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Changes in Health Care Financing & Organization (HCFO)

findings brief

Financing American Indian Health Care: Impacts and Options for Improving Access and Quality

key findings

- Indian Health Service (HIS) per patient funding is less than half of national per capita health spending, and declined further between 2003 and 2006.
- Under-funding of the IHS system has led to explicit rationing of services to American Indian and Alaska Native patients, with many specialized services provided only for "life or limb threatening" conditions.
- IHS patients report experiencing access barriers and rate the quality of care process substantially lower than do Medicaid beneficiaries, but most indicate they prefer to use IHS for their health care.
- Options to increase the funding for American Indian and Alaska Native health care exist, but would impose higher costs on federal and state budgets and are unlikely to be feasible in the current economic environment. However, IHS might be able to make certain organizational changes that would increase efficiency and its ability to extend existing funding to cover more services.

Robert Wood Johnson Foundation

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Overview

Health disparities between American Indians and Alaska Natives and the majority population are substantial and have been particularly resistant to improvement. A Centers for Disease Control and Prevention (CDC) report on trends in racial and ethnic rates for *Healthy People 2000* health status indicators (HSIs) between 1990-1998 concluded: "…American Indians or Alaska Natives do not appear to have experienced the same improvements in these indicators as the other racial/ethnic groups experienced. While there may be alternative explanations for these findings, such as improvement in the identification of native peoples during this period, further investigation is needed."[1] A 2002 Indian Health Service (IHS) report documented that the health status of American Indians and Alaska Natives actually worsened over the last decade.[2] Age-adjusted mortality rates of American Indian and Alaskan Native people rose from 698.4 per 100,000 to 730.1 per 100,000 between 1994-1996 and 1997-1999, and the ratio of the American Indian and Alaskan Native rate relative to the U.S. all races' rates increased from 1.4 to 1.5 over that period.

The causes of poorer health status, high morbidity, and premature death among and within American Indian and Alaskan Native populations are diverse. Poverty, poor living conditions and sanitation, and residence in rural and frontier areas with scarce health providers and facilities disproportionately affect American Indians.[3, 4, 5] Inadequate financing of American Indian and Alaskan Native health care, however, contributes to these conditions and to the substantial and worsening health disparities of this population.[6,7] The IHS Federal Disparities Index Workgroup has estimated that a benefits package for IHS users comparable to the Federal Employees Health Benefit Program page would require twice the funding currently appropriated for IHS by Congress.[8] The focus of this HCFO grant was to understand the implications of underfunding IHS for access to care and quality of care provided to American Indians who reside in rural and frontier areas and are

dependent on the IHS for their health care. The grant studied two reservations and IHS facilities to assess their organization and financing levels, as well as tribal members' experiences and perceptions of the health care they receive through IHS.

Methodology

The study was structured in several components that, together, provided a comprehensive assessment of the level of financing of IHS, impacts of financing and organization on access to and quality of care, and the feasibility and costs of options to increase financing and improve operational efficiency and effectiveness.

Per capita funding of health care on the two participating reservations was estimated from 2003-2006 data on funding allocations, reimbursements from third-party payers, and number of patients served, obtained from the IHS Web site and from the participating IHS facilities. Per capita funding for each reservation was calculated for each year and compared to average IHS per capita funding and to national average per capita health expenditures for each year.

Patients' experiences and perceptions of access to and quality of care were obtained from administration of a modified version of the Consumer Assessment of Health Plans Survey© (CAHPS) completed by 600 tribal members who obtained care through IHS facilities on the two reservations and from focus groups conducted with tribal members on each reservation. Use of the CAHPS© instrument permitted comparison of the study findings with CAHPS© results for Medicaid beneficiaries and with CAHPS© results from other tribes in the region.[9] Survey results were examined overall and for two categories of health services: 1) those dimensions of care over which IHS has greater control (i.e. services that are provided directly by IHS); and 2) those dimensions of care over which IHS has less control (i.e. specialized services that must be referred to outside providers, which are rationed due to financial constraints). Additional multivariate analyses of the CAHPS© data were conducted to examine associations between specific performance dimensions and overall ratings of health care, in order to identify specific operational strategies that would be most likely to increase patient satisfaction.

Organizational and operational issues were examined by development of detailed profiles of each IHS facility using data collected during three-day site visits, key informant interviews conducted with IHS department managers and staff and with tribal health department staff, and review of internal IHS organization charts and documents.

Options for increasing access to and quality of IHS health care were identified through discussions with tribal members, IHS management and staff, and interviews with several experts who were knowledgeable about IHS financing issues and operations. Identified options fell into two categories: 1) options for increasing the available funding for health care; and 2) options for organizational and operational changes that would improve access and quality of IHS services. Estimates were then made of the potential costs, distribution of costs, and feasibility of each option.

Key Findings

Per Capita Funding Levels, 2003-2006: Overall, the IHS was funded, through congressional appropriations and third-party reimbursements, at a level that declined from 50 percent of U.S. average per capita health expenditures in 2003 to 45 percent of the U.S. average in 2006. Per capita funding for the two study reservations was lower than the overall IHS levels. By 2006, per capita funding for one study reservation had declined to 37 percent of the U.S. average and to 33 percent of the U.S. average at the second study reservation. During the 2003-2006 period, third-party reimbursements grew substantially at each of the study reservations but were not sufficient to offset the essentially flat IHS allocations, increase in patient population, and growth in average U.S. health care expenditures due to inflation and other factors.

Patient Perceptions of Access and Quality: Analysis of the CAHPS© survey data indicated that tribal members were substantially less satisfied with the care they receive from the IHS than were the comparison group of Medicaid beneficiaries. Nineteen percent of tribal respondents rated their overall IHS care as a 9 or 10 (on a scale of 0-10), compared to 54 percent of Medicaid beneficiaries. As expected, tribal members were more satisfied with specific dimensions of care over which IHS has greater control than with those dimensions of care over which IHS has less control. Patients who actually received care at IHS during the preceding 12 months rated their overall health care more positively ($p < .01$) than did patients who had not recently used IHS services, suggesting that those who had less positive experiences may be deterred from using health services. Higher ratings of "office staff courtesy" were also positively

Table 1: Per Capita Funding for Participating Reservations, 2003-2006

Site	2003	2004	2005	2006
Site #1 Per Capita	$ 2,108	$ 2,090	$ 2,061	$ 2,212
% U.S. PC	42%	39%	37%	37%
Site #2 Per Capita	$ 1,809	$ 1,900	$ 1,913	$ 1,916
% U.S. PC	36%	36%	35%	33%
All U.S. Per Capita	$4,985	$5,298	$5,518	$5,902

Data Sources: 1) Reservation-specific IHS allocations, third-party reimbursements, patient populations were obtained from specific reservation IHS managers; 2) All IHS per capita funding was obtained from IHS Billings Area Office expenditure and obligations financial data reporting documents; 3) U.S. per capita spending for health was obtained from "Table 6: Personal Health Care Expenditures Aggregate, Per Capita Amounts, and Percent Distribution, by Source of Funds: Selected Calendar Years 1970-2007," National Health Expenditures Data.

and significantly related to the patients' rating of overall health care ($p < .05$). There also was a positive and significant relationship ($p < .001$) between "physician spends enough time" and the respondents rating of overall IHS health care. These results suggest that IHS could increase patients' perceptions of the quality of the overall care that they receive by providing more training and incentives for office staff to interact with patients in ways that are perceived as courteous and helpful. In addition, making it possible for physicians to spend more time with patients or to interact and communicate with patients in ways that increase patients' perceptions that they have the physician's attention could have a positive impact on overall ratings of IHS health care.

Organizational and Operational Issues: A number of the identified organizational and operational issues that affect access to and quality of care provided by the IHS are associated with the rural/frontier locations of the two study reservations, including: difficulties attracting and retaining health professionals; limited market power; barriers to economies of scale; and the need for extended travel to obtain specialized services. These factors are not unique to IHS and pose substantial access and quality barriers for most people residing in remote areas.

Other issues are specific to the IHS and could, potentially, be addressed through internal organizational re-engineering or by policy changes. These include:

- **Explicit rationing of care:** Approval of payment for referral services is generally limited to health conditions that are "life or limb threatening" due to inadequate funding of IHS. As a result, patients go without needed care or obtain services but are unable to pay for these services, imposing substantial uncompensated care burdens on local non-IHS providers.

- **Lack of a "Business Model":** IHS does not offer a defined set of benefits nor does it have a fixed known patient population. This makes it difficult to manage health care as a business—with an emphasis on productivity, efficiency, and cost management—and creates ambiguity and uncertainty for IHS managers, providers, and patients.

- **Limited physician-patient relationships:** Fewer than half of IHS patients report having someone at IHS that is their personal provider. The inability of IHS to ensure that patients have a primary care provider relationship has implications for patient satisfaction, coordination and continuity of care, and effective physician-patient communication.

Despite the lengthy list of organizational and operations problems identified by tribal and IHS managers and staff, it is interesting to note that 67 percent of tribal members served by IHS say that they would continue to receive their care at IHS even if they could afford to go to other providers.

Options for Strengthening the American Indian Health Care System

Six major options for improving the American Indian health care system were identified through discussions with tribal and IHS managers and patients and with several individuals with expertise on American Indian health care issues. These include:

Options for increasing the funding available for American Indian health care

Option 1: Congress could fully fund the IHS through increasing appropriations for IHS to the estimated level of need and then annually increasing the appropriations to fully account for population growth and the rate of increase in national health expenditures.

Option 2: Expand enrollment of eligible American Indians and Alaskan Natives into federal and federal-state health programs, through establishment of benefits counseling programs on each reservation that would provide culturally-tailored intensive outreach, counseling, and assistance with enrollment and re-certification requirements.

Option 3: Increase coordination and collaboration between state Medicaid and Children Health Insurance (CHIP) programs, tribes, and IHS to increase mechanisms for enrollment, offer flexible benefits that are responsive to the unique issues on reservations, and ensure that tribal and IHS providers are eligible for reimbursement.

Option 4: Create an IHS Medicare Advantage plan to serve tribal members enrolled in Medicare. IHS could enroll tribal Medicare beneficiaries in the Medicare Advantage plan and offer a defined set of benefits that equal or exceed the standard Medicare benefit package. The Medicare Advantage capitation payment from CMS is currently greater than $7,000 annually in rural areas (compared to average IHS per capita funding of $2,671 in 2006). This would permit IHS to provide comprehensive services to Medicare beneficiaries and permit IHS funds that would have been used for services to Medicare-covered patients to be used to cover more services and programs for non-Medicare patients served by IHS.

Options to Increase the Efficiency and Effectiveness of the IHS

Option 5: The IHS could incorporate effective management strategies from the private sector to improve efficiency and better manage its limited funding in order to maximize service to its patients. This might require regulatory changes to permit IHS to adopt types of managed care strategies, including formally enrolling tribal members into the IHS health system, developing a defined set of benefits based of actuarial analysis, and providing incentives to providers and staff based on productivity and efficiency.

Option 6: The IHS could develop collaborations and partnerships with local health systems to share resources, coordinate care, and obtain training and assistance for improving organizational and operational processes. Local health systems often receive significant funds for providing referral services to IHS patients and could be encouraged to collaborate and partner with IHS through exclusive contracts and other financial incentives.

Table 2: Cost Implications and Feasibility of Options

Option	Federal Costs	State Costs	Private Sector Costs	Feasibility
1. Fully fund IHS	Increase of $4.2 billion in 2006	Decrease, due to lower Medicaid costs	Decrease, due to reduced uncompensated care	Low, due to current federal budget deficits
2. Expand American Indian and Alaskan Native Medicaid/CHIP enrollment	Increase of $65 million, plus federal match costs	Increase, due to state match costs for Medicaid and CHIP	Decrease, due to reduced uncompensated care	Low, due to current federal and state budget deficits
3. Increase coordination and collaboration with states	Increase, due to federal Medicaid and CHIP match	Increase, due to state Medicaid and CHIP match	Decrease, due to reduced uncompensated care	Low, due to current federal and state budget deficits
4. Establish IHS Medicare Advantage plan	Increase of up to $840 million	Possible decrease due to fewer American Indian and Alaskan Native Medicaid dual eligibles	Decrease, due to reduced uncompensated care	Medium, but would require CMS agreement and regulatory changes
5. Develop and implement IHS "business model"	Minimal, but initial start-up costs could be significant	Minimal	Decrease, due to reduced uncompensated care	Medium
6. Partnerships with local health systems	None	None	Minimal	Medium/high

Discussion

The IHS has a critical role as a provider of health services to American Indians and Alaska Natives living in remote rural areas. Although IHS faces many challenges and is not able to provide the full range of health services that insured Americans take for granted, American Indian and Alaskan Natives living on reservations would have very limited access to health services in its absence. The options presented in this paper offer the potential to increase funding for American Indian and Alaskan Native health care and increase organizational and operational efficiencies which could improve access to and quality of care for IHS patients. While the feasibility of some of these options is limited due to current economic conditions and pressures on federal and state budgets, other options would have little impact on public spending and would require minimal expenditures for IHS to implement.

An important current consideration for American Indian and Alaskan Native health care is the impact of national health reform on the IHS. If national health reform that includes universal insurance coverage is legislated, the role of the IHS in the new system may be questioned, since financial access to health care would be guaranteed. For American Indians and Alaska Natives, however, the IHS provides accessible services in remote areas where other health services are not available. Preserving the IHS within a new national health system may be an important policy issue for maintaining and increasing access to quality health care for this population over the coming decades.

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Endnotes

1 Keppel K.G., et al. "Trends in Racial and Ethnic-Specific Rates for the Health Status Indicators: United States, 1990-1998." Health People Statistical Notes, National Center for Health Statistics, No. 23. January 2002.

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8 Crouch, J. and C. Wiggins, Co-Chairs. "Letter to the Director of Indian Health Service," Federal Disparity Index Workgroup, March 2002.

9 Comparison data were obtained from the National CAHPS© Benchmarking Database, and to a survey of six Tribes for a previous study. See: Andersen, S., Langwell, K. and C. Helba, "Development and Interpretation of CAHPS© for Tribal Health Systems," Report to the Montana-Wyoming Tribal Leaders Council, Billings, MT, 2007.