes sometimes, and never for the rest.

Portland

More than half of the Portland Area tribes (56 percent) find the Area Office encouraging about contracting and the others regard it as neutral. Among the tribes that answered the question about compacting, 60 percent found it encouraging and 40 percent neutral. A majority of the tribes in the study thought that the size of the Area Office was about right, but 22 percent said it was too big. Among those answering the question, half said the Area Office sometimes consults with them prior to negotiating with other tribes, a third said they are never consulted, and 17 percent said that they are always consulted. A majority of the tribes said that they sometimes receive the information they need to make decisions, with the others evenly divided between "always" and "never." All of the tribes said that the training and technical assistance provided by the Area Office sometimes meets their needs. The health director of a compacting tribe explained, "We don't expect information/Technical Assistance from the Area Office now that we have taken over the responsibility for program administration and delivery under self-governance."

Tucson

Only one of the two tribes in the Tucson Area returned the Health Directors Survey questionnaire. That tribe found the Area Office encouraging about contracting and

neutral about compacting. They think the Area Office is too small. They say they are sometimes consulted prior to negotiations with the other tribe. They always receive the information they need to make health care delivery decisions. The training and technical assistance provided by the Area Office sometimes meets their needs.

IMPORTANCE OF HEALTH CARE IN EMPLOYMENT AND ECONOMIC DEVELOPMENT

One reason that tribes might want to operate their health care delivery systems is to increase employment for tribal members. This was expressed by a number of tribal leaders from Alaska villages that are seeking to withdraw from the regional corporations and the statewide compact and to contract for health care services to their villages:

> We need the funds to generate at local level, to improve our village economy, and also to work with our people in our own office, rather than through non-profit organizations, where they use our money for their offices, and/or other expenditures.

Another study has found that tribes that have high rates of employment, through gaming and other types of economic development, are less concerned with health care employment than tribes that have high unemployment.[48]

Tribal Leader Survey Question: "How Important is the employment of your Tribal members in health care to your Tribe's overall economic development?"

The tribal leader survey asked, "How important is the employment of your Tribal members in health care to your Tribe's overall economic development?" Tribal leaders from compacting tribes indicated this was "very important" at a rate of 78 percent. This same response from contracting tribes occurred at a rate of 71 percent, and only 60 percent of IHS direct service tribes gave this response.

Number of Tribal Employees Working in Health Care

The number of tribal employees working in health care is greater for tribally-operated programs than for IHS direct service operations. According to the health directors survey, the median (point at which half are larger and half are smaller) number of tribal employees in the health care workforce is 34 for IHS direct service tribes, 38 for contracting tribes, and 80 for compacting tribes.

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[48] Dixon, Mim, Judith K. Bush, and Pamela E. Iron, "Factors Affecting Tribal Choice of Health Care Organizations," in *A Forum on the Implications of Changes in the Health Care Environment for Native American Health Care*, The Henry J. Kaiser Family Foundation, 1450 G Street NW, Suite 250, Washington, DC 20005 (1997),. pp. 53-88.

Number of Tribal Members Working in Health Care

The median number of tribal members working in health care was 27 for IHS direct service tribes in the study, 20 for contracting tribes, and 25 for compacting tribes. Thus larger tribal health departments do not necessarily mean more opportunities for tribal members to gain employment with their tribe. As tribes take on more services, they are likely to hire more health care professionals. If tribal members have not had sufficient educational opportunities, they may not have the advanced education required to work as health care professionals.

Availability of Local Training for Tribal Members

Health Directors were asked about the availability of local training for tribal members for five types of health careers that are potential sources of employment in tribally-operated programs. These were Community Health Representatives (CHRs), Emergency Medical Technicians (EMTs), Licensed Practical Nurses (LPNs), Dental Assistants, and Alcohol and Drug Abuse Counselors. The percentage of tribes in the study reporting that these types of training were available locally is summarized in Figure 8.4.

Figure 8.4

Percent of Tribes by Area Reporting that Training is Available

Area	# Tribes	CHR	EMT	LPN	Dental	Counselor
Aberdeen	10	60%	80%	60%	40%	80%
Alaska	6	50%	100%	17%	50%	66%
Bemidji	11	64%	64%	91%	82%	73%
Billings	5	80%	80%	20%	20%	60%
California	5	80%	80%	20%	20%	60%
Nashville	9	22%	78%	89%	56%	44%
Oklahoma	5	60%	80%	100%	60%	60%
Portland	9	56%	67%	67%	67%	67%
Southwest	10	30%	70%	30%	40%	70%

Figure 8.4 suggests that fewer than half of the tribes have training available locally for CHRs in Nashville and the Southwest. Training for LPNs is a problem for more than half of the tribes in Alaska, Billings, California and the Southwest. More than half of the tribes do not have training for Dental Assistants available locally in Aberdeen, Billings, California, and the Southwest. Counselor training is not available locally for more than half the tribes in Nashville.

Tribes could increase the opportunity for tribal members to work in health careers if more training were available locally. As the leader of a compacting tribe explained:

> One of the Tribal Council's priorities for Self Governance is that the tribal members have opportunities to pursue a college education and subsequently assume professional staff positions. In June of this year there was a record of eight individuals [from our Tribe] graduating with BA degrees.

There must be both jobs and training available for tribes to take such steps to provide employment for their members.

MANAGEMENT TRAINING NEEDS OF TRIBES

In an open-ended question about changes that were needed at the local level to enable tribes to more fully exercise their sovereignty in the delivery of health services, 38 tribal leaders recommended training and technical assistance for tribal leaders and tribal employees. This was the need identified most often by tribal leaders. Among those who identified training as a need, 75 percent said that management training was needed, including identification of health needs, development of delivery systems and quality assurance. Other types of training and technical assistance requested included budget processes, changes in laws and regulations, treaties and Indian law (including the Indian Self-Determination Act) and traditional healing and cultural practices (particularly for non-Indian employees).

While the need for training and technical assistance was documented through the tribal leaders and health directors surveys, this study attempted to provide a preliminary assessment of the availability of that training by conducting telephone interviews with IHS offices, tribal colleges, private consulting firms and other organizations. In Indian country, word of mouth is still the fastest and most reliable source of information exchange. Training and technical assistance needs are identified locally and professional sources are sought to fill that need. Typically a tribal leader has met or been told about someone who does certain training and they will hire that individual or firm. Tribes still rely on the federal government to provide for training needs; however, a shift has begun wherein tribal governments are using each other and private sources, as well.

There is no single source or entity that has compiled a comprehensive assessment of training or technical assistance needs for Indian health care. Nor is there a comprehensive document that lists who provides what type of training or technical assistance. Through telephone interviews with 40 organizations as part of this project, an overall assessment of training opportunities was made. These are summarized first by type of organization and then by IHS Area.

Training Provided by Organizations

Consultants and Independent Firms.

The 14 private consulting organizations that were contacted include some that provide services on a national basis and others servicing tribes in the region in which

they are located. They tended to focus on administrative training, such as personnel and financial management, board training, marketing, enhancing third party collections, and billing systems. Some firms also provide training and technical assistance in health policy development and planning. Negotiations, communications, and conflict resolution are also subjects of training. Most of these organizations are for-profit, minority-owned firms serving Indian communities. Though most of the organizations had specific areas of interest, some stated they do accommodate request on a case-by-case basis. While Indian health workers tend to believe there is a plethora of consultants available, in actuality there are few. It is recognized that there are more organizations that need to be identified than the 14 contacted.

Universities and Colleges

Six academic institutions were identified that provide training or technical assistance to tribes on an as-needed or as-requested basis. Conflict resolution, consensus building, recruitment and retention of health professionals, community planning, research methods, and grant writing were some of the subject areas provided by these institutions. Several universities coordinate and host various wellness or health conferences if there is an Indian program or office on that campus. In addition, offices of rural health that are affiliated with universities had varying degrees of working relationships with tribal communities and do offer training courses on an as-requested basis.

Community Colleges

In responding to the survey, the 8 community colleges prioritized the following as some of the courses they might offer: data systems, management, targeted case management, Medicaid reimbursement process, and business education. Although tribal community colleges are becoming a much stronger force in the area of training, most continue to provide education designed for individual academic success. Course works in pre-medicine, nursing, math and science are readily available at all community colleges. Many tribal colleges have attained accreditation as four-year programs and provide local preparation for some types of health careers, such as nursing. Most community colleges work with the local tribal government and accommodate specific training or technical assistance on an as-requested basis. A new focus being established within tribal community colleges is training for gaming operations, for example courses in accounting, personnel management, and game-specific training. Some of these courses may be of value to students interested in health care management, but more targeted training would certainly be preferable.

National Indian Organizations, Professional Associations and Trade Organizations

National organizations often hold meetings and offer training. While the National Indian Health Board's annual Consumer Conference is the only health-related training provided on a national level specifically for American Indians and Alaska Natives, there are many national organizations that provide training for smaller and larger audiences. Other national Indian organizations that provide networking, information and training for

;pecific subjects or groups include the National Congress of American Indians (NCAI), he Tribal Self-Governance Education Project, the National Service Unit Directors \ssociation, and others.

Some examples of non-Indian professional and trade associations are the National \ssociation of Health Plans, the Medical Group Management Association, the National \ssociation of Community Health Centers, and the National Rural Health Association. 'articipation in these meetings is often costly and may require paying membership fees. Vhile the information is often transferable to tribally-operated programs, most of the ıational professional and trade associations and their presenters are not aware of the :omplexities and unique contexts in which most of the Indian health services operate.

ndian Health Service

Telephone interviews were conducted with 4 Headquarters Offices and 12 Area)ffices of the IHS. Of the thirteen types of training listed on the survey form, all 16 IHS ıffices responded that the most requests were for: quality assurance, self-determination, ıolicy, case management, management, and other. ("Other" denotes technical ıssistance or training not on the list such as welfare reform, community mobilization, ıolicy and legislation, recruitment and retention, facilitation, and assumption of esponsibilities under contracting or compacting).

The role of the Indian Health Service is changing with respect to training and technica ıssistance as tribes take control of health systems. Tribes are relying more on each other a ıon-federal organizations to provide these services. All Indian Health Service offices contac ıtated that they are doing increasingly less training and that tribes are assuming this esponsibility. The IHS continues to provide training if it is requested and if employees are ıvailable to conduct the training.

The IHS Clinical Support Center in Phoenix, AZ, coordinates continuing medical ıducation courses for health professionals in the IHS, tribal, and urban Indian health system)ther IHS Headquarters offices providing training and technical assistance include the Offic' 'ersonnel; Office of Tribal Activities, and the Office of Planning, Evaluation, and Legislation.

Review of Training and Technical Assistance Available in Each Area

A review of types of training and technical assistance identified as available in each \rea is provided below. The Area Offices are not included in this review because tribal ıerceptions of Area Office training and technical assistance were already discussed in the ırevious section on Area Offices. The Area summaries provided below are not an exhaustiv :ompilation of resources, but rather an overview based on 40 telephone interviews.

Aberdeen

Five tribal community colleges operate in this area: Cankdeska Cinkana Community College, Little Priest Tribal College, Nebraska Indian Community College, Sinte Gleska

University, and Sitting Bull College. The United Tribes Technical College is also located in this Area. A private consulting firm provides training and technical assistance in quality assurance, computers, case management, planning, board development, and disease prevention.

Alaska

Several consulting firms in Alaska provide training and technical assistance in legal and contractual issues, financial management, facilities planning, and program planning.

Albuquerque

The Albuquerque Indian Health Board provides training and technical assistance in tribal management development and planning. They also assist in board and council facilitation. The University of New Mexico Office of Rural Health provides training in such areas as quality assurance, contracting, case management, cultural competence, planning, management, research methods, and disease prevention. They also provide training for Health Boards. Crownpoint Institute of Technology is a technical college in New Mexico that provides some health careers training. Private consulting firms offer training and technical assistance in quality assurance, contracting, planning, management, board development, cultural orientation, grant writing, mediation, and justice-oriented programs.

Bemidji

In addition to the IHS Area Office, the only other training resource identified was Leech Lake Community College.

Billings

Two community colleges serve the tribes in the Billings Area: Fort Belknap College and Salish Kootenai College. A private consultant from the Aberdeen Area provides training and technical assistance to Billings Area tribes in quality assurance, computers, case management, planning, board development, and disease prevention.

California

DQ University in Davis provides training in economic development, planning and self-determination. Private consultants provide training in management, supervision, financial management, customer service, and communications for California tribes and nationally.

Nashville

The Nashville Area includes the Washington, D.C., region where there are a number of private consulting firms that offer services on a national basis. One such firm, for example, offers courses in management, conflict resolution, board development, contracting, budgets, and finance.

Tribes in the Area also benefit from the Cherokee Training Center (CTC), which is operated under a P.L. 93-638 contract. This center plans meetings, training sessions, and workshops for the Area tribes. The United South and Eastern Tribes (USET) Health Information Office is also operated under a P.L. 93-638 contract, on behalf of the Area tribes. This office arranges training for the Area tribes at the request of the tribes or the IHS Area Office. The training offered by both USET and the CTC includes traditional healing, CPT and ICD9 coding, basic epidemiology, and managed care.

Navajo

The Navajo Staff Development Training Program offers classes in planning, management and other aspects of staff development.

Oklahoma

The University of Oklahoma Division of Continuing Education offers training in systems development, case management, cultural competence, management, research methods, health and wellness.

Phoenix

The University of Arizona provides a variety of programs within the context of degree programs.

Portland

The Northwest Portland Indian Health Board publishes a training catalog that lists courses in such areas as computer training, coding, medical terminology, billing, prevention, planning, and policy. The University of Washington Department of Family Medicine offers

"Programs for Healthy Communities" that include training in self-determination, data systems, marketing, planning, management and board training.

Tucson

Arizona State University School of Medicine has worked with tribes in developing their governing and management systems.

Training Summary

Attempts have been made to both identify the needs and the resources available to address components of unmet training or technical assistance needs. A follow-up study is needed to compiled a more formal assessment and thorough assessment of training needs and resources. There is great development potential within this field as tribes take over management and control of the health systems.

SUMMARY

Opportunities are the incentives that encourage tribes to move in a direction. Barriers are the disincentives that discourage tribes from moving in a direction. Public policies contain a mix of incentives and disincentives that help to shape tribal decisions about contracting and compacting health services. A driving force in decision-making about health care management, particularly for compacting tribes, is the opportunity to exercise tribal sovereignty and control.

Leaders of tribes in the study with IHS direct services explained the reasons for this choice in terms of barriers to other choices: no other option, historical circumstances, too little funding to contract, limited local staffing, ineligibility to compact. Four of the 69 tribal leaders in this group cited opportunities associated with retaining IHS direct service, including the exercise of tribal sovereignty and federal responsibility. This suggests that if some of the barriers were reduced or eliminated, many of these tribes might make different decisions.

The leaders of compacting tribes focussed more on opportunities than barriers in their decision making. Their tribes chose compacting to take advantage of opportunities including flexibility in the management of programs, improving quality of care, and maximizing funding.

Contracting appears to be a middle ground, with both opportunities and barriers cited as reasons for their choices of health care management form. Many of the contracting tribal leaders, particularly from California, felt that their choices were limited by historical circumstances and small size. Other contracting tribes felt that contracting provided more tribal control, and the opportunity to gain management experience and to build tribal capacity. Since federal regulations require tribes to contract for 3 years before compacting, it is possible that these tribes may move into compacts after they have gained the requisite experience. In what may be a counter-trend, some tribal leaders

from Alaska expressed a desire to withdraw from the statewide compact and the regional non-profit health corporations to exercise more control at the local level through contracting.

According to the health directors survey, the lack of Indian Self-Determination (ISD) contract support funding was regarded as a barrier to contracting or compacting for 27 percent of the IHS direct service tribes, 28 percent of contracting tribes, and 11 percent of compacting tribes.

In general, Area Offices are facilitating the transition to tribal management of health care. Most of the 12 IHS Area Offices were regarded by a majority of tribes in the Area as encouraging or neutral toward contracting and compacting; however, 2 of the Area Offices were perceived as discouraging compacting. In 5 of the 12 Areas, more than half the tribes said they were never consulted prior to the Area Office negotiating with other tribes in the Area. In only 4 Areas did any tribe say it was always consulted prior to negotiations with other tribes, and in those Areas the percentage of tribes with this response was below one-third. Information provided by Area Offices always or sometimes meets the needs of tribes for making decisions regarding health care delivery. In 7 of the 12 Areas, half or more of the tribes participating in the study thought the Area Office was too big. In only one Area was the Area Office regarded as too small.

If the federal government wants to encourage tribal management, policies could be changed to remove barriers and increase opportunities. According to the findings of this study, these could include:

(1) removing the limits on the numbers of tribes that can compact;
(2) full funding for both direct and indirect costs for tribal management of health services;
(3) more training available locally to provide entry for tribal members into health careers;
(4) more training and technical assistance to help tribes acquire and maintain management expertise; and
(5) changing attitudes in those few IHS Area Offices where tribes perceive that compacting is discouraged.

These changes will likely be effective, but not all tribes will contract and/or compact even if they are implemented, since some tribes want to address larger issues of the federal trust responsibility partially through their decision to retain direct federal provision of their health care.

CHAPTER 9

TRIBAL SOVEREIGNTY AND THE FUTURE

As this study assesses the present tribal perceptions of the effects of past decisions about how to receive their health care, it is also important to think about future directions the tribes may take. This section considers contracting and compacting in the context of tribal sovereignty and government-to-government relationships. The political environment, which includes the continuing redefinition of the concepts of sovereignty and government-to-government relations, is likely to shape the future of contracting and compacting. Tribal leaders were asked about the changes in their Tribe's health care delivery systems that they expect in the next five years. These responses provide information for predicting tends. Also in this section are recommendations that tribal leaders made for changes at the federal, state, and tribal levels that would enable tribes to more fully exercise their sovereignty.

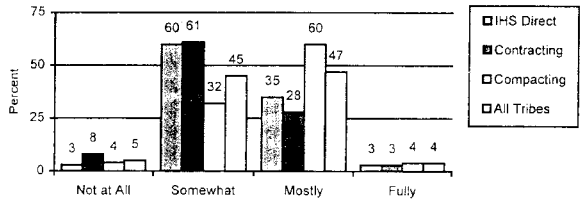
FEDERAL-TRIBAL RELATIONSHIPS

Tribal leaders were asked two questions about federal-tribal relationships in the delivery of health care: "To what extent is the federal government fulfilling its treaty and/or other legal obligations to provide health care to your Tribe?" and "In your current system of health care, does the federal government respect your tribal sovereignty in the delivery of health care for your tribe (and/or tribes in your Regional Health Organization)?" For each of these questions, tribal leaders were given a choice of responding "not at all," "somewhat," "for the most part," and "fully."

Tribal Leader Responses: "To What Extent is the Federal Government Fulfilling its Treaty and/of Other Legal Obligations to Provide Health Care for Your Tribe?"

Over 95 percent of the tribes felt that the federal government was fulfilling its legal obligations to some extent. However, 5 percent responded that the federal government was not at all fulfilling its legal obligations. Only 4 percent said that the federal government was fully fulfilling its obligations. That 4 percent was comprised of 6 tribal leaders, 1 from an IHS direct service tribe, 1 from a compacting tribe, and 4 from compacting tribes. Contracting tribes were less likely to say that the federal government was fulfilling its obligations "for the most part." Only 28 percent of the tribal leaders of contracting tribes answered with this response, compared to a 35 percent of the IHS direct service tribes and 60 percent of compacting tribes.

Figure 9.1
"To What Extent is the Federal Government Fulfilling its Treaty and/or Other Legal Obligations to Provide Health Care to Your Tribe?"

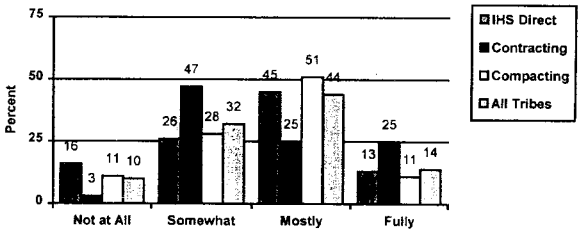


Source: Tribal Leader Survey

Tribal Leader Responses: "Does the Federal Government Respect Your Tribal Sovereignty in the Delivery of Health Care?"

With regard to tribally sovereignty, compacting tribes were the most satisfied, with 61 percent answering "for the most part" or "fully." IHS direct service tribes were similar in their response, with 58 percent answering "mostly" or "fully". Only half the contracting tribes had these responses. But while they are not the most satisfied, contracting tribes are not the most dissatisfied, either. Included in the 10 percent of all tribes who say that the federal government doesn't respect their sovereignty at all are 16 percent of IHS direct service tribes, 11 percent of compacting tribes, and only 3 percent of contracting tribes.

Figure 9.2
"Does the Federal Government Respect Your Tribal Sovereignty in the Delivery of Health Care?"



Source: Tribal Leader Survey

Reasons for Making Changes

Another part of the tribal leaders questionnaire asks about changes tribes are planning to make in the next 5 years. About half the tribal leaders who answered the question (69 people) indicated that they expected to make changes in the management of their health care delivery system, such as more contracting or compacting. They were asked, "What are the primary reasons for this change?" This was an open-ended question. Nearly a third of the tribal leaders answered that the primary reason for their anticipated change was tribal control, local control, sovereignty, self-governance or self-determination. For example, the tribal leader of an IHS direct service tribe in the Albuquerque Area said they want to "assume responsibility for health care so that the care can be redesigned to meet the needs of the reservation residents." This type of response was given more frequently than any other answer.

The second most frequent response related to quality of care (29 percent), followed by more services (14 percent), access to care (13 percent) and funding (12 percent). As a reason for change, tribal sovereignty was nearly 3 times more important to tribal leaders than funding.

Contracting Tribes' Dissatisfaction

Contracting tribes are less happy with the federal government than either IHS direct service tribes or compacting tribes. There are several possible explanations for this. First, a high percentage of the contracting tribes are located in California. Among all 176 contracting tribes and tribal organizations, 98 are located in California comprising 56 percent of the total. In this study, 22 of the 36 tribal leaders of contracting tribes were from California, comprising 61 percent of the contracting sample. In California, historic circumstances have resulted in less choice of health care delivery systems, in poor facilities, and in underfunding. Furthermore, the small size of many California tribes and rancherias is often a problem, as expressed by one California tribal leader: "being a small tribe, we are at times not taken seriously."

Other reasons contracting tribes could be less satisfied is that they are not getting their contract support costs met. They may feel trapped between taking over the management of health care services, but still needing technical assistance and other types of support to become independent and self-sufficient in their management. Thus, they may be expecting more from the Area Offices at a time when the IHS is less able to meet their needs. It is also possible that the IHS is focusing attention on direct service tribes and compacting tribes, and that the contracting tribes are feeling left out. They may be ready and willing to begin compacting, but feel blocked by the federal government in making this transition.

Relationships with Other Federal Agencies

While the issues of federal-tribal relationships in health care are most often considered in the context of the Indian Health Service, tribes are also concerned about other sources of health care financing. Block grants going to states and state Medicaid

programs that are changing to managed care are two issues where the federal role is being delegated to states. One health director of a contracting tribe expressed these concerns:

> To date, there has been no negative impact on our Tribe as a result of contracting or compacting, i.e., tribal share distributions. Rather, the negative impact has been a result of a lack of recurring dollars being put into the overall IHS budget.
>
> Our Tribe has been managing health care delivery with in the confines of a restricted budget. Health care rationing has been a reality since June of 1990 due to no significant increases in funding. Our current per capita funding is currently $656.70 / registered patient. Our benefit package has been reduced, i.e., 0 eyeglasses, 0 dental specialty, non-emergency surgeries. I believe that the term "negotiation" is a misnomer. We are told what our base budget will be for fiscal year and we develop a spending plan. Any deficiencies in funding are sought through alternate resources and program income from Medicaid, Medicare, and private insurance receipts.
>
> I worry more about the impact of changes in Medicaid/Medicare and Managed care. Without the additional dollars from program income, our budgets would get tighter and tighter, and services would have to be reduced. As we are today, we are not able to compete with Managed Care Organizations due to our restricted benefit package. Most. . . are for-profit organizations and can provide a better benefit package for Medicaid population. I worry that if our contracts can't keep up with inflation, we will lose these patients and our program income.

Thus, tribes expect the Health Care Financing Administration, as well as the Indian Health Service, to respect tribal sovereignty and to carry out the federal trust responsibility with tribes.

TRIBAL LEADER EXPECTATIONS: CHANGES IN NEXT FIVE YEARS

More Contracting and Compacting

About half the tribal leaders in the study indicated that they expect to see changes in their health care delivery systems in the next 5 years. According to this survey, 26 percent expect to contract more services and 19 percent expect to compact more services. About 13 percent of the tribes are expecting to assume Service Unit functions. A tribal leader from an IHS direct service tribe in the Aberdeen Area expressed the transition expected in his Tribe this way:

> Initially, no other choice was made available to the Tribe. The Tribe also felt that they were incapable of managing or assuming the IHS health functions with its inadequate funding. Now, the Tribe is planning to assume the local service unit functions.

The trend toward more contracting and compacting is definitely expected to continue.

Area Office Changes

Area Offices are likely to change significantly in the next five years, not only as a result of the Indian Health Design Team (IHDT) recommendations, but also as a result of contracting and compacting. Among the tribal leaders participating in this study, 12 percent expect to assume Area Office functions. Tribes from all Areas except Aberdeen and Oklahoma expressed the expectation that they would be assuming Area Office functions. It is not clear whether they expect to assume these functions by withdrawing tribal shares or by contracting to manage the Area Offices. Based on the number and percentage of responses, the Area Offices most likely to be managed by tribes or tribal organizations within 5 years are Navajo, Alaska, Bemidji, Portland, and Tucson

Multi-Tribal Agreements

Another trend predicted by about 20 percent of the tribal leaders is multi-tribal agreements. Among IHS direct service tribes and contracting tribes, 22-23 percent of tribal leaders expect to enter into multi-tribal agreements. An Aberdeen Area tribal leader stated:

> Due to the recent congressional actions (i.e., FTE reductions, restructuring, etc.), the tribes are forced to assume more authority and responsibilities to empower them to have destiny over their own delivery of services. Tribes can stretch their dollars by entering into multi-tribe agreements for specialty clinics and/or delivery of services.

Only 16 percent of compacting tribes expect to enter into new multi-tribal agreements, a percentage that is low probably because so many of the compacting tribes in Alaska are already in multi-tribal agreements. Only 1 percent of the tribal leaders expect to break up existing multi-tribal agreements. Thus, at the same time that the federal system is devolving, one-fifth of the tribal leaders envision the growth of tribally-controlled regional or national organizations. There are already many successful models for this, including the regional health corporations in Alaska and the Alaska compact, the health care delivery organizations in California, the Area Health Boards, the Tribal Self-Governance Education Project, and the National Indian Health Board.

Purchase of Services

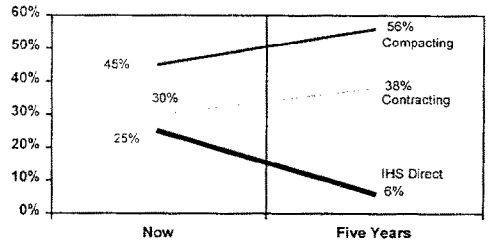
Some of the tribes predict that they will be purchasing more services, including 35 percent of IHS direct service tribes, 17 percent of contracting tribes, and 7 percent of compacting tribes. Only 2 tribes in this study predict that they will be giving services back to the IHS for management and both are contracting tribes. One is a newly-recognized tribe that has been contracting services for less than a year and is concerned about having a steady source of income. The leader of the other tribe did not provide an

explanation, but she also said that they planned on contracting more services and assuming Service Unit functions.

Summary

The half of the tribal leaders who expect their tribe to maintain the status quo for the next five years include 25 percent of IHS direct service tribes, 56 percent of contracting tribes, and 61 percent of compacting tribes. This means that 75 percent of the IHS direct service tribes are expecting to make changes in their health care delivery systems. Based on this survey, it can be anticipated that about half the IHS direct service tribes will increase their contracting and 25 percent will move into compacting.

Figure 9.3
Trends in Health Care Management

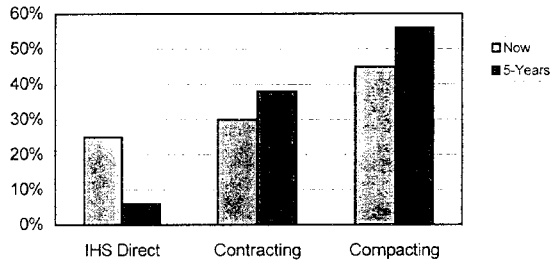


If this survey is representative and the tribal leader predictions are correct, with no new tribes added, we can expect some major changes in the next 5 years. Using the study categories to analyze tribal leader predictions, the percentage of tribes in each category would change. In 5 years from now only 6 percent of the tribes will fit the study category of IHS direct service, about 40 percent of the tribes will be contracting, and over half will be involved in at least some compacting.[49] It is important to note that the study categories span a broad range of management of different types of programs. The percentages in these predictions reflect predominantly the organization of outpatient medical services. Thus, the projected increase in contracting and compacting tribes may occur at the same time that IHS continues to manage most hospitals and environmental health programs for those tribes. Therefore, the statement that only 6 percent of the

[49] Notes on methods for making projections: 1) To project the number of IHS direct service tribes, the current number IHS direct service tribes was multiplied by .25, which is the percentage of tribal leaders in the survey from IHS direct service tribes that expect no changes in the next five years. 2) To project the number of compacting tribes, the number of tribes currently compacting (265) was added to the number of IHS direct service tribes that tribal leaders in the study expect to be compacting in 5 years (146 x .25) and the number of contracting tribes that expect to be compacting in 5 years (176 x .14). 3) The number of contracting tribes was projected by subtracting the projected number of IHS direct service tribes (37) and the projected number of compacting tribes (326) from the total of 587 tribes and tribal organizations. Percentages were calculated using a denominator of 587.

tribes will be IHS direct service tribes does not mean that IHS will manage only 6 percent of the IHS budget or facilities. What it does mean is that tribes will be increasingly managing health care programs and that they will need the training, technical assistance and federal support to engage in those management activities.

Figure 9.4
Five Year Projections by Type of Tribe



Source: Tribal Leader Survey

RECOMMENDATIONS BY TRIBAL LEADERS

In an open-ended question, tribal leaders recommended changes that were needed at the federal, state, and tribal levels to enable their tribes to fully exercise tribal sovereignty in the delivery of health care. Following is a summary of their recommendations. These examples do not represent a consensus, but rather individual opinions and summaries.

Federal Level

At the federal level, two types of recommendations were given most often. The first dealt with issues of sovereignty and the second concerned the federal budget for Indian health.

Tribal leaders said that the federal government should respect, recognize and support tribal sovereignty. They suggested that this could be done if the federal government treated tribes like states for reimbursements under Medicaid, certifications, and eligibility for grants and other sources of funding. They requested more tribal control and more flexibility in regulations and program requirements. Tribal leaders suggested passing laws to protect tribal sovereignty. Stopping block grants to states is another way to protect tribal sovereignty, because utilizing this method for distribution of benefits is seen as circumventing the government-to-government relationship between tribes and

the federal government and because a founding principle of federal Indian law is that dealing with tribes is a federal concern. Tribal leaders also requested broader consultation with the federal government, and they want representation on advisory committees formed by federal and state governments.

Tribes want Congress to provide adequate funding, increased funding and/or full funding for the IHS. They cited the need for more funding for specific programs, including Contract Health Services and prevention. They want funding for facilities construction and contract support costs.

Tribal leaders also suggested changes in the management and organization of the IHS. They stated that they want to see the Indian Health Design Team recommendations implemented at both Headquarters and the Area levels. The compacting tribes want a more timely distribution of funding under their annual funding agreements (AFAs). Tribes want improved services and increased employment of Alaska Natives and American Indians. Some of the employment-related changes they recommended include reducing educational requirements for employment and reducing salaries paid to administrators.

Several tribal leaders expressed concerns about equity in the Indian health system. They want to see more equity in funding between tribes. One tribal leader expressed a concern that self-governance activities were being funded at the expense of IHS direct services. Another tribal leader felt that small tribes did not have enough recognition, power or voice in the system. Another leader expressed concern that there was age discrimination in the IHS system because long term care was not provided for elders.

Tribal leaders felt that respect for sovereignty would be increased if there were more education and training provided to federal employees, tribes, and Congress. They also suggested that there was a need to improve federal/tribal/state communications.

State Level

Many of the tribal leaders in the study called on states to recognize tribal sovereignty, support tribal rights, and develop a government-to-government relationship with tribes. However, one tribal leader said that the State had no jurisdiction and therefore no role in tribal sovereignty.

Tribal leaders felt that states should do a better job of consultation and communication with tribes. They had several suggestions for carrying out this recommendation. Some felt that states that have not already done so should develop a long term process for consultation, such as an Indian Commission. Others stated that treating each tribe as a sovereign nation means determining each tribe's protocol and using those avenues for communication, policy review, and legislative collaboration. With either method, tribal leaders felt that states should be sharing more information with tribal leaders and working with tribes to develop state laws and regulations.

State budgets were another area where tribal leaders think that changes should be made. They are seeking state funding to supplement federal funding for health care.

They want states to give tribes a fair share of federal block grants and other federal funding. They would like to see more contracting with tribes to manage state health programs for tribal members. One change that is needed to facilitate greater tribal participation in state grant programs is the elimination of matching requirements, since tribes may not have the resources necessary to meet the requirements, and thus tribal members are precluded from enjoying benefits available to other citizens.

Another area identified for changes is the coordination of services between states and tribes. This includes the coordination between state agencies and tribes to meet the needs of reservation populations that are eligible for state services. Tribal leaders suggested that memoranda of agreement (MOAs) would be useful in this process, as well as devising methods to share services. Several tribal leaders said that states could help tribes to access services at lower costs, for example by letting tribes use the state-negotiated rates for purchasing health care services.

Tribal leaders said that there needs to be education for state officials and state employees on tribal sovereignty, Indian health care, Indian issues, cultural differences between tribes, and related topics.

Tribal Level

Tribal leaders who participated in this study had many suggestions for changes at the tribal level that would allow tribes to more fully exercise their sovereignty. These responses offer insight as to what the tribes themselves can do locally to improve their own situation.

The leading suggestion was to acquire more training and technical assistance for tribal leaders and tribal employees, particularly in the areas of health care management, health care needs, delivery systems, and quality assurance. They also saw a need for training in treaties and Indian law, including the Indian Self-Determination Act, and current changes in laws and regulations. Another area identified for training was the budget process. One tribal leader thought that training on traditional healing and cultural practices for non-Native employees and others was needed.

Tribal leaders recommended changes in tribal planning and evaluation activities. They said that there was a need to analyze and document program effectiveness. There was a need for strategic planning and to assess the costs and benefits of alternatives.

Many tribal leaders identified a need for changes in attitudes and values. They said it was important to assert tribal sovereignty, to insist on being treated as a government. They saw a need for more focus on prevention, empowerment, and individual responsibility. Tribal leaders felt they should act as role models. They also identified a need for more of a customer-service orientation in the delivery of services.

Cooperation between tribes was also suggested. This includes forming statewide organizations to provide a strong unified voice at the state level. One tribal leader suggested forming consortia to assume services such as Service Unit or Area functions. However, two tribal leaders expressed concerns about the existing multi-tribal

organizations. One stated that these organizations should change their method of representation on their Board of Directors to reflect tribal size, that larger tribes should have more representation than smaller tribes. A tribal leader from Alaska said that the power of regional non-profit corporations in Alaska should be limited and that tribes should operate independent programs.

SUMMARY

Most of the tribal leaders participating in this study are "somewhat" or "mostly" satisfied that the federal government is fulfilling its treaty responsibilities and that the method of health care delivery for their tribe respects their tribal sovereignty. In general, the compacting tribes are more satisfied than other types of tribes, while contracting tribes are the least satisfied. About half the tribes expect changes in their health care delivery systems in the next five years. They predict a shift to more contracting and compacting. The projections based on tribal leader responses suggest that the IHS direct service will go from 25 percent of the tribes to 6 percent in the next five years. With about 95 percent of the tribes managing their own health care systems, more than half the tribes will be doing so under annual funding agreements (AFAs). Tribal leaders make a number of recommendations for changes that are needed at the federal, state and tribal levels to facilitate these changes in the health care delivery system.

CHAPTER 10

CONCLUSIONS

This study has provided the opportunity to survey a broad cross-section of tribal leaders and health directors from every Area of the IHS and every type of health care delivery system. In combination with financial analysis, the information obtained provides a quantitative and qualitative assessment of the impacts of self-determination contracting and self-governance compacting on the system of health care services for American Indians and Alaska Natives. It is significant because it offers a tribal perspective on the changes that have occurred in the past 3-4 years in which tribal self-governance demonstration projects have become part of the landscape of Indian Country.

When the implementation of the Indian Self-Determination Act was evaluated in 1984, the following definition was used for successful outcomes:

> Exemplary programs are characterized as those that provide better health care opportunities than had been previously provided by IHS or that meet tribal needs. The manner in which this is achieved includes the assumption of small IHS responsibilities, the full takeover of IHS facilities and services, and the establishment of services where none existed before.[50]

Now, 14 years later, the same definition can be applied. For the past two decades many tribes have gained experience managing portions of their health care delivery systems. Today there are many examples of tribes providing better health care opportunities for their members than previously had been provided by the IHS. At the same time, there are many examples of improvements within the IHS-operated portions of the health care delivery system.

In this concluding chapter, the information from this study is used to answer some of the most provocative questions about tribal management of health care: Has the health of American Indian and Alaska Native people suffered as a result of changes in the Indian Health Service due to increased tribal management of programs? Are there "winners" and "losers" among tribes with different types of health care delivery systems? When tribes assume control of health care, does the emphasis change from prevention to clinical services? Does the quality of care decline when tribes manage their own health care systems? Do tribes have more difficulty than the IHS in recruiting and retaining health care professionals? Is compacting just about "grabbing money"? Do resources for IHS direct services decline disproportionately as tribes assume management of their health care systems? Has federal funding for Areas with more IHS direct services been moved to Areas with more tribally-operated programs? Is the system becoming disintegrated as a result of tribal management? Does compacting hurt other tribes? Does tribal management of health care lead to termination? Is the federal policy of self-determination working? If this study is the first step in providing a national assessment of

[50] National Indian Health Board and American Indian Technical Services, *Evaluation Report: The Indian Health Service's Implementation of the Indian Self-Determination Process*, Indian Health Service, 1984, p. iv.

the impacts of contracting and compacting, what is the next step? What is the future of self-determination contracting and self-governance compacting?

Has the health of American Indian and Alaska Native people suffered as a result of increased tribal management of programs?

This study did not collect health status information. However, the Indian Health Service does collect health status information and reports it annually. According to the IHS statistics, health status for American Indian and Alaska Native people has continued to improve over the past 20 years as tribes have increasingly assumed control of management of their health care programs. Health status of Native Americans is still well below that of most other Americans, but this can be attributed to such things as an underfunded health care delivery system, poverty and education, rather than tribal management.

Are there "winners" and "losers" among tribes with different types of health care delivery systems?

No. This study shows improvements in health services and health facilities for every type of Tribe in the past 3-4 years. Health programs were added or expanded by half the IHS direct service tribes, 77 percent of contracting tribes and 70 percent of compacting tribes. New facilities were built by half the tribes in the study, including 24 percent of IHS direct service tribes, 53 percent of contracting tribes and 74 percent of compacting tribes.

Program reductions affected about one-third of the survey respondents and facilities closures affected about 20 percent of the tribes. About 30 percent of the facilities that were closed were replaced with new facilities. Under tribal management, some tribes have re-prioritized their services to eliminate some programs and expand others. About 65 to 70 percent of the programs and facilities that were eliminated had this result due to funding shortages. Program and facilities closures affected a higher percentage of IHS direct service tribes than contracting and compacting tribes. One factor could be that tribally-operated programs were more likely to have alternative sources of funding, including collections from Medicaid and other third party payers and funding from successful tribal economic enterprises.

Overall, in the past three years there have been more gains than losses in programs in every type of service and in every type of tribe. If one takes the number of new and expanded programs and subtracts the number of programs eliminated or significantly reduced, the net gain is substantial. On average, the gains are more impressive among tribally-operated programs than IHS direct service.

Of course, these are averages and not every tribe fits this profile. Those that close programs for financial reasons may not be adding programs. Clearly, some tribes feel that their services and facilities have suffered due to a combination of problems, including population growth, inflation, and unfunded mandatories. The analysis in this report shows

that there has been a decline in the adjusted per capita expenditures from $1,442 to $1,183 per person, a decline of 18 percent from FY 1993 to FY 1998. Most tribes in the study, even those that have seen dramatic improvements, feel that many more health care services are needed to bring their health to parity with the general population and that this requires greater funding by Congress.

When tribes assume control of health care, does the emphasis change from prevention to clinical services?

No. When tribally-operated programs have had the opportunity to add or expand services, prevention has been the leading area for expansion. Among the tribes in this study that added new programs, tribally-operated programs had a higher percentage increase in prevention programs than IHS direct service. IHS direct service tribes had a higher percentage increase in clinical services than tribally-operated programs. When forced to eliminate programs, IHS direct service was more likely to eliminate prevention services than tribally-operated programs. Both try to maintain their level of clinical services in the face of program reductions.

Does the quality of care decline when tribes manage their own health care systems?

This is a difficult question to answer because, as was found in our pilot study, health care facilities measure the quality of care in many different ways making it difficult to compare quality indicators using existing data. However, the existing data are still used by tribal leaders to make health care decisions, so this study focused on the perceptions of tribal leaders and health directors about the changes in the quality of care delivered by the health care systems serving their communities based on whatever data is available to that tribal leader or health director. This is the first large scale study that specifically asks tribal leaders and health directors about their perceptions of the quality of care in the health systems that serve their tribes.

From the tribal perspective, the study found that the majority of the tribal leaders and health directors who responded believe that the quality of care is getting "better" in Indian health. Specifically, 57 percent of tribal leaders and 84 percent of tribal health directors thought that the quality of care has gotten "better" over the past 3-4 years.

In addition, tribal leaders and health directors from compacting tribes more commonly responded that the quality of care is getting "better", compared to tribal leaders and health directors from IHS direct and contracting tribes. Of the compacting tribal leaders who responded, 92 percent outside Alaska and 68 percent in Alaska rated the quality of care as "better" over the past 3-4 years, which exceeded the percentages for contracting tribal leaders (59 and 50 percent, respectively) and IHS direct tribal leaders (38 to 50 percent, respectively). And while 19 - 22 percent of tribal leaders of IHS direct services tribes and contracting tribes outside of Alaska thought that the quality of care had changed for the worse, none of the compacting tribal leaders had this response. Similarly, 95 percent of compacting and 93 percent of contracting health directors rated

the overall quality of health care as "better", compared to only 62 percent of IHS direct tribal health directors.

So the results of this study suggest that from the tribal perspective, the quality of care in Indian health is improving overall, and the tribes that manage their own health care systems more commonly rate the quality of care as "better." Therefore, from the tribal perspective, there appears to be no decline in the quality of care with tribally managed health care systems; indeed, the quality of care is perceived to be improving under tribal management.

Do tribes have more difficulty than the IHS in recruiting and retaining health care professionals?

Recruitment and retention of health professionals is a problem for all parts of the Indian health system, due in large part to location of health facilities in remote, rural areas. While some might be concerned that health care professionals will not want to work for tribes, this concern is not borne out by the survey data. Tribes report fewer problems recruiting health care professionals than the IHS direct service programs. This may be because tribal organizations have more strategies available to them than the federal government offers. There appears to be little difference in retention of health care professionals between IHS direct service tribes and tribally-operated programs.

Is compacting just about "grabbing money"?

When tribal leaders were asked about the reasons they chose their form of health care management, 53 percent of leaders of compacting tribes cited political reasons related to tribal sovereignty and local control, 40 percent cited management reasons related to flexibility to meet the needs of tribal members, 33 percent cited opportunity to improve the quality of care, and 7 percent cited maximizing funding. The exercise of tribal sovereignty appears to be a driving force in the decision to enter into compacts.

Do resources for IHS direct services decline disproportionately as tribes assume management of their health care systems?

No. The findings from this study do not provide any support for the notion that resources are being moved from IHS direct service tribes to tribally-operated programs. There is no evidence that Areas with predominantly IHS direct services have experienced a decline in actual federal expenditures. In every area where tribally-operated programs have expanded, direct IHS expenditures have either grown or remained constant, except the Portland and California Areas where almost all services are tribally-operated. Furthermore, the overall expenditures at IHS headquarters and Area Office have remained relatively constant from FY93 to FY97. Area Offices have responded in different ways to the pressures to downsize and reallocate resources to field health programs.

To cope with the less than adequate levels of Congressional appropriations, both the IHS and tribes that operate health programs have relied increasingly on alternate resources. Only a portion of the tribally-operated revenues from third parties are reported in the DHHS financial data system used in this analysis. However, the figures show that tribes were collecting almost 4 times as much in Medicaid and Medicare revenues in FY97 as they collected in FY93 ($10.5 million compared to $40 million). This is due in large part to a Medicaid rate increase of nearly 50 percent in FY97.

Has federal funding for Areas with more IHS direct services been moved to Areas with more tribally-operated programs?

Despite the movement of approximately $48 million in tribal shares from IHS Headquarters and Area Offices to tribal operations, the overall expenditures at IHS Headquarters and Area Offices remained relatively constant over the 5 year period from FY93 to FY97.

Within the Areas, however, there has been much variation. For example, among Areas with predominantly IHS direct service, the change in expenditures has ranged from a 44 percent growth in the Aberdeen Area Office cost center to a 29 percent reduction in the Albuquerque Area Office cost center. While it would seem that Areas with a high rate of tribal operations would have experienced a reduction in the size of the Area Office, this has only happened sometimes. For example, while the Alaska Area Office was reduced by 33 percent, the Oklahoma Area Office grew by 36 percent.

While some Areas with a large proportion of resources in Title III agreements (like Alaska and Portland) have dramatically reduced the resources expended directly from the Area Office, so have some Area Offices with no Title III agreements (Tucson and Albuquerque). Several Area Offices with large direct IHS components have continued to expand federal expenditures for the Area Office (Aberdeen and Navajo).

These findings do not provide any support for the notion that resources are being moved from Areas with mostly IHS direct service to Areas with mostly tribally-operated programs.

Is the system becoming disintegrated as a result of tribal management?

It has been said that the Indian Health Service is changing from providing health services to providing resources to tribes. The integrated federal health care delivery system is changing in some Areas as tribes find innovative ways to better meet the need of their tribal members.

System integration occurs in various ways. Most tribes have their services delivered through a variety of management approaches. For example, some of the compacting tribes are using IHS direct service hospitals as their primary source of health care. In some places, the Area Office has been diminished, but the tribally-controlled area health board is providing coordination, communication, training and technical assistance to tribes in that area. While tribes want more local control, many tribes see

the efficiency of entering into multi-tribal agreements for purchasing and delivering services. Multi-tribal agreements are expected to increase in the next five years according to the leaders of 23 percent of IHS direct service tribes, 16 percent of contracting tribes and 19 percent of compacting tribes. At the same time that there is a disintegration of the federally-controlled system, there is a trend toward integration within a tribally-controlled system.

Does compacting hurt other tribes?

While many tribes in this study said that they were hurting from lack of adequate federal funding, few reported that they were hurting as a result of other tribes compacting. Overall, most of the tribes that were not compacting reported improvements in services, management, and quality of care.

One of the negative impacts cited (which could be related to withdrawal of tribal shares, or reductions as a result of the implementation of IHDT recommendations, or inadequate federal funding) included the shift of responsibilities from IHS Headquarters to Area Offices and from Area Offices to Service Units; but, this was also perceived in a positive way as resulting in more local control. Another negative impact cited was the reduction in Area Office discretionary funds to cover shortfalls at the end of the fiscal year.

Does tribal management of health care lead to termination?

Only time will tell. Title II of P.L. 103-413, the Self-Governance Permanent Authorization Act, which affected the BIA programs, included a provision stating the there was no intent on the part of Congress to diminish the federal trust responsibility to Indians or Indian tribes. However, many tribal leaders who participated in this study would feel more comfortable about the future if there were changes at the federal level to protect their sovereignty.

Some tribal leaders suggested passing additional laws to protect tribal sovereignty. They suggested that the federal government treat tribes like states for reimbursements under Medicaid, certifications, and eligibility for grants and other sources of funding. They requested more tribal control and more flexibility in regulations and program requirements. Tribal leaders also requested broader consultation with the federal government. They want representation on advisory committees. Tribes want Congress to provide adequate funding, increased funding and/or full funding for the IHS.

Tribal leaders felt that respect for sovereignty would be increased if there were more education and training provided to federal employees, tribes, and Congress. They also suggested that there was a need to improve federal/tribal/state communications.

Is the federal policy of self-determination contracting and self-governance compacting working?

Yes, but it could be working better. Currently, approximately 25 percent of tribes receive their services directly from the IHS, 30 percent of tribes are contracting and 45 percent of tribes are compacting. About half the tribes would like to make changes in the next five years. Many tribes would like to do more contracting and compacting.

The basic premise of P.L. 93-638 is that tribes have a choice of IHS direct service or tribal management under contracts or compacts. However, a significant number of tribal leaders felt that they had no choice in the management of their health care systems, including 13-18 percent of IHS direct service tribes and 21 percent of contracting Tribes. Compacting tribes believe they have exercised a choice. In addition to the perception that there was no choice, many tribal leaders felt that historic circumstances had limited their choices. Approximately one-fourth of the tribal leaders outside Alaska from IHS direct service tribes and contracting tribes said that historic reasons dictated the form of health care management for their tribes.

Furthermore, according to the Health Directors Survey, the lack of Indian Self-Determination (ISD) contract support funding is preventing tribes from exercising their options including 27 percent of the IHS direct service tribes, 28 percent of contracting tribes, and 11 percent of compacting tribes.

Overall, self-determination is working in that tribes that have chosen to manage their health care programs have been very successful. Compacting tribes express a high degree of satisfaction with their relationship with the federal government and report significant gains in services, facilities, management, and quality of care. Contracting tribes report fewer gains than compacting tribes, although they cite improvements over IHS direct services.

If this study is a first step in providing a national assessment of the impacts of contracting and compacting on Indian health, what is the next step?

Follow up studies are needed to more fully explore some of the issues identified in this report. It is important to continue the work begun by the Baseline Measures Workgroup to further define ways of measuring quality of care indicators so that data may be aggregated nationally, by region and/or by type of tribe for purposes of monitoring trends and comparing performance. While the financial information presented in this report provides a quantitative assessment of the impacts of contracting and compacting, much of the information provided by the IHS has limited utility and the quality of financial information needs improving. The picture will certainly continue to change and it is necessary to monitor those changes. The changes in the system predicted by the tribal leaders should be monitored in the context of changes in federal policies.

What is the future of self-determination contracting and self-governance compacting?

If tribes make the changes they predict in this study, the Indian health system will look very different in five years. Using the study categories, the projected management

of the Indian health system will have 6 percent of tribes receiving IHS direct services, 38 percent of tribes contracting, and 56 percent compacting.

To some extent, these changes are dependent on congressional actions and federal policy. If the federal government wants to encourage tribal management, policies could be changed to remove barriers and increase opportunities. According to the findings of this study, these could include:

- Full funding for both direct and indirect costs for tribal management of health services;
- Removing the limitations on the number of tribes than can enter into self-governance compacts;
- More training available locally to provide entry for tribal members into health careers;
- More training and technical assistance to help tribes acquire and maintain management expertise; and
- Changing attitudes in those few IHS Area Offices where tribes perceive that compacting is discouraged.

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