NIHB Health Reporter

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Indian Health Care Bills Introduced in House, Senate

WASHINGTON, D.C. — Citing statistics that indicate "an intolerable gap" still exists in the health status between Indians and the rest of the United States population, lawmakers in both the House and Senate introduced legislation November 18 to improve the health care of American Indians and Alaska Natives.

Introduced in the House by Congressman Morris Udall (D-Ariz.) and in the Senate by Senator Mark Andrews (R-N.D.), the two bills would reauthorize and extend the Indian Health Care Improvement Act (P.L. 94-437), which expires at the end of the current fiscal year. The House bill (H.R. 4567) would extend the Act through fiscal year 1987, while the Senate version (S. 2166) would run through fiscal year 1988.

The two bills, which are similar in some respects and markedly different in others, are largely based on Indian health oversight hearings conducted earlier this year by the House Interior and Insular Affairs Committee and the Senate Select Committee on Indian Affairs. Both committees plan to hold hearings early next year to solicit additional comments and recommendations on the legislation. Passage of a reauthorization bill is necessary in order to assure funding for the Act's provisions in fiscal year 1985.

As stated in the original Act, Congress declared that "it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy."

In introducing the House reauthorization bill, which was co-sponsored by 14 other representatives, Udall stressed the importance of the federal commitment to improving the health care of Indian people. Most

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Photo by Kenji Kawana

RUNNING FOR LIFE: Orville Hongeva, 37, runs with Kenneth Riggs, 14, and Howard Woody, 14, on the last of a three-day, 294-mile relay in early October. The "Run For Tomorrow" united runners of all ages who carried a pouch filled with corn pollen along highways in the Arizona portion of the Navajo Nation. Originally a fund raiser for Navajo and Hopi alcoholism programs, the relay became a symbolic and spiritual effort. Photo courtesy of the Navajo Times.

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treaties with Indian tribes, he noted, "included a provision that the tribe involved recognized that it was 'under the protection of the United States of America and no other sovereign whatsoever.' These kinds of contractual commitments, founded upon the constitutional power of Congress to regulate commerce with Indian tribes, form the basic obligation, legal and moral, to provide health services to Indian tribes."

Although some consider these treaty responsibilities to be outdated, Udall continued, to Indian people "these treaties are living documents and the loss of their homelands a living memory. With respect to health services, (Indian people) feel that, through the cession of their most valuable lands, they have bought a prepaid health insurance policy from the United States."

"To the extent that we have given the word of this Nation to see to the health needs of Indian people, whether generally or specifically, we should keep our word to the best of our ability," Udall said.

Despite progress "in narrowing the health gap between Indians and the rest of the population" over the past 30 years, Udall maintained that "an intolerable gap still exists." He pointed to statistics that show Indians suffer from significantly higher death rates for sudden infant death syndrome, tuberculosis, chronic liver disease, diabetes, alcoholism, pneumonia and influenza.

Similar evidence regarding the health status of Indian people was cited by Andrews, who co-sponsored S. 2166 with 14 other senators. Stated Andrews: "Recent outbreaks of bubonic plague among Indians in the Southwest and of hepatitis B among Alaska Natives are a present day reminder that diseases long ago eradicated from incidence in the non-Indian population continue to afflict Native Americans. Infant mortality rates among Indians are still higher than for all other races in the United States, and while over 66 percent of all Americans live to at least the age of 65, 65 percent of all Indian people cannot expect to reach that age."

"To further compound this very serious state of affairs, the geographic isolation and economic deprivation of many reservation communities make it difficult to attract doctors, nurses, and other essential health care personnel needed to treat diseases and other health problems," Andrews stated.

Provisions

To address these and other health problems affecting Indian and Alaska Native populations, both the House and Senate bills extend most of the original Act's basic provisions. Existing programs that would be reauthorized under both bills include: Indian Health Manpower (Title I), which is designed to increase the number of Indians practicing in the health professions through programs for recruitment, preparatory scholarships, health professions scholarships, and externships; Health Services (Title II), which provides funding authority to eliminate backlogs in Indian health services through the provision of patient care (direct and indirect), field health care, dental care, mental health care, alcoholism treatment, and maintenance and repair activities; Health Facilities (Title III), which provides authority for construction of hospitals, health clinics, personnel quarters, and water and sanitary waste disposal facilities; and Health Services for Urban Indians (Title V), which provides authority for urban Indian health centers.

Both bills also provide for two similar amendments to the existing Act. The first, under Health Services (Title II), provides funding authority for existing programs for Community Health Representatives (CHR's) and Alaska's Community Health Aides (CHA's). The House bill authorizes "such additional sums as may be necessary," while the Senate bill authorizes the following specific amounts for the CHR and CHA programs: $37.52 million for FY 1985; $40.16 million for FY 1986; $42.98 million for FY 1987; and $45.97 million for FY 1988.

The second major amendment included in both the House and Senate bills concerns the elevation of the Indian Health Service (IHS) within the Department of Health and Human Services (DHHS) to an Assistant Secretary level. However, the bills differ slightly in this matter. In the House bill, Title VIII creates an "Office of Indian Health Affairs " for the administration of all Indian health programs and authorities. The office would operate under the direction of an Assistant Secretary for Indian Health, who would report directly to the Secretary of DHHS.

In Title VIII of the Senate bill, IHS would retain its existing name under the direction of an Assistant Secretary for Health and Human Services for Indian Health. The Senate version also provides for the creation of a Presidentially-appointed, 15 member Indian Health Advisory Board to advise the Secretary on matters related to the administration of Indian medical or health programs. The board would also have authority to assist in the development of regulations, evaluate health projects, and provide technical assistance to health agencies, institutions, and organizations to assist them in improving the health care of Indian people.

In addition to these amendments, each bill contains its own separate provisions to amend the orignal Act. Among the major items included in H.R. 4567 are the following:

- *Title II (Health Services)* — establishes an Indian Health Care Improvement Fund for the purpose of raising all tribes to Level II on the IHS Health Services Priority System (defined as not more than 40 percent deficient in total health resources); requires implementation of a plan to reduce infant mortality among Indian tribes to a rate no greater than that of the general population; and creates a $15 million Catastrophic Health Emergency Fund to meet "the extraordinary costs associated with health or medical disasters or catastrophic illnesses falling within the responsibility of (IHS);"
- *Title III (Health Facilities)* — provides for a plan authorizing the design and construction of the five top priority Indian inpatient and ambulatory care facilities, with a provision that would enable the affected tribes

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to contract for the design and construction of such facilities in cases where IHS fails to obligate funds for those activities in the fiscal year for which they are appropriated; declares that "the provisions of safe water supply and sanitary sewage and solid waste disposal systems is basically and primarily a health consideration and function" and that "it is in the best interest of the United States and it is the policy of the United States that all Indian communities and Indian homes, new and existing, be provided with safe and adequate water supply and sanitary sewage and solid waste disposal facilities as soon as possible;" requires IHS to establish a ten-year plan to provide adequate water and sanitation facilities to new and existing Indian homes and communities; authorizes $30 million in fiscal years 1985, 1986, and 1987 for water and sanitation facilities in existing Indian homes and communities, and authorizes "such sums as may be necessary" to provide water and sanitation facilities in new and renovated Indian homes;

• *Title VII (Miscellaneous)* — extends eligibility for IHS care to: persons 18 and under who are dependents of eligible Indians; non-Indian spouses, provided such care is authorized by the governing tribal body; and, upon the concurrence of the tribe, to other non-eligible persons within a facility's service area where the Department has determined that no reasonable alternative health facility exists and where fees would be charged for such services.

Major amendments provided for in the Senate reauthorization bill (S. 2166) include:

• *Title VI (Health Services for Rural Indians)* — establishes authority for programs in rural communities to make health services more accessible to rural Indian populations; authorizes $3.2 million in FY 1985, $3.4 million in FY 1986, $3.6 million in FY 1987, and $3.9 million in FY 1988 to fund such programs;

• *Title VII (Miscellaneous)* — requires IHS to implement a program to control and prevent the incidence of Hepatitis B in Alaska; requires IHS to analyze the effects of implementing nationally-established clinical care priorities by determining the total number of IHS beneficiaries that would have been denied care had such priorities been in effect during fiscal years 1980-1983; and prohibits the implementation of any nationally-

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Future of SSCIA to be Decided Next Session

WASHINGTON, D.C. — When the U.S. Senate reconvenes in late January for the second session of the 98th Congress, one of the first items on its agenda will be the determination of whether or not to retain the Senate Select Committee on Indian Affairs. The Senate's decision will affect the future of Indian health legislation, particularly the reauthorization of the Indian Health Care Improvement Act, as well as most other legislative and oversight matters related to Indian affairs.

Under a compromise reached just minutes before the Senate adjourned for the holidays November 18, the Indian Affairs Committee has been extended through July 1, 1984. The committee had been scheduled to expire January 2, 1984, with its responsibilities transferred to other Senate committees. The temporary extension will allow the full Senate to consider three options next session: make the Indian Affairs committee a permanent body of the Senate; extend the committee's authority for another temporary period (probably 2-5 years); or abolish the committee.

Created in 1977 as a select (or temporary) committee under the Senate's reorganization plan in the 95th Congress, the Indian Affairs committee was subsequently granted extensions in 1978 and again in 1980. During this time the committee has played a crucial role in the area of Indian health, both in the development of legislation and in the oversight of Indian Health Service (IHS) operations. In the past year, for example, the committee conducted extensive oversight hearings on the IHS budget, the reauthorization of the Indian Health Care Improvement Act, the IHS Director's Contract Health Services Task Force Report, and other Indian health-related issues. Overall, the committee has over the past six years considered more than 200 bills, held 172 hearings, and reported 80 bills which became public law.

As a result of the committee's activity in dealing with the many complex issues related to federal Indian law, a number of senators and Indian leaders have called for the establishment of a permanent full committee on Indian affairs. In November, the Senate Rules Committee unanimously recommended passage of a measure, Senate Resolution 127, to make the Select Committee on Indian Affairs a permanent committee of the Senate. The resolution has been endorsed by 55 senators.

Despite the apparent support for a permanent committee, Senate Resolution 127 was effectively blocked from a Senate vote prior to the November 18 recess, and it will likely face a stiff challenge when the Senate returns. Opposition to the resolution is led by Sen. Slade Gorton (R-Wash.), a member of the Select Committee on Indian Affairs, who contends that "the committee would be both too small and too narrowly focused to be an appropriate functioning full committee of the Senate. I prefer the solution which would be created by its going out of existence and its jurisdiction being transferred, I gather primarily, to the Committee on Energy and Natural Resources."

Senate leaders have indicated they will bring the matter of the Indian Affairs Committee to the Senate floor early next session. For additional information about the committee's status, contact: Theresa Carmody; National Congress of American Indians; 804 D St., N.E.; Washington, D.C. 20002. Phone: (202) 466-5680. ■

Health News Across the Nation

The following is a regular feature of the NIHB Health Reporter. In this section we present our readers with short briefs on issues and activities from around the country, including such topics as conference and workshop dates, legislative notices, news on local events, etc. We invite our readers to submit material for publication in this section. Additional information on the items mentioned here can be obtained from the NIHB Public Information Office.

ROCKVILLE, MD. — Under a directive issued by the Indian Health Service (IHS) December 5, tribal health facilities will be required to take part in the IHS patient registration system, which was initiated agency-wide January 1, in the same manner as IHS direct care facilities. The directive mandates that a clause be included in all tribal contracts to require tribes to collect the same information on IHS beneficiaries as that collected by the IHS direct care program. Special notice is given to the collection of data related to patients' Indian blood quantum: "The blood quantum field should be completed if the patient will furnish the information. It is mandatory that the question be asked of the patient, but the patient cannot be required to furnish an answer." Patient data collected beginning January 1 will become part of a centralized patient registration system, which IHS officials believe will improve identification of the IHS service population, provide more reliable data on Indian health care problems and services, assist in the allocation of IHS resources, and benefit the overall operation of the agency.

In a separate matter, an IHS policy to bill private insurance companies for services rendered at IHS facilities has been temporarily delayed pending Department review of the "UB-82" billing forms used to generate the claims. IHS service units are still required to determine a patient's eligibility for third party benefits and submit relevant patient information to the IHS Data Processing Service Center (DPSC) in Albuquerque. However, the bills will not be issued from DPSC until departmental approval is granted. The billing of private insurance companies is required in order to comply with Administration budget projections that IHS can recover some $30 million from private insurers in fiscal year 1984.

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WASHINGTON, D.C. — Assistant Secretary for Health Dr. Edward Brandt announced plans to proceed with the design of a new 25-bed hospital to replace the existing Indian Health Service (IHS) hospital at Rosebud, S.D. The Rosebud Sioux Tribe has tried for more than 10 years to replace the dilapidated facility, and congressional committees have repeatedly criticized the Department for its delays in planning the replacement facility. As noted in the report language of the Interior Appropriations Act of 1984 (P.L. 98-146), the appropriations committees are "extremely concerned with the failure of the Department to release funds for the planning of the Rosebud hospital, which were appropriated in fiscal year 1982. As a result of the Department's failure to proceed with the planning, the managers have had to delete the funds for initial construction, with great reluctance . . ." The committees directed the Department to release the Rosebud planning funds within 45 days of the law's enactment, which was November 4. The new facility is designed with the potential for expansion to 35 beds and the addition of a surgery department. Cost for construction of the Rosebud hospital is estimated at $17.5 million.

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PORTLAND, ORE. — The Northwest Indian Nursing Recruitment Program is seeking applicants for a six-week Summer Enrichment Program to be held at Portland State University June 16-July 27, 1984. The Summer Enrichment Program, administered by the Northwest Portland Area Indian Health Board, is designed to strengthen the students' basic skills in math, science, and communications. Applicants must be American Indian or Alaska Native, have completed high school (or G.E.D.) by June, 1983, and show an interest in a nursing career. Preference will be given to applicants from the 36 federally-recognized tribes in Oregon, Washington, and Idaho. Application deadline is January 15. For additional information, contact: Patty Sahmaunt; Northwest Portland Area Indian Health Board; 123 N.W. Second Ave., Suite 321; Portland, OR 97209. Phone: (503) 228-4185.

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PHILADELPHIA, MISS. — The Mississippi Choctaw has been awarded three grants from the Department of Health and Human Services (DHHS) to provide for Head Start child development services, meals for the tribe's elderly, and economic development on the reservation. The Head Start grant, funded through the Administration for Children, Youth and Families, will assist 140 low-income pre-school children and their families in dealing more effectively with their environment and later responsibilities in school and community life. The grant for the elderly, through the Administration on Aging, will provide for 15,000 meals as well as nutrition education. The Administration for Native Americans economic development grant will create approximately 270 new jobs, expand existing tribal enterprises, establish a tribal shopping center, and promote a number of Indian-owned small businesses. Presentation of the three grants, which total $738,110, was made to Tribal Chief Phillip Martin by Dorcas Hardy, Assistant Secretary for Human Development Services, during her recent visit to the Mississippi Choctaw Reservation.

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ROCKVILLE, MD. — The Indian Health Service (IHS) published a Notice of Proposed Rulemaking in the *Federal Register* November 17 seeking public comment on proposed technical amendments to its grant regulations. According to the announcement, the amendments are necessary to comply with grant administration regulations of the Department of Health

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and Human Services. The IHS regulations affected by the proposed changes pertain to grant programs administered under Section 104(b) of the Indian Self Determination and Education Assistance Act (P.L. 93-638) and Section 102 of the Indian Health Care Improvement Act (P.L. 94-437). The notice states that IHS proposes "to remove provisions in regulations governing (these) IHS grants which conflict with, duplicate, state in different terms, or expand upon provisions of Part 74 (of Title 45, Code of Federal Regulations)." Written comments on the proposed changes should be submitted by January 16 to: Richard McCloskey; Indian Health Service, Rm. 6A-14; 5600 Fishers Lane; Rockville, MD 20857. Phone: (301) 443-1116.

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ROCKVILLE, MD. — The Indian Health Service (IHS) is seeking qualified applicants for the position of secretary to the Director, Division of Program Formulation. Candidates must have experience in administrative or clerical work that demonstrates the knowledge, skills, and abilities required as a principal office assistant, including typing proficiency, organizational and filing skills, and the ability to compose non-technical correspondence. The position begins at a GS-5 or GS-6 level ($13,369/$14,901), with promotion potential to GS-8 ($18,339). Indian candidates outside the federal government are encouraged to apply. Preference will be given to qualified Indian and Alaska Native applicants. Closing date for applications is January 24, 1984. For additional information, contact: Carolyn Erbal; IHS Personnel Operations Branch, Rm. 6A-15; 5600 Fishers Lane; Rockville, MD 20857. ■

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Solomon Named to Head New CHR Program Office

ROCKVILLE, MD. — Winnebago Tribal Health Director Nicki Solomon has been selected as director of the newly-established Headquarters Community Health Representatives (CHR) Office here. The office was created within the Indian Health Service (IHS) last May to provide for overall coordination and direction of the $30 million CHR program.

Solomon brings an extensive background of tribally-based health experience to her new position. As a tribal CHR from 1969-1978 she made numerous home health visits and helped coordinate local health services for her community in Winnebago, Nebraska. Following a 14-month stint as area alcoholism for the Aberdeen IHS Office, Solomon returned to Winnebago as the tribe's health director. Under her direction the Winnebago program has emerged into a full-fledged tribal health department, with programs for CHR's, audiology, environmental health, emergency medical services, health education, social services, diabetes control, and other health services.

Nicki Solomon

Solomon has also been actively involved in local, state, and national organizations, including the Winnebago Tribal Council, the Nebraska Indian Commission, the state Citizens' Mental Health Advisory Group, the National Indian Health Board Core Group, and the National Association of CHR's. In addition, she served on a National CHR Task Force last year which recommended a number of important changes in the CHR program, including the establishment of an IHS headquarters-level director's office.

Solomon believes that her experience as a CHR and a tribal health director will be a valuable asset in managing the CHR program, since most CHR activities are reservation-based and tribally administered. "The only way to really understand the heartbeat of the reservation is to live and work there. I'm from the field, I've worked with the CHR's on a daily basis, and I understand the problems on the reservation," she said.

One area of the CHR program that Solomon wants to see strengthened is the reporting and collection of data, which is needed to demonstrate the program's effectiveness. She noted that CHR's urged the adoption of a mandatory reporting system years ago, but their request was never implemented. Lack of reliable program data is viewed as one reason for the Administration's attempts over the past two years to abolish the CHR program.

Solomon feels that three major projects undertaken as a result of the CHR task force's recommendations will significantly improve the program's accountability. The three projects are designed to develop standard guidelines for CHR contracts and scopes of work; establish CHR medical and cost effectiveness criteria; and develop a CHR program resource allocation methodology. "Being accountable is a fact of life that we all have to live up to," Solomon says. "If we don't do this, we're not being fair to the tribes that have been doing well and, most of all, we're not being fair to the people we're supposed to be serving."

Solomon adds that a stronger commitment must be made to provide training to CHR's, an activity which has practically been eliminated due to budget constraints in recent years.

The need for a central CHR director was first identified by CHR's years ago, and Solomon says she is hopeful that the new office will benefit the tribally-run CHR programs throughout the country. "The CHR's have been in the field for 16 years now. They have been the springboard for other tribal health programs and they are the most important tribal health resource we have." ■

Tribes, Indian Organ
by CHS Task Force Repo

ROCKVILLE, MD—Perhaps at no time in the history of the Indian Health Service (IHS) has a single document generated as much concern over the administration and delivery of health services to Indian people as the report prepared by the IHS Director's Task Force on Contract Health Services. Today, nearly one year after its completion, the report continues to trouble tribes, Indian organizations, and many IHS officials as efforts proceed to further examine and implement the changes proposed by the task force.

Composed of ten federal health officials and two tribal chairmen, the task force was originally established last fall to address past criticisms of the IHS contract health services program, which in FY 1984 alone will provide for nearly $158 million in emergency and specialized health services purchased (or contracted) from the private sector. However, the CHS task force's review was eventually expanded to include administrative and policy issues that affect virtually all aspects of the Indian health care program. The group's final report contains statements and recommendations on the legal status of IHS as a "residual" provider; new requirements for health services eligibility; institution of a patient registration system; creation of national medical priorities; development of a new methodology for the allocation of IHS resources; the use of "fiscal agents" in the processing of IHS contract health care claims; and modification of IHS procurement and payment procedures.

Since its release last January the task force report has been a subject of controversy throughout the Indian health program and has received considerable attention at congressional hearings, tribal meetings, and IHS-sponsored "orientation" sessions. And while Indian officials have endorsed certain recommendations as potentially beneficial to IHS program administration, they have also criticized the overall thrust of the report and the lack of tribal involvement in its preparation. Tribal leaders have frequently cited the need for additional study of the proposed changes, and several Indian organizations, including the National Indian Health Board and the National Congress of American Indians, have requested a detailed impact analysis of the report's recommendations.

One of the most recent displays of tribal concern over the CHS task force report occurred during a special public meeting at the Warm Springs Reservation in Oregon, September 9. Tribal representatives at the meeting, which was convened by the Affiliated Tribes of Northwest Indians and the Northwest Portland Area Indian Health Board (NWPAIHB), repeatedly expressed dissatisfaction with different elements of the report. For example, in testimony that reflected the consensus of the meeting's participants, Yakima Tribal Councilman Mel Sampson stated that his tribe "is distressed and deeply concerned with the general approach and long-range implications of the Task Force on Contract Health Services report. Imple-

Key Dates: IHS Task Force

October, 1982—IHS Director Dr. Everett Rhoades establishes 12-member Task Force on Contract Health Services, comprised of 10 federal officials and 2 tribal chairmen (Seneca Nation President Lionel John and Cherokee Nation Principal Chief Ross Swimmer).

January 31, 1983—Final CHS Task Force Report is completed and presented to the IHS Director.

February 9-11, 1983—A work group is assembled at the IHS Office of Research and Development (ORD) in Tucson, Arizona, to prepare an initial "draft implementation plan."

February 14-April 8, 1983—Under the direction of ORD Director Charles Erickson, staff of the IHS and the Health Resources and Services Administration (HRSA) continue to review and modify the implementation plan. The plan is completed and submitted to the IHS Director April 8.

March 14, 1983—CHS Task Force Report is distributed to tribes and Indian organizations. Tribal leaders are asked to review and comment on the report.

March 30-July 31, 1983—Seven oversight hearings on Indian health care are conducted by House and Senate committees in various regions of the country. While some tribal representatives testify in support of certain CHS recommendations, many other witnesses oppose the changes and call for a halt to all implementation efforts.

April, 1983—Seneca Nation President Lionel John issues a statement criticizing the report's assertion that the task force was unanimous in its support of all 24 recommendations.

May 4, 1983—At its mid-year conference, the National Congress of American Indians (NCAI) adopts a position opposing the implementation of the task force report and requesting a detailed impact analysis of each recommendation.

June 6, 1983—HRSA publishes a general notice in the *Federal Register* soliciting public comments on the issues of health services eligibility and eligibility verification.

June, 1983—A separate IHS task force is established to redefine IHS resource allocation methodology. The group's initial draft is reviewed by IHS executive staff November 17-18, and a final resource allocation formula is scheduled to be completed by December, 1983

June 28, 1983—The U.S. House of Representatives approves the FY 1984 Interior Appropriations Bill (H.R. 3363), which includes report language stating that IHS is expected "to work closely with the tribes in implementing recommendations from the Director's Task Force on Contract Health Services."

izations Still Troubled
rt, 'Implementation' Process

mentation of these recommendations, when examined in light of other Administration policies, will adversely affect health services provided to Indian people."

"By subtle and not so subtle changes in terminology and a compelling desire for 'preserving the right of Indians to receive first benefits under other Federal, State and private programs,'" Sampson continued, "the task force has justified the changing of the role of Indian Health Service from a primary provider of health services to a third-party resource identifier."

Sampson noted that while the Yakima Tribe supports several of the changes proposed by the CHS task force, they also "strongly oppose those recommendations and implementation plans that directly change the role of the Indian Health Service and consequently affect the Federal/Indian relationship." He requested a "stop action" on implementation activities until tribal concerns are adequately addressed, and concluded that "we definitely feel that the report in its current state imposes a threat to our people and our treaty rights."

"issues... not new and startling"

In response to concerns that the task force recommendations are being implemented without tribal consultation, officials within the Department of Health and Human Services (DHHS) have steadfastly maintained that tribal comments on the report have been and will continue to be sought. Both Dr. Robert Graham, administrator of the Health Resources and Services Administration (HRSA), and Dr. Everett Rhoades, IHS Director, have offered public assurances that tribes will be consulted before any major changes are initiated. In addition, DHHS officials point out that the task force report has been distributed to tribes, notices related to possible changes have been printed in the *Federal Register,* and "orientation" meetings have been held by the 12 IHS Area/Program offices to inform tribal leaders about the report and its "tentative implementation plan."

More recently, Rhoades announced his intent to provide tribes with a monthly status report on activities related to the task force's recommendations. In his first monthly report, issued October 7, Rhoades notes that "the issues identified by the task force were not new and startling. In fact, the tribes, IHS and Congress have been struggling with many of these issues for years." Rhoades also stated that "... all activities associated with policy recommendations need additional dialogue with tribal governments, IHS field staff, and Congress. Policy changes calling for the review of regulations require the IHS to follow the Administrative Procedures Act which mandates that the proposed changes be published in the *Federal Register* and comment sought from the public."

Part of the confusion surrounding the implementation process can be traced to differences in the potential impact of the 24 original task force recommendations, which range in scope from major policy issues

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on Contract Health Services

July 6, 1983—IHS Area/Program Directors petition the IHS Director to clarify the status and intent of the CHS Task Force Report, and urge that area meetings be conducted to inform tribal leaders of the task force report and the implementation plan.

July 12-13, 1983—IHS representatives from the 12 Area/Program Offices convene in Denver, Colorado, for an update on the CHS report and the implementation plan, and to develop plans for "orientation" meetings for tribal officials.

July 15, 1983—HRSA publishes a notice in the *Federal Register* soliciting public comments on billing private insurance companies of insured IHS beneficiaries.

July 21, 1983—At a special meeting the National Indian Health Board (NIHB) requests that all action on the report be delayed "until a responsible and acceptable methodology is developed... to allow for full tribal consultation and review" of the report's recommendations.

August 4-24, 1983—IHS Area/Program offices conduct meetings with tribal representatives to review the status of the CHS report and the implementation plan.

September 9, 1983—IHS Director convenes an all day meeting of executive staff to review issues related to health services eligibility. General consensus of the meeting is that data provided from the patient registration system, scheduled to begin January 1, 1984, is needed for the decision on whether to change existing eligibility regulations.

September 26, 1983—IHS completes a revised, updated implementation plan for the CHS task force recommendations.

October 1, 1983—As required by the Office of Management and Budget and higher levels of the Department of Health and Human Services, IHS prepares for the possible billing of private insurance companies. Final determination of this billing has been delayed pending final review and approval by the Department.

October 7, 1983—IHS Director issues the first of monthly status reports to tribes on activities associated with the implementation plan. Two of the original task force recommendations (6, 20) are eliminated. The status report contains a detailed description of action-to-date as well as charts that indicate proposed timeframes for future implementation activities.

November 17-18, 1983—IHS Area/Program Directors and key IHS headquarters staff meet to review proposed new resource allocation methodology.

November 28, 1983—IHS Director issues the second monthly status report.

TRIBAL MEETINGS around the country have addressed the recommendations made by the IHS Director's Task Force on Contract Health Services. Here, NIHB Executive Director Jake Whitecrow discusses the report and the implementation plan at the annual convention of the Inter-tribal Council of Nevada November 17-19. (Photo courtesy the ***Native Nevadan****.)*

Tribes...

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(such as eligibility) to lessor administrative matters (such as procurement procedures). To distinguish between these differences, IHS has identified the task force recommendations as either "policy" or "technical": the proposed policy changes are considered important enough to warrant additional review and comment, while the technical recommendations are to be carried out as part of IHS' ongoing administrative responsibilities.

However, the distinction between the policy and technical issues is not always clear. For example, recommendations calling for an IHS patient registration system are characterized as "primarily technical and operational, but formal permission to go ahead to build the patient registration data base requires a policy decision." As noted by one high-level IHS official: "I think you should look at both the so-called policy recommendations and the technical recommendations as potentially having the same affect on what happens in the future. I wouldn't be misled or lulled into some false sense of security simply because something is called a technical recommendation."

Another factor affecting the implementation of the task force recommendations is the apparent pressure to comply with certain Administration requirements, as evidenced by efforts to initiate billing of private insurance companies. Although such billing would appear to be a policy initiative, and a general notice related to this issue was published in the *Federal Register* July 15, IHS has nonetheless been required by the Office of Management and Budget (OMB) and the Department to proceed with preparations to institute agency-wide billing. (For an update on this policy see related story pg. 4.) Although it is not an explicit task force recommendation, the billing policy, which was necessitated by the Administration's FY 1984 budget projection that IHS could collect $30 million from third-party insurers, has nevertheless added to speculation among Indian health officials that the task force recommendations are being imposed on IHS without the approval of agency officials or the tribes.

Two Recommendations Rejected

On the other hand, the tentative status of the task force recommendations and IHS' control over their implementaton was clearly demonstrated in Rhoades' October 7 memorandum to tribal leaders in which he rejected two of the task force's original recommendations: number 6, which would have required IHS to satisfy all enrollees' needs for services in one medical priority category before authorizing any services in the next lower category; and number 20, which called for 24-hour notification (rather than the present 72-hour requirement) in cases where non-IHS providers render emergency care to IHS enrollees. The two recommendations were turned down because they would have been "impractical to administer" and could pose a hardship to Indian people, Rhoades explained.

As presented in Rhoades' status report, which includes an updated CHS Task Force Implementation Plan, the remaining 22 task force recommendations have been grouped into ten major "tasks." Each task is defined in terms of its implementation plan description; its importance and relationship to other tasks; the status and activities related to the task's implementation; and a work chart that illustrates past and proposed future activities related to the task. In addition, an IHS or HRSA staff person has been designated to coordinate each task.

Briefly, the status of the ten tasks, as described in Rhoades' October 7 report and updated in a second report issued November 28, is described below:

• *Redefining Eligibility (Task A)*—Comments received in response to the June 6 *Federal Register* notice on eligibility have been analyzed by IHS staff, but no decision has been made as to whether changes in the existing eligibility requirements will be proposed. A review of the eligibility issue by IHS executive staff in early September resulted in a general consensus that "implementation and operation of the registration system and completion of the health survey (Task C) will provide essential information to consider in deciding how and if the current (eligibility) regulation should be changed." In the event that IHS chooses to proceed with changing the regulations, the tentative schedule calls for publication of a Notice of Proposed Rulemaking (NPRM) in the *Federal Register* in July, 1984, and publication of a Final Rule in June, 1985. "If it is determined that current regulations are unsatisfactory, proposed revisions will be developed and published in an NPRM. Tribes will be able to comment formally on the proposed new eligibility criteria," the plan states. (Recent indications from IHS staff are that no definitive decisions have been reached

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on health services eligibility, although several options remain under consideration. Given the serious legal, moral, and administrative questions raised by the issue of eligibility, it is possible that IHS may seek additional analysis and dialogue with tribes on the potential impact of changes in existing eligibility requirements.)

• *Creating a Registration Data Base and Necessary ADP Support System for This and Other Tasks (Task B)*—Three major activities are identified in this task: (1) creating and maintaining an IHS patient registration data base; (2) developing and implementing a centralized contract health services payment process; and (3) dealing with issues related to automated third-party billing. Of particular importance here is the development of the registration data base, which will "contain appropriate identification, demographic, eligibility, and linkage data elements for all recipients of IHS services (and) will provide other benefits to IHS including improved statistics on the incidence and prevalence of health problems and the potential for more responsive and more comprehensive health care and patient follow-up." Planning for all three activities is in the advanced stage, and start-up of the IHS patient registry system is set for January 1, 1984.

• *Re-establishing Services Priorities (Task C)*—As explained in the implementation plan, existing IHS policy allows the different areas to establish their own medical priorities based upon available resources, with an emphasis on life and limb threatening emergencies. "Assuming the demand for services will continue to outstrip IHS capabilities and resources," states the plan, "it is imperative that we develop national priorities for clinical care with group services according to their effect on IHS enrollees' access to the health care delivery system, which emphasize health promotion, disease prevention and which best foster the IHS goal of raising the health status of the Indian people." Completion of the task will take at least three years and will cost more than $2 million. The first phase of the task, which involves the analysis of historical medical data and development of prioritized categories of standardized health services, could begin in fiscal year 1984, pending a decision on whether to proceed with full implementation of the task.

• *Redefining Resource Allocation Methodologies (Task D)*—This task will "change the present method of resource allocation and may result in shifts of resources throughout IHS," according to the implementation plan. A separate IHS task force was established in June to develop a new resource allocation methodology, which should be completed by the end of the year. The new methodology will then be tested and analyzed in a pilot project to be conducted in the first quarter of 1984. In addition, IHS will request approval from Congress to merge the budget subactivities for clinical services.

• *Changing Payment Policy (Task E)*—Under this task, IHS would initiate changes to reimburse contract health providers at Medicare rates and make retroactive adjustments for payments which apply to previous fiscal years. These changes are subject to modification under the Interior Appropriations Act for FY 1984 (P.L. 98-146), which requires IHS to "establish reasonable rates for contract care payments in place of the current system which generally pays 100 percent of billed charges." The new billing and payment procedures are expected to begin July 1, 1984.

• *Maximizing the Use of Third Party Resources (Task F)*—As noted in the task description, "it is the Department's position that the IHS program is legally residual to all third party resources." In order to increase third-party reimbursements, legislative and administrative changes will be sought to encourage third party payers to reimburse IHS for services and to permit IHS better access to Medicaid enrollment files. HRSA published a *Federal Register* notice on billing July 15, and comments have been analyzed. Efforts to prepare for billing private insurance companies are underway.

• *Improving IHS Procurement (Task G)*—Three activities, which are described as technical, are identified in this task: (1) requiring IHS area offices to review their service units' procurement plans to ensure that projections are made for appropriate contract health service categories; (2) determining the extent of area and service unit compliance with IHS procurement policy, and (3) implementing a training program in CHS procurement for field managers. All three activities are expected to be completed by June 1, 1984.

• *Employing a Fiscal Agent (Task H)*—The use of fiscal agents to process IHS contract care claims was recommended by the task force as a method for maximizing collections from other programs and for reducing errors in payment. Activities related to this task include: (1) development of a legislative proposal to use fiscal agents; (2) development of a contract scope of work for fiscal agents; (3) and preparation of a cost benefit analysis of fiscal agent options, as requested last summer by the Senate Interior Appropriations Subcommittee. Work on the first two activities has been completed, while the cost benefit analysis is in progress.

• *Changing IHS Terminology (Task I)*—Terminology changes—such as the use of "alternate resources" rather than "third party resources"—were recommended by the task force in order to describe IHS activities and resources "more precisely." The task is considered to be "not critical to the operation of management of the IHS and is not critical to the implementation of other Task Force recommendations."

• *Developing a Detailed Implementation Plan (Task J)*—According to the implementation plan, "activities initially identified in this sub-task have been completed, i.e., development of an implementation plan, orientation of tribal leaders and IHS personnel, and seeking comments from tribes and tribal groups." The initial plan has been revised, and monthly reports on the status of the implementation activities will be provided to IHS Area/Program offices, tribal leaders, and national Indian organizations. Manager of this task, and overall coordinator of the implementation plan for the task force recommendations, is Jack Casebolt, Director of the IHS Office of Program Planning.

Copies of the CHS Task Force Implementation Plan and the monthly status reports can be obtained from IHS Area/Program Officers. ■

REV. JESSE JACKSON, pictured here with NCAI President Joe de la Cruz, was the featured speaker at NCAI's 40th Annual Convention in Green Bay, Wisc., October 9-14. Among other things, Jackson urged passage of a bill to reauthorize the Indian Health Care Improvement Act and stressed the need for creating better opportunities for Indians to enter the health professions.

NCAI Calls for Stronger Federal Commitment to Indian Health

GREEN BAY, WISC. — Recommendations to preserve and strengthen the Indian health care delivery system form the basis of the health policy statement adopted at the 40th Annual Convention of the National Congress of American Indians here October 9-14.

According to NCAI health subcommittee co-chairman Jake Whitecrow, the position statement addresses "the current legal and administrative matters that will affect the health care of Indian people for years to come. It is our hope that the recommendations made here will serve as a guide to the many important health policy deliberations that will take place over the next year."

The policy statement consolidates a number of positions taken during the past year by NCAI, NIHB and numerous tribes and Indian organizations. Among the important areas covered in the committee's paper are: support for the reauthorization of the Indian Health Care Improvement Act; health services eligibility; the Indian Health Service (IHS) Director's Contract Health Services Task Force Report; the Community Health Representatives (CHR) program; and establishment of a National Indian Health Policy Group.

In addition to its work on the health policy statement, the NCAI health committee met with IHS Director Dr. Everett Rhoades to review the agency's activities in 1983. Rhoades reported that despite the severe budget constraints experienced by IHS in 1982, the agency has made a number of significant improvements, particularly in the area of management.

"We have been forced to realize that IHS can no longer operate like a family-owned storefront business. We have had to institute a corporate-type management structure, and I believe this is going to benefit our program tremendously," he said. He pointed to accomplishments in the areas of tribal affairs, employees' performance evaluations, data collection, health facilities accreditation, and environmental health as indications of improvements made within IHS.

Rhoades also told the committee that the Indian health program has undergone a dramatic turnaround in 1983, which should enable IHS to make additional headway in the months ahead. He added that in the future he hopes to see a stronger emphasis on prevention and health promotion, particularly to bring about a decline in Indian alcoholism and traumatic deaths on reservations. "The real improvement in the health care of Indian people will come from allowing them to remain healthy rather than getting medical attention to them after it's too late," he said.

"deeply concerned . . ."

Despite the report of improved prospects, the NCAI health committee expressed strong doubts about the future of the Indian health program. As stated in the NCAI policy statement: "We are deeply concerned with statements that the Indian Health Service is a 'discretionary' health program; we believe that such statements represent an effort to reduce the responsibility and scope of the Indian health care program.

"Comprehensive health care for American Indians and Alaska Natives is a legal and moral obligation of the United States government, based in law and paid for with the blood and vast lands of our ancestors. It is *not* a welfare program."

The NCAI policy statement condemns budgetary cuts which would seriously jeopardize advances made in the improvement of Indian health over the past 30 years. The statement also notes that "experience has shown that when budget trimming decisions are made the Department of Health and Human Services invariably chooses to protect IHS administrative personnel and operations at the expense of tribal health delivery programs. Additional cuts in tribal service programs cannot be endured."

To insure that future health care services to Indian people are not diminished, the NCAI policy statement makes the following recommendations:

— requesting Congress to reaffirm the federal policy of "providing the highest possible health status to Indians and to provide existing Indian health services with all resources necesary to effect that policy"

— urging Congress to reauthorize the existing provisions of the Indian Health Care Improvement Act (Indian health recruitment and scholarship programs, health services, facilities construction, and urban

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National Indian Health Conference Set for May 21-24 in Reno

RENO, NEVADA — *"The Key to Prevention — YOU!"* has been adopted as the theme for the Sixth National Indian/Alaska Native Health Conference to be held at the MGM Grand Hotel in Reno, Nevada, May 21-24, 1984.

The theme was chosen to promote the importance of preventive health and individual responsibility in achieving and maintaining good health. Special attention will be given to the role that self-image, self-esteem and motivation plays in enhancing the quality of life for the Indian individual.

Preparations for the conference, which will be sponsored by the National Indian Health Board (NIHB), are presently underway and recommendations are being sought for general assembly presentations and workshop topics. As tentatively planned, there will be three major general assemblies and approximately 24 workshops.

Recommendations are especially encouraged from Indian health projects that have successfully incorporated unique or innovative approaches to prevention and health promotion as part of their services. Conference planners are hopeful that such projects (such as suicide prevention, alcoholism control, health promotion for Indian youth, etc.) can be featured as models for conference participants that may wish to develop similar programs.

In addition to direct care topics, the conference will examine many of the crucial legislative, budgetary, and administrative matters affecting the delivery of health care services to Indian people. An especially important issue in 1984 will be the reauthorization of the Indian Health Care Improvement Act, and conference participants will be given a full report on the status of congressional action on that legislation. Opportunities will also be provided for conferees to ask questions and exchange information with key Indian Health Service (IHS) and other Department of Health and Human Services (DHHS) staff on such issues as Indian health services eligibility, IHS resource allocation, patient registration, the fiscal year 1985 budget, and other important administrative matters.

In conjunction with these activities, the conference will feature a health run, a health fair, and a pow-wow that will include an awards ceremony for individuals that have made significant contributions in the area of Indian health. Nominations for health awards, as well as recommendations for conference resolutions, should be submitted to area Indian health boards, area inter-tribal councils, or NIHB Area Representatives.

Information about registration, the conference agenda, speakers, hotel accommodations and other conference-related activities will be announced shortly. Recommendations for conference speakers and workshop topics should be sent to: National Indian Health Board, Atten: Scott Cull; 1602 S. Parker Rd., Suite 200; Denver, Colo. 80231. Phone: (303) 752-0931. ■

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health services) and include amendments to provide for emergency medical services, public health safety, Community Health Representatives and Community Health Aides, the elevation of IHS within the Department of Health and Human Services, authority for a system of Indian health consumer boards and Tribal Specific Health Planning, and authority for direct funding for tribes under the DHHS block grant program

— with respect to Indian health services eligibility, recommending that "each tribe be allowed to determine its own eligibility requirements"

— requesting a detailed impact analysis of the Director's Contract Health Services Task Force Report and a delay of any further implementation efforts on that report's recommendations

— supporting continued funding and the development of a mandatory reporting system for the Community Health Representative program

— establishing a National Indian Health Policy Group composed of representatives of all major national Indian organizations to serve as a "sounding board" for decision-making on major IHS policy issues

Copies of the NCAI Health Policy Statement can be obtained by contacting: National Congress of American Indians; Attn: Athena Brown; 804 D St., N.E.; Washington, D.C. 20002. ■

NIHB to Review IHS '638' Contracting

DENVER, COLO. — Under a contract awarded by the Health Resources and Services Administration (HRSA), the National Indian Health Board will investigate certain aspects of the Indian Health Service (IHS) contracting process established by the Indian Self-Determination and Education Assistance Act (P.L. 93-638).

Among the issues that NIHB will review during the course of the six-month study are: the types of technical assistance and consultation provided by IHS and tribal perceptions of their adequacy; the effectiveness of IHS approaches for determining tribal needs for consultation and technical assistance; the extent to which IHS has provided consultation and technical assistance that are responsive to tribal needs in content and amount; and development of a tool for measuring the degree of participation and relative degree of success in Indian Self-Determination.

NIHB Executive Director Jake Whitecrow states that the purpose of the project is to examine existing IHS P.L. 93-638 contracting procedures in order to determine the "maximum participation," successful outcomes, and technical assistance available in the IHS Indian Self-Determination process.

Whitecrow stressed that the review will be limited to the IHS process leading up to the award of a P.L. 93-638 contract and will not address issues related to contract management after a program has been contracted. To carry out the study, NIHB will conduct a number of field visits to IHS Area/Program Offices, IHS facilities, tribes, and Indian organizations. Current plans call for site visits to Oklahoma, Alaska, California, USET (the United South and Eastern Tribes), and the Bemidji (Wisconsin, Minnesota, Michigan) area.

Completion date for the project, which will cost $73,800, is scheduled for March 16, 1984. American Indian Technical Services, Inc. (AITS), of Denver, Colo., is the prime subcontractor on this evaluation. ■

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established clinical care priorities until Congress directs IHS to do so;

• *Title IX (Payment for Health Care)* — authorizes a kind of "impact aid" system to reimburse any state, county or local public assistance program financed by property taxes (to which Indian land is not subject) whenever such programs provide payment for expenses associated with the provision of health care to Indians; and exempts IHS from the requirements of competitive bidding in certain cases for contract health services in order to assure that those health services are provided at locations not more than one hundred miles from the majority of Indians to be served.

Hearings on the respective bills will be announced at a later date. For additional information about the hearings, contact: House Interior and Insular Affairs Committee; U.S. House of Representatives; Washington, D.C. 20510. Phone: (202) 226-7393; or Senate Select Committee on Indian Affairs; U.S. Senate; Washington, D.C. 20515. Phone: (202) 224-2251. ■

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NIHB encourages readers to submit articles and comments for publication. Please send correspondence and mailing requests to John P. O'Connor, National Indian Health Board; 1602 S. Parker Rd., Suite 200; Denver, Colorado 80231.

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