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The Indian Health Service and Medicaid Reform:

The Issues Surrounding 1115 Waivers and the Reauthorization of the Indian Health Care Improvement Act

Edith G.C. Wolff, JD, MPH, Kellogg Foundation Fellow, Center for American Indian and Alaska Native Health, Johns Hopkins School of Hygiene and Public Health, Baltimore, Maryland; and Kitty E. Marx, JD, Acting Team Leader, Legal Affairs Branch, Division of Regulatory and Legal Affairs, The Indian Health Service Headquarters East, Rockville, Maryland

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As managed care has swept the nation and transformed nearly every aspect of our health care system, it has begun to affect the Indian health care system in States using 1115 waivers to enroll their Medicaid populations in managed care plans. Because the Indian Health Care Improvement Act (IHCIA), Public Law (P.L.) 94-437, will soon be coming up before Congress for reauthorization, it is imperative that the issues surrounding 1115 waivers and the transition to managed care be addressed in a timely manner by Indian health care practitioners and legal advocates. The pending reauthorization of the IHCIA presents the IHS and Indian tribes an opportunity to advocate for a consistent legislative approach to tribal participation in the managed care arena. It is the intent of the authors to offer a comprehensive overview of the issues surrounding 1115 waivers in a way that may prove useful to tribes and their advocates as they address the transition to managed care.

First, to put the issues in context, there will be a brief overview of the history and development of managed care, ending with a discussion of the most recent trend of enrolling Medicaid beneficiaries in managed care plans. Then, the authors will explore the three main issues surrounding this transition to managed care for American Indian populations in 1115 waiver States: enrollment, reimbursement, and monitoring and continuity of care.

Managed Care Background

By the mid-1990s, Medicaid reform was well underway as States undertook the far-reaching effort to control the spiraling cost of their Medicaid programs. Many States have attempted to control the cost of Medicaid by enrolling their eligible populations in managed care organizations (MCOs) through the use of 1115 waivers. Under Section 1115(a) of the Social Security Act, 42 U.S.C. 1315(a), States can request

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waivers of many standard Medicaid requirements to enact a broad variety of initiatives. Approved waiver programs range from small-scale pilot projects testing new benefits or financing mechanisms to major restructuring of State Medicaid programs. Some States are even using Section 1115 waivers for welfare reform projects. In the early 1990s, MCOs were touted by many to be the more efficient use of the Medicaid (and Medicare) dollar, though the voice of dissent on that point is rising, and some MCOs are backing away from this innovation. Nevertheless, the movement to apply for 1115 waivers and enroll Medicaid eligible citizens in MCO plans spread quickly, and the percentage of Medicaid recipients in MCOs grew rapidly during the mid- to late-1990s.

There are five 1115 waiver States that also have significant American Indian populations: New York, Minnesota, Oregon, Oklahoma, and Arizona. These and other States with significant Indian populations choosing to pursue waivers are faced with the challenge of developing programs to serve their Medicaid-eligible American Indian populations adequately. The IHS, tribal and urban health programs must devise ways, within the new managed care system, to continue to provide, and even improve, culturally appropriate care to this unique population. In addition, the participation of IHS-funded programs* in managed care must ensure the continuation, or even increase, of Medicaid reimbursement levels. All parties will need to take into account the uniqueness of Indian people in cultural, legal, and political terms, and consider especially the importance of the federal trust relationship in weighing various options.

What is Managed Care? In order to understand what the implications of the 1115 waiver programs are for IHS beneficiaries in those five States (and possibly in other States to follow, if the trend grows), it is first necessary to understand what managed care is and why it has grown so rapidly.

Under the traditional health care system that was prevalent in the United States until the late 1970s and early 1980s, the financing and delivery of health services were separate. Employers paid insurance companies to take care of their employees; doctors provided what services they deemed appropriate to those employees and billed the insurance companies; and the insurance companies paid the bills. Providers had no reason to control costs and could focus solely on patient care; and insurers had no incentive to keep costs down as they could adjust to rising costs by raising premiums. The "buck stopped" with employers who finally called for controls on the spiraling costs that were passed on to them and their employees in the form of rapidly rising premiums.

By the mid-1980s, managed care was emerging as a dominant force in health care and was quickly overtaking the traditional fee-for-service system in both the private and public health care sectors. Most basically, the term "managed care" describes a system in which the financing and delivery of health services are integrated and managed by one business entity. In other words, the employer pays an MCO which then manages the delivery of health care services to employees. The MCO hires or contracts with a network of health care providers and manages costs by controlling the amount and type of care that is delivered, usually using such tools as capitation, utilization management, provider profiling, and consumer education.[1]

Managed Care and Medicaid. Established in 1965 to provide medical care for the poor, Medicaid is a Federal-State partnership program, funded partly by each and administered by the States. The introduction of Medicaid radically altered the shape of the health care system in the United States and in Indian Country by introducing the government as a significant payer. Some have blamed Medicaid for the explosive growth of health care costs, which ultimately resulted in the introduction of managed care.

Though the States, overall, have run the programs efficiently, Medicaid in 1995 served only about 60% of the poor.[2] In addition, Medicaid providers were paid poorly and services were limited.[3] The States had little control over how the program was administered locally, as it was strictly governed by Federal law. Policy makers in many States wanted to explore the option of using managed care to provide health services to their poor populations. Lawmakers used two sections of the Social Security Act that appeared to allow them to try this approach. The first was Section 1915(b), which allowed the States to restrict enrollee choice as to providers. The second was Section 1115, which allowed the States to develop innovative research and development projects for the delivery of health services to the poor.

In examining the role of Medicaid, it is important to understand the significant difference between the importance of Indians to Medicaid and the importance of Medicaid to Indians. Indians are not a significant population in the entire Medicaid scheme; they comprise only 0.9% of Medicaid recipients and account for only 0.6% of Medicaid provider payments.[4] Conversely, Medicaid is a significant source of health financing for Indian populations, with 39% of Indian people enrolled.[5] This difference likely has an impact on policy decisions made by the States and tribes when considering the feasibility of tailoring programs specially for tribes.

1115 Waivers. As of this writing, the Department of Health and Human Services (DHHS) has approved sixteen Section 1115 waiver proposals as research and development projects for the delivery of health care to the poor.[6] In effect, States implementing 1115 waiver programs have been enrolling their poor populations in managed care programs with an eye toward using their funds more efficiently and cutting costs. It is projected that, with the more efficient use of funds, Medicaid will be able to cover millions of previously uninsured people once the waiver programs are approved.[7] There has been explosive growth in MCO enrollment in the Medicaid population in the last several years, although this

* The term "IHS-funded programs" is used throughout this paper to describe programs operated by IHS, tribes or tribal organizations pursuant to the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, and operated by Urban Indian organizations pursuant to Title V of the IHCIA, P.L. 94-437, as amended.

trend appears to be waning.[8] In 1993, approximately 14.39% of Medicaid enrollees were in managed care; by 1997, that figure had grown to 47.62%, according to the Health Care Financing Administration (HCFA) data. Currently, the HCFA is the largest purchaser of managed care in the country, financing the coverage of approximately 18 million Americans.[9]

One of the overall difficulties with the 1115 waiver programs is the "chaos effect"[10] that results from requiring Medicaid enrollees to choose a health plan or be enrolled in one by default. Often, these enrollees discover that the provider they prefer is not in their health plan and so they enroll in another plan or use the provider out of plan. This enrollment/disenrollment process takes time and effort and slows the transition to a system that is designed to cut costs. It also can be very frustrating and confusing for the Medicaid patient unless the process is explained well.

This transition, already complicated enough, becomes even more so in an Indian health care setting. In Indian Country, tribal members who might be enrolled in a managed care plan may prefer to go to their IHS-funded program to receive culturally appropriate care. And for IHS-funded programs, Indians who are enrolled in Medicaid cannot be denied IHS direct care services. However, if the IHS-funded program provides services to an Indian Medicaid patient enrolled in a health plan that does not include the IHS in its network provider system, the IHS-funded program may not always get reimbursed by the health plan.

A significant difficulty for 1115 waiver programs is that costs may not always be as low as anticipated. The MCOs could change their cost structures and premiums over time, the market could change, or the structure of managed care could change as it has so rapidly and so often in the recent past. Ultimately, the State will have to deal with many different contracts and enrollees in different plans. In the case of Indians, matters are even more complex because of the involvement of the IHS and the legal obligation to provide care. The 1115 waiver trend could turn out to be an administrative nightmare that costs, rather than saves, money. This remains to be seen.

The IHS and 1115 Medicaid Waivers

Officials in the five States with 1115 waiver programs and significant American Indian populations (Oklahoma, Arizona, New York, Oregon and Minnesota; Wisconsin pending) have been negotiating with tribal officials to determine how services provided to Indian Medicaid eligibles by IHS funded programs, including direct care and contract health services (CHS), will be reimbursed by Medicaid. In determining how IHS-funded programs and Indian Medicaid beneficiaries will participate under managed care, it is important to remember that, while Indian health care is a significant issue for many States, Indians usually make up a very small percentage of both the US and Medicaid populations. Overall, Indians account for about 0.8% of the US population, and, as stated above, only about 0.9% of Medicaid recipients.[11]

Tribes have been concerned with many aspects of Medicaid's transition to managed care. There are multiple issues that arise as a result of this change, but the main issues revolve around whether Medicaid managed care 1) ensures the delivery of culturally appropriate services to Indian people, 2) maintains or improves Indian health care funding, and 3) respects and preserves tribal sovereignty.[12] Tribes are concerned that their members' ability to receive services from their usual IHS providers in the appropriate way will be curtailed as States attempt to reform State Medicaid programs.

Development and Review Process. The HCFA published a notice in the Federal Register (FR) on September 27, 1994 (59 FR 49249) informing the public of the principles the DHHS considers in deciding whether to approve a demonstration project under Section 1115. The FR notice also informs the public of the procedures States should employ to involve the public in the development of the proposed demonstration projects and of the procedures the DHHS follows in reviewing the demonstration proposals. The process for development and approval of a Section 1115 demonstration proposal begins with the State giving the public notice (in newspapers or via the Department of Health which notifies various organizations and councils) that it is developing a waiver plan, inviting the public's input. Then, after the proposed plan is completed with public input, the State submits the proposal to the HCFA for approval. The proposal is then reviewed by the HCFA and other agencies within the DHHS, including IHS. After a series of questions to and responses from the State, the HCFA continues to work with the State to resolve outstanding issues and finalize the proposal for approval. If the waiver is approved, the HCFA issues an award letter, and the State and the HCFA negotiate the terms and conditions for implementation of the waiver.

Step 1: Development of the Proposal: State-Tribal Consultation. On 3 July 1997, the HCFA issued a State Medicaid Director letter requiring States to consult with tribes in the development and implementation of 1115 waivers. The interests of States and tribes may be at odds on many points, but, in devising plans, States are now required to engage in "meaningful consultation" with tribes to resolve these issues and ensure the provision of appropriate health services to Indian Medicaid enrollees. It is important for tribes to advocate their own interests and be fully involved in the development of the waiver at the State level from the earliest stages in order to ensure that the tribal health programs are an integral part of the State waiver plan and, thus, that no significant or complicating problems arise after implementation. In effect, meaningful consultation with their significant Indian populations will be the most efficient means for both States and tribes to use in devising a waiver plan.

Step 2: Review and Approval of Proposal: HCFA Guidelines. Implementation plans have been successfully developed and implemented in New York and Oklahoma.[13] The 1115 waiver program in New York was approved by the HCFA in 1997. As a condition of approval, the HCFA required the

State to consult with tribes in the development of an implementation plan. Those conditions were that the State of New York must[14]:

- ensure that Indian health programs be reimbursed for care Indian clinics provide to Indian Medicaid beneficiaries;
- ensure that CHS providers be reimbursed for private or emergency care provided to Indian Medicaid beneficiaries;
- inform Medicaid eligible Indians of their managed care enrollment options; and
- monitor the impact of the enrollment of IHS population members in Medicaid managed care programs and make that information available to the Indian health programs.

The authors would recommend that the HCFA continue to include similar terms and conditions when approving 1115 waivers for other States with significant Indian populations. The 1115 waiver programs in Oregon and Arizona were approved and implemented prior to the development of the terms and conditions developed by the HCFA. However, the HCFA did include a term and condition when approving the State of Minnesota's 1115 waiver program (Phase I) that required the State to develop an implementation plan with its tribes. The State of Minnesota has recently submitted proposals for Phases II and III of its 1115 waiver program that include a description of how IHS-funded programs and IHS beneficiaries would participate. The State's proposal was developed in consultation with tribes but has not, to date, been approved by the HCFA.

In the development of an implementation plan, the following issues serve as guidelines for tribes as they advocate for the continuity and improvement of their health care programs in the face of the States' transition to managed care.

1. Enrollment
   - is enrollment mandatory or voluntary?
   - if enrollment is voluntary, are Medicaid eligible IHS beneficiaries presumptively included or excluded?
   - how are Indians informed of their enrollment options?
2. Reimbursement
   - are IHS/tribal facilities reimbursed by the State on a fee-for-service basis?
   - are IHS/tribal facilities reimbursed by Medicaid MCOs?
   - how are IHS/tribal facilities reimbursed if they are operating as Medicaid MCOs?
3. Monitoring/Continuity
   - how is the 1115 waiver program's impact on Indian health monitored?
   - is the information gathered during monitoring shared with the tribes?
   - is the information gathered shared with quality assurance groups?

The following is an in-depth discussion of these three main issues that shape the managed care debate for tribes.

Enrollment Issues. States and tribes must decide whether IHS beneficiaries will be required to enroll in managed care or whether enrollment will be voluntary. If voluntary, the next issue is whether the IHS beneficiaries will be presumptively included or excluded from the waiver plan implemented by the State. If a State Medicaid managed care program allows a voluntary enrollment option for American Indians, they can be *presumptively excluded* from or *presumptively included* in the managed care plan. The term *presumptively included* means that a Medicaid beneficiary must affirmatively disenroll from a managed care plan, or in other words, choose to "opt out." The term *presumptively excluded* means that a Medicaid beneficiary must affirmatively enroll with a managed care plan, or in other words, choose to "opt in." Because the enrollment process, so crucial in determining what kind of care American Indians will receive, can be so confusing, a critical part of any State/tribal implementation plan will be a clear explanation of how American Indians will be informed of their enrollment options and whether the information they get will be adequate. Currently, only under Oklahoma's 1115 program are Indians mandated to enroll in managed care plans. Medicaid eligible IHS beneficiaries can continue to receive Medicaid covered services at IHS funded programs or through their managed care plan. The other four States (Arizona, Oregon, New York and Minnesota) have voluntary enrollment. Minnesota has voluntary enrollment only for on-reservation Indians, though it is proposing, in Phase II, mandatory enrollment in managed care regardless of residence on reservation. Each State varies as to whether there is an "opt in" or "opt out" method. For instance, Oregon chose an opt out method of enrollment, presumptively including rather than excluding American Indians.[15]

Reimbursement Issues. The introduction of Medicaid managed care has had a significant impact on how IHS is reimbursed for services rendered to its beneficiaries. Currently the IHS-funded programs are operating as fee-for-service providers under State Medicaid Managed Care programs. A future concern is whether States will continue to allow a fee-for-service component under their Medicaid Managed Care systems. If States eliminate a fee-for-service component, it might be difficult for the IHS-funded programs to convert to managed care systems. They will still be required to provide services to Medicaid eligible IHS beneficiaries but might not receive Medicaid reimbursement. Although the transformation of IHS-funded programs to Medicaid managed care would undoubtedly take time and could cost money up front, it could result, in the long run and with adequate support, in better health care for this special population, both rural and urban. The following is a discussion of current reimbursement issues affecting IHS-funded programs in 1115 waiver States with significant Indian populations.

Direct Care. In all five states, IHS-funded programs are reimbursed by the State for services rendered in IHS-funded programs. The extent to which the IHS-funded programs are reimbursed varies from state to state depending upon whether the IHS beneficiary is enrolled in a managed care plan. In

Oklahoma, where all IHS beneficiaries are required to enroll in a managed care plan, the State reimburses the IHS-funded programs on a fee-for-service basis at the IHS payment rate.[16] The State adjusts the capitation rate paid to the HMOs based on utilization of services received at IHS funded programs. In the other States, for the IHS beneficiaries who are not enrolled in a managed care plan and receive services at IHS-funded programs, the State reimburses those programs on a fee-for-service basis at the IHS payment rate for Medicaid-covered services provided. The IHS-funded programs are not always reimbursed for services provided in their direct care facilities if the IHS beneficiary is enrolled in a managed care plan. In Arizona, as of this date, this issue is still unresolved, and the State and IHS are currently discussing the various and complex aspects of reimbursement. Under the waiver programs in Oklahoma, Oregon, and New York, the State reimburses the IHS-funded programs for direct care services provided in their facilities, even when the patient is enrolled in a managed care plan.

Contract Health Services (CHS). An additional issue entails how CHS services rendered to Medicaid enrollees are reimbursed. In Oklahoma, CHS services are coordinated by the IHS-funded programs through the MCO where the IHS beneficiary is enrolled. State and tribal officials in Oklahoma have worked together to resolve referral and approval issues. In Minnesota, Oregon, and Arizona, CHS providers directly bill the State; in New York, CHS providers bill either the State or the MCO if they are part of that MCO's network.

Cost Sharing provisions. Some 1115 waiver States have imposed premiums and co-payment requirements as a condition of eligibility to participate in their waiver programs. These cost-sharing provisions require Medicaid enrollees with incomes over a certain percentage of poverty level to pay a premium based on household income and size. In addition, Medicaid enrollees must contribute a co-payment of $1 to $5 as a certain share of the cost of the services. Tribes, however, have objected to these provisions because of the federal obligation, arising out of treaty and trust obligations, to provide free health care to their members. The HCFA, in approving Oregon's 1115 waiver, allowed the State to exempt Native Americans from premium and co-payment requirements. The current DHHS policy is that the States may waive cost-sharing provisions, however, the States and tribes should hold consultation meetings to discuss exemption of tribal members from cost-sharing provisions under a State's 1115 waiver proposal.

Monitoring and Continuity Issues. In order to measure the success of the program and the transition to managed care overall, the State and tribes should devise a monitoring system. This is a complex task under any circumstances, but could prove even more so in the context of a managed care program. Currently, the IHS is unaware of any monitoring and quality of care assessments being conducted by the HCFA, States, or IHS specifically addressing the IHS-funded programs in the context of Medicaid Managed Care. The Section 1115 waiver programs require the States to conduct monitoring and evaluation but the programs of some States with significant American Indian populations have been implemented only recently. This is one area where more follow-up will be needed, especially in those States, such as Arizona and Oregon, where a 1115 waiver has been in existence for some time. Quality assurance groups such as JCAHO,[17] NCQA, or FACCT could be utilized to review the facilities' measures and make recommendations for improvement in the programs. This is already being done to a certain extent, but may need to be revisited or expanded to address the impact of Medicaid Managed Care on the quality of health care services to IHS beneficiaries.

Summary

The transition to Medicaid Managed Care has been, some would say, precipitous. As States rush to enroll their Medicaid populations in managed care plans, those with significant Indian populations find they must deal with the complicated issues of how to reconcile the requirements of these two health systems: the Medicaid system and the IHS system. Tribes also must make sure that their populations continue to receive culturally appropriate and adequate care. Additionally, they must ensure that their care givers are reimbursed.

Establishing an important policy precedent, the HCFA has required the States to consult meaningfully with tribes in the development of an 1115 waiver proposal. As a result, different systems with different parameters have been established in the five States. For example, regarding voluntariness of enrollment, in Oklahoma only, IHS beneficiaries are required to enroll in an MCO, but can continue to receive services at IHS funded facilities. However, in four of the five 1115 waiver States with significant Indian populations, (Arizona, Oregon, Minnesota, and New York), the IHS beneficiaries have voluntary enrollment and thus have the option but are not required to enroll in a managed care plan. Essentially, the HCFA has approved a carve-out for IHS beneficiaries from the mandatory enrollment requirements of the States' 1115 waiver programs (the HCFA has also approved carve-outs for other special populations such as mental health patients and HIV/AIDS patients). The carve-out allows the IHS-funded programs to continue to bill the State for Medicaid covered services provided on a fee-for-service basis. The IHS beneficiaries have the option to receive services from a managed care plan and can also continue to receive services at IHS funded facilities.

The 1115 Medicaid waiver programs that have been approved to date serve as important precedents and have been the models used by other States submitting waiver proposals. In requiring that States consult meaningfully with the tribes, the HCFA is seeking to ensure that IHS-funded programs are reimbursed for care delivered; Indian Medicaid eligibles understand their options regarding enrollment in a managed care plan; and the impact of the transition to managed care is properly monitored. These requirements must be kept in sight as the States and tribes grapple with such issues as voluntariness of enrollment, reimbursement, and monitoring and continuity of care.

Conclusion

The IHS and tribes should continue to work with States on a case-by-case basis to ensure meaningful tribal consultation in the development and implementation of future 1115 waiver proposals, as well as other state health care reform efforts such as 1915(b) waivers, Children's Health Insurance Programs, and welfare reform programs. Through "meaningful consultation" with the tribes, the States and tribes can work proactively to develop managed care systems that work within the unique context of tribal cultural, political, and financial situations.

Some analysts have suggested that the IHS and tribes work with States and the HCFA to develop IHS managed care demonstration projects by either subcontracting with MCOs or establishing tribal MCOs. With adequate funding and technical support from the State, the federal government, and the HCFA, IHS-funded programs could become the best of MCOs. They would continue to provide service to their distinct populations and maintain their provision of culturally appropriate health care. The States of Arizona and Minnesota have proposed, as part of their 1115 waiver programs, to work with the IHS and/or tribes to establish tribal managed care at-risk provider arrangements. The IHS and tribes could use these demonstration projects as an opportunity to refine cost reporting data, as well as billing and information systems, so that IHS-funded programs could better compete in a managed care environment. The tribes and IHS could also advocate that Congress provide protection to the IHS-funded programs during the transition to Medicaid managed care.

The Reauthorization of the IHCIA provides an opportunity for the development of legislative initiatives necessary to remove barriers that currently prohibit IHS and tribal participation in managed care. The IHS has begun a comprehensive consultative process in Indian Country to reach consensus on key managed care policy issues in preparation for reauthorization. Managed care policy issues have been extensively studied both by the IHS and other organizations, and serve as useful resources to assist tribes in identifying advantageous legislative approaches.[18] The reauthorization process provides an opportunity for those working in the Indian health field to advocate legislative changes to ensure choice for Indian Medicaid/ Medicare beneficiaries; continuity of culturally appropriate care for this population; and continued reimbursements to I/T/Us for Medicaid and Medicare services provided. □

References

1. Weiner JP, de Lissovoy G. Razing a Tower of Babel: A taxonomy for managed care and health insurance plans. *Journal of Health Politics, Policy and Law,*18(1), Spring 1993. This article contains a useful glossary of managed care terms
2. Riley T. State health reform and the role of 1115 waivers. *Health Care Financing Review.* 1995;16(3):p.142
3. Id. 142
4. Wellever A, Hill G, Casey M. Commentary: Medicaid reform issues affecting the Indian health care system. *American Journal of Public Health.*1998;88(2):p.195
5. Schneider, A, Martinez J. Native Americans and Medicaid: Coverage and Financing Issues. Policy Brief, The Kaiser Commission on the Future of Medicaid, The Center on Budget and Policy Priorities, December 1997
6. Alabama, Arizona, Arkansas, California, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, New York, New Jersey, Ohio, Oklahoma, Oregon, Tennessee, and Vermont
7. HCFA Fact Sheet, Managed Care in Medicare and Medicaid, 28 January 1997, p. 3. This states that when all 16 demonstration waiver projects currently approved have been implemented, 2.2 million previously uninsured will have health coverage
8. Currently, thirty-eight States have 1915(b) waiver plans in place and contract with MCOs to deliver health care to their eligible populations. Instead of providing Medicaid benefits directly to the enrollees, the States contract with MCOs, which then deliver the health care to the enrollees
9. Overview of Medicaid Managed Care. A bar graph prepared by HCFA/CMSO/FCHPG/DIHS, p. 2; and HCFA Fact Sheet, supra, p.1
10. Holahan, J, Coughlin T, Ku L, Lipson D, Rajan S. Insuring the poor through Section 1115 Medicaid. *Health Affairs.*1995;14(1):p.211
11. Wellever, et al, supra, at p.193
12. Id. at p.195
13. A working group comprised of representatives from various New York tribes, HCFA, IHS, and New York State outlined some of the issues that arise in developing a waiver program plan: identification of Native Americans; payment of Indian health programs for services rendered to Indian Medicaid enrollees; referrals outside the Indian health system and payment for them; delivery and reimbursement for ER services; voluntariness of enrollment in the MMC plan; and monitoring of the program to assess its impact on Native American health. Many of the same issues were raised in similar meetings in Oklahoma, although with different results since Oklahoma has mandatory enrollment. Final Draft of Implementation Plan for Services to American Indians, Oklahoma Indian Health Reform Committee, 3 November 1995. Both of these implementation plans are available upon request
14. The HCFA Terms and Conditions governing the provision of MMC services to Native Americans within the context of Section 1115 Waivers, cited in Native American Medicaid Managed Care Policies and Procedures for New York State, revised 16 September 1997, p.2
15. Wellever et al, supra., p.194
16. The IHS payment rate is reimbursement for Medicaid covered services according to an all-inclusive (sometimes called per diem) rate. The IHS and HCFA, pursuant to an agreement with the Office of Management and Budget (OMB), developed an all-inclusive rate to be used for billing Medicaid. Thus, this rate is sometimes referred to as the "OMB rate" and is updated and published in the FR on an annual basis
17. Since 1994, all Indian health facilities (IHS and tribally operated hospitals and IHS operated health centers) have been accredited by JCAHO. Wellever, supra., at 195, citing: Trends in Indian Health - 1994. Rockville, MD: IHS, Public Health Service, 1995
18. Dixon M. Indian Health in Nine State Medicaid Managed Care Programs (unpublished), National Indian Health Board, Denver, Colorado, 30 September 1998; Schneider A, Martinez J. Native Americans and Medicaid: Coverage and Financing Issues. Policy Brief. The Kaiser Commission on the Future of Medicaid, The Center on Budget and Policy Priorities, December 1997; IHS Round Table Report: Integrating Indian Health Programs into Medicaid Managed Care Systems, DHHS, Public Health Service, IHS, Rockville, MD, March 13-14, 1996.

U.S. Geological Survey:
Environmental Impacts on the Health of Native Americans

Sharon S. Crowley and Robert B. Finkelman, both of the U.S. Geological Survey, Reston, VA; and Mary Beth Skupien, Indian Health Service, Rockville, MD

The U.S. Geological Survey (USGS) is exploring opportunities for evaluating the impacts of geology on American Indian and Alaska Native (AI/AN) health. The goal of this effort is to create a comprehensive research program to identify geologic processes and materials that cause or exacerbate ecosystem and AI/AN health problems. The USGS is interested in developing cooperative projects with biomedical and public health agencies, Indian tribes, and urban programs to help focus this activity on relevant issues.

Geologic processes and materials can affect human health in various ways. Mining, fossil fuel combustion, volcanic emissions, earthquakes, industrial and agricultural activities, and other natural and human-induced processes can result in degraded water and air quality. Wind-blown mineral dust, transmission of disease from animals, and water leaching of potentially toxic substances from rocks are all known to cause human health problems. The USGS, with its expertise in geology, hydrology, biology, mapping, and remote sensing, is uniquely qualified to help identify these environmental health problems.

How can the USGS apply its expertise to assist Indian tribes with hazardous chemical and environmental situations that may affect their health?

Indian tribes and organizations may contact the USGS at the number below to discuss environmental health issues that they feel might be appropriately addressed by USGS scientists. For instance, USGS research has already been applied to numerous health-related issues. Regional geochemical studies have provided many insights into the distribution of potentially toxic elements such as arsenic, mercury, cadmium, and selenium. For example, the USGS mapped the geochemical composition of soils in the San Joaquin Valley of California and demonstrated that selenium-bearing black shales in the foothills to the west of the valley were the source of selenium in the valley's agricultural soils. The selenium was the ultimate cause of highly publicized health problems in waterfowl. Similar regional geochemical studies, when linked to studies examining the regional occurrences of health problems such as cancer and heart disease, may help to elucidate the relationships between health problems and naturally occurring distributions of potentially toxic substances in the environment.

The USGS is currently collaborating with the Armed Forces Institute of Pathology and with Chinese scientists to better understand the arsenic and fluorine poisoning that affect as many as 10 million people in Guizhou Province, China. The USGS is also working with the National Cancer Institute to identify the components of coal that contribute to the formation of polycyclic aromatic compounds (PACs). It is believed that PACs produced during coal combustion are related to the high incidence of esophageal and lung cancers in China and elsewhere.

The USGS is also involved in studying potential health issues related to biological and water resources. Examples include studies of 1) acid mine drainage to evaluate impacts on aquatic ecosystems, and 2) the fate of the gasoline additive methyl tert-butyl ether (MTBE) and crude oil in the environment. In about half the States, the USGS is participating in assessments of the quality of water in source areas for public supply. Geographic information systems, remote sensing satellites, and other state-of-the-art technologies are also providing scientists with the tools and the data to identify the geographic relationships between environmental habitats of disease agents and the occurrence of disease.

What can the USGS do to address specific environmental health problems in tribal lands?

The USGS encourages tribal leaders and health departments to contact us to discuss environmental health issues that they feel might be appropriately addressed by USGS scientists and biomedical/public health collaborators. The causes of certain human health problems may be identified through comprehensive mapping of soil and surface rock chemistry, characterization of wind-blown dust particles, monitoring of water quality, or monitoring the health of plant and animal sentinels.

What are our goals?

Our goals include 1) developing long-term collaborative relationships with the biomedical research and public health communities, 2) acquiring and providing information on the composition of geologic materials and other natural elements that may impact ecosystem and human health, and 3) assisting the biomedical community and the American public as a valuable resource for environmental toxicological information.

What can you do?

We invite you to identify health issues and to collaborate with us in resolving them. We welcome your interest. Please contact:

Sharon S. Crowley
American Indian and Alaska Native Liaison
Geologic Division; U.S. Geological Survey
National Center, MS 956, Reston, VA 20192
phone: (703) 648-6453 fax: (703) 648-6419
email: *scrowley@usgs.gov* □

A Novel Risk Management Strategy to Reduce Medical Liability and Enhance Learning

Peter D. Magnus, MD, MH, FAAP, Clinical Director, Lower Brule PHS Indian Health Center, Lower Brule, South Dakota

Improving Organization Performance (IOP; also known as Continuous Quality Improvement, CQI; or Quality Assurance, QA) is an important part of maintaining a quality health care delivery system in Indian Health Service (IHS) hospitals and clinics. IOP strategies can include weekly or monthly continuing professional educational meetings. Risk Management (RM) activities are, of course, another integral part of IOP efforts. The Lower Brule PHS Indian Health Center has developed a format for quarterly risk management/continuing education meetings called "RM Scenarios," during which we present and discuss clinical situations that are fabricated, are based on real events, or which have been copied or altered from cases in medical journals; all the scenarios, however, are pertinent to our ambulatory care setting.

Background

As first described in the January 1987 issue of the *IHS Primary Care Provider*,[1] the former IHS Office of Health Programs, in cooperation with the IHS Clinical Support Center in Phoenix, Arizona, have made risk management learning materials available through periodic publication of Risk Management Modules. These group study exercises reviewed scenarios developed from actual IHS tort claim cases, and included discussion about the particular risk management issues presented. Eventually, eleven such modules (with both ambulatory care and inpatient cases) were offered by the CSC, the last of which was issued August 19, 1994.[2]

The CSC suggested that all interested IHS service units organize teaching sessions based on the materials presented in the modules, for which CSC awarded attendees continuing education credit.

For the past five years the Lower Brule facility has emulated this process with quarterly "RM scenario" educational sessions, using real or "imagined" situations, with a goal of improving communication, developing risk reduction strategies, and improving patient care, all while reducing the chance of a litiginous occurrence. To make the sessions more worthwhile, in terms of community health and wellness activities on our small reservation, tribal program employees (EMTs, CHRs, mental health workers, alcoholism program counselors, and tribal health employees) have been invited to participate in these quarterly sessions. The CSC has been kind enough to grant CE credit to eligible participants.

Examples of Scenarios

Our sessions have included many different topics over the years, a few of which are as follows:

1. Wandering dogs and dog bite injuries
2. Trash, solid, and liquid waste management, zoonoses, and gastrointestinal illnesses conveyed by fecal-oral transmission[3]
3. Polite and professional conversations between IHS personnel alone, and in the presence of patients
4. People slipping on icy clinic walkways
5. Patient and staff confidentiality issues
6. Rights of minors with regard to birth control and pregnancy
7. Crisis management for adults or adolescents with self-destructive ideation or behavior
8. Chart documentation and provider charting issues
9. Availability and accessibility of the IHS clinic and the local hospitals "afterhours," including on weekends and holidays
10. Contract Health issues, including priorities by which patients' care needs are funded or deferred
11. Food safety and child care provider issues on the reservation
12. Advice against IHS personnel who are driving government cars picking up familiar persons who they see hitchhiking

To illustrate our methods the following are some brief illustrations of contrived scenarios:

1. An irate clinic doctor yells at the pharmacist to "hurry up and fill the prescription, the patient's been waiting too long." His voice carries to the waiting patients (illustrating a problem with lack of professionalism).
2. A 3-week-old baby, whose mother had been drinking alcohol prenatally and who had required interventions by social services for previous children, is found dead at home, lying in a prone position. No visits to the clinic had occurred. (illustrating the importance of early, well-child clinic visits, home nursing visits, and the "back-to-sleep" recommendations).
3. A morbidly obese 70 year old diabetic patient sues the IHS because exercise equipment that had once been

used by patients is no longer available.

4. A temporary duty physician accidentally sticks himself with a needle while giving influenza vaccine to a diabetic patient. (How do you design a plan for 3 and 6 month "needle stick" follow-up, when the doctor may be gone).
5. A 17-year-old mother of a 10-month-old wants to look at her medical records and those of her child. What are her rights? What problems are there and how can they be solved?
6. An irate elder wants to look into his diabetes management and wants to review his health care with a provider. What problems are there and how can they be handled?
7. What obligations do IHS personnel have to influence the driver status of persons at increased risk of having an automobile accident on the reservation (e.g., a non compliant patient with seizures, or one with alcoholism)?
8. The dental clinic is in a separate building 100 meters away from the IHS clinic. A temporary duty dentist has a dental patient who experiences an allergic reaction to xylocaine during a procedure on a Friday afternoon. He aborts the procedure and documents the problem in the chart on the PCC as a new problem. On Sunday the same patient suffers an anaphylactic reaction to xylocaine during suturing of a laceration in the emergency room. Consider the same situation when the computer or the printer are "down" for an extended period.
9. A 2-year-old male patient has had three clinic visits over a two year span, two for otitis media and one for an abrasion. His immunizations are up to date. During a fourth visit for an intercurrent illness, the mother describes the inattention and lack of focus of the child. The physician performs a thorough eye and vision exam, and refers the patient in a timely fashion to an ophthalmologist. The eye doctor finds blindness in one eye, and feels that the tumor he found was probably congenital. The mother later files a tort claim and states that the child's vision problem should have been detected at an earlier age. The Indian Health Service responds that the mother was at fault for not bringing the child sooner for pediatric, well-child, or regular "appointment" clinics, despite the urging of the doctor and the Healthy Start Project personnel.
10. A blizzard occurs, canceling IHS clinics for three consecutive days. A patient with seizures taking two anticonvulsants experiences grand mal seizures after running out of medication.
11. A former IHS employee, who lives in the community, discloses confidential information about another person in the community during a phone call to a relative elsewhere in South Dakota. The former employee worked for the IHS three years prior and had access to medical records as part of his/her job.
12. The reservation roads are icy, and an uninsured 15-year - old crashes into an IHS vehicle being driven appropriately, by a seat-belted IHS employee, during normal IHS work hours.
13. Because of a temporary loss of water, the clinic is closed. A patient needing an x-ray and medical attention is sent to a doctor in a nearby town. This local physician makes an error in medical judgement, which leads to a lawsuit against both the doctor and the IHS clinic. Is the IHS clinic responsible for the actions of its back-up physicians and facilities that exercise usual standards of care?
14. A local, hospital-based physician calls a Lower Brule IHS physician for advice on a patient hospitalized with a new illness. The Lower Brule physician does offer some advice. The patient eventually expires. The Lower Brule physician is included in a lawsuit against the hospitalizing physician. The Lower Brule physician claims that only advice, and no direct care was offered.
15. A physician and a nurse would like to help at a first aid booth at a festival being sponsored by a local charity, off the reservation. Is there any legal risk, or would the Good Samaritan Law in the state protect them?
16. It is Friday evening and a 16-year-old male teenager dislodges a board from the IHS garage, and squeezes into the building. He replaces the board and then hangs himself. The mother sues the Indian Health Service, as his body wasn't found until Monday and she claimed that surveillance of the building was lacking. The same scenario occurs, but a passing policeman notices the "break in," and interrupts the intended suicide. What should happen with the young man? Is there a suicide prevention plan?
17. A patient is dyspneic and tachypneic. Oxygen is brought to the patient in an exam room, but the previously full tank is found to be empty; apparently some waiting patients opened the valve, releasing most of the oxygen.
18. A 14-year-old female is having her eyes checked for vision as part of her school (sports) physical examination. She can only read the top three lines. Her peers waiting in the lobby for their exams note her poor vision and "kid" her. The teasing continues at school, so much so that her mother sues the Indian Health Service for breach of "auditory confidentiality," as the lawyer put it.

Frank discussions about many of our contrived or fabricated scenarios, along with our true ones (none of which are presented in this article) have led to improvements in many areas, such as environmental health, dog control, patient and staff communication, interagency networking, policies on patients' and employees' rights, and enjoyment of work, to name a few. The IHS manual entitled "Risk Management and Medical Liability" is a helpful, frequently consulted guide for

addressing many of our RM problems.[4] Of course, policies do not cover all conceivable day-to-day activities and challenges. It has therefore been valuable for us to consider what we would do in any number of real life situations, before they occur.

Our sessions have recently expanded to include quarterly discussions of injury data led by our sanitarian/safety control officer and the EMTs present. We may consider incorporating discussion of nosocomial infections, both in-house and in referral hospitals and clinics, in the future.

If any reader would like copies of our RM scenarios, please contact the author. Words of special thanks are extended to Ms. Kimm Schweitzer for help in the preparation of this manuscript, and to the Lower Brule Sioux Tribe. □

References

1. Risk management. *The IHS Primary Care Provider.* 1987;12(1):6-7
2. Risk Management Modules #l through #11, available from the IHS Clinical Support Center, Phoenix, Arizona
3. Magnus P. Containment of a community-wide hepatitis A outbreak using hepatitis A vaccine. *The IHS Primary Care Provider.* 1996;21(9):117-118
4. Heath S. Risk Management and Medical Liability, A Manual for IHS and Tribal Health Care Professional. Rockville, MD: IHS Office of Health Programs; 1996

New Officers for National Councils

At the combined annual meeting of the National Councils of Clinical Directors, Service Unit Directors, Chief Medical officers, and Nurse Consultants in Phoenix in January, there was a "Hail and Farewell" for the outgoing leadership of the Clinical Directors and Service Unit Directors. Rebecca Loving, the Chair of the National Council of Nurse Consultants, continues in that position for the remaining year of her two-year appointment.

During the combined meetings, Dr. Trujillo acknowledged the contributions of the departing leaders, welcomed the new ones, and gave a brief description of the scope and responsibility of these voluntary positions. "I thank Judy Thierry, Rebecca Loving, and John Daugherty for their involvement in the Executive Leadership Group and the Indian Health Leadership Council this year and for their tremendous effort. They put in a lot of work and probably compromised some of their personal and professional time at home, but what they have brought to the Council, the Agency, and to others will be long standing. I do want to thank them and congratulate them for their continuing efforts and thoughts, and sometimes strong reminders to us of what we need to do."

Dr. Trujillo then acknowledged that Hunt Kooiker, MD, MPH, will be assuming the responsibilities as Chair of the National Council of Clinical Directors, and Richard Huff will be leading the National Council of Service Unit Directors for the next year. "My goal is to assist the IHS leadership by representing all clinicians of the Indian Health Service, tribal, and urban programs," he said, and stressed the term "all" in his comments. "I want to help translate the human and financial resources of the I/T/U into improved health care for American Indians and Alaska Natives well into the next millennium."

Dr. Kooiker is the first physician from a "638" (tribal) program to serve as the Chair of the National Council of Clinical Directors. He has also worked in each of the components of the Indian health system. He served as a Commissioned Officer from 1977 to 1981 and worked with Navajo and Hopi Indians at Tuba City, Arizona. In the late 1980s he provided care to urban Indians through his work with the San Diego American Health Clinic. He is currently a tribal employee at the Indian Health Council, Inc., clinics in rural San Diego County.

"The decisions of the Agency are helped when the perspective of the Service Unit Directors is included," said Richard Huff, MBA, the Service Unit Director in Sisseton, South Dakota. "Working with the IHS leadership in 1999 is critical for laying the foundation for health care for Indian people in the next millennium." Mr. Huff has worked with the IHS since 1989. He has been the Service Unit Director for Sisseton since 1990. □

Interdisplinary Elder Care Teams

Bruce Finke, MD, Director, Elder Care Initiative, and Staff Physician, Zuni-Ramah Service Unit, Zuni, New Mexico

I have proposed that time be set aside in May 1999, Older Americans Month in the International Year of the Older Person, to develop and energize interdisciplinary elder care teams in our I/T/U clinics and hospitals. Previous articles in *The Provider* have addressed the rationale for and practical details of setting up elder teams. In this brief article I will review some project ideas for teams to consider.

Access

Create an "elder friendly clinic." Find out from your elders what they see as barriers to care in your facility and develop an action plan to address those issues. Publicize this in local papers.

Patient and Caregiver Education

Create large print educational materials for common geriatric issues. Consider outreach education to Senior Centers and education programs for caregivers to frail elders. Ask the elders what they see as their education needs.

Disease prevention

Evaluate your immunization program and consider immunization outreach for the elderly (Pneumovax, influenza). Develop a strategy for yearly preventive health exams that incorporates dental, audiology, optometry, nutrition, and other available services.

Injury Prevention

Develop a home safety inspection process for frail elders. Create a protocol for secondary prevention of injury from falls, evaluating for remediable causes.

Staff Education

Set up a CME series on geriatric topics. Team members could each do presentations on topics in their discipline.

Quality Improvement

Develop an audit strategy that crosses disciplines and highlights important areas of care for the elderly (e.g., drug prescribing and dosing, fall prevention on inpatient wards).

Other possible projects include the establishment of an outpatient or inpatient comprehensive geriatric assessment program or a case management system for frail elders.

There are so many things a team can do. Regardless of where you start, you will find that as your team focuses on the needs of your elders, care will improve. Set aside time in May to get your elder teams going!

For further information contact the Elder Care Initiative at *elders@nm.net*; telephone (505) 782-4431; fax: (505) 782-5723.

The Annual Elders Issue

May is National Elders Month. In recognition of this, for the past three years *The Provider* has dedicated its May issue to articles related to the health and health care of Indian elders. We would like to invite our readers to submit articles for this issue as soon as possible. In addition to clinical or descriptive articles, we would welcome submissions from elders themselves who are willing to share their viewpoints about the status of health care for Indian elders and their perceptions of future needs. If you would like to submit an article, please send it to:

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