Indian Health Financing Series

Supplement II

Sovereign Capacity as a Financing Solution: The Fond du Lac Model

A Case Study in the Indian Health Financing Series

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Designation Note. *Supplement II is designated separately from the numbered papers to reflect its character as extended case study analysis rather than primary policy and financing analysis. Its analytical argument is policy-oriented — that the FMAP gap for urban AI/AN patients is not constitutionally unavoidable — but that argument is grounded in the institutional biography of a single program rather than in the quantitative and documentary analysis that defines Papers VI and VII. Supplement II should be read after Paper VI's Section 4, which introduces the four-type classification framework of which the Fond du Lac/CAIR program is the Type 4 archetype.*

Abstract

The FMAP disparity between Title V Urban Indian Organizations and IHS/Tribal programs — documented in Papers VI and VII — is often treated as a structural inevitability: UIOs receive standard FMAP because that is what their legal authority provides, and changing it requires Congressional action. This supplement examines an alternative proposition, demonstrated by a single tribe over nearly four decades: that a federally recognized tribe with sufficient administrative capacity can close the financing gap for its own urban-dispersed members by extending its Tribal 638 program authority off-reservation into the cities where those members live.

The Fond du Lac Band of Lake Superior Chippewa, whose ancestral territory is the site of present-day Duluth, Minnesota, has operated the Center for American Indian Resources (CAIR) in downtown Duluth since 1988 as a satellite of its on-reservation Human Services Division — under the same 638 authority, with the same eligibility rules, and at the same financing rates as its primary clinic in Cloquet. A Fond du Lac member in Duluth using CAIR receives care at 100% FMAP with OMB rate billing and Contract Health Services access — the same financing as if they had never left the reservation. The program was built incrementally over 37 years under the direction of Phil Norrgard, who served as Director of Human Services from 1979 until his retirement in January 2017. Norrgard's career illustrates both the potential and the demands of the Type 4 model: the financing innovations he pursued at state and federal levels were inseparable from the program's urban reach.

1. The Historical and Territorial Foundation

Before the establishment of the Fond du Lac Reservation, the Fond du Lac Band of Lake Superior Chippewa were located at the head of Lake Superior, at the mouth of the Saint Louis River — the site where Duluth subsequently developed. The 1854 LaPointe Treaty relocated the Band to its current reservation near Cloquet in Carlton and Saint Louis counties, approximately

15 miles west of Duluth. The Band's ancestral territory is therefore not a coincidental adjacency to the city but its actual ground. This historical claim is operationalized institutionally: the Fond-du-Luth Casino on East Superior Street in downtown Duluth was built on a block the Band purchased and had placed into federal trust by the BIA, and the Band has maintained continuous political and civic relationships with the City of Duluth and St. Louis County across decades.

The Band's relationship to Duluth is therefore a different kind of urban presence than most tribes have in the cities where their members have dispersed. It is not a relocation-program relationship — the Band was not sent to Duluth; Duluth was built on its land. The urban reach of the CAIR program is, in a meaningful sense, a return rather than an extension. That distinction matters less legally than politically: the Fond du Lac Tribe's urban presence in Duluth has the legitimacy of a historical claim, not merely the legitimacy of a funding strategy.

2. Building the Program: Phil Norrgard and the Human Services Division

Phil Norrgard arrived at the Fond du Lac Reservation in 1979 as a University of Minnesota Duluth Master of Social Work student volunteer. He described his first health care clinic this way: the living room was the waiting room, two bedrooms were examination rooms, the kitchen was the lab and pharmacy — with employee lunches on the rack above the medicines — and his own grant-writing office was in the basement. That program had five employees and a budget of $258,000.

Nearly 38 years later, when Norrgard retired in January 2017, the Fond du Lac Human Services Division operated six modern facilities in Cloquet, Duluth, and Minneapolis, with 325 employees and an annual budget exceeding $43 million. On the day of his retirement, Governor Mark Dayton proclaimed January 18, 2017 as "Phil Norrgard Day," citing his service to "Fond du Lac, Minnesota, and the nation." The University of Minnesota subsequently awarded him its Outstanding Achievement Award. Scott Giberson, deputy director of human capital at CMS, wrote that Norrgard "was a pioneer of support, facilitating innovative healthcare delivery at its highest level 15 years ago — well before the current health reform movement."

Norrgard's own description of his operating philosophy was precise: "If you want to start programs, you need the money. So my job as a technocrat was to figure out where the resources were. I was a bird dog." That framing — director as financing technician — captures the essential mechanism of the Type 4 model. The urban extension was not primarily a political or cultural decision, though it had both dimensions. It was a financing strategy: the recognition that Fond du Lac members living in Duluth generated a federal health obligation that was not being met, and that ISDEAA provided the legal mechanism to meet it if the program architecture could be built to reach them.

The CAIR Timeline

The Human Services Division was established in 1974 when the Band first contracted with IHS for the Community Health Representative program — the Band's initial entry into 638 contracting. By 1985, the division had been reorganized and was growing toward 40 employees. In 1988, the Center for American Indian Resources opened at 211 West Fourth Street in Duluth, initially providing social services and public health functions. In 1992, a full outpatient medical clinic was established at CAIR, adding physician services, pharmacy, lab, and x-ray to the existing community health and social services. Subsequent expansions added occupational and physical therapy, adult and adolescent chemical dependency treatment, behavioral health services, and dental care. The multi-story building at the current address — 221 West 4th Street — was designed with floor-to-ceiling windows overlooking Lake Superior and appointed with works by regional Native American artists, signaling that this was not an outpost but a permanent institutional presence in the city.

CAIR operates as a satellite of the Fond du Lac Human Services Division under the same 638 authority that governs Min No Aya Win, the primary clinic on the reservation in Cloquet. Patients register through either location using the same process. The Division's eligibility rules apply uniformly: proof of tribal enrollment is required for medical and dental Direct Care services, and Contract Health Services for referred care are available to enrolled members at both locations. A Fond du Lac member receiving care at CAIR accesses the same federal financing — 100% FMAP, OMB rate billing, CHS for referrals — as a member receiving care on the reservation. The urban address does not alter the financing outcome.

3. The Financing Innovations That Made the Model Sustainable

The CAIR program's urban reach would have been administratively possible but financially unsustainable without a set of parallel financing innovations that Norrgard drove at the state and federal levels across his career. The program building and the policy advocacy were inseparable; each depended on the other.

1990s: Medicaid Reimbursement Reform

In the 1990s, Norrgard led tribal efforts to craft Minnesota laws and regulations allowing tribes and IHS to collect Medicaid reimbursement from the state for services they were providing. This was the foundational financing reform for the CAIR model: establishing that a tribal 638 satellite clinic operating in a city could bill Minnesota Medicaid at 100% FMAP for enrolled members, rather than at the standard FMAP a community clinic would receive. Without that reimbursement, the medical clinic added at CAIR in 1992 could not have sustained the staffing and service levels that made it a genuine primary care program rather than a limited outreach operation. Norrgard later received awards from the National Indian Health Board and Harvard University's Honoring Nations Program for this and subsequent financing work.

2000s: Medicare Part D Tribal Sponsorship

In 2005, Norrgard developed a "tribal sponsorship" program under which the Fond du Lac Band paid Medicare Part D drug insurance premiums for tribal members — allowing their

pharmaceutical costs to be covered by Medicare rather than falling on the tribal health budget. An electronic pharmacy billing system created under his direction pursued third-party reimbursements aggressively across both the Cloquet and Duluth programs. These systems were not limited to CAIR's urban patients; they improved the financial position of the entire Human Services Division. But for CAIR specifically, they meant that enrolled Fond du Lac members in Duluth had access to the same pharmacy benefit infrastructure as members on the reservation. The tribal Medicare Part D sponsorship model proved exportable: it has since been adopted by tribes across the country as a template for maximizing Medicare revenue within tribal health programs.

2010s: ACA Total Coverage and MNsure

With the passage of the Affordable Care Act in 2010, Norrgard developed the Fond du Lac Total Coverage program, which helped more than 95 percent of FDL patients obtain health insurance coverage — a rate of coverage that few tribal programs, and few health care organizations of any kind, achieved in the ACA's early years. Governor Dayton appointed Norrgard to the MNsure Board of Directors in 2013, where he served as board chair from 2017 to 2019. His work through MNsure brought coverage to enrolled AI/AN populations across Minnesota, including urban members served by programs like CAIR. The ACA enrollment work completed the financing picture: enrolled Fond du Lac members in Duluth could now be served by CAIR with IHS-rate Medicaid billing for covered services, Medicare Part D coverage for pharmaceuticals, and ACA marketplace or Medicaid coverage for remaining gaps — a coverage architecture built incrementally over more than three decades of policy work alongside the clinical program.

4. The Minneapolis Extension and the Replicability Question

Fond du Lac's urban reach extended beyond Duluth. The Band operates the Mashkiki Waakaaigan Pharmacy — Medicine House — in Minneapolis, providing pharmaceutical services to enrolled Fond du Lac members dispersed into the Twin Cities metropolitan area. The Minneapolis pharmacy represents a more targeted extension than CAIR — a single-service satellite rather than a full primary care program — but it operates on the same legal and financing logic: tribal 638 authority extended to where the members are, generating the same Medicaid billing treatment as the on-reservation program.

The two-city model — full clinical program in Duluth, pharmacy satellite in Minneapolis — suggests that Fond du Lac has institutionalized the urban extension rather than treating CAIR as a one-time experiment. It also illustrates a scalable architecture: a tribe can extend different service components to different cities depending on where its members are concentrated and what services that concentration requires, without replicating the full clinical infrastructure in every location.

The replicability question is real but should not be overstated as a barrier. The Type 4 model requires three things that are not universally available: a tribe with sufficient 638 administrative capacity to operate a satellite clinic in a city; an IHS area office willing to include the off-

reservation satellite within the compact or contract; and state Medicaid cooperation to recognize the off-reservation facility at 100% FMAP. Fond du Lac had all three, plus a specific historical relationship to Duluth that gave the extension institutional legitimacy. Many tribes with significant urban-dispersed membership do not have comparable administrative capacity or comparably cooperative state Medicaid relationships. The model is replicable in principle; building the conditions for it is the work of years or decades.

5. What the Fond du Lac Model Demonstrates

The policy argument of this supplement is narrow but important: the FMAP gap for urban AI/AN patients is not constitutionally or administratively unavoidable. It is a default outcome — what happens in the absence of a Title V UIO and in the absence of a tribe willing and able to extend its 638 authority into the city. Fond du Lac changed that default for its own members in Duluth. The gap persists for the large majority of urban AI/AN patients not because the law forecloses a solution, but because the solution requires a level of sustained administrative capacity and policy sophistication that most tribes cannot maintain across the decades it takes to build what Fond du Lac built.

This reframing matters for the 100% FMAP reform argument in Paper VII. That argument is sometimes framed as asking Congress to create a new financing mechanism for a population that currently lacks access to federal health financing. The Fond du Lac model shows that is not quite right. Congress does not need to create a new mechanism; ISDEAA already provides it, and Fond du Lac has used it. What Congress needs to do — if the trust responsibility argument in Paper VI is accepted — is extend systematically what tribal sovereignty can achieve only episodically: full federal assumption of the Medicaid cost for IHS-eligible AI/AN patients, regardless of whether they happen to live near a tribe willing and able to operate an off-reservation satellite clinic.

Phil Norrgard's career is the empirical demonstration of that argument. He arrived at a five-person program in a converted house, saw that Fond du Lac members in Duluth had no access to what tribal program financing could provide for them, and spent 37 years building the program, the financing architecture, and the policy infrastructure to close that gap — one grant, one state regulation, one federal program, one partnership at a time. What he built took a career. The H.R. 4722 reform would extend its effect to every enrolled Tribal member in every city, without requiring a Phil Norrgard in each of them.

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