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Successful Strategies for Increasing Direct Health Care Quality, Accessibility and Economy for American Indians and Alaska Natives

Indian Health Service, Rockville, MD.

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REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT
P.L. 94-437

"SPEAKING WITH ONE VOICE IHS, TRIBES, URBAN"

HEALTHY INDIAN PEOPLE AND COMMUNITIES

Roundtable Report
June 8-9, 1998
Rockville, Maryland
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Final Report
A Roundtable Discussion on
The Reauthorization of the Indian Health Care Improvement
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June 8-9, 1998

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"Speaking With One Voice"

EXECUTIVE SUMMARY

Background

On June 8-9, 1998, the Indian Health Service (IHS) convened "A Roundtable to Discuss the Reauthorization of the Indian Health Care Improvement Act, P. L. 94-437." The meeting was held at IHS Headquarters in Rockville, Maryland. The focus of the roundtable was the reauthorization of the Indian Health Care Improvement Act (IHCIA), Public Law 94-437, which is up for reauthorization in the next session of Congress. This Act funds health care services provided to and for American Indians and Alaskan Natives in the United States at the local, area and national levels. The annual funding appropriation for the IHS is approximately $2.2 billion dollars which provides health services to over 1.5 million Indian and Alaska Native beneficiaries served by Indian Health Service, Tribal, and Urban (I/T/U) health programs each year. The Indian Health Care Improvement Act represents one of the most critically important pieces of legislation affecting Indian health today. Originally enacted in 1976, the IHCIA provides comprehensive statutory authority for a variety of health programs. While there have been substantial improvements in health status, American Indians and Alaska Natives still lag far behind that of all other races in the United States. With shrinking federal appropriations for the IHS, the job of maintaining and improving health status is becoming far more difficult.

Purpose

The Roundtable brought together approximately 25 participants from the field of Indian health care delivery and program services. Each participant brought extensive background and expertise in the Indian health care field as tribal leaders, health care providers, public health administrators, urban program directors, and Congressional technical advisors. The participants were asked to think globally and futuristically about the national health care environment as it is currently evolving, and the applicability of those effects and results on Indian health care. The purpose of the Roundtable was to stimulate discussion and recommendations regarding the Indian Health Care Improvement Act (IHCIA) that would result in a base of information from which the IHS will begin to plan a tribal consultation process. The expiration of the IHCIA in fiscal year 2000 is of great concern to the participants of this roundtable discussion. The results of this discussion will assist the IHS and local tribal and urban health officials define the many issues involved in the
pending reauthorization; changes in the health care environment affecting Indian health today; and an analysis of the of the opportunities presented through the passage of comprehensive health care legislation.

The upcoming reauthorization of the Act provides opportunities for the Indian Health Service, tribes and urban providers (I/T/U’s) to be creative in updating the legislative authority. Participants in this roundtable were asked to be open-minded in their analysis of the reauthorization. The roundtable was given the following directive:

- Take a global view of the reauthorization process and look futuristically, thinking of Indian health care over the next 10 to 20 years. Be creative;
- Identify environmental influences and changes in the health care industry and the impact on I/T/U systems;
- Look at the reauthorization process and identify opportunities for change;
- Envision how ‘Indian Country’ will work with U.S. Congressional committees;
- Identify the ‘key issues’ and goals of the new legislation;
- Provide guidance to the IHS on how to proceed with a consultation process;
- Discuss emerging trends and how they impact on Indian health care, such as managed care, state health and welfare reforms, increased tribal contracting and compacting;
- Don’t limit discussion to existing provisions of the IHCIA, but keep an open mind and be solution oriented.

Recommendations of the Roundtable

The Roundtable participants identified health care issues into two major areas. Each of these major areas was reviewed in detail by subgroups of the roundtable participants. The two groups are (1) Patient Bill of Rights for Indian People; and (2) Changing Health Care Environment.

**“Patient Bill of Rights for Indian People”**

**Purpose:** To examine the feasibility of establishing a guaranteed level of health care benefits, including emphasis on prevention for all American Indian and Alaska Native beneficiaries of the I/T/U system. To be successful, this effort would require a definition of the “standard services” or guaranteed package of benefits, which are available. Second, these services must be articulated to the beneficiaries, so that there is adequate understanding from the users of the I/T/U system. Finally, a mechanism for the continual monitoring and evaluation of services should be in place, so that services could improve based upon the needs and input of patients, not the shortcomings of federal budgets.
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1. Political Environment

- The basic rights and needs of American Indians and Alaska Native for health services have been overshadowed in the political environment. A Patient’s Bill of Rights must ensure that Congress, the Administration and those charged with administering the trust responsibilities of the federal government are cognizant of the impact cuts to the I/T/U system have on the health care of Indian families. The political and legislative process needs to be more responsive to situation of Indian health systems.

- The reauthorization process should avoid legislating internal operational procedures and requirements in the law. The new Act should stand the test of time, provide fundamental policy and mandates regarding the protection and enhancement of Indian health, and avoid operational issues.

- American Indian and Alaska Native leaders should examine which programs have been successful in realizing substantial budget increases, such as the National Institutes of Health (NIH), AIDS Research, women’s health, immunization initiatives, child health insurance, and which have been losers, such as the IHS budget. Examine the reasons why some health issues prevail in the political process and others do not.

- Consider transferring the duties for appropriating funds for Indian Health Service out of the Interior Appropriations Subcommittee and into the Labor, Health and Human Services Appropriations Subcommittee, which handles all other health, related appropriations. Under this scenario, the IHS would be balanced against other federal health programs in the allocation of funds, instead of shifting funds from BIA or other Interior Department programs to restore IHS budget cuts.

- Within the Department of Health and Human Services, examine the role of Public Affairs Office in addition to the Management and Budget Office, when educating federal officials about the needs of Indian patients and the need for appropriate funding for the I/T/U systems.

- Balance of power has been shifted to states in area of health care, particularly with regard to Medicaid related programs. Indian patients as Medicaid beneficiaries are entitled to Medicaid covered services and the I/T/U systems are entitled to be reimbursed for these services. More attention should be given to protecting Indian patient rights and provider rights under state administered systems.

2. Refocus Act on Prevention and Other Issues

- Indian and Alaska Native patients have a right to have high quality and comprehensive prevention services available through their community I/T/U system. A shift in focus in the IHCIA toward preventive measures is
appropriate given the types of health problems experienced by native populations.

- Access to more comprehensive health care is a right of American Indian and Alaska Native patients. An effort to balance the scope of services across the board should be a priority.
- Elderly patient care should be evaluated to ensure high quality and appropriate scope of services is provided. The changing nature of health problems experienced by Indian elderly, might suggest new strategies and more community-based intervention.
- Identify why the Act is currently not working, that is which programs work and which do not. Assess how it can be re-designed to give both tribal and urban access to contracting under self-determination.
- Focus IHCIA priorities on meeting needs of the patient base. The unmet health needs of American Indian and Alaska Native communities should dictate the priorities of the new legislation. Quality of care from the perspective of the patient should be considered.

3. Public Health Infrastructure

- The provision of basic public health functions under the umbrella of the Indian Health Service has been a major benefit to the elevation of Indian health status through environmental improvements. Preservation of the public health infrastructure within the context of increased tribal self-determination contracting and self-governance compacting is important to consider, and if necessary ensure adequate legislative provisions for the public health and environmental safety of Indian communities to continue.

4. Community Ownership of Health Care Delivery Systems

- Innovative, community-based strategies for the development of comprehensive health services should be fostered and expanded under the IHCIA. An assessment of innovative strategies should be conducted for consideration of how I/T/U systems could better organize and manage their health services.

5. Urban Programs

- Allow for expanded considerations of the relationship of urban health programs under the I/T/U structure, and how urban programs relate to the Indian Self-Determination Act. The rights of patients residing in urban areas should be considered. They are still enrolled tribal members and there should be some reassessment of eligibility and funding for services that respects the rights of urban patients.
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10. Cost Factors

- The I/T/U system is on the losing end of virtually all health care financing systems currently being applied. The Balanced Budget Agreement has eliminated any hope that the I/T/U’s will receive needed increases to keep pace with inflation and population growth. Federal administrative initiatives, such as “Reinventing Government” and GPRA further threaten the IHS structure within the Public Health Service. Welfare Reform has increased the demand on the I/T/U mental health and alcohol services, without proportionate increases in resources. Welfare Reform has also triggered a drop in Medicaid enrollments in each state and Medicaid managed care has reduced revenue, thus depleting I/T/U anticipated revenues. The financing systems are driving a reduction in services to American Indian and Alaska Native patients. Our patients should have an “entitlement” to health services and be fully recognized as Medicaid and Medicare patients, when they are eligible.

8. Other Factors

- Federal Tort Claims Act coverage under the I/T/U system should be evaluated to ensure it is adequately covering all providers and ensuring the protection of patient’s right to access high quality care and due process for patient claims. FTCA coverage should be extended to urban providers under the I/T/U.
- The formal consultation policy developed by Secretary Donna Shalala (DHHS) should be included in the regional consultation meetings pertaining to the reauthorization of the Indian Health Care Improvement Act.
- Elevation of IHS Director within DHHS to an Assistant Secretary position is absolutely critical to ensure the rights of our patients are protected at the highest levels of budget deliberation.

Changing Health Care Environment

Purpose: These recommendations are designed to identify key changes in our health care environment, including public health and clinical services; and identify key health care delivery issues related to Urban Indians. These recommendations address issues related to our “entitlement” to health services; the ability of our patients to access basic services within the I/T/U network; and financial barriers and proposed solutions to improve the financing of I/T/U systems.
6. Managed Care

- Over 80% of Americans now receive their health services through some sort of "managed care organization". States are increasingly implementing mandatory managed care in their state Medicaid programs, thereby, purchasing through managed care organizations and requiring Medicaid patients to enroll. The I/T/U systems are becoming more and more dependent upon the third party payor to reimburse for covered services. The IHCIA reauthorization process should include some assessment of managed care on Indian patient rights, and whether our I/T/U systems are adequately prepared to compete in a managed care system. And provide for the policy development to assure the protection of the I/T/U infrastructure and its enhancement in the future.

7. Partnering - Federal, State, Tribal Governments and I/T/U System

- The provision of health services to Indian patients goes beyond the scope of IHS resources. The IHCIA should include an assessment of all federal, state and local resources, which combine to assist Indian patients. Legislation, which will improve the position of I/T/U's to negotiate benefits for Indian and Alaska Native patients, is recommended. Agencies, such as the Health Care Financing Administration play major roles in the effort to improve Indian health. Federal legislation should be considered to eliminate roadblocks experienced in many of these agencies and create policy and program opportunities for collaboration.

8. Psychosocial and Behavioral Health Areas

- The task of elevating Indian health status goes beyond the provision of clinical services. Other social issues and factors include family violence, substance abuse, injury issues, lack of viable economic development ventures, etc. The IHCIA should expand the resources available to I/T/U's to intervene in the psychosocial or behavioral health areas.

9. Tribal Self-Determination and Self-Governance

- There should not be penalties for those tribes opting to contract, compact or receive services through the Indian Health Service. Provisions should be considered which will ensure equity for all partners in the I/T/U system, regardless of which administrative mechanism each chooses. The basic rights of Indian and Alaska Native patients to health care, should not be dramatically affected by the contracting methods employed to deliver services.
1. Facilities

- New and innovative facility construction financing options should be examined for inclusion in the reauthorization of the IHCIA. There may be different approaches for the different problems to address tribal and urban facility needs. Consider establishing a capital loan from loan guaranteed programs with emphasis on ambulatory care facilities. Consider balanced, fair approach to fund all types of facilities construction, so majority of money doesn't go to just one type of facility.
- Include Joint Venture Demonstration projects as a permanent part of the IHCIA, which will allow tribes and urban programs to fund the expansion or replacement of their facilities and be ensured adequate staffing and equipment through the IHS, as partners in the overall system.
- Consider other capital projects such as management information systems, integrated service delivery development, etc.

2. Health Care and Manpower Issues

- The IHCIA should exempt all direct health care providers from any restrictions on Full-Time Equivalent ceilings imposed by the Administration or through federal law.
- The IHCIA should include a Mentor Program to assist Indians going through health professional programs, include leadership training.
- Remove impediments from current legislation on how the loan repayment program money is being allocated; let it be driven more by where manpower needs really are.

3. Political Strategy for Indian Access to Other Funding Programs

- Need to develop political strategy to access other funding programs. Some of this might be accomplished through legislative language in the IHCIA reauthorization. Also, from resources available through Health Services and Resources Administration and being tapped into for Historically Black Colleges and Universities (HBCU). Tap into those resources for Indian tribal colleges and universities to create opportunities and incentives.

4. Billing, Reimbursement and Financing

- Health care providers and I/T/Us should have the right to reasonable cost reimbursement under Medicaid and Medicare and authority to receive reimbursements directly from the Health Care Financing Administration (HFCA), by-passing the States. Search out successful demonstrations that have occurred and consider new an innovative legislation to bring I/T/U's on a level playing field with states in regards to Medicaid administration.
• Include amendments to IHCIA to allow IHS or tribal Self-Determination Act contractors to bill tribal employee insurance programs and self-insurance programs, if authorized by the tribal government. Eliminate or amend the current prohibition in the IHCIA against billing tribal self-insurance programs.
• Permit I/T/U’s to bill each other for services provided to Indians from other I/T/U systems.
• Exempt tribes and Indians from costs of premiums they are currently required to pay in Children’s Health Insurance Program (C.H.I.P.), Medicare - Part B., etc. Our right to health care has already been pre-paid.
• Tribe must receive full Contract Support Costs in compliance with amendments to the Indian Self-Determination Act, when contracting and taking over the administration of IHS services. The inability of Congress to keep pace with CSC, is creating a depletion in overall resources for delivery of services to American Indians and Alaska Natives. The problem of funding for CSC expenses must be dealt with in the IHCIA.

5. Urban Issues

• Urban Indian providers have not been provided full opportunity for consultation; Urban Indians should not lose their right to be a part of consultation when they leave the reservation.
• Clarify the rights and benefits of urban patients and urban health providers under the new IHCIA. Urban Indian populations should be included in the allocation formula of the Indian Health Service to ensure adequate funding for all Indian and Alaska Native people, regardless of residence. Urban programs should receive funding based upon user populations and be able to provide the full range of services to patients.
• Expand and make permanent the two urban demonstration projects in Oklahoma. These projects have proven that urban providers can be merged into the overall I/T/U system successfully.
• Amend the Federal Tort Claims Act to include FTCA coverage for urban contractors under Title V of the IHCIA, just as the IHS and tribal contractors are now covered.

6. Access To Health Care

• The allocation of health care services and resources should be based upon tribal enrollment and not geographical location. Contract Health Service Delivery Area (CHSDA) should follow the individual regardless of residence. Access to I/T/U services should be an “entitlement” for enrolled Indian and Alaska Native people. The eligibility criteria is too vague and needs to be more clearly defined.
• Medicaid/Medicare eligibility mechanism needs to be strengthened, including I/T/U authority for on-site eligibility determinations. Amendments to federal
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- Tribe must receive full Contract Support Costs in compliance with amendments to the Indian Self-Determination Act, when contracting and taking over the administration of IHS services. The inability of Congress to keep pace with CSC, is creating a depletion in overall resources for delivery of services to American Indians and Alaska Natives. The problem of funding for CSC expenses must be dealt with in the IHCIA.

5. Urban Issues

- Urban Indian providers have not been provided full opportunity for consultation; Urban Indians should not lose their right to be a part of consultation when they leave the reservation.
- Clarify the rights and benefits of urban patients and urban health providers under the new IHCIA. Urban Indian populations should be included in the allocation formula of the Indian Health Service to ensure adequate funding for all Indian and Alaska Native people, regardless of residence. Urban programs should receive funding based upon user populations and be able to provide the full range of services to patients.
- Expand and make permanent the two urban demonstration projects in Oklahoma. These projects have proven that urban providers can be merged into the overall I/T/U system successfully.
- Amend the Federal Tort Claims Act to include FTCA coverage for urban contractors under Title V of the IHCIA, just as the IHS and tribal contractors are now covered.

6. Access To Health Care

- The allocation of health care services and resources should be based upon tribal enrollment and not geographical location. Contract Health Service Delivery Area (CHSDA) should follow the individual regardless of residence. Access to I/T/U services should be an “entitlement” for enrolled Indian and Alaska Native people. The eligibility criteria is too vague and needs to be more clearly defined.
- Medicaid/Medicare eligibility mechanism needs to be strengthened, including I/T/U authority for on-site eligibility determinations. Amendments to federal
1. Facilities

- New and innovative facility construction financing options should be examined for inclusion in the reauthorization of the IHCIA. There may be different approaches for the different problems to address tribal and urban facility needs. Consider establishing a capital loan from loan guaranteed programs with emphasis on ambulatory care facilities. Consider balanced, fair approach to fund all types of facilities construction, so majority of money doesn't go to just one type of facility.
- Include Joint Venture Demonstration projects as a permanent part of the IHCIA, which will allow tribes and urban programs to fund the expansion or replacement of their facilities and be ensured adequate staffing and equipment through the IHS, as partners in the overall system.
- Consider other capital projects such as management information systems, integrated service delivery development, etc.

2. Health Care and Manpower Issues

- The IHCIA should exempt all direct health care providers from any restrictions on Full-Time Equivalent ceilings imposed by the Administration or through federal law.
- The IHCIA should include a Mentor Program to assist Indians going through health professional programs, include leadership training.
- Remove impediments from current legislation on how the loan repayment program money is being allocated; let it be driven more by where manpower needs really are.

3. Political Strategy for Indian Access to Other Funding Programs

- Need to develop political strategy to access other funding programs. Some of this might be accomplished through legislative language in the IHCIA reauthorization. Also, from resources available through Health Services and Resources Administration and being tapped into for Historically Black Colleges and Universities (HBCU). Tap into those resources for Indian tribal colleges and universities to create opportunities and incentives

4. Billing, Reimbursement and Financing

- Health care providers and I/T/Us should have the right to reasonable cost reimbursement under Medicaid and Medicare and authority to receive reimbursements directly from the Health Care Financing Administration (HFCA), by-passing the States. Search out successful demonstrations that have occurred and consider new an innovative legislation to bring I/T/U’s on a level playing field with states in regards to Medicaid administration.
law beyond IHCIA should be examined to achieve better access by I/T/U patients to Medicaid and Medicare covered services and payments.

- Language and authority is recommended to allow the I/T/U's to purchase health care and health care insurance and to provide it under the Indian Health Service system.
- Third-party collections should not be used to offset IHS budget. There should be a legal prohibition against offsetting the IHS budget with projections of third party revenues.
- Need specific language for access of I/T/U's to all special initiative funds such as the Tobacco Settlement legislation, which should include direct access for I/T/U's, bypassing States.

7. Managed Care

- Federal law should be amended to provide for a direct set-aside at the national level for all Medicaid and Medicare payments to I/T/U's to be centrally administered through the IHS for the benefit of I/T/U's and their Indian and Alaska Native patients. I/T/U's should not be forced to negotiate with states or state contractors for reimbursement of services.
- Short of a direct set-aside, Federal law should be amended so that states are required to contract with I/T/U's for the provision of health care to Indian Medicaid beneficiaries who are patients of the I/T/U system. It should not be allowable under federal law to have Indian patients arbitrarily assigned to other managed care providers of the state, and I/T/U's suffer a loss in revenues. In most cases, Indian patients continue to utilize the I/T/U, but their Medicaid reimbursement is lost due to arbitrary assignments to other MCO's.
- Freestanding I/T/U clinics, should be able to bill Medicare-Part B.
- Legislation is need to allow I/T/U's to assume risk and have their own managed care plans, including the need to amend the Anti-Deficiency Act to eliminate impediments that keeps I/T/U's from taking on these capitated, managed care ventures.
- Tribes need investment risk capital for development of plans and reserves for carrying risk
- Adjustment on capitation rates for I/T/U's should be provided in federal law to ensure that even under a capitated system, the I/T/U's are more likely to receive 100% reimbursement for high-risk populations. Through a risk adjusted capitation or a Federal wrap-around, the reasonable cost levels.

8. Prevention and Public Health Care Services

- The IHCIA should provide that I/T/U's have access to all Federal program services and funds under Public Health Service. If funds are available to States, they should be made available to I/T/U's.
• Access and coordination with other services by other departments and programs to better utilize available resources, i.e., Veterans Administration, etc. should be included in the IHICIA reauthorization.

• Departments and agencies of the federal government should be required accountability to I/T/Us for funds they received that address Indian health care issues, i.e., research funds, Center for Disease Control, etc.

9. Data and Technology

• Legislative language needs to specifically instruct and require the Public Health Service (PHS) to collect more comprehensive data and statistics on American Indians and Alaska Natives. Need to have a comprehensive assessment of what is going on in Indian Country. Currently, there is concern over accuracy and scope of available PHS data. IHS (RPMS), tribal and urban systems collect different types of data; need national data set and repository; need common indicators. I/T/Us should have access to Center for Disease Control (CDC) data systems

• Legislative language should include access to new technology as it becomes available to enable I/T/U’s to provide better and more comprehensive health care services.

10. Long-Term Health Care

• Explore long-term demonstration projects to provide national and legislative authority for tribes to have flexibility, i.e., provision for home and community-based care and other long-term services. Would enable Tribe to identify what their most important needs are. Also, need to maximize Medicare and Medicaid as these programs have responsibility for covering these services.

The roundtable recommended that the IHS begin an Area by Area consultation process and provided specific recommendations on how those meetings should be held. The culmination of these Area and Regional consultation meetings is expected to be the drafting of legislation which reflects the concerns and needs of tribal and urban health providers, and is consistent with the changes in health care nationally. The Roundtable participants provided suggestions and recommendations in regard to conducting tribal and urban consultation meetings. Their comments were grouped into the following 10 topics:

1. Agenda
2. Asking for Support
3. Atmosphere and Setting of the Consultation Meetings
4. Considerations for the Content of the Bill
5. Developing Support for Reauthorization Orientation For All Those in the Reauthorization Process

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The analyses and information from the Roundtable is intended to stimulate discussion and provide a framework for consultation to advance. It is of critical importance that the I/T/U leadership work together to ensure that the new Indian Health Care Improvement Act is reflective of the health care needs of Indian communities for the next 15 to 20 years. The IHCIA is one of the most important pieces of federal Indian law supporting our communities today. Efforts to ensure the continuation of a comprehensive health care statute should be carried out in a unified and thoughtful process. In concluding the roundtable meeting, the IHS Director offered the suggestion that Indian country would be best served for all stake-holders in the reauthorization process to be “speaking with one voice”.

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I. INTRODUCTION

The U.S. Indian Health Service has initiated a series of roundtable discussions over the last several years as a means to convene leading experts from the fields of Indian health, community development, Indian law, research, academia, tribal and urban health leadership, and the larger health industry to examine current and sometimes controversial topics related to Indian health care. On June 8-9, 1998, for a day and a half, the Indian Health Service (IHS) convened "A Roundtable to Discuss the Reauthorization of the Indian Health Care Improvement Act, P.L. 94-437." The meeting was held at IHS Headquarters in Rockville, Maryland. This meeting was convened to provide the IHS and others the opportunity to discuss the reauthorization of the Indian Health Care Improvement Act, which is authorized until fiscal year 2000. First enacted in 1976, the Indian Health Care Improvement Act represents one of the most critical foundations shaping Indian health services and improvement of Indian health status today.

The Roundtable convened approximately 25 participants from the field of Indian Health care delivery and program services. Participants reflected a variety of experiences, perspectives and expertise in the Indian health care field. They represented tribal leaders, urban and rural health care providers, public health administrators, and U.S. Congressional staff from relevant committees. A cross-section of the existing network of Indian Health Service, tribal and urban health providers (I/T/U’s) were recruited to participate in this important roundtable discussion.

The purpose of the Roundtable was to stimulate discussion and recommendations regarding the Indian Health Care Improvement Act (IHCIA) that would result in a base of information from which the IHS will begin to plan a tribal consultation process. The expiration of the IHCIA in fiscal year 2000 is of great concern to the participants of this roundtable discussion. The results of this discussion will assist the IHS and local tribal and urban health officials define the many issues involved in the pending reauthorization; changes in the health care environment affecting Indian health today; and an analysis of the opportunities presented through the passage of comprehensive health care legislation.

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- Take a global view of the reauthorization process and look futuristically, thinking of Indian health care over the next 10 to 20 years. Be creative;
- Identify environmental influences and changes in the health care industry and the impact on I/T/U systems;
- Look at the reauthorization process and identify opportunities for change;
- Envision how ‘Indian Country’ will work with U.S. Congressional committees;
- Identify the ‘key issues’ and goals of the new legislation;
- Provide guidance to the IHS on how to proceed with a consultation process;
- Discuss emerging trends and how they impact on Indian health care, such as managed care, state health and welfare reforms, increased tribal contracting and compacting;
- Don’t limit discussion to existing provisions of the IHCIA, but keep an open mind and be solution oriented.

These discussions will help form the framework upon which the IHS will conduct consultation and further develop an approach to revising or reauthorizing the IHCIA. With the results of this roundtable, the IHS will conduct tribal and urban consultation meetings across the United States. Recommendations from the tribal and urban consultation meetings will be incorporated and reflected in the content and structure of the new Indian health legislation.

II. BACKGROUND ON INDIAN HEALTH CARE

The United States maintains a legal and moral responsibility to provide health services to America’s Indian and Alaska Native population. These obligations are based upon numerous treaties signed between the U.S. and tribes which ceded millions of acres of land in exchange for certain reserved rights and basic provisions guaranteed by the United States, including health care. The unique relationship between tribes and the United States is underscored in the U.S. Constitution (Article I, Section 8). Federal laws and court decisions have confirmed the unique relationship between tribes and the federal government, and upheld the obligation of the United States to provide health services to American Indians and Alaska Natives.

The provision of health services to American Indians began during the Indian war era and continued through the turn of the century. For most Indian tribes the devastation of new diseases, wars, forced relocations and cultural upheaval had a drastic impact on the health and well being of the tribe. In 1921, President Hoover signed into law the Snyder Act, which provides the underpinning for a variety of federal Indian programs, including the Indian Health Service. The Snyder Act provided, “...such sums as Congress may from time to time appropriate for the benefit care and assistance of Indians”. The transfer of
these responsibilities to the U.S. Public Health Service in 1955 sparked the beginning of the U.S. Indian Health Service, and a slow but measured rebound in the health status of American Indians today.

The legislative history of Indian health care, can be traced back to the Snyder Act in 1921. Only the Indian Health Care Improvement Act has provided more direction and foundation for the improvement of Indian health status.

  The Snyder Act authorizes Congress to appropriate funds for the “relief of distress and conservation of health and for the employment of physicians” for Indians throughout the United States. It represents permanent statutory authority for Indian health programs.

  The JOM Act authorizes the Secretary of the Interior to contract with states and other local governments to provide education, medical attention, agricultural assistance and social welfare for Indian people in hardships related to the allotment process or other hardships related to Indians living off the reservation.

  The Act established the U.S. Indian Health Service under the Department of Health, Education and Welfare, and removed responsibilities for Indian health services from the Department of Interior.

- **Indian Health Facilities Act of 1957 (42 U.S.C. 2005)**
  This Act provides the IHS with the authority to fund construction of hospitals for the benefit of Indian tribal patients.

  This federal law expanded the duties of the IHS to ensure public health requirements were being met, including safe and sanitary drinking water, sewer systems, drainage facilities, waste and access to of water and sewer systems for Indian homes.

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This was landmark legislation, which elevated and invigorated Indian health care improvement measures to a higher level within Indian communities and within the federal government. The Act provided clear policy for the Nation to elevate the health status of Indians and Alaska Natives to the highest possible level. The Act set out specific new programs and initiatives, which will be described in detail in a later section.

This Act provided specific authorizations to address the problem of alcoholism, alcohol abuse and drug abuse in Native American communities. Each tribe developed an action plan to combat addictions, and inpatient treatment centers for Indian adolescents were authorized.

The IHS is an agency established under the U.S. Public Health Service within the Department of Health and Human Services (DHHS). The mission of the IHS is to provide a comprehensive health service delivery system for American Indians and Alaska Natives. The range of services provided through the IHS includes a broad spectrum of preventive, curative, rehabilitative and environmental services. The transfer of federal health activities for Indians from the Interior Department to the Public Health Service was a major event resulting in a formalized, structured and vastly improved Indian health system. The IHS has developed a model of service delivery, which incorporates direct outpatient and inpatient facilities, contracting for the provision of services from the private sector, contracting with tribes and urban providers of health services. The IHS approach is comprehensive and includes public health nurses, community health representatives, sanitation initiatives and housing quarters for providers in rural remote areas.

The IHS provides health services through 144 Service Units which are composed of more than 500 direct healthcare delivery facilities, including 49 hospitals, 190 health centers, 7 school health centers, and 287 health stations, satellite clinics, and Alaska village clinics. In addition to direct services provided by IHS, within the system 1) Indian tribes deliver IHS funded services to their own communities with about 35 percent of the IHS direct
services budget in 11 hospitals, 129 health centers, 3 school health centers, and 240 health stations; 2) various health care and referral services are provided to Indian people away from the reservation settings through 34 urban center programs; and, 3) the purchase of contract health services from non-IHS providers to support, or in some cases in lieu of, direct care services that IHS is unable to provide in its facilities.

Many of the American Indian and Alaska Native people served by the IHS live in some of the most remote and poverty stricken areas of the United States. For them, the IHS represents the only source of health care available. Others reside in larger communities but face cultural or financial barriers to care. While the IHS represents the primary health resource for most Indian people in the U.S., Indian people are also eligible for a variety of alternate resources, such as Medicaid, Medicare, state programs and private insurance. The IHS requires beneficiaries to exhaust these alternate resources before expending contract health resources. For federal, tribal and urban providers of services under the IHS, this myriad of alternate resources and requirement makes providing vital health services to American Indians and Alaska Natives a challenge.

Improvements in health outcomes between the years 1972 and 1993 records indicate the following:

- Infant mortality was reduced by 54%
- Years Potential Life increased by 54%
- Overall mortality was reduced by 42%
- Maternal mortality was reduced by 65%
- Gastrointestinal disease mortality was reduced by 75%
- Tuberculosis Mortality rate was decreased by 80%.

American Indians and Alaska Natives, while improving in health status since 1972, remain one of the most vulnerable populations in the United States. Dying at rates higher than other racial groups in America in many categories.

- The median age for Indians living in the 34 reservation States Indian Health Services provides services for is 24.2 compared to 32.9 for the U.S. All Races and 34.4 for the White Race.

- For Indians, 33 percent of the population was younger than 15 years and 6 percent was older than 64 years. For the U.S. All Races population, the corresponding percentages were 22 and 13, respectively.

- According to the 1990 Census, the median household income in 1989 for Indians residing in the current Reservation States was $19,897, compared with $30,056 for the U.S. All Races population. During this period, 31.6 percent of Indians lived below the poverty level, in contrast to 13.1 percent for the U.S. All Races population.
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The IHS is an agency established under the U.S. Public Health Service within the Department of Health and Human Services (DHHS). The mission of the IHS is to provide a comprehensive health service delivery system for American Indians and Alaska Natives. The range of services provided through the IHS includes a broad spectrum of preventive, curative, rehabilitative and environmental services. The transfer of federal health activities for Indians from the Interior Department to the Public Health Service was a major event resulting in a formalized, structured and vastly improved Indian health system. The IHS has developed a model of service delivery, which incorporates direct outpatient and inpatient facilities, contracting for the provision of services from the private sector, contracting with tribes and urban providers of health services. The IHS approach is comprehensive and includes public health nurses, community health representatives, sanitation initiatives and housing quarters for providers in rural remote areas.

The IHS provides health services through 144 Service Units which are composed of more than 500 direct healthcare delivery facilities, including 49 hospitals, 190 health centers, 7 school health centers, and 287 health stations, satellite clinics, and Alaska village clinics. In addition to direct services provided by IHS, within the system 1) Indian tribes deliver IHS funded services to their own communities with about 35 percent of the IHS direct
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- **Inadequate Funding for Indian Health:** The impact of federal budget cuts to the U.S. Indian Health Service has been staggering. The annual expenditure on health services for IHS beneficiaries was 75% of the national per capita expenditure in 1975, as reported in the 1986 report, “Bridging the Gap: Report of the Task Force on Parity of Indian Health Services”. Today, the per capita expenditure for American Indian and Alaska Native patients of the IHS has dropped to just one-third of what other Americans spend on their health care per person. Even among other federal health systems, such as Medicaid and the Veteran’s Administration, the per capita expenditures for beneficiaries of these systems outpace American Indians and Alaska Natives by three times, according to
National Indian Health Board studies. Federal budget cuts have cost the Indian Health Service in dollars and staffing. The IHS budget is targeted to receive no substantial increases through the year 2002. Yet, the cost to provide the same level of services increases annually, the I/T/U system must provide pay increases to federal employees and continue to purchase services from an increasingly expensive health care industry.

- **State Tribal Funding**: The new reauthorization should also consider how tribes are treated differently from state to state in regards to state administered systems. This problem should be rectified if possible. Consideration should be given to Congress taking Medicaid and Medicare money proportionate to Indian needs and giving it to IHS to administer rather than HCFA who goes through the States.

- **Increasing Patient Needs**: The I/T/U system is funded at levels, which are estimated to meet approximately 60% of actual patient needs. The rate of need funded varies from Area to Area within the IHS system, depending on patient access to major facilities. The population base of eligible patients is increasing at a rate of 2.1% per year, not counting the impact of newly recognized Indian tribes. The IHS budget has not increased at that same rate to keep pace with the growing patient demand. While Indian mortality statistics are still alarming, Indian and Alaska Native people are living longer today than we did in 1955. While this is good news, it also requires the I/T/U system to be prepared for more patients with chronic diseases and more complicated and more expensive interventions. At the same time our knowledge and understanding of major health problems reveals that the leading causes of death and disease among Indian and Alaska Native people is preventable and lifestyle related. Comprehensive, culturally sensitive prevention programs present the greatest opportunity to make long lasting improvements in health status. Unfortunately, with a severely under funded system, where services are rationed through-out the year, prevention activities sometimes take a back seat to high cost and urgent care.

- **Tribal Contracting and Compacting**: Amendments to the Indian Self-Determination Act have created new opportunities for tribal governments to assume control and management of Indian health services. Tribes are not bound by many of the restrictions of the IHS when administering Indian Self-Determination Act contracts or Self-Governance compacts. Today, close to 40% of the total IHS budget is under a tribal contract or compact, with anticipated increases in the number of tribes administering their own health systems. As tribes exercise their right to contract or compact programs, services, functions or activities of the IHS, tribes are also entitled to receive their proportionate “tribal shares” from IHS Area and Headquarters budgets. The Indian Health Service is adjusting to these incremental reductions at Headquarters and Area levels. Tribes are also entitled to receive funding over and above the dollars administered by the IHS, to cover new costs associated with tribal administration of the system.
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- **IHS Restructuring:** In 1995, the Indian Health Service released a final report from its Indian Health Design Team (IHDT), which was described as “...the first attempt in 40 years to change the overall structure of the IHS...”. It represented a partnership of IHS, tribal and urban health providers, and responded to the increasing pressures on the IHS to redesign. Three major forces were impacting the IHS. They were (1) increased tribal contracting and compacting; (2) rapid changes and inflation in the health care industry; (3) federal downsizing initiatives of the Clinton Administration. The first phase of the redesign was to downsize and restructure IHS Headquarters. The second phase involves Area and local redesign, and is being handled on an Area by Area basis with the involvement and consultation of tribes and urban health providers.

- **Complexity and Disparity in the System:** The I/T/U system has been described as “a mile wide and an inch deep”. The system serves a large and diverse patient population in vastly different regions of the United States, with way too little resources. There is no single guaranteed benefit package for all IHS beneficiaries. Services are rationed based upon annual Congressional appropriations and geographical access to larger IHS or tribally operated medical centers and clinics. The amount of funds provided to each region varies on a per capita basis. Some areas operate no IHS facilities, while others include large IHS inpatient medical centers. Tribal contracting and compacting is more frequent in some areas than others. Urban Indian health providers are scattered across the map in 34 cities, and serve large numbers of patients with less than 1% of the total IHS budget.

- **Managed Care:** Managed care is having a great impact on I/T/U systems across the United States. The increasing reliance on third party reimbursement systems, such as Medicaid, Medicare and private insurance has accelerated the move of I/T/U’s into the managed care field. I/T/U providers are finding themselves in a position of competing for their own patients against large managed care organizations. States have not always consulted with I/T/U’s in the planning and implementation of state health reforms, including changes in how Medicaid is administered. For many tribal and urban providers, this has resulted in a loss in revenues and confusion and reduced access for their patients.
• **Media and Communications:** Most I/T/U providers have not benefited from improved and advanced media and communication technology. A special emphasis is needed to bring disease prevention and health promotion materials to our patients at home and in the waiting rooms. Computerized, multimedia options should be available to our patients in most of our facilities, just as it is in other facilities. Prevention efforts must be evaluated and reconfigured to better fit with our information age.

• **Partnering:** As tribes and urban providers assume more control over the Indian health system, there is a need for innovative approaches to provide services. There have not been adequate incentives to encourage inter-tribal or tribal/urban ventures in the delivery of comprehensive health care delivery systems. The Indian Health Care Improvement Act should assess the changing health care environment and provide incentives for partnering among various components of the I/T/U structure.

• **Urban Populations:** The lack of consistency in how tribes and urban health providers are treated should be examined. States, in particular deal with tribes and urban providers differently from state to state. The Indian Health Service, also treats tribal providers different from urban providers. The roundtable participant’s question whether there can be a consistent policy developed which will clarify the relationship of the providers within the I/T/U system. Urban Indian populations reflect a large percentage of the overall IHS beneficiaries, yet the allocation of resources continues to be minimal in comparison.

• **Expand Our Resource Base:** One of the largest challenges facing Indian health care providers is finding ways to expand the base of resources and funding to support services. The flat-line budget of the Indian Health Service, suggests that increases in resources must come from expanding our third party revenues and involving other federal or state health care initiatives in our effort. For many tribes, who have contracted or compacted the delivery of health services, they are finding themselves subsidizing these services with other tribal revenues. The long-term impact of this approach could devastate many tribes. Other federal agencies with health care mandates, should be required to include American Indian and Alaska Native populations in their funding system. These alternate fund sources should be researched and if necessary, changes in federal law provided to ensure American Indian and Alaska Native populations participate fairly in these resources, e.g. Medicaid, Medicare, Veterans Administration, Children's Health Insurance program.

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IV. BRIEF OVERVIEW OF PUBLIC LAW 94-437, THE INDIAN HEALTH CARE IMPROVEMENT ACT (IHCIA)

On September 30, 1976, the President signed Public Law 94-437, the Indian Health Care Improvement Act (IHCIA). The goal of this Act is to "provide the quantity and quality of health services necessary to elevate the health status of American Indian and Alaska Natives to the highest possible level and to encourage the maximum participation of tribes in the planning and management of these services." The Act contains numerous program authorities along with specific health status objectives that were to be achieved for American Indians and Alaska Natives in the United States. In summary, the Indian Health Care Improvement Act includes the following Titles and Programs:

- **Declaration of Health Objectives** - Enumerates 61 specific health measurements or objectives, which are to be met by the Indian Health Service by the year 2000.

- **Title I - Indian Health Manpower.** Several health professions programs are included such as Health Professions Recruitment; Health Professions Preparatory Scholarships; Indian Health Professions Scholarships; the Extern Program; Continuing Education Allowances; Community Health Representative (CHR) Program; IHS Loan Repayment Program; Scholarship and Loan Repayment Recovery Fund; Recruitment Activities; Tribal Recruitment and Retention Program; Advanced Training and Research; Nursing Program; Nursing School Clinics; Tribal Culture and History; INMED Program; Health Training Programs of Community Colleges; Additional Incentives for Health Professionals; Retention Bonus; Nurse Residency Program; Community Health Aide Program for Alaska; Matching Grants to Tribes for Scholarship Programs; Tribal Health Program Administration; University of South Dakota Pilot Program.

- **Title II - Health Services.** Intended to improve service delivery, this title includes the following programs: Indian Health Care Improvement Fund; Catastrophic Health Emergency Fund; Health Promotion and Disease Prevention Services; Diabetes
Prevention, Treatment and Control; Hospice Care Feasibility Study; Reimbursement from Certain Third Parties for Costs of Health Services; Crediting Reimbursements; Health Services Research; Mental Health Prevention and Treatment Services; Managed Care Feasibility Study; California Contract Health Service Demonstration Program; Mammography Screening Coverage; Patient Travel Costs; Epidemiology Centers; Comprehensive School Health Education Programs; Indian Youth Grant Program; American Indians Into Psychology Program; Prevention, Control, and Elimination of Tuberculosis; Contract Health Service Payment Study; Prompt Action on Payment of Claims; Demonstration of Electronic Claims Processing; Liability for Payment; and Office of Indian Women's Health Care.

- **Title III – Health Facilities.** Numerous health facilities, sanitation construction projects were impacted by the provisions of this title. Programs covered under Title III include: Consultation, Closure of Facilities; Safe Water and Sanitary Waste Disposal Facilities; Preference to Indians and Indian Firms; Soboba Sanitation Facilities; Expenditure of Non-Service Funds for Renovation; Grants for Construction, Expansion, and Modernization of Small Ambulatory Care Facilities; Indian Health Care Delivery Demonstration Project, Land Transfers; and Applicability of Buy American Requirement.

- **Title IV – Access to Health Services.** Provisions for the billing of Medicare and Medicaid are included in this title. Programs in Title IV include: Treatment of Payment Under Medicare Program; Treatment of Payments Under Medicaid Program; Reports Required; Grants to and Contracts with Tribal Organizations; Demonstration Program for Direct Billing of Medicare, Medicaid and other Third Party Payors; and Authorization for Emergency Contract Health Services.

- **Title V – Health Services for Urban Indians.** This Title provides authority for services to urban Indian populations. Programs include: Purpose Statement; Contracts With and Grants To Urban Indian Organizations; Contracts and Grants for the Provision of Health Care and Referral Services; Contracts and Grants for the Determination of Unmet Health Care Needs; Evaluations and Renewals; Other Contract and Grant Requirements; Reports and Records; Limitation on Contract Authority; Facilities Renovation; Urban Health Programs Branch; Grants for Alcohol and Substance Abuse Related Services; Treatment of Certain Demonstration Projects; and Urban NIAAA Transferred Programs.

- **Title VI – Organizational Improvements.** This title includes: Establishment of the Indian Health Services as an Agency of the Public Health Service; and Automated Management Information System.

- **Title VII – Substance Abuse Programs.** Title VII includes: Definition of IHS Responsibilities; IHS Programs; Indian Women Treatment Program; IHS Youth Program; Training and Community Education; Gallup ASA Treatment Center;
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IV. BRIEF OVERVIEW OF PUBLIC LAW 94-437, THE INDIAN HEALTH CARE IMPROVEMENT ACT (IHCIA)

On September 30, 1976, the President signed Public Law 94-437, the Indian Health Care Improvement Act (IHCIA). The goal of this Act is to "provide the quantity and quality of health services necessary to elevate the health status of American Indian and Alaska Natives to the highest possible level and to encourage the maximum participation of tribes in the planning and management of these services." The Act contains numerous program authorities along with specific health status objectives that were to be achieved for American Indians and Alaska Natives in the United States. In summary, the Indian Health Care Improvement Act includes the following Titles and Programs:

- **Declaration of Health Objectives** – Enumerates 61 specific health measurements or objectives, which are to be met by the Indian Health Service by the year 2000.

- **Title I – Indian Health Manpower.** Several health professions programs are included such as Health Professions Recruitment; Health Professions Preparatory Scholarships; Indian Health Professions Scholarships; the Extern Program; Continuing Education Allowances; Community Health Representative (CHR) Program; IHS Loan Repayment Program; Scholarship and Loan Repayment Recovery Fund; Recruitment Activities; Tribal Recruitment and Retention Program; Advanced Training and Research; Nursing Program; Nursing School Clinics; Tribal Culture and History; INMED Program; Health Training Programs of Community Colleges; Additional Incentives for Health Professionals; Retention Bonus; Nurse Residency Program; Community Health Aide Program for Alaska; Matching Grants to Tribes for Scholarship Programs; Tribal Health Program Administration; University of South Dakota Pilot Program.

- **Title II – Health Services.** Intended to improve service delivery, this title includes the following programs: Indian Health Care Improvement Fund; Catastrophic Health Emergency Fund; Health Promotion and Disease Prevention Services; Diabetes
V. ROUNDTABLE FINDINGS AND RECOMMENDATIONS

The focus of the Roundtable was the reauthorization of the Indian Health Care Improvement Act (IHCIA), Public Law 94-437. The upcoming reauthorization of the Act provides opportunities for the I/T/Us to be proactive in updating the Act by incorporating provisions related to the current health care environment and other issues pertinent and relevant to I/T/U programs. The participants were asked to think globally and futuristically about the Indian health care environment.

To gain a global perspective of the Act and the areas it impacts, the Roundtable participants, by group consensus, chose to remain in a large group to share open discussions on issues related to the Act and relevant to the current environment of health care delivery and services impacting I/T/U systems. Following large group discussions, two umbrella topics were identified: "Patient Bill of Rights for Indian People" and "Changing Health Care Environment." Participants then formed a workgroup for each topic. Each workgroup brainstormed major concepts or themes and looked at what is needed to support all activities and service delivery systems of the I/T/U. This would include discussing viewpoints, perspectives, impacts, effects, relationships, creative and futuristic thinking, long-term and short-term elements. Following these intense discussions, each workgroup identified underlying themes that resulted from their discussions of various issues and then listed the issues.

Each workgroup presented their recommendations through a designated spokesperson to the whole group of Roundtable participants for discussion. The discussion of the topics,
themes and issues resulted in a base of information to begin consultation with leadership of tribes and urban Indian health programs for their input on the content of the reauthorization legislation so that their views are reflected.

A. "Patient Bill of Rights for Indian People"

Purpose: To examine the feasibility of establishing a guaranteed level of health care benefits, including emphasis on prevention for all American Indian and Alaska Native beneficiaries of the I/T/U system. Minimally, no less than Medicaid covered services; also see FQHC/RHC funded services in Federal statutes. To be successful, this effort would require a definition of the "standard services" or guaranteed package of benefits, which are available. Second, these services must be articulated to the beneficiaries, so that there is adequate understanding from the users of the I/T/U system. Finally, a mechanism for the continual monitoring and evaluation of services should be in place, so that services could improve based upon the needs and input of patients, not the shortcomings of federal budgets.

1. Political Environment

- The basic rights and needs of American Indians and Alaska Native for health services have been overshadowed in the political environment. A Patient’s Bill of Rights must ensure that Congress, the Administration and those charged with administering the trust responsibilities of the federal government are cognizant of the impact cuts to the I/T/U system have on the health care of Indian families. The political and legislative process needs to be more responsive to situation of Indian health systems.

- The reauthorization process should avoid legislating internal operational procedures and requirements in the law. The new Act should stand the test of time, provide fundamental policy and mandates regarding the protection and enhancement of Indian health, and avoid operational issues.

- American Indian and Alaska Native leaders should examine which programs have been successful in realizing substantial budget increases, such as the National Institutes of Health (NIH), AIDS Research, women’s health, immunization initiatives, child health insurance, and which have been losers, such as the IHS budget. Examine the reasons why some health issues prevail in the political process and others do not.

- Consider transferring the duties for appropriating funds for Indian Health Service out of the Interior Appropriations Subcommittee and into the Labor, Health and Human Services Appropriations Subcommittee, which handles all other health, related appropriations. Under this scenario, the IHS would be balanced against other federal health programs in the allocation of funds,
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Reporting Requirements; Fetal Alcohol Syndrome and Fetal Alcohol Effect Grants; Pueblo Substance Abuse Treatment Project for San Juan Pueblo, NM; Thunderchild Treatment Center; Substance Abuse Counselor Education Demonstration Project; Gila River Alcohol and Substance Abuse Treatment Facility; Alaska Native Drug and Alcohol Abuse Demonstration Project;

- **Title VIII – Miscellaneous.** This Title includes: Reports; Leases with Indian Tribes; Availability of Funds; Limitation of Use of Funds Appropriated to the IHS; Nuclear Resource Development Health Hazards; Arizona as Contract Health Service Delivery Area; Eligibility of California Indians; California as a Contract Health Service Delivery Area; Contract Health Facilities; National Health Service Corps; Health Services for Ineligible Persons; Infant and Maternal Mortality and Fetal Alcohol Syndrome; Contract Health Services for the Trenton Service Area; IHS and VA Health Facilities and Sharing of Services; Reallocation of Base Resources; Demonstration Project for Tribal Management of Health Care Services; Child Sexual Abuse Treatment Programs; Tribal Leasing; Home and Community-Based Care Demonstration Project; Shared Services Demonstration Project; Results of Demonstration Projects; and Priority of Indian Reservations.

**V. ROUNDTABLE FINDINGS AND RECOMMENDATIONS**

The focus of the Roundtable was the reauthorization of the Indian Health Care Improvement Act (IHCIA), Public Law 94-437. The upcoming reauthorization of the Act provides opportunities for the I/T/U's to be proactive in updating the Act by incorporating provisions related to the current health care environment and other issues pertinent and relevant to I/T/U programs. The participants were asked to think globally and futuristically about the Indian health care environment.

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instead of shifting funds from BIA or other Interior Department programs to restore IHS budget cuts. Also, need collaboration with Senate Finance committee and House Energy and Commerce Health Sub-Committee to get at Medicaid policy and legislative initiatives.

- Within the Department of Health and Human Services, examine the role of Public Affairs Office in addition to the Management and Budget Office, when educating federal officials about the needs of Indian patients and the need for appropriate funding for the I/T/U systems.

- Balance of power has been shifted to states in area of health care, particularly with regard to Medicaid related programs. Indian patients have a right as dual citizens to access alternate resources, and the I/T/U budget have come to depend upon third party revenues. More attention should be given to protecting Indian patient rights under state administered systems.

2. **Refocus Act on Prevention and Other Issues**

- Indian and Alaska Native patients have a right to have high quality and comprehensive prevention services available through their community I/T/U system. A shift in focus in the IHCIA toward preventive measures is appropriate given the types of health problems experienced by native populations.

- Access to more comprehensive health care is a right of American Indian and Alaska Native patients. An effort to balance the scope of services across the board should be a priority.

- Elderly patient care should be evaluated to ensure high quality and appropriate scope of services is provided. The changing nature of health problems experienced by Indian elderly, might suggest new strategies and more community-based intervention.

- Identify why the Act is currently not working, that is which programs work and which do not. Assess how it can be re-designed to give both tribal and urban access to contracting under self-determination.

- Focus IHCIA priorities on meeting needs of the patient base. The unmet health needs of American Indian and Alaska Native communities should dictate the priorities of the new legislation. Quality of care from the perspective of the patient should be considered.

3. **Public Health Infrastructure**

- The provision of basic public health functions under the umbrella of the Indian Health Service has been a major benefit to the elevation of Indian health status through environmental improvements. Preservation of the public health infrastructure within the context of increased tribal self-determination contracting and self-governance compacting is important to consider, and if necessary ensure adequate legislative provisions for the public health and environmental safety of Indian communities to continue.
4. Community Ownership of Health Care Delivery Systems

- Innovative, community-based strategies for the development of comprehensive health services should be fostered and expanded under the IHCIA. An assessment and development of innovative strategies should be conducted for consideration of how I/T/U systems could better organize and manage their health services in a competitive managed care environment.

5. Urban Programs

- Allow for expanded considerations of the relationship of urban health programs under the I/T/U structure, and how urban programs relate to the Indian Self-Determination Act. The rights of patients residing in urban areas should be considered. They are still enrolled tribal members and there should be some reassessment of eligibility and funding for services that respects the rights of urban patients.

6. Managed Care

- Over 80% of Americans now receive their health services through some sort of “managed care organization”. States have adopted managed care organizations as the system through which state health programs, such as Medicaid are administered. The I/T/U system is becoming more and more dependent upon the third party payor to cover increased costs. The IHCIA reauthorization process should include some assessment of managed care on Indian patient rights, and whether our I/T/U system is adequately prepared to compete in a managed care system. Medicare and Medicaid should be first payor for Indians who are eligible and tribes should be able to set up their own health maintenance organizations or Congress should give IHS Medicare and Medicaid money directly to IHS to administer.

8. Partnering - Federal, State, Tribal Governments and I/T/U System

- The provision of health services to Indian patients goes beyond the scope of IHS resources. The IHCIA should include an assessment of all federal, state and local resources, which combine to assist Indian patients. Legislation which will improve the position of I/T/U’s to negotiate benefits for Indian and Alaska Native patients is recommended. Agencies, such as the Health Care Financing Administration play major roles in the effort to improve Indian health. Federal legislation should be considered to eliminate roadblocks experienced in many of these agencies.
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substance abuse, injury issues, lack of viable economic development ventures, etc. The IHClA should expand the resources available to I/T/U's to intervene in the psychosocial or behavioral health areas.

9. Tribal Self-Determination and Self-Governance

- There should not be penalties for those tribes opting to contract, compact or receive services through the Indian Health Service. Provisions should be considered which will ensure equity for all partners in the I/T/U system, regardless of which administrative mechanism each chooses. The basic rights of Indian and Alaska Native patients to health care, should not be dramatically affected by the contracting methods employed to deliver services.

10. Cost Factors

- The I/T/U system is on the losing end of virtually all health care financing systems currently being applied. The Balanced Budget Agreement has eliminated any hope that the I/T/U's will receive needed increases to keep pace with inflation and population growth. Federal administrative initiatives, such as “Reinventing Government” and GPRA further threaten the IHS structure within the Public Health Service. Welfare Reform has increased the demand on the I/T/U mental health and alcohol services, without proportionate increases in resources. Welfare Reform has also triggered a drop in Medicaid enrollments in each state, depleting I/T/U anticipated revenues. The financing systems are driving a reduction in services to American Indian and Alaska Native patients. Our patients should have an “entitlement” to health services, as do Medicaid and Medicare patients. Maybe consider IHS money as an entitlement; this would create major changes organizationally and politically that would need to be analyzed beforehand.

11. Other Factors

- Federal Tort Claims Act coverage under the I/T/U system should be evaluated to ensure it is adequately covering all providers and ensuring the protection of patient’s right to access high quality care and due process for patient claims. FTCA coverage should be extended to urban providers under the I/T/U.
- The formal consultation policy developed by Secretary Donna Shalala (DHHS) should be included in the regional consultation meetings pertaining to the reauthorization of the Indian Health Care Improvement Act.
- Elevation of IHS Director within DHHS to an Assistant Secretary position is absolutely critical to ensure the rights of our patients are protected at the highest levels of budget deliberation.
B. "Changing Health Care Environment"

Purpose: These recommendations are designed to identify key changes in our health care environment, including public health and clinical services; and identify key health care delivery issues related to Urban Indians. These recommendations address issues related to our "entitlement" to health services; the ability of our patients to access basic services within the I/T/U network; and financial barriers and proposed solutions to improve the financing of I/T/U systems.

1. Facilities

- New and innovative facility construction financing options should be examined for inclusion in the reauthorization of the IHCIA. There may be different approaches for the different problems to address tribal and urban facility needs. Consider establishing a capital loan or guaranty program with emphasis on ambulatory care facilities. Consider balanced, fair approach to fund all types of facilities construction, so majority of money doesn't go to just one type of facility.
- Include Joint Venture Demonstration projects as a permanent part of the IHCIA, which will allow tribes and urban programs to fund the expansion or replacement of their facilities and be ensured adequate staffing and equipment through the IHS, as partners in the overall system.

2. Health Care and Manpower Issues

- The IHCIA should exempt all direct health care providers from any restrictions on Full-Time Equivalent ceilings imposed by the Administration or through federal law.
- The IHCIA should include a Mentor Program to assist Indians going through health professional programs, include leadership training.
- Remove impediments from current legislation on how the loan repayment program money is being allocated; let it be driven more by where manpower needs really are.

3. Political Strategy for Indian Access to Other Funding Programs

- Need to develop political strategy to access other funding programs such as those available through Health Services and Resources Administration and being tapped into for Historically Black Colleges and Universities (HBCU). Tap into those resources for Indian tribal colleges to create opportunities and incentives.
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4. Billing, Reimbursement and Financing

- Health care providers and I/T/U's should have the authority to receive reimbursements directly from the Health Care Financing Administration (HFCA), by-passing the States. Search out successful demonstrations that have occurred and consider new an innovative legislation to bring I/T/U's on a level playing field with states in regards to Medicaid administration.
- Include amendments to IHCIA to allow IHS or tribal Self-Determination Act contractors to bill tribal employee insurance programs and self-insurance programs, if authorized by the tribal government. Eliminate or amend the current prohibition in the IHCIA against billing tribal self-insurance programs.
- Permit I/T/U's to bill each other for services provided to Indians from other I/T/U systems, after billing third party payors.
- Exempt tribes and Indians from costs of premiums they are currently required to pay in Children’s Health Insurance Program (C.H.I.P.), Medicare -Part B., etc. Our right to health care has already been pre-paid.
- Tribe must receive full Contract Support Costs in compliance with amendments to the Indian Self-Determination Act, when contracting and taking over the administration of IHS services. The inability of Congress to keep pace with CSC, is creating a depletion in overall resources for delivery of services to American Indians and Alaska Natives. The problem of funding for CSC expenses must be dealt with in the IHCIA.

5. Urban Issues

- Urban Indian providers have not been provided full opportunity for consultation; Urban Indians should not lose their right to be a part of consultation when they leave the reservation.
- Clarify the rights and benefits of urban patients and urban health providers under the new IHCIA. Urban Indian populations should be included in the allocation formula of the Indian Health Service to ensure adequate funding for all Indian and Alaska Native people, regardless of residence. Urban programs should receive funding based upon user populations and be able to provide the full range of services to patients.
- Expand and make permanent the two urban demonstration projects in Oklahoma. These projects have proven that urban providers can be merged into the overall I/T/U system successfully.
- Amend the Federal Tort Claims Act to include FTCA coverage for urban contractors under Title V of the IHCIA, just as the IHS and tribal contractors are now covered.
6. Access To Health Care

- The allocation of health care services and resources should be based upon tribal enrollment and not geographical location. Contract Health Service Delivery Area (CHSDA) should follow the individual regardless of residence. Access to I/T/U services should be an "entitlement" for enrolled Indian and Alaska Native people. The eligibility criteria is too vague and needs to be more clearly defined.

- Third Party, Medicaid/Medicare, and CHIP eligibility mechanism needs to be strengthened, including I/T/U authority for on-site eligibility determinations. Amendments to federal law beyond IHCIA should be examined to achieve better access by I/T/U patients to Medicaid and Medicare.

- Language and authority is recommended to allow the I/T/U's to purchase health care and health care insurance and to provide it under the Indian Health Service system.

- Third-party collections should not be used to offset IHS budget. There should be a legal prohibition against offsetting the IHS budget with projections of third party revenues.

- Need specific language for access of I/T/U's to all special initiative funds such as the Tobacco Settlement legislation, which should include direct access for I/T/U's, bypassing States.

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- Freestanding I/T/U clinics, should be able to bill Medicare-Part B.

- Legislation is need to allow I/T/U's to assume risk and have their own managed care plans, including the need to amend the Anti-Deficiency Act to eliminate impediments that keeps I/T/U's from taking on these capitated, managed care ventures.

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- Health care providers and I/T/Us should have the authority to receive reimbursements directly from the Health Care Financing Administration (HCFA), by-passing the States. Search out successful demonstrations that have occurred and consider new an innovative legislation to bring I/T/U’s on a level playing field with states in regards to Medicaid administration.
- Include amendments to IHCIA to allow IHS or tribal Self-Determination Act contractors to bill tribal employee insurance programs and self-insurance programs, if authorized by the tribal government. Eliminate or amend the current prohibition in the IHCIA against billing tribal self-insurance programs.
- Permit I/T/U’s to bill each other for services provided to Indians from other I/T/U systems, after billing third party payors.
- Exempt tribes and Indians from costs of premiums they are currently required to pay in Children’s Health Insurance Program (CHIP), Medicare -Part B., etc. Our right to health care has already been pre-paid.
- Tribe must receive full Contract Support Costs in compliance with amendments to the Indian Self-Determination Act, when contracting and taking over the administration of IHS services. The inability of Congress to keep pace with CSC, is creating a depletion in overall resources for delivery of services to American Indians and Alaska Natives. The problem of funding for CSC expenses must be dealt with in the IHCIA.

5. Urban Issues

- Urban Indian providers have not been provided full opportunity for consultation; Urban Indians should not lose their right to be a part of consultation when they leave the reservation.
- Clarify the rights and benefits of urban patients and urban health providers under the new IHCIA. Urban Indian populations should be included in the allocation formula of the Indian Health Service to ensure adequate funding for all Indian and Alaska Native people, regardless of residence. Urban programs should receive funding based upon user populations and be able to provide the full range of services to patients.
- Expand and make permanent the two urban demonstration projects in Oklahoma. These projects have proven that urban providers can be merged into the overall I/T/U system successfully.
- Amend the Federal Tort Claims Act to include FTCA coverage for urban contractors under Title V of the IHCIA, just as the IHS and tribal contractors are now covered.
• Adjustment on capitation rates for I/T/U's should be provided in federal law to ensure that even under a capitated system, the I/T/U's are more likely to receive 100% reimbursement for high-risk populations.
• Change Urban and tribal outpatient programs FQHC right to reasonable costs in Medicare/Medicaid and eliminate barriers.

8. Prevention and Public Health Care Services

• The IHClA should provide that I/T/U's have access to all Federal program services and funds under Public Health Service. If funds are available to States, they should be made available to I/T/U's.
• Access and coordination with other services by other departments and programs to better utilize available resources, i.e., Veterans Administration, etc. should be included in the IHClA reauthorization.
• Departments and agencies of the federal government should be required accountability to I/T/U's for funds they received that address Indian health care issues, i.e., research funds, Center for Disease Control, etc.

9. Data and Technology

• Legislative language needs to specifically instruct and require the Public Health Service (PHS) to collect more comprehensive data and statistics on American Indians and Alaska Natives. Need to have a comprehensive assessment of what is going on in Indian Country. Currently, there is concern over accuracy and scope of available PHS data. IHS (RPMS), tribal and urban systems collect different types of data; need national data set and repository; need common indicators. I/T/U's should have access to Center for Disease Control (CDC) data systems
• Legislative language should include access to new technology as it becomes available to enable I/T/U's to provide better and more comprehensive health care services.

10. Long-Term Health Care

• Explore long-term demonstration projects to provide national and legislative authority for tribes to have flexibility, i.e., provision for home and community-based care and other long-term services. Would enable Tribe to identify what their most important needs are.

C. Recommendations Concerning the Consultation Process

The Roundtable participants felt the manner in which the tribal consultation meetings are conducted and carried out will be critical to successfully gaining the support for the
reauthorization of the IHCIA. The participants also felt all the stakeholders (I/T/U's) need to participate and be well informed and oriented to what is involved in the reauthorization process, as well as those who are part of the process in the Department, OMB, and in Congress. Changes have occurred in the health care environment at the State and national levels; in the I/T/U health care delivery systems; in Congress and at the Department of Health and Human Services. This has created a void in knowledge and support for Indian health, that will be critical to the reauthorization of the Act. It is essential that everyone be informed and oriented to the meaning and importance of the Indian Health Care Improvement Act. Participants shared the following comments that have been grouped into these topics:

1. Agenda
   - Use a roving core group at the consultation meetings to elaborate on points made at the Roundtable. Use this same core group to work with OMB and Congress.
   - Have a forum for urban providers; identify where they can be supportive.
   - Need to develop the agenda well; we have an ambitious agenda and our political clout needs to be strengthened.
   - Identify specific products of the meeting.
   - Implementation and follow-through important; share with the chairpersons and tribes; let tribes help shape the Act; keep tribes informed.
   - Target achievable goals in the reauthorization process.
   - Identify "budget neutral" issues; significant barriers, committees.
   - Keep lines of communications open; even if there is a dissenting vote;

2. Asking for and Developing Support
   - Say, "we need you"; this is important legislation;
   - Communicate with the White House; involve the First Lady
   - Elevation of the IHS Director to Assistant Secretary level should assist in the Reauthorization process.
   - Invite support groups to attend the Regional consultation meetings; include Friends of Indian Health on a regional basis.
   - Identify all the groups that can support Reauthorization, i.e. Self-Governance tribes and Advisory Committee, 638 contractors, Chairpersons, organizations, groups, etc.
   - Involve the Domestic Policy Council as a pathway to the White House.
   - Expand the presence and use of health boards, organized groups, advisory boards, etc., and keep them in the loop.
   - Don't forget other departments, specialized services, Department of Defense and other partnerships, American Public Health Association, foundations, etc.

3. Atmosphere & Setting of the Consultation Meetings
   - Make tribal leaders feel welcome
   - Seating arrangements important--sit together, same level if possible
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• Use personal touch during meetings.
• Need to be very cognizant of government-to-government relationships.
• Should promote a "partnership" environment for I/T/U's

4. Considerations for Content of the Act
• Grasp complexities of the act — try to improve quality and access to health care in the new one.
• This is the time to include AI/AN in the recent evolution that has occurred in health care; people are ready to re-write programs; and states looking for fresh approach to Medicaid and tribes
• Information used in the last re-authorization should be updated - charts/financial and data studies, and actuarial work.
• Identify strengths and weaknesses of the Act.
• Need to identify standard benefit plan/package for American Indians and Alaska Natives and present measurable data on how funding is being used to provide for quality health care and address needs.
• Identify the fundamental issues of the Act
• Reauthorization is an opportunity to address issues in the Act that are of common concern.
• We are in a new era where Tribal leaders are involved in development of regulations. The consultation process should present ideas for discussion and re-shaping as needed, working toward consensus or the development of different models.
• Need to take a whole new look on how we approach the Act, encouraging creativity and new ideas

5. Developing Support for Reauthorization Orientation For all Those in the Reauthorization Process
• Need to educate/orient individuals and offices involved in the reauthorization process to Tribal Consultation, Tribal health care needs, etc.
• Need to develop and shape the reauthorization package with the Office of Management and Budget (OMB) ahead of time to make the approach and process smoother.
• Invite Dr. Satcher to consultation meetings with Dr. Trujillo escorting him.
• Write letters from Chairpersons to HHS officials to familiarize them with tribal needs, issues, and why they need to support the Reauthorization Act; include OMB officials. Also, invite them to the regional meetings or take them on trips to the field
• Discretionary spending is decreasing, the source of IHS funding; need to raise awareness of Deputy Secretary Thurm and the Secretary to the impact and affect on I/T/Us.
- HHS Public Affairs Office has a key role; involve them; they go beyond public affairs.
- Many members of the House of Representatives are new and will be unfamiliar with reauthorization and I/TUs; they will have not have experience or knowledge of government-to-government relationship of Tribes.
- Need to draw into orientation committees of Congress to make sure they understand Indian Country. Support is no longer among some of the committees (Senate Finance Committee, House Commerce, void in Indian Affairs Subcommittee); need to cultivate new understanding and support for reauthorization.

6. Materials/Information
   - Keep it simple
   - Use bullets. Keep it simple but reflect complexities.
   - Use graphics; visuals work in Indian country.
   - Keep materials to a minimum.
   - After developing materials for consultation meetings, bounce materials off several chairpersons for feedback.
   - Develop a briefing document of the matter or condensed summaries of materials to reduce volume of material.

7. Preliminary Preparations
   - Need to get Area Directors up to speed to address questions and go to advisory boards.
   - Personally telephone call each chairman in the region of the meeting; keep at it until they are all reached
   - Encourage Chairperson to personally attend;
   - Stress their importance in developing a partnership to support Reauthorization
   - Address correspondence to Tribal leaders individually, as persons and heads of states, in correspondence; eliminate the "Dear Tribal Leader" letter.
   - Do pre-press work
   - Use the same method as used with budget formulation process
   - Give ample notice of meetings
   - Use Chairpersons to help present at the meetings
   - Keep HHS Public Affairs Office informed; they sometimes influence and shape issues.

8. Regional/Tribal Differences
   - Identify regional/tribal differences ahead of time so they can be addressed
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   - Take time to know peculiarities of each area, i.e. Alaska people fish entire month of July, therefore, no one available to meet during that period until August.
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   - The National Medical Expenditures report needs to be updated.

10. Urbans
   - Involve Urban Indian health providers in the process;
   - 34 metropolitan centers are ready to make contacts to support reauthorization, and have been very effective in all prior Indian health amendments.

It is important for all participants in the consultation process to understand that the IHS is required to follow certain internal federal procedures in the preparation of legislation, in addition to the consultation process itself. A series of consultation meetings will be conducted throughout the year with the IHS and the Department of Health and Human Services. Following this consultation process, a legislative proposal must be submitted to the Office of Management and Budget (OMB). A series of questions will be raised and discussions held with IHS and legislative staff. The DHHS Tribal Consultation policy should be reinforced throughout this process.
The proposal will next be forwarded to the Office of General Counsel (OGC) within the DHHS to be developed as legislation. When it goes from IHS to them, they will want to know how much is it going to cost and will conduct their own assessment in addition to what IHS and the tribes submit to them. DHHS will draft the specific legislative language based on the A-19 process including the financial and staffing impacts. Finally, the legislation will be included as part of the Administration’s request to the President in the annual budget process.

VI. CLOSING REMARKS

Dr. Michael H. Trujillo, Director of Indian Health Service, provided closing remarks. He said he would be updating the Deputy Secretary of HHS regarding the activities and outcomes of the Roundtable. He felt the Roundtable was a good, productive brainstorming session.

Regarding the legislation he stated it should continue to reflect and address I/T/U issues and be adapted to the changing national health care environment. Each title needs to be reviewed and reassessed for appropriateness and we need to have accountability in the I/T/U programs. Continuing struggles with the budget and changes in the Administration in the Department and in Congress present different challenges and opportunities relative to how to approach the legislation. The reauthorization process itself is cumbersome and complicated and a strategy needs to be developed to move the legislation along.

Regarding the tribal consultation process, Dr. Trujillo suggested we assess the results of each meeting and evaluate the process for improvement as it is implemented. A number of products will be developed as a result of the regional consultation meetings which will need to be tracked. We will need a team to manage the process and take charge of tasks and logistics, especially after the passage of legislation. They will need to identify strategic points of time, assess other parallel legislation, and dates for development of products to ensure accomplishment of tasks, specific dates, and identify deadlines.

Dr. Trujillo expressed his appreciation to all the Roundtable participants for their participation and contributions to the meeting. He plans to stay involved with them throughout the consultation meetings and reauthorization process. He felt the I/T/U’s have the initiative and ingenuity to accomplish the goals of the reauthorization legislation and believes the focus of our effort should reflect us “speaking with one voice”.

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A Roundtable to Discuss the Reauthorization of the Indian Health Care Improvement Act - June 8-9, 1998  Page 36
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- Key Facts on Indian Health Programs
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AGENDA

Monday, June 8, 1998:

7:30 a.m.  Continental Breakfast and Registration

8:00 a.m.  Welcome
           Blessing
           Introductions: Facilitator, Participants, Others
           Opening Remarks -
               Dr. Michael H. Trujillo, M.D., M.P.H., M.S.
               Assistant Surgeon General
               Director, Indian Health Service
           Purpose - Michael Mahsetky
               Director, Congressional & Legislative Affairs, IHS

10:00 a.m.  Break

10:15 a.m.  Work Group Discussions

12:00 p.m.  Working Lunch - Conference Room “M”

1:00 p.m.  Reporting Out By Groups

2:15 p.m.  Break

2:30 p.m.  Group Discussions

3:30  Where Are We? Next Steps?

5:00 p.m.  Adjournment
Tuesday, June 9, 1998:

7: 30 p.m. Continental Breakfast

8:00 a.m. Welcome
          Introductions
          Announcements

8:30 a.m. Concluding Recommendations & Discussions

9:00 a.m. Reauthorization Process -
          Michael Mahsetky
          Director, Congressional & Legislative Affairs, IHS

9:45 a.m. Tribal Leaders Presentations/Responses

11:15 a.m. Closing Remarks -
            Dr. Michael H. Trujillo, M.D., M.P.H., M.S.
            Assistant Surgeon General
            Director, Indian Health Service

1:00 p.m. Adjournment