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The future of Indian Health Services for native Americans in the United States: an analysis of policy options and recommendations

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Abstract: The passage of the Affordable Care Act in the United States has opened a policy window for the establishment of an independent Medicaid agency for the Navajo Nation. This article explores several policy options to improve health care services for Native Americans. Although there is a lack of scholarly research on the impact of healthcare reform and the effectiveness of current health care programs for American Indians, policymakers should utilize evidence-based research to inform policy decisions.

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Introduction

The possibility of an alternative model for financing health care services provided to members of the Navajo tribe rests in part with a decision to be made in Congress. The reauthorization of the Indian Health Care Improvement Act of 2009 (IHCIA) and passage of the Patient Protection and Affordable Care Act of 2010 (ACA) stimulated a request to Congress from the Navajo Nation that they be recognized as an independent state for purposes of managing their own Medicaid Agency. The authorization of Medicaid expansions and the introduction of health exchanges support arguments for such an approach.

The 5.2 million Native Americans in this country have an uninsured rate of 30% and many have poor health outcomes and difficulty accessing health care (Vestal, 2013). The role of the Navajo Nation in providing access to health care services for tribal members could be altered if a study submitted to Congress in May 2014 were to receive an affirmative vote permitting the establishment of a Navajo Nation Medicaid Agency (Econometrica, 2014). The Navajo Nation has a vested interest in operating an independent Medicaid agency because there are a significant number of tribal members currently receiving Medicaid services and the

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ACA expansion of Medicaid will produce an estimated 30% increase in new tribal Medicaid enrollees (Keane, 2013; Econometrica, 2014). Moreover, there has been discord between the Navajo Nation and States over the management of Medicaid due to issues with tribal members' eligibility for Medicaid, lack of coordinated care, language barriers, geographical barriers, provider shortages, *a priori* biases against managed care organizations, state funding cuts, and long wait times for covered services (Donovan, 2013; Keane, 2013).

This article explores the potential for achieving change to policy so that a different approach to providing and funding health care services to the Navajo Nation could occur. Changes brought about by passage of the ACA and the reauthorization of the IHCIA introduce an agenda setting path potentially leading to new policy options for health care for the Navajo Nation. A window of opportunity for the establishment of an independent Medicaid agency for the Navajo Nation presents itself because of these laws. A Medicaid Feasibility study submitted to Congress on behalf of the Navajo Nation serves as an impetus to support consideration of a change to policy on funding as well as a change to the organization of health care delivery for the Navajo. This article discusses the unique opportunity to explore the establishment of a Navajo Medicaid program and two other potential policy options that are relevant to the Navajo community. This article also reviews challenges associated with delivering health care services to the Navajo and recommends a possible course of action for the Navajo Nation.

Background

The passing of the (ACA) with its provisions to change Medicaid and other insurance programs has specific implications for American Indians and Alaskan Natives (AI/AN). However, scholarly research focus on the impact of health insurance exchanges and Medicaid expansion affecting individual states and falls short in its examination of the effects of health care reform on Native Americans. For example, the Navajo Nation opposes mandatory enrollment of American Indians in managed care organizations which, as Medicaid eligibility expands, could become a more common option (Navajo Nation, 2012).

However, other changes brought about by the passage of the ACA may combine with provisions for Medicaid expansion to provide additional opportunity for the Navajo Nation to operate their own health system through an independent Medicaid Agency. Surprisingly, the request to be treated as a state in order to operate an independent Medicaid Agency, a matter of public record, has received little attention from the media.

This article explores the initial stages of policymaking regarding the establishment of an independent Medicaid agency by analyzing the historic and current status of the Navajo Nation as recipients and providers of health care. The article

begins with a discussion on the history of Native American sovereignty and the establishment of partnerships between the United States and recognized tribes. Three health policy options offered by the Navajo Nation in their submission to the New Mexico Legislature are explored. Each option is analyzed to include the potential impact to the states most affected by the establishment of a Navajo Medicaid Agency.

This article concludes with a suggested course of action and recommendations for policymakers, policy researchers and health scholars. This article contributes to the extant body of literature on health policy by:

- detailing the complexity of policymaking as applied to establishing a political precedent,
- offering insight into the challenges that need to be considered when making policy decisions for under-represented populations,
- and by raising awareness about potential policy developments arising through health care reform.

History of sovereignty and federal legislation affecting Native Americans

A partnership among AI/AN and the federal government for the delivery of health care has existed since the 1800s (Warne, 2011). The history of partnerships with state health care systems varies by state. This section details precedent for recognition of sovereignty of Indian tribes by the Federal government in support of the argument permitting the establishment of an independent Medicaid agency by the Navajo Nation.

The earliest form of a partnership occurred when physicians in the US army contained contagious diseases in areas surrounding military posts by vaccinating members of local Indian tribes (Bergman *et al*., 1999). In 1868 the Treaty of Fort Laramie solidified the authority and sovereignty of each tribe but included specific concessions. The agreement specified that Indian tribes would give up some of their land in exchange for access to physicians and medical equipment from the federal government (Treaty of Fort Laramie, 1868).

The United States Constitution through the Commerce and Treaty Clause of 1787 recognized the sovereignty of Indian tribes by permitting the federal government to regulate commerce and enter into treaties on behalf of the nation (Shelton, 2004). In 1832, the Supreme Court noted in *Worchester v. Georgia* that Acts passed by Congress recognize Indian nations as separate political communities with exclusive authority over their own territorial land (Worchester v. Georgia 31 US (6 Pet.) 515 1832).

Additionally, laws and treaties between the government and Indian nations are considered separate from state laws or agreements with the States (Shelton, 2004). Shelton (2004), a consultant and attorney for a nonprofit organization called the Native American Rights Fund, notes that the federal government has the authority

and responsibility to preside over Indian affairs for tribes that are recognized as such by the government. He further explains that there are four principles that set the precedent for federal Indian law:

1. The federal government cannot encroach upon the sovereignty of Indian tribes.
2. The states cannot involve themselves in Indian Affairs even if a tribe resides within their borders.
3. The federal government has the authority to preside over AI/AN issues if the tribe is federally recognized.
4. There is a relationship of trust between Indian nations and the Federal government that must be honored.

Perry and Foster (2010) note that the Federal Trust Responsibility Doctrine, central to the US government's legal and moral responsibilities to Native American tribes, authorizes the exchange of land and resources for the provision of education and health care.

In fact, in 1921, the Snyder Act enacted by Congress recognized Indian tribes as eligible to receive federal funds for health care and education (Perry and Foster, 2010; Snyder Act, 25 U.S.C. § 13). The Indian Self-Determination and Education Assistance Act of 1975 signed into law by President Ford granted authority to Indian tribes to design, administer, and operate their own programs for health care services (Perry and Foster, 2010; The Indian Self-Determination and Education Assistance Act, 25 USC § 2507).

The Indian Health Care Improvement Act (IHCIA) of 1976 was enacted to assist Indian Tribes with participation in the management and planning of health initiatives to enhance access to and quality of health care services (Perry and Foster, 2010; Indian Health Care Improvement Act, 25 U.S.C. §1601). Following the IHCIA, the Tribal Self-Governance Program (TGSP) was created in 1988 to allow flexibility in the management of health care programs. Under TGSP tribes are able to secure health care services from the federal government through the following options:

1. Allow the Indian Health Service (IHS) to administer health care programs,
2. Obtain a contractual agreement to manage individual programs formerly operated by the IHS (also known as Title I Self-Determination Contracting) and
3. Enter into a compact with the IHS to gain authority to manage and operate health care programs (also known as Title V Self-Governance Compacting).

These options provide tribes with alternative approaches to deliver health care services that fit the needs of their members (IHS, 2015). In the last report to Congress on funding needs, the IHS and the US Department of Health and Human Services (2012) reported that the Navajo Nation received three Title I Self-Determination Contracts and three Title V Self-Governance Compacts totaling $158,967,450.

The number of awards granted to the Navajo pales in comparison to the Alaskan Natives which are reported to have 25 compacts as of 2011 (Office of Tribal Self-Governance and Indian Health Service, 2011). This fact could suggest, although not necessarily so, that the Navajo Nation, the largest tribe in the United States, is wary about assuming risk under government contracts where funding could be capped. Such a perspective, if accurate, could influence Navajo decision making regarding the establishment of an independent Medicaid Agency.

However, the creation of Temporary Assistance for Needy Families under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 presents a different scenario. This program allows states and tribes to design and implement their own welfare programs through block grants funded by the federal government (United States General Accounting Office, 1998). In response to the PRWORA, the Navajo Nation passed the Local Governance Act which provided local tribal governing authorities access to resources and the ability to administer welfare programs (Pandey and Collier-Tenison, 2001). Since 2000 the Navajo Nation has received an annual grant for $31,174,026 (US Department of Health and Human Services, 2015).

The discussion thus far details programs already in place to facilitate the management and operation of health care programs. The IHCIA, reauthorized when President Obama signed the Affordable Care Act into law in 2010 (IHS, 2010), included a number of additional provisions affecting Indian tribes such as:

- extending services for hospice and assisted living care,
- allowing the IHS director to have more latitude with advocacy and consultations on issues that affect Indian tribes,
- making recovery of payments from third parties easier, and
- permitting partnerships between the IHS and the Department of Defense and Veteran Affairs for medical services and use of facilities (IHS, 2010).

As described, the historical context for providing health care and federal recognition of tribes as Sovereign Nations is an established fact embedded in the United States Acts and Treaties. The request of the Navajo Nation to be treated as an independent state is therefore not without legislative standing, opening the door for authorization of an independent Medicaid Agency.

The dilemma confronting the Navajo Nation in regards to providing and receiving health care services

The passage of the Affordable Care Act of 2010 which includes authorization of state expansion of Medicaid programs and the simultaneous reauthorization of the IHCIA could be viewed as a window of opportunity for the Navajo Nation to pursue status as a state for purposes of establishing an independent Medicaid

Agency. This section explores the implications of the opportunity and the potential outcomes.

In a report submitted to the New Mexico Human Services Department, the Navajo Nation stated that they were concerned with the following fundamental objectives for the tribe's health care program (Navajo Nation, 2012):

- coordinating a health care system that considers the needs of the AI population,
- decreasing barriers for access to care and
- incorporating traditional healing therapy.

It is recommended that policy proposals advocating for changes that affect the delivery or funding of health care for the American Indian population meet the above stated fundamental objectives of the Navajo Nation.

Out of concern for the health and welfare of tribal members, the Navajo Nation has proposed several solutions for improving access to care, coordinating care and reducing health disparities. Proposed solutions to improving delivery of health services to Native Americans include:

1. Recognizing the Navajo Nation as a state for purposes of devising their own Medicaid program.
2. Exempting the IHS and their associated facilities from federal Medicaid cuts and reductions in services.
3. Increasing Native American involvement in the future development of policies, strategies, and procedures related to plans and programs for the delivery of health care to the Navajo Nation.
4. Developing partnerships between existing Medicaid managed care organizations and their IHS affiliate facilities (Navajo Nation, 2012).

To better understand the proposed solutions for improving funding and the health care services provided to Native Americans, we provided an analysis of three policy options.

Policy option 1: Recognize the Navajo Nation as a state and authorize the establishment of an independent Medicaid agency

The Navajo Nation is entitled by statute to federally funded health care services. At the time of the reauthorization of the Indian Health Care Improvement Act in 2010, the Navajo Nation submitted a feasibility plan for review by the United States Department of Health and Human Services. Congress received the plan in March of 2013. In the plan, the Navajo Nation stated their intent to become authorized to operate their own Medicaid program (Kennedy, 2013; Navajo Nation Medicaid Agency Feasibility Study, 25 USC § 1647d; Donovan, 2013). In 2014 an additional study was commissioned by the Centers for Medicare and Medicaid services through a research group called Econometrica.

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The determination as to whether the Navajo Nation should be treated as a state with authority to self-operate Medicaid programs depends on Congressional authorization subsequent to their review of the additional study authorized by the Centers of Medicare and Medicaid Services (Econometrica, 2014). The study entitled 'Report to Congress on the Feasibility of a Navajo Nation Medicaid Agency' was submitted in 2014 with no Congressional ruling to date (Econometrica, 2014). The Congressional ruling when it does occur, if supportive of this option, could open the door for the operation of a separate Medicaid program for the Navajo Nation.

However, the following facts detail issues that may prove challenging to the operation of a tribal Medicaid Program:

- tribal members are not required to pay a penalty if they do not buy insurance so there is no clear incentive to enroll in any Medicaid program,
- the same challenges faced by state Medicaid agencies and IHS (i.e. limited specialty networks, enrollment issues, transportation) are barriers that may still exist in a tribal Medicaid program.

The authorization and establishment of an independent Navajo Medicaid Agency could raise the question of appropriate and efficient use of taxpayer dollars. Many Native Americans are already eligible for state Medicaid programs and would, if enrolled, have access to services. The total cost of a fully operating Medicaid Agency for the Navajo Nation is expected to cost anywhere between $359,678,275 to $413,043,829 with the federal government assuming more than 80% of program expenditures (Econometrica, 2014). Additionally, New Mexico, Arizona and Utah would experience a reduction of Medicaid enrollees in the state program and a subsequent diminution of federal funds due to the decline in state Medicaid recipients, additional perhaps duplicative health care costs could be incurred and transitional expenditures related to the operation of a tribal Medicaid Agency would occur (Econometrica, 2014).

The expansion of Medicaid, whether state administered or administered by the Navajo Nation, serves the same purpose: to address gaps in coverage for all underserved people. The question to be considered, therefore, is how to most effectively use scarce resources to achieve the most good.

Policy option 2: Exempt IHS facilities and services from federal funding cuts to Medicaid and reductions in payment and services

The exemption of federal cuts to Medicaid programs for Native Americans, paid by allocating funds directly from the federal agencies to the tribal agencies, could improve access and quality of care for recipients by stabilizing operations and maintaining financial access to services. Federal funding is appropriated each year by Congress and distributed to IHS and tribal facilities. If health care expenditures exceed the amount of funds allocated to IHS, then medical services are either rationed or prioritized (Boccuti *et al*., 2014). Although federal funding for health

has risen for American Indians incrementally over the years; the cost of medical care, a growing AI/AN population, and federal government sequestration cuts have negatively impacted Indian health budgets (National Congress of American Indians, 2016). Policy option two assumes that funds would pass from federal to tribal entities without state match or administrative involvement.

In the past, heath care barriers that have had an observable negative effect on the AI/AN population included the following: inadequate funding at the federal level, bureaucratic red tape, administrative inadequacies, and communication and trust issues. Other barriers include the devolution of health care services involving contracts (legal arrangements for specific clinical services) and tribal compacts (legal agreements that allow individual tribes to implement health programs), and program changes (i.e. Medicaid and Medicare) at the federal and state level (Noren *et al.* 1998).

There is consensus among Navajo community leaders that an increase in health disparities such as chronic disease, suicide, and substance and alcohol abuse will occur if programs are subjected to federal Medicaid cuts and continuity of services and providers are lost (Navajo Nation, 2012). Currently, the IHS is under-funded and there is a shortage of providers in tribal areas (Navajo Nation, 2012). Health care services provided by IHS facilities are mostly primary care services. Although IHS allocates a certain portion of funding to be reserved for out of network providers, the availability of specialty services and access to such care is limited due to fiscal and geographical constraints (Boccuti *et al.*, 2014). Fox (2011) reports that the IHS engages in rationing health care and denying referrals from medical professionals to specialists due to fiscal constraints.

Funding issues have plagued the AI/AN population for many centuries. As far back as 1890, the Commissioner of Indian Affairs determined that 'the government valued people [at] $21.91 per soldier, $48.10 per sailor, and $1.25 per Indian' (Sarche and Spicer, 2008: 132). In 2014, a contributor for mint press news reported that 'tribes had been underpaid 'between 77 percent and 92 percent of the tribes' aggregate contract support costs' during previous decades' (Graef, 2014).

The exemption of federal funding cuts and reductions to payment and services provides a resolution that tackles a myriad of problems that affect the Navajo Nation. Stabilized federal funding and regular funding updates can assist in reducing health disparities among the Navajo by sustaining continuity of services and, the IHS can dedicate more time and resources toward improving and expanding the network for the delivery of health care vs having to ration health care services. Disruptions of health care services can be prevented when exemptions from federal cuts and health care services are implemented. Moreover, a report titled 'Health Care Reform: Tracking Tribal, Federal, and State Implementation' submitted to the Centers for Medicare and Medicaid services by Edward Fox, a health policy researcher, analyzes the effects of health care reform on AI/AN and states, based on operating costs and duplicative administrative burdens, that state Medicaid expansion would be more beneficial than permitting a tribal health insurance exchange (Fox, 2011).

Policy option 3: Continue eligibility and services offered through state Medicaid programs and ensure inclusion of representatives of the Navajo Nation in the development of policies for state Medicaid programs and Medicaid managed care programs

The leading cause of death among the Navajo population is unintentional injury (Navajo Nation, 2012). However, for the total population of AI/AN males the major causes of death in ranking order include heart disease, cancer, unintentional injury, diabetes and chronic liver disease. The leading causes of death for females in ranking order are cancer, heart disease, unintentional injury, diabetes, stroke and chronic liver disease (Espey *et al*., 2014). Other problems include behavioral problems, substance and alcohol abuse, suicide, accidents, homicide and obesity. The mortality rate is 5.6 times higher than that of the general population of the United States (Navajo Nation, 2012).

In the treatment of the major causes of disease suffered by members of the Navajo tribe, the Navajo Nation would like to see an integration of their cultural worldviews with those of western medicine. They believe membership in managed care and services provided by such organizations, should require more focus on health literacy and cultural competency, better coordination of care, protection of behavioral health services, maximized technology use for rural areas and improved use of school health clinics. They want individuals to be rewarded for healthy behavior and have cost sharing plans and fees based on a sliding scale. Additionally, they want providers to be rewarded for practicing cost-effective medicine that focuses on outcomes (Navajo Nation, 2012).

Increasing representation of the Navajo Nation in developing state Medicaid policies and procedures specific for Native American recipients could result in New Mexico, Arizona and Utah funding additional services, such as Native American healers, not accessible to the rest of the Medicaid population. These states do have existing partnerships with tribal representatives; however, the degree of participation by Navajos in shaping Medicaid programs varies by state. These differences are addressed briefly in the next sections. Positive outcomes and areas for improvement are noted.

States take the lead

Arizona

In 2012 the state of Arizona created an initiative to improve health outcomes for AI's who declined enrollment in managed care programs in favor of enrollment in fee-for-service programs. A Tribal Health Care Coordinator was hired to assist in developing strategies to enhance the health care system and coordinate care for tribal members. The initiative is part of Arizona's plan to improve quality, but the program only focuses on three populations: long-term care patients, diabetic clients and individuals being discharged from hospitals who are enrolled in fee-for-service plans (Betlach, 2013).

This partnership between Arizona and the Tribal Health Care Coordinator is further limited because it does not include tribal members who are enrolled in managed care plans. Leveraging this service by expanding the role of the Tribal Care Coordinator to include all tribal members through a partnership arrangement between the state Medicaid Agency, managed care organizations, and the Navajo Nation could improve access to care, navigation of the health care system, provision of alternative medicine and use of health care services.

New Mexico

In New Mexico, in 2014, the Health Services Department (HSD) created a strategic plan to address modernizing the Medicaid program and establishing a state-based health insurance exchange (New Mexico Human Services Department, 2012). The nature of the relationship between the New Mexico HSD and the Navajo Nation as described in this strategic plan is not clear. This strategic plan does not suggest a partnership between the New Mexico HSD and the Navajo Nation with respect to the development of policies. However, an existing Native American workgroup does suggest full inclusion in the development and design of policies and programs affecting Native Americans with input from representatives of the IHS, Tribal programs and Urban Indian programs (Health Insurance Exchange Native American Workgroup, 2013).

The New Mexico HSD does seek to enhance management structures by ensuring compliance with federal and state regulations and encourages HSD managers to participate in Tribal Collaboration Trainings (New Mexico Human Services Department, 2012, 2015; New Mexico HSD, 2013, 2014). Participation by New Mexico HSD employees in Tribal Collaboration Trainings is not mandated. However, participation could open the door for additional collaboration between the New Mexico HSD Department and the Navajo Nation so that health disparities and the unique needs of the Navajo Nation can be addressed more fully.

Utah

In Utah, the decision to expand Medicaid was placed on hold by currently presiding Governor Gary Herbert, but the state is engaging in a pilot program through a state innovation waiver to assist low-income individuals obtain health insurance (Kaiser Health News, 2013; Office of Governor Herbert, 2014).

There is a small population of AI/AN's in Utah, and there is a nonprofit community health center that serves the Navajo Nation called the Utah Navajo Health System Inc. This health system does not receive any state or county funding and they provide medical and dental services to rural Navajo communities in Utah (Utah Navajo Health Systems Inc., 2013). The Health, Education, and Human Services Committee for the Navajo Nation has found that this system has made significant progress in meeting the needs of tribal members (Navajo Nation

Council, 2013). This organization could serve as a liaison between the Navajo Nation and the state to expand needed services that are culturally acceptable to tribal members of the Navajo Nation in Utah.

Barriers to self-sufficiency of a Navajo Medicaid agency

The IHS is tasked with improving the health status of AI/AN (Zuckerman *et al.*, 2004). Tribes view the development and funding of IHS as an inherent and fundamental right through the Federal Trust Responsible Doctrine (Noren *et al.*, 1998). Moreover, according the Department of Health and Human Services and Office of the Inspector General's (1996) manual on 'Tribal Contracting for Indian Health Services' tribal 638 providers can contract to receive funds and directly provide services. The 1996 manual provides the following information:

> Within the Department of Health and Human Services, IHS is the primary provider of health care to tribes. Through a contract, tribes can receive the money that IHS would have used to provide direct health services for tribal members. Tribes can use these funds to provide directly, or through another entity, a broad range of health services. This option was part of P.L. 93-638 and is commonly known as '638 contracting.' The extent of 638 contracting varies widely among tribes and IHS areas, ranging from as much as 91 percent to as little as 1 percent of an Area Office's budget. According to 1994 IHS data, tribes and tribal organizations operate 9 hospitals and 342 health centers, stations, and clinics. The IHS operates 119 health centers, stations, and clinics and oversees 40 hospitals. Tribes contract for nearly 32 percent of the total IHS budget, which is approximately $1.7 billion. Because tribes view 638 contracting as an opportunity to customize and improve health care for their communities, almost 75 percent of them want to increase the number and scope of their contract. (3)

Although the IHS provides hospitals, clinics, and primary care services on reservations or near targeted communities and IHS 638 providers contract to provide care, funding limits affect the availability and accessibility of local health care services. Regardless of who is the authorized provider of health service delivery, there are still health disparities, financial and physical, that exist among members of native communities.

Case in point, specialty services are typically contracted out to private providers who may not practice in proximity to native communities limiting access to services. There are many tribal members who do not live on or near their reservation so they cannot access IHS services or other forms of health service models and must therefore seek alternate means to access services outside of native communities and facilities. If tribal members lack financial access they may not receive necessary health care services (Zuckerman *et al.*, 2004). As a result of a lack of financial access, Ruth Katz (2004) notes that AI/AN's have a higher incidence of premature death, illness, and injury than Whites who are not Hispanic. Furthermore, among Native Americans there is a wide gap between use

of health care services and access to care compared to non-Hispanic Whites. Devi (2011) points out that there are 170,000 tribal members who live in the desert and alpine forest and 18,000 homes do not have electricity.

The Navajo Nation is plagued by issues such as unemployment, poor housing, restricted access to food supplies, and lack of transportation. These social determinants must be considered in any plan that impacts service and use of health care services (Brennan *et al*., 2008). For example, in a report submitted to the New Mexico Human Services Department and the Medical Assistance Division of New Mexico a spokesperson for the Navajo Nation (2012) stated that 'the unemployment rate for the Navajo Nation was more than ten times higher than that of New Mexico in general. In 2007, 36.76% of Navajos were living below poverty level as compared to 18.13% of New Mexicans thus qualifying Navajo individuals for Medicaid programs in New Mexico' (Navajo Nation, 2012: 2).

The next section of this article discusses reasons that the Navajo, although eligible for established state Medicaid programs, are resistant to enrolling and becoming beneficiaries.

Psychological, sociological, cultural, geographic and business barriers

The Navajo Nation believes that commercial and government managed care organizations do not understand the problems associated with poverty and the specific health needs of the AI population. Specific health issues include treatment for depression, physical and emotional neglect, child abuse and chronic health problems (Navajo Nation, 2012).

Lamphere (2005) described the 1990's advent of privatization of health care and the mandatory enrollment of Medicaid eligible recipients in managed care organizations as a system of chaos. Local leaders representing the Navajo Nation assert they were not consulted about new systems and changes in Medicaid programs led to issues with billing, provider credentialing, and inadequate access to care for tribal members (Lamphere, 2005). Others who worked directly with the Navajo Nation from 1996 to 2000 disagree and state that in New Mexico, there was extensive communication and consultation.

A report by the Government Accountability Office (GAO) analyzing the coordination of public programs for the IHS found that a major barrier confronting AI/ANs is information inaccessibility. This could contribute to the perceived problems with transition to Medicaid managed care programs. Also, privacy laws limit outreach efforts for renewal of Medicaid applications and for checking the status of new applicants (US Government Accountability Office, 2013). Keeping track of tribal members who do not have a permanent address is difficult, which can contribute to health disparities due to interruptions in care and follow-up. For example beneficiaries eligible for health insurance through Medicaid will lose their insurance coverage because they do not receive and do not act on renewal notices.

This issue, of course, is not limited to tribal members but also affects the general Medicaid population.

There are language barriers which make communication with non-Navajo providers difficult. Many AI/AN's practice traditional healing remedies such as prayer, chants, and dance (Navajo Nation, 2012). Marrone (2007) found that 70% of American Indians who live in both rural and urban areas use traditional healing practices which sometimes lead to conflicts between cultural beliefs and practices and systems used in western medicine. Western health care systems are generally not designed to incorporate spirituality into the health and healing process of indigenous people.

A geographical perspective must also be considered when crafting and implementing changes to the delivery of health care to Native Americans. Many AIs live in rural areas with a limited number of available providers (Navajo Nation, 2012). Baldwin *et al.* (2008) conducted a study on access to specialty services for AI/ANs and found that there were long wait times, an excessive amount of travel time, problems with obtaining transportation, and a lack of knowledge on the part of the patient in regards to navigating the health care system.

Zuckerman *et al.* (2004) also found that many AI/ANs were not satisfied with the quality of their care, they lacked confidence in accessing care for medical problems, and reported poor communication with providers. Moreover, the GAO (2013) reported a lack of capacity building indicating that a national plan is not the place to handle increased services for eligible tribal members.

The states of New Mexico, Utah and Arizona provide Medicaid services for a large population of Navajos and use fee-for-service as well as managed care organizations to deliver that care. Conducting a cost benefit analysis to compare the cost effectiveness of providing additional services through functioning managed care organizations vs permitting the Navajo Nation to manage their own Medicaid Agency would provide useful and important information for decision makers. However, any analysis or evaluation should include an assessment of the needs and concerns as expressed by representatives of the Navajo Nation.

Discussion

The passage of the Affordable Care Act created a window of opportunity for the Navajo Nation to request status as a state in order to manage a Medicaid Agency. This request has been made but it has not gained national attention and the request requires governmental action which has not as yet been forthcoming.

The Navajo Nation appears to be the sole policy entrepreneur pushing the proposal to establish a Medicaid Agency for tribal members as part of the national agenda under the ACA. The Vice President, Rex Lee Jim, of the Navajo Nation is actively involved in advocating for an independent Medicaid Agency. He stated, 'The Navajo Nation Medicaid Program is worth pursuing. The leadership has an

interest in expanding its jurisdiction, and the Navajo Nation is willing to stretch as far as possible' (Econometrica, 2014: B-45). Others interested in pursuing the option of establishing an independent Medicaid Agency include Navajo legislative representatives, and Roy Begay, a Program Evaluation Manager for the Navajo Division of Health (Econometrica, 2014). However, according to a report in the *Daily Times Four Corners News*, in New Mexico there are other politicians who have concerns about the planning and management of a stand-alone Medicaid program run by the Navajo Nation (Kane, 2013).

Nonetheless, legislation in the form of the ACA of 2010 and IHCIA of 2009 provides the Navajo Nation with an opportunity to request authorization as an independent state in order to administer a Medicaid Agency. Unresolved is the question of whether this is the best policy option for achieving the stated goals of the Navajo Nation: optimal health benefits, reducing health disparities and providing access to care.

Research should be used to inform change. For example, grants awarded to the Indian HSD to assess unmet needs could direct findings toward effective solutions to benefit all tribes. Grants awarded to tribes by the federal government for health policy research to prevent or manage chronic illness could result in multi-level benefits as there is promise in research related to the targeted care of multiple health conditions, informed decision making, and self-care (Goetzel *et al.*, 2005). Applying measures to assess effectiveness of care, entry and structural barriers to care, safety, timeliness, health care utilization, patient-centered care to improve health care services and patient satisfaction for tribal members has to be a requirement for implementing and sustaining any health care practices (Moy *et al.*, 2006).

The implementation of health policy research should certainly include performance measures as well as qualitative and quantitative methods for assessing cost-savings and satisfaction with care to provide evidence based data on the effectiveness of each partnership with the Navajo Nation. Inclusion of AI/AN leaders in the development of policies and new initiatives for Medicaid and other health care programs affecting Native Americans should be maintained as common practice. Partnerships between states and the Navajo Nation could enhance the decision-making process for all parties as they learn from each other.

After all options have been tested and evaluated, if there is no progress toward goals for better care and health, then the establishment of a Medicaid Agency explicitly for and by the Navajo Nation, should be revisited.

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Charles Milligan reviewed and advised on the content of this manuscript. He is currently the CEO of United Health Care Community Plan of New Mexico, and Commissioner on the Medicaid and CHIP Payment and Access Commission. Previously he served as Deputy Secretary for Healthcare Financing (Medicaid

Director) Maryland Department of Health/Mental Health (2011–2014), and as the Medicaid Director for the New Mexico Human Services Department (1996–1999).

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