TRIBAL ANALYSIS
FOR
WASHINGTON STATE HEALTH BENEFIT EXCHANGE
&
HEALTH CARE AUTHORITY

AMERICAN INDIAN HEALTH COMMISSION
FOR WASHINGTON STATE

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EXECUTIVE SUMMARY

Provisions in the Patient Protection and Affordable Care Act of 2010 (ACA) call out the intent of Congress to assure the trust responsibility of the federal government to American Indian and Alaska Native (AI/AN) people and Tribal governments is protected and advancements in Indian health can be achieved. The ACA contains a number of special statutory benefits and protections for AI/AN people served by the Indian health system. The Indian Health Care Improvement Act (IHCIA) that was passed as an amendment to the ACA also contains a number of provisions that will affect the manner in which States develop their Exchange functions and how they relate to the Indian Health System. The Indian Health Service (IHS) and Tribally-operated health programs operate under a very unique and complex body of laws that require specialized expertise.

It is important to consider the uniqueness of this health care delivery system as Washington develops and designs its Health Benefit Exchange (HBE). A certain level of analysis, planning and technical assistance to the Washington State Health Benefit Exchange Board (WHBEB) will be required to assure the HBE appropriately addresses the needs of AI/AN people and the Indian health delivery systems in Washington.

The following Tribal Analysis report has been created as a resource tool for the WHBEB and a guide for the American Indian Health Commission of Washington (AIHC) in that effort. It describes the demographics of the AI/AN population and AI/AN health status in Washington, details the complex system of services, programs and supports that comprise the Indian health delivery system, outlines the provisions within the ACA that impact AI/ANs, and summarizes the approach AIHC will use in assisting the WHBEB in addressing the unique provisions and requirements for AI/AN and Indian health systems as the HBE is fully developed and implemented.

American Indian Population & Health Status

There are an estimated 192,114 AI/ANs in Washington, approximately 2.9% of the total state population and 3.9 % of the total 4.9 million AI/AN population in the United States. Washington has the sixth largest AI/AN population. Over one-half of the population resides in urban areas.

Washington's AI/AN population is younger, has lower income and less formal education than nearly every other ethnicity. They are more likely to live in poverty than any other racial or ethnic group in Washington. AI/AN people also experience a disproportionately higher mortality and morbidity burden compared to the general population.

Washington's AI/AN un-insured rate is 23.1%, approximately 41,000 individuals. Although Washington's AI/AN uninsured rate is the 12th lowest among the states, Washington's AI/AN uninsured rate is nearly twice the 13.4% rate for the entire state.

While Washington AI/ANs have achieved great gains in health status over the past 50 years, they continue to lag behind the general population significantly in key health indicator areas.

Washington's Indian Health Delivery System

The Indian health system has been developed under a complex and comprehensive amalgam of Federal Indian policy that draws upon treaties between Indian Nations and the United States, Indian-specific provisions in the U.S. Constitution, federal laws, U.S. Supreme Court cases and other case law.

While Federal Indian policy has shifted significantly over time, there are three basic legal principles that have remained constant that continue to guide the administration of federal Indian health programs: (1) Federal trust responsibility; (2) Government-to government relationships; and, (3) Tribal sovereignty.

The federal governmental responsibility of health services to Indian Tribes is a direct result of treaties and executive orders made between the United States and Tribes. The exchange of Indian land and resources forms the basis of the federal obligation for health care and other services. The origins of federal-provided health care to AI/AN people began in the nineteenth century as the United States was founded and westward expansion increased. The Federal government's earliest goals were to prevent disease and to speed Indians to assimilate into the general population by promoting Native American dependence on Western medicine and by decreasing the influence of traditional Indian healers.

The Snyder Act of 1921 is the basis for the modern Indian health care delivery system. The Act directed the federal government to provide appropriations " … *for the benefit, care and assistance . . . [and] for the relief of distress and the conservation of health . . . for Indians tribes throughout the United States*." This provided the first formal authority for the Federal provision of health services to members of Federally-recognized Tribes.

The Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638, ISDEAA) changed the Indian health care delivery system forever by allowing Tribes the authority to assume the responsibility for administering their own health programs.

The Indian Health Care Improvement Act of 1976 (P.L. 94-437, IHCIA) is the key Federal law today that authorizes appropriations for the provision of health care to AI/AN people. It establishes the basic programmatic structure for delivery of health services to Indian people and authorizes the construction and maintenance of health care and sanitation facilities.

The IHS is the primary source of funding for tribal and urban Indian health programs. It provides appropriations from Congress that are used to provide direct medical and specialty care services to eligible AI/AN people. Along with ambulatory primary care services, dental care, mental health care, eye care, and substance abuse treatment programs and traditional healing practices are also provided.

Because the IHS' Contract Health Services (CHS) program is severely underfunded and cannot meet its level of need in providing services, IHS has special rules dealing with its eligibility and provider payments. The circumstances associated with managing the CHS program's eligibility rules are one of the key reasons why the Indian health system must be effectively integrated with state insurance exchanges. Federal rules require a very stringent eligibility system for CHS service and patients must exhaust all alternate resources before qualifying for eligibility.

These rules also use a medical priority system in order to determine priorities for purchasing services, and require providers to accept Medicare-Like Rates for any CHS referral, or risk their participation in the Medicare program.

In order to address IHS funding shortfalls, Washington's Tribes have aggressively sought third party payment strategies. All of the Tribes that have tribal health clinics contract with the state Medicaid agency to be providers to access Medicaid financing to help provide health services to tribal members. Ten Tribes also participate in the Basic Health Plan's (BH) sponsorship program and are currently financing 912 enrollees. Tribal sponsors represent 56% of all BH sponsors.

Washington's tribal delivery system is statewide and provides care to AI/AN people residing in both rural and urban areas. 28 of the 29 tribes have clinics that provide medical or behavioral health services. There are 2 urban Indian health clinics in Seattle and Spokane that provide care to urban AI/AN people. Several Tribes located near the I-5 corridor also are able to serve urban AI/AN people.

There are some 60 clinic sites across the state. Of key importance to the HBE, there are 34 tribal medical clinics. In addition to providing primary care, 22 of the medical clinics also provide dental care, 12 provide pharmacy services, 19 provide mental health treatment and 15 provide chemical dependency services. In addition to the medical clinics, 18 Tribes also have separate sites that provide mental health and behavioral health services at 23 locations.

The Tribes and urban Indian health programs are the essential community providers for Washington's AI/AN population. In spite of limits on IHS-CHS funding, the Tribes have built a capacity to serve Indian people. With the estimated expansion of coverage for some 41,000 AI/AN people through the ACA, these clinics will be the key health homes and essential community providers for most Indian people.

ACA, IHCIA & State AI/AN Provisions

The ACA includes a number of provisions to improve the health of AI/AN people and to support the Indian health systems participation in the ACA HBEs and 2014 Medicaid expansion. The ACA also reauthorizes and amends the IHCIA, which includes specific tribal program provisions designed to support the Indian health systems participation in Medicare, Medicaid, Children's Health Insurance Program (CHIP) and HBEs.

AI/AN Cost-Sharing Exemption. AI/AN people in households with incomes up to 300 % of the federal poverty level (FPL) are exempted from any cost-sharing requirements in the HBE individual market.

Tribal Program Cost-Sharing Provisions. Qualified health plans (QHP) are prohibited from reducing payments to providers to off-set the cost of the AI/AN cost-sharing exemption.

AI/AN Exemption from Health Insurance Penalties. Certain persons are exempt from the penalty for not having health insurance, including a member of an Indian Tribe. The law exempts members of Indians on the basis of the federal trust relationship.

AI/AN Monthly Enrollment Periods. Under the ACA, AI/AN applicant have special monthly enrollment periods to facilitate prompt enrollment in the HBE. Federal rule defines this to mean that an AI/AN person may enroll in a QHP or change from one QHP to another 1 time per month.

HBE Consultation. HBEs are required to consult with stakeholders relevant to the implementation and administration of the Exchange. Federal rules require the HBE have on-going consultation with federally-recognized tribes located within the Exchange's geographic area.

Navigator Program. HBEs are required to have a program that awards grants to entities that serve as a "navigator." Federal rule lists entities that can be navigators, which includes Indian Tribes, tribal organizations, and urban Indian organizations.

Program Essential Community Provider Status. The ACA requires the Department of Health and Human Services (HHS) to establish minimum certification criteria for health plans to become QHPs in the HBE. QHPS must contract with "essential community providers that *"… serve predominately low-income, medically-underserved individuals."* Federal law and rules include tribal programs and urban Indian health programs to be HBE essential community providers.

Special Indian Contracting Requirements. To prompt tribal program participation as QHP essential community providers, HHS will be developing an Indian contract addendum for state HBEs on federal requirements that must be meet when contracting with Indian providers. These include: the Anti-Deficiency Act, the Indian Self-Determination and Education Assistance Act, the Indian Health Care Improvement Act, the Federal Tort Claims Act, and the Federal Medical Care Recovery Act.

Tribal and Urban Indian Program Licensing Requirements. The IHCIA requires that federal health care programs accept an entity operated by IHS, Tribes or urban Indian organizations as a provider eligible to receive payments, on the same basis as other qualified providers, if it meets the applicable licensure requirements for its provider type, regardless of whether the facility obtains the applicable license. This licensing requirement applies tribal programs that contract with HBE QHPs.

Tribal Professional Provider Licensing Requirements. The IHCIA provides that licensed health professionals that are employed by a tribal health program are exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services. These provisions apply to professionals working for tribal programs that are QHP providers.

Tribal Program Payments. The IHCIA requires that all Indian health providers have the right to recover from third party payers, including insurance companies up to the reasonable charges billed for providing health services or, if higher, the highest amount the insurer would pay to other providers to the extent that the patient or another provider would be eligible for such recoveries.

WHBE Tribal Consultation. Consistent with federal HBE requirements, Washington's HBE law specifically requires the B WHBEB to consult with the AIHC on the implementation and administration of the HBE.

Sponsorship. State legislation directs the WHBEB to establish rules or policies that permit city and county governments, Indian tribes, tribal organizations, urban Indian organizations, private foundations, and other entities to pay premiums on behalf of qualified individuals.

Essential Community Providers. State legislation re-affirms federal requirements that tribal programs and urban Indian health programs are HBE essential community providers. This requirement also re-affirms state policy that health plans regulated by the State Insurance Commission under Chapter 48 RCW require plans to contact with tribal programs.

AIHC Approach to Addressing HBE AI/AN and Indian Delivery System Issues

Preparing AI/AN for HBE Enrollment. Develop tools and mechanisms to assure enrollment of AI/AN in qualified health plans in the Exchange. This will include development of a tribal-centric navigator model, creation of a Tribal model for premium sponsorships, technical assistance to the HBE call center to facilitate AI/AN enrollment with special provisions, education and outreach to help prepare Tribes for enrolling AI/AN, and technical assistance to the HBE in assuring AI/AN provisions are included in the design of the IT system.

Tribes/Urban Programs as In-Network Providers. Work with WHBEB to assure tribal health programs are integral to the provider networks of qualified health plans. This will include: deeming tribal and urban Indian health providers as essential community providers; "any willing" essential community provider must be contracted with by QHPs; tribal and urban Indian health providers are reimbursed at rates consistent with federal requirements; and, there is the development of a "Indian" addendum to all standard QHP contracts. The AHIC will partner with QHPs and others to prompt these issues, and review essential health benefits design for any policy issues that may need to be addressed.

Tribal Consultation. Develop a consultation policy that is vetted by Tribes and urban Indian health programs. Work with the WHBEB to finalize this policy for implementation. During the 2011 Washington State Legislative Session, lawmakers passed SB 5445 which created a Washington State Health Benefit Exchange, a mandated provision of the Patient Protection and Affordable Care Act of 2010 (ACA). Along with establishing Washington's intent to create an exchange, SB 445 sets forth the governance structure and process for which policy decisions will be made in establishing the exchange. The goal of the exchange is to provide a central marketplace where individuals, families and small businesses can access and purchase affordable health care coverage and if applicable, apply for Medicaid and CHIP programs or qualify for tax subsidies to help pay for health insurance premiums.

In recognition of the government-to-government relationship between Federally-recognized Tribes and Washington State and to acknowledge the need to assure that Indian specific provisions contained in the ACA are addressed in the design of the exchange, the following language was also included in the state law, *"(9) In recognition of the government-to-government relationship between the state of Washington and the federally recognized tribes in the state of Washington, the [health benefit exchange] board shall consult with the American Indian health commission." (Emphasis added)*

INTRODUCTION

In December 2011, the American Indian Health Commission (AIHC) received funding from the Washington State Health Care Authority (HCA) to conduct an assessment of Washington State Health Benefit Exchange (HBE) work and analyze impacts that the Patient Protection and Affordable Care Act's (ACA) health benefit exchange (HBE) would have on American Indian/Alaska Natives (AI/AN) and the Indian health delivery system in Washington. Another component of the scope of work included the development of a funding proposal to be included in the HCA Level 2 Establishment Grant proposal that would be submitted to the U.S. Department of Health & Human Services (HHS), Center for Consumer Information and Insurance Oversight (CCIIO), at the end of March 2012. An assessment of the HBE has been completed and was submitted under separate cover. It outlined preliminary areas on which AIHC and Tribes will need to focus in the coming year.

The following report is an analysis of the Indian health delivery system and identifies issues that are relevant to the HBE design. The material provided in this report is intended to serve as an educational piece for the Washington Health Benefit Exchange Board (WHBEB) and their staff as they begin development of the HBE. This information will also serve as a guide for the AIHC's work with the WHBEB, HCA, and the Office of Insurance Commissioner (OIC). It will assure that the ACA Indian specific provisions are adequately addressed in the development of the HBE so that AI/ANs have the greatest access possible to insurance plans in and outside the Exchange. The report is divided into four sections:

1. The American Indian/Alaska Native (AI/AN) population in Washington State – This section provides an overview on the demographics, health status and health insurance rates of AI/AN people. It is important to understand how Indian people will/will not access insurance plans through the HBE. It highlights unique challenges and access to care issues that have been identified to demonstrate the need to assure the HBE works for AI/AN people.

2. The Indian Health Service Delivery System – The Indian health system is unique in that it was created and designed by the Federal government to carry out the Federal trust responsibility for Indian health. It is governed by a complex set of statutes and regulations and has many special challenges. This section provides an overview of these issues including, but not limited to: Indian Health Service (IHS) being funded at only 60% of its level of need; a brief overview of the federal and state laws and regulations that Indian health programs operates under; a summary of the tribal and urban Indian health programs in Washington; and, how the importance of understanding these complexities is necessary knowledge in working collaboratively with Tribes and the AIHC as the HBE is designed and implemented.

3. Analysis of the ACA and the Newly-Authorized Indian Health Care Improvement Act (IHCIA) – This section identifies those ACA and Indian Health Care Improvement Act (IHCIA) provisions that either specifically pertain to AI/AN and tribal health programs or provisions that have a major impact on AI/AN and tribal health programs. This information will be critical to the on-going technical assistance AIHC can provide to the WHBEB and their staff in further HBE design AND development.

4. Summary of AIHC's Funding Proposal – Based on the HBE assessment previously completed and the outcomes of this report, AIHC has identified key areas in which it will need to engage both the HBEB and Tribes in over the coming year. These areas are summarized in this report.

SECTION ONE: American Indian Population & Health Status

Population

There are an estimated 192,114 AI/ANs in Washington, approximately 2.9% of the total state population and 3.9 % of the total 4.9 million AI/AN population in the United States. Washington has the sixth largest AI/AN population, with California (662,000 AI/N population) having the largest population, followed by Oklahoma (482,000) and Arizona (334,000).

Contrary to general assumptions, a significant proportion of Washington's AI/AN population reside in urban areas. Forty-one percent (estimated 78,600 people) of Washington's AI/AN population reside in the Seattle-Tacoma-Bellevue Metropolitan Statistical Area (MSA) and 6% (estimated 12,400 people) reside in the Spokane MSA.

Washington's AI/AN population is younger, has lower income and less formal education than nearly every other ethnicity. A much larger proportion is under the age of 18 than the all races population (32% compared to 23.6% for all races). A much smaller number is over 65 with just 6.5% compared to 12.1 % for all races in Washington.

Health and Socio-Economic Status

The AI/AN population in Washington State is diverse, geographically dispersed, and economically disadvantaged. [1] AI/ANs are more likely to live in poverty than any other racial or ethnic group in Washington. This population also experiences a disproportionately higher mortality and morbidity burden compared to the general population. While Washington AI/ANs have achieved great gains in health status over the past 50 years, they continue to lag behind the general population significantly in key health indicator areas.

Mortality

The life expectancy of an AI/AN individual is lower than any other population in Washington. In the *"Washington State Vital Statistics Report of 2008*[2]*,"* mortality data was assessed over a five year period from 2002 – 2006, using ten (10) leading causes of death. The outcomes were disheartening for AI/AN people. Misclassification of AI/AN as white or Hispanic that frequently occurs could mean the outcomes are far worse than even indicated:

- AI/AN males and females had the lowest life expectancy than any other population in Washington (71 and 75 years of age, respectively)
- AI/AN age-adjusted mortality rates (1,187.5 per 100,000) exceeded all other groups, and was significantly higher than Whites ((897.6 per 100,000)
- From 1990 – 2006, there were significant decreases in age-adjusted mortality rates for Whites, Blacks, and Asian/Pacific Islanders, yet no significant downward trend was seen in AI/AN male rates, and AI/AN females experienced a 1.3% increase per year in mortality rates.

[1] American Indian Health Care Delivery Plan: Opportunities for Change. 2012 – 2013.

[2] Washington State Department of Health, Center for Health Statistics. Vital Statistics 2006 Report. November 2008

Leading causes of death for AI/AN include:

- Heart disease
- Cerebrovascular disease
- Unintentional injuries
- Cancer
- Diabetes Mellitus
- Chronic Liver Disease and Cirrhosis

If one looks at death by age, AI/AN people are much more likely (nearly twice) to die in middle age (25-65) than the general population. Conversely, only 45% AI/AN people die after 65 compared to 74% of the general population.[3] Suicide is also much more common among AI/AN people than the general population.

Data for Washington State AIANs from the American Community Survey is utilized for this analysis since it contains information on a broad range of socio-economic factors thought to influence health. Over 6,300 Washington AIANs responded to the survey for the three years 2008, 2009, 2010. The data is pooled and adjusted for inflation and other factors to produce a 3-year report. Given the relative small size of the AIAN population the three year estimate is a vast improvement over surveys with much smaller sample size.

Morbidity

The leading causes of outpatient visits for AI/AN people are diseases of the respiratory system, mental health disorders, injuries and poisoning, and diseases of the nervous system and musculoskeletal system. Hospitalizations are required for pregnancy, respiratory, injury and poisoning, diseases of the digestive system, and mental health disorders. Falls, suicide attempts and assaults, motor vehicle and poisoning accidents are the most common reasons for hospitalizations related to injuries. In the AI/AN population, chronic liver disease and cirrhosis was the sixth leading cause of death but was not even ranked in the top 10 for the white, black, or Asian/Pacific Islander populations in 2005.

Lifestyle Risk Factors

Smoking prevalence among AI/AN people is much higher than for non-Indians. Thirty-one percent (31%) of AI/AN smoke compared to only 15% for all races in Washington and the rate of second hand smoke exposure is over double the all-races rate (19% vs. 7%). Not surprisingly, youth smoking rates also exceed the general population's rate with 21% of tenth graders reporting they smoked compared to 13% of all races. Binge drinking and alcoholism are also more common in the AI/AN population.

Additionally, AI/AN adult's rate of obesity (40% v. 26%) and high blood pressure (33% v. 26%) exceed all other races. Other AI/AN chronic diseases also are significantly higher than in other races (asthma at 18% v. 9%; diabetes at 11% vs. 7%; and heart disease and stroke (10% v. 6%).

Maternal-Infant Health[4]

There are eight significant causes of AI/AN infant mortality that exceed mortality rates of all other Washington populations:

- The SIDS rates is 3 times higher
- AI/AN infant's experience 30% more birth defects

[3] Chronic Disease Profile, Washington State Department of Health, December 2011, p. 7

[4] *Healthy Communities: A Tribal Maternal-Infant Health Strategic Plan.* American Indian Health Commission for Washington State. December 2010.

- Causes of death related to behavior/injuries occur at a rate 5 times here
- Infant deaths from complications of pregnancy or delivery are 50% greater
- AI/AN infants' die from being born prematurely or from low birth weight at a 60% higher rate
- Infectious diseases account for nearly 10% of the AI/AN infant deaths, more than 3 times higher than non-Indian children.
- Digestive system problems result in deaths of AI/AN infants' at 3 times the non-Indian rate.
- 5% of AI/AN deaths are from unknown or ill-defined causes, 4.5 times higher than all infants.

Cancer and Cancer Screening

Screening rates have improved for AI/ANs in Washington and only breast cancer screening differs markedly from the all races rate with 34% lacking breast cancer screening compared to 24% of the all races rate. Cervical, colorectal and preventive care for diabetes all have rates equal to that of the all races rate. [5]

Employment, education and Income

The workforce participation of AI/AN adults does not vary greatly from the general population with 62% in the labor forces compared to 66% of the general population. However, income, particularly household income, varies a great deal. Family composition may be part of the reason (along with the greater proportion who are children), since an AI/AN family is less likely to be headed by a married couple with 36.3% for AI/AN people compared to 49.8% married couple households for all races. Predictably, more single parent headed of households results in lower household income with AIAN households at $41,960 per year compared to an all-races household income of $56,911. Per capita income also trails the general population with an AI/AN per capita income of $18,335 compared to $29,420 for all races in Washington. The federal poverty rate for AIAN people in Washington is 18% compared to 8.4% for the general population.

Educational achievement, measured by years of formal education, depicts a population less educated than the general population. Fifteen person of AI/AN adults have not completed high school/GED compared to 10.3% for all races. Further, 10.7% of the state's AI/AN people have completed college compared to 20% for all races.

Income Distribution

Washington's AI/AN population has a higher rate of poverty and is more likely to participate in the state's Medicaid program than the general population. With 40% of the population between 139% and 400% of poverty it is also more likely to be eligible for subsidies to purchase health insurance in the exchange.

Table 1 **Washington** **2009 ACS estimates**	Total AIANs Non-institutionalized	Percent of total
Total	181,196	
0-139 % FPL	58,511	32%
139-400	71,595	40%
400+	51,090	28%

[5] Chronic Disease Profile. Washington State Department of Health. December 2011.

Health Insurance Status

Washington's AI/AN un-insured rate is 23.1%, or approximately 41,000 individuals. Nationally, tribal uninsured rates range from 6.6% (Massachusetts) to 39.2% (New Mexico). Washington's uninsured rate is the 12th lowest among the states. However, Washington's AI/AN uninsured rate is nearly twice the 13.4% rate for the entire state.

It is important to determine what the AI/AN uninsured rate is for each of these categories in order to plan outreach and education as well as planning for the WHB's web portal and enrollment system. A 2009 ACS, analysis for Washington depict an uninsured population heavily weighted toward the lowest income categories despite the state's generous CHIP and Medicaid program. [6]

Table 2: 2009 Health Insurance Status by ACA income category for AI/ANs Washington

Washington	Total	Uninsured	Insured	% uninsured	% insured
Total	181,196	40,154	141,042	22%	78%
0-139	58,511	17,310	41,201	30%	70%
139-400	71,595	15,320	56,275	21%	79%
400+	51,090	7,524	43,566	15%	85%

The American Community Services (ACS) 2010 reported insurance status estimated 187,367 civilian (non-institutionalize) AI/AN population in Washington - 51.3% have private insurance, 43% employer sponsored insurance (ESI), 9.0% individual private; 35.8% had public insurance; and, 21.3% are considered uninsured. Private insurance is higher than average for all states, and with over 96,000 AI/AN people having private insurance. The state ranks 5th in the nation in percentage of AI/AN people with private insurance. This means the generalization that AI/AN people do not have experience with health insurance is less true in Washington than it is in many other states such as South Dakota or Montana where less than 30% have private insurance.

Table 3: 2008-2010 ACS estimates of the Health Coverage Status for AIANs in 8 States

	Medicare	Uninsured	Medicaid	ESI	IHS
Alaska	9%	38%	36%	27%	85%
New Mexico	12%	39%	30%	26%	68%
Oklahoma	13%	28%	23%	41%	61%
Arizona	12%	29%	39%	27%	58%
Idaho	15%	29%	25%	36%	36%
Washington	12%	26%	29%	43%	34%
Oregon	12%	26%	23%	43%	26%
California	13%	20%	23%	50%	12%

Data presented at the Port Gamble S'Klallam Tribe's February 1, 2012 Ready for Reform Workshop, by Ed Fox, compiled from PUMS data released December 2011.

Similarly Arizona and Alaska AI/AN people have 33% and 36% respectively with large AI/AN populations, many of whom have never been covered by private health insurance. This experience with private insurance means many are familiar and perhaps more accepting of the concept of private insurance than

[6] Source: Unpublished Data compiled by Ed Fox from data set developed by the California Rural Indian Health Board, November, 2011 from the 2009 ACS.

in these states with less experience. On the other hand, the ACA requires that an offer of employer-sponsored insurance (ESI) be accepted if it meets minimum coverage and cost thresholds. This means fewer than average (i.e., AI/ANs nationally) Washington AI/AN people will be able to access HBE qualified health plans (QHP) if they have offers of insurance from qualified employer plans. Tribes have advocated for an exemption from this requirement, but proposed rules indicate that there will be no exemption.

The Census/ACS has yet to breakout public insurance into Medicare or Medicaid insurance in public reports, but a preliminary analysis of the raw data allows computation of these rates. In Washington about 80,000 have public insurance. ACS reports an estimated 58,000 (29%) have Medicaid and 22,000 (12%) have Medicare.[7] Table 3 demonstrates the wide variation for three factors: Uninsured rate, Employer sponsored (ESI) rate, and percentage saying they have access to IHS.

Medicaid coverage is about average (at 29%) compared to other states with reported AIAN coverage, but understates the fact that it reaches a higher income level than any state with a large AI/AN population. It also offers a generous benefits package making it an important source of coverage and the largest source of third party revenue for every Indian health program in the state.

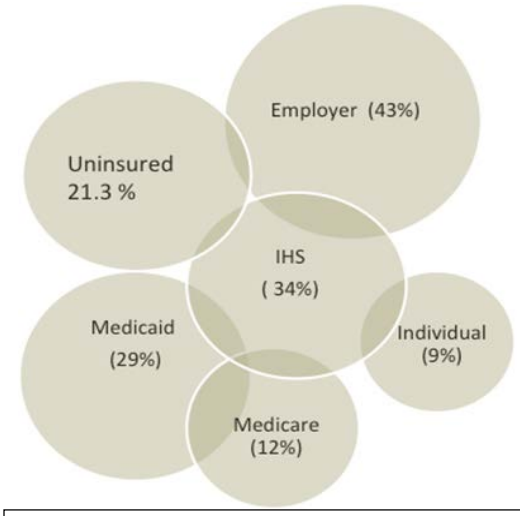


Figure 1: Washington state health insurance status of American Indians and Alaska Natives, American Community Survey, 2008-2010

Figure 1 on the following page depicts the overlap between IHS and all other health insurance status types, and the overlap between Medicare and Medicaid.

In addition to insurance coverage, the ACS also reports respondents who indicate they have access to IHS programs. Thirty-four percent of respondents in Washington indicated they have access to IHS programs.

IHS access, however, is not considered health insurance coverage (since it does not have defined set of benefits). The balance of the respondents, less than 3%, indicate they have Veteran's Administration or Military /Tricare coverage. Health Insurance status, as reported by the ACS, often provides a confusing picture of the mix of various types of coverage, particularly when IHS access is included in the mix. The simple reason for the confusion is that each type of coverage can overlap with other coverage---even at a single point in time, particularly true for IHS coverage, with other coverage(s) common.

Conclusion

In summary, although Washington's AIANs have enjoyed improved health status over the past 50 years and comparatively good health status compared to AIANs in other states, there remain significant and persistent disparities between AI/AN health status and that of the general population.[8] As noted above, AI/ANs in Washington experience disparities in health insurance status, with less private insurance coverage and higher rates of uninsured than the general population. Research has proven that lack of

[7] Fox, Edward and Verne Boerner, January 12, 2012; testimony to the Washington State House Health Appropriations Committee.
[8] Office of Minority Health and Health Disparities; American Indian and Alaska Native Populations, Centers for Disease Control and Prevention

health coverage does lead to worse health outcomes.[9] The ACA could be the most significant impetus to reduce health status disparities in the next generation who may grow up knowing they have access to health care services that will not threaten their economic security.

[9] The Oregon Health Insurance Experiment: Evidence from the First Year, Finkelstein, et al. The Oregon Health Study Group; 2011. National Bureau of Economic Research

SECTION TWO: The Indian Health Care Delivery System

This section of the Tribal Analysis provides an overview of the Washington Indian health care delivery system. The Indian health system has developed under a complex and comprehensive amalgam of Federal Indian policy that draws upon treaties between Indian Nations and the United States, Indian-specific provisions in the U.S. Constitution, federal laws, U.S. Supreme Court cases and other case law. While federal Indian policy has shifted significantly throughout history, there are three basic legal principles that have remained constant that continue to guide the administration of federal Indian health programs:

1. **Federal trust responsibility.** The federal government has a unique historical and enduring legal relationship with and resulting responsibility to Indian Tribes, including the responsibility to provide health care for tribal members.

2. **Government-to-government relationship.** The federal government has acknowledged its responsibility to interact with Indian Tribes on a government-to-government basis. A key feature of this relationship obligates federal [and now state Medicaid] agencies to consult with tribal governments on federal policies that affect Tribes. The fundamental principles of consultation are set out in Executive Order 13175 (Nov. 6, 2000) and the related Presidential Executive Memorandum dated September 23, 2004.

3. **Tribal sovereignty.** Tribes are independent sovereign governments that are subordinate only to the United States as superior sovereign. They are not political subdivisions of any state and are not subject to state laws, except by Acts of Congress.

In order to understand the unique and complex Indian health care system, following is a legislative history of its origins. It is followed by a description of HIS, as it is the principle funding source for services provided by tribal and urban Indian health programs. The Medicaid, Medicare and Basic Health (BH) programs relationship with the Indian health system is outlined next because they provide a significant resource for providing health care. The final section provides an overview of Washington's 29 tribal programs and the two urban Indian health clinics.

Legislative History [10]

The federal government's responsibility for health services to Indian tribes is a direct result of treaties and executive orders made between the United States and Tribes. The exchange of Indian land and resources forms the basis of the federal obligation for health care and other services. This forms a "special relationship" between the United States and Indian Tribes that creates a trust responsibility toward Indian people regarding health care. The existence of this truly unique obligation supplies the legal justification and moral foundation for health policy making specific to AI/AN people -- with the objectives of enhancing their access to health care and overcoming the chronic health status disparities of this segment of the American population.

[10] Sources: Holly T. Kuschell-Haworth, "*Jumping Through Hoops: Traditional Healers And The Indian Health Care Improvement Act"*, 4 DEPAUL J. OF HEALTH CARE L. 843 (Summer 1999). American Indian Health Commission, "*American Indian Health Delivery Plan 2010-2013*" (August 2009). National Indian Health Board, "IHCIA Summary" (June 2010). Heisler and Walke, Congressional Research Report 7-5700, "*Indian Health Care Improvement Act Provisions in the Patient Protection and Affordable Care Act*", (March 30, 2010).

The origins of federal-provided health care to AI/AN people began in the nineteenth century as the United States was founded and westward expansion increased. This time marked a time of conflict between the United States and Tribes. During this era, the U.S. Army took steps to curb contagious diseases, such as smallpox, among Tribes, that were living in proximity to military posts in an effort to protect its soldiers and neighboring non-Indians.[11] These diseases also threatened the once substantial populations of AI/AN people. The Federal government's earliest goals were to prevent disease and to speed Indians to assimilate into the general population by promoting Native American dependence on Western medicine and by decreasing the influence of traditional Indian healers.

In 1849, responsibility for AI/AN health was transferred from the War Department to the Bureau of Indian Affairs (BIA). The BIA oversaw the use of congressional appropriations for the establishment of health programs for AI/AN people.

In 1912, President Taft sent a special message to Congress summarizing the results of several surveys documenting deplorable health and sanitary conditions on reservations. This eventually led Congress to take action to improve AI/AN health services by passing the Snyder Act in 1921. The Snyder Act was the first principal legislative authorization for federal health programs for Indians. The Act directed the federal government to provide appropriations " … *for the benefit, care and assistance . . .[and] for the relief of distress and the conservation of health . . . for Indians tribes throughout the United States*." This provided the first formal authority for the Federal provision of health services to members of Federally-recognized Tribes.

In 1928, the Institute for Government Research (today known as the Brookings Institution) completed a study on economic and social conditions on Indian reservations. The report, known as the Merriam Report of 1928, revealed deplorable health and social conditions filled with poverty, suffering, and discontent. This report concluded that the problem of this existence was the attitude of the federal government toward the Indian. The emphasis in the past had been on the Indian's property rather than on the Indian person.

This report formed the basis for the Indian Reorganization Act of 1934, and was used by the Administration to advocate for resources to help solve the "Indian problem" that the U.S. Government had created. This paved the way for the Johnson O'Malley Act of 1934 to affirm the federal government's financial responsibility for Indian health services. It authorized the Secretary of the Department of Interior to contract with state and local governments and private organizations to provide educational, medical, and other assistance to American Indian people who no longer lived on the reservation.

The Transfer Act of 1954 transferred responsibility for Indian health services from the Interior Department to the Public Health Service, which then was a division within the Department of Health, Education and Welfare. The IHS was created in 1955 as an agency in the Public Health Service Division. [12] The primary motivation for the transfer was to improve quality of medical services to American Indians through supervision by an agency with more administrative expertise and funding in health care.

[11] "Legal and Historical Roots of Health Care for American Indians and Alaska Natives in the United States", Issue Brief by Henry J. Kaiser Family Foundation, Brett L. Shelton, J.D., M.A.

[12] The Department of Health, Education & Welfare was later reorganized as the Department of Health & Human Services (HHS).

The Indian Self-Determination and Education Assistance Act of 1975 (P.L. 93-638, ISDEAA) changed the Indian health care delivery system forever by allowing Tribes the authority to assume the responsibility for administering their own health programs. In order to do so, Tribes entered into contracts with the Federal government to operate health programs that were provided by IHS. It also made grant funds available to Tribes for planning, developing, and operating health programs. Subsequent federal legislation further expanded the concepts of P.L. 93-638 by authorizing Tribes to enter into self-governance compacts negotiated with the IHS to assume responsibility for service delivery and resource management.

Together, self-determination contracts and self-governance compacts allow Tribes more flexibility to design and develop programs that better meet local needs, without any diminishment of the federal trust responsibility. In FY 2012, Tribes nationally controlled an estimated $2.5 billion, or 65 % of the total IHS budget, under self-determination contracts and self-governance compacts. Today, all but one of Washington's 29 tribes manage their health programs under the authority P.L. 93-638.

The Indian Health Care Improvement Act of 1976 (P.L. 94-437, IHCIA) is the key Federal law that authorizes appropriations for the provision of health care to AI/AN people. It establishes the basic programmatic structure for delivery of health services to Indian people and authorizes the construction and maintenance of health care and sanitation facilities. The IHCIA has been periodically reauthorized and amended, most notably was its reauthorization as an amendment in the ACA (Pub. L. 111-148, Title X, Part III, Section 10221).

The amendments to the Indian Health Care Improvement Act set forth a "declaration of national policy," in fulfillment of the special trust responsibilities and legal obligations to Indians "to assure the highest possible health status for and raise the health status of Indians and urban Indians through the provision of health services and to provide all resources necessary to effect that policy."

The IHCIA reauthorization sets forth the following goals for the IHS:

- To assure AI/AN people access to high-quality comprehensive health services in accordance with need;
- To assist tribes in developing the capacity to staff and manage their own health programs and to provide opportunities for tribes to assume operational authority for IHS programs in their communities; and
- To be the primary federal advocate for AI/AN people with respect to health care matters and to assist them in accessing programs to which they are entitled. Subsequent amendments in 1992 extended the purpose of the IHCIA to raising the health status of Native Americans over a specified period of time to the level of the general United States population. Additionally, the IHCIA sought a high level of participation by Indian tribes in the planning and management of IHS programs, services, and demonstration projects under subsequent self-determination amendments.

During the late 1990s, the IHS worked with Tribes and governments to draft amendments to IHCIA that would provide greater administrative capabilities to tribal health programs and increase quality of care given. The IHCIA expired in 2000, but was extended through 2001 in the belief that Congress would reauthorize it shortly thereafter. While the IHCIA continued to be funded, it was not re-authorized until the ACA was passed in 2010. The version of the IHCIA signed into law on March 23, 2010, differs in several ways from the original 1976 version. It includes changes and improvements to effectuate the delivery of health care services to AI/ANs, including:

- Expands and enhances the responsibility of the IHS Director to provide direct advice to the HHS Secretary on policy and budget matters and to advocate and promote consultation on Indian health matters within HHS.

- Provides authorization for hospice, assisted living, long-term, and home- and community-based care.

- Extends authority for tribal programs to recover reasonable costs from third party payers like insurance companies and tort-factors including relying on federal law to tribally operated facilities.

- Updates current law regarding collection of reimbursements from Medicare, Medicaid, and CHIP (Children's Health Insurance Program) by Indian health facilities.

- Provides authority to allow tribes and tribal organizations operating programs under the ISDEAA to use Contract Health Service (CHS) funds to purchase health benefits coverage for Tribal members.

- Authorizes IHS to enter into arrangements with the Departments of Veterans Affairs and Defense for the purpose of reimbursement and to share medical facilities and services.

- Allows a Tribe or tribal organization carrying out a program under the ISDEAA and an urban Indian organization carrying out a program under Title V of IHCIA to purchase coverage for its employees from the Federal Employees Health Benefits Program.

- Authorizes the establishment of a Community Health Representative program for urban Indian organizations to train and employ Indians to provide health care services.

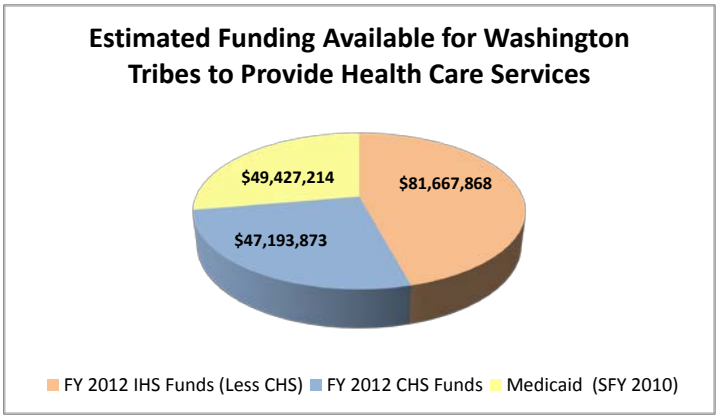
- Directs the IHS to establish comprehensive behavioral health, prevention, and treatment programs for Indians.

Indian Health Services [13]

[13] Source: GAO 11-767 Report, "*Indian Health Services: Increase Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Needs*", (September 2011). Source: GAO Report 05-789, "*Indian Health Services: Health Care Services Are Not Always Available to Native Americans*" (August 2005), Table 2. Indian Health Services, "IHS Fact Sheet" (January 2012).

The IHS, Tribes, and urban Indian health programs comprise the Indian health system and are collectively referred to as the "I/T/U". Federally operated health programs are administered by the IHS and make-up the "I". Tribally-operated health programs are administered under the Indian Self-Determination and Education Assistance Act (P.L. 93-638, ISDEAA) and make up the "T". Urban Indian health programs are operated under title IV of the Indian Health Care Improvement Act (P.L. 94-437, IHCIA) and make up the "U". This system collectively, the I/T/U, operates under a complex set of federal statutes and regulations that are administered by the HHS and the IHS. Washington's I/T/U also provides services for their members through the Medicaid, Medicare and CHIP programs. Some Tribes also purchase health coverage through the BH program and private health insurance for Tribal members.

IHS is the primary source of funding for tribal and urban Indian health programs. It provides appropriations from Congress that are used to provide direct medical and specialty care services to eligible AI/AN people. Along with ambulatory primary care services, dental care, mental health care, eye care, and substance abuse treatment programs and traditional healing practices. Many tribes are also served by community health (e.g., childhood immunizations, home visits) and environmental health (e.g., sanitation, injury prevention) programs.



A critical program in the Northwest is the CHS program which provides most inpatient and specialty services. The CHS program provides funds that are used to purchase inpatient and specialty care services from private health care providers in situations where no IHS or Tribal direct care facility exists, the direct care element is not capable of providing required emergency and/or specialty care, the direct care program has an overflow of medical care workload, and supplementation of alternate resources is required (i.e., Medicare, private insurance) to provide comprehensive care to eligible AI/AN people.

Because the CHS program is severely underfunded and cannot meet its level of need in providing services, IHS has special rules dealing with its eligibility and provider payments. The demand for the CHS program is very high. The rising cost of health care services and transportation along with the demand are the reasons for these special rules. The circumstances associated with managing the CHS program's eligibility rules are one of the key reasons why the Indian health system must be effectively integrated with state insurance exchanges. Federal rules require a very stringent eligibility system for CHS service and patients must exhaust all alternate resources before qualifying for eligibility. These rules also use a medical priority system in order to determine priorities for purchasing services, and require providers to accept Medicare-Like Rates for any CHS referral, or risk their participation in the Medicare program.

IHS Headquarters administers the CHS program through a decentralized system of 12 Area Offices, which oversee CHS programs in 35 states where Tribes are located. IHS Headquarters sets program policy and distributes CHS program funds to the 12 Area Offices. The 12 Area Offices then distribute funds to Tribally-operated CHS programs within their respective areas, monitor the programs, establish procedures within the policies set by IHS, and provide programs with guidance and technical assistance. Approximately 337 Tribes operate CHS programs under Title V compacts and

231 Tribes under Title I contracts of the ISDEAA. Over half of the IHS' congressional appropriation is administered by Tribes, through Self-Determination or Self-Governance compacts and contracts. About 46 % of CHS funds are distributed to federal programs operated by the IHS and the other 54% to tribally-operated CHS programs.

In FY 2012, Congress appropriated $4.3 billion to the IHS for health services and facility programs and an additional $150 million for diabetes related care. Of this amount, $3 billion is provided for direct medical care and $844 million is provided for CHS services. The balance of IHS funding is provided for facilities construction, maintenance and sanitation-related services. Because there are no inpatient hospitals in the Washington, Oregon or Idaho, the CHS program is an extremely important program for Washington Tribes. This is demonstrated in that the Portland Area (i.e., Idaho, Oregon and Washington) makes up only 7% of all IHS users nationally, but receives over 12% of the CHS budget, and, the CHS program comprises only 18% of the IHS budget nationally, but comprises over 33% of the Portland Area's budget. Acknowledging the importance of the CHS program in the context of overall health services funding is important to understanding why Tribes are concerned about how their programs will interface with the HBE.

Washington's Tribes receive over half the available CHS funding provided to the Portland Area Office. Approximately $47 million in CHS funds are provided to Washington Tribes. Because of the alternate resource rule in the CHS program, Washington Tribes are very assertive at conducting outreach and enrolling their clients into the Medicaid program. As a result, Washington Tribes were able to collect an estimated $49 million from the Medicaid program. This amount exceeds the available funding provided by the Federal government for CHS related services. Overall, IHS provides approximately 72% of the total funding available to Tribes to provide health services, while Medicaid compromises 28%. For many Tribes, the Medicaid portion is much higher and is equally if not more important than funding that comes from the IHS.

In order to stay within limited CHS program budgets, IHS and Tribes are forced to comply with stringent eligibility and medical priority guidelines so that as many services as possible may be provided. It is because of these circumstances that IHS programs are accused of "rationing care" and patients complain they do not receive care unless you are in danger of losing "life or limb."

To be eligible to receive CHS services, patients must be members of federally recognized tribes and live in specific areas. In addition, patients must meet specific administrative requirements. If there are alternate health care resources available to a patient, such as Medicaid and Medicare, these resources must pay for services because the CHS program is the "payer of last resort". Thus, Indian people do not have access to comprehensive medical care unless they qualify for alternate resources through Medicaid or Medicare because the CHS program will not pay for specialty care unless the patient meets life or limb tests within certain medical priorities. Because of this, health care is rationed within the Indian health system.

The CHS program has four broad medical priority levels of health care services eligible for payment and a fifth for excluded services that cannot be paid for with CHS program funds. [14] These are:

- Level I. Emergent/acutely urgent care**:** Trauma care, acute/chronic renal dialysis, obstetrical delivery, neonatal care, emergency psychiatric care

[14] Source: GAO Report 05-789, "*Indian Health Services: Health Care Services Are Not Always Available to Native Americans*" (August 2005), Table 2.

- Level II. Preventive care**:** Preventive ambulatory care, prenatal care, screening mammograms, public health intervention

- Level III. Primary and secondary care**:** Scheduled ambulatory services for non-emergent conditions, elective surgeries, specialty consultation

- Level IV. Chronic tertiary and extended care**:** Rehabilitation care, skilled nursing home care, highly specialized medical care, organ transplant

- Level V. Excluded care**:** Cosmetic and experimental services, services with no proven medical benefit

Each Area Office is required to establish priorities that are consistent with these medical priority levels and are adapted to the specific needs of the CHS programs in their area. Federal CHS programs must assign a priority level to services based on the priority system established by their area office. Funds permitting, federal CHS programs first pay for the highest priority services (priority level I: emergent/acutely urgent care), and then for all or only some of the lower priority services they fund. Tribal CHS programs must use medical priorities when making funding decisions, but unlike federal CHS programs, they may develop a system that differs from the set of priorities established by IHS.

The 60 federal CHS programs that reported not having CHS funds available to pay for all services in fiscal year 2009 varied in the extent to which they had funds available to pay for services in each of the priority levels. Thirty-nine of these programs reported having funds available to pay for all priority level I services (emergent/acutely urgent care) and some services in lower priority levels. Ten of these programs reported having funds available to pay for all priority level I services, but no services in lower priority levels. Some of these CHS programs reported that they never fund services beyond priority level I because their funds are so limited.

These finding are consistent with a 2005 GAO study examining 13 IHS-funded health care facilities, they reported that primary care services were generally offered at the facilities, but certain specialty and other services were not always directly available to American Indians and Alaska Natives. [15] These facilities also generally lacked funds to pay for all of these services through their CHS programs. The 2005 GAO report also noted that, in some cases, gaps in services resulted in diagnosis or treatment delays that exacerbated the severity of a patient's condition and required more intensive treatment.

In the 2011 ACA GAO study, tribal programs reported using a variety of strategies to fund federal CHS programs to expand access to care. Forty-six of the 103 tribal CHS programs reported that they supplement their CHS programs' funding with tribal funds—funds earned from tribal businesses or enterprises. For example, Tribes reported using profits from its tribally funded medical and dental clinics, which served non-IHS patients on a fee-for-service basis, to supplement its CHS funding.

In the survey, tribal CHS programs identified the categories of services paid for with tribal funds in fiscal year 2009. The three most commonly cited categories of services were prescription drugs, dental services, hospital services, and orthopedic services. Tribal programs also reported supplementing their

[15] GAO Report 05-789, "*Indian Health Service: Health Care Services Are Not Always Available to Native Americans*, (Washington, D.C.: Aug. 31, 2005).

CHS funding by using reimbursements from third party payers to pay for CHS services, a strategy not available to federal CHS programs. Thirty-four of the 103 tribal CHS programs that responded to the GOA survey used reimbursements for services provided at their IHS-funded facilities from third party payers such as Medicare, Medicaid, or private insurance to pay for additional services through their CHS programs.

In addition, five tribal CHS programs reported using strategies to expand access to care that reduced their reliance on CHS funds. For example, two programs directly enroll patients in a state-based insurance program for low-income individuals who did not qualify for Medicaid, and to pay the premiums using tribal funds. For uninsured CHS-eligible patients who are ineligible for government programs, one program reported using its IHS-allocated CHS funds to purchase private insurance coverage under a waiver from IHS. Enrolling eligible patients in alternate coverage reduced the reliance on CHS funds because the CHS program would only have to pay for services to the extent they are not covered by the alternate resources.

The Pacific Northwest does not have an IHS hospital or specialist services. Tribes must purchase all inpatient care and the vast majority of specialty care from private health care providers using CHS dollars. Many Washington Tribes have operated under Priority 1 for many years, meaning CHS funds are so limited they can only be used to purchase health care that will save life or limb.

Washington's Tribes have aggressively sought third party payment strategies. All of the Tribes that have tribal health clinics have contracted with the state Medicaid agency to be providers in order to access Medicaid financing to help provide health services to tribal members. Ten Tribes also participate in the Basic Health Plan's sponsorship program and are currently financing 950 enrollees. Tribal sponsors represent 56% of all BH sponsors. Despite these tribal efforts, Washington's AI/AN uninsured rate remains nearly twice (23.1 vs. 13.4 %) the statewide rate.

Financing Health Care Services at a Typical Washington Indian Health Program

Tribes receive about $2,600 per capita to provide ambulatory, primary health care services for their tribal and eligible Indian community members. If a tribal member or eligible Indian lives within the Tribe's designated contract health service delivery area they are also eligible for care purchased through the CHS program.

The method of determining how much funding is distributed to Tribes has as much to do with historical funding patterns as need. Since Indian health is not treated as an entitlement, its increases seldom equal or exceed the rate of medical inflation. If a Tribe experiences rapid growth in its 'active user population' it is guaranteed that its per capita funding is going down not up to reflect new users. If a Tribe has a decline in its active users it does not lose its right to funding increases unless it is determined that it has more funding than is needed to secure the equivalent of a standard health benefit package. Stated another way, new funding for Tribes can only come from additional funding increases and not from the recurring 'base' of other Tribes. Since all Tribes are underfunded there has never been a case of a tribal program receiving a cut in its base funding in order to meet the greater needs of other tribes.

The methodology for determining how much funding goes to individual tribes is also historical in another sense. Although the majority of Tribes are contracted or compacted Tribes who have the right to spend their funding on its own self-determined priorities, the determination of how much funding they received is still based on the line items contained in the IHS budget line items (but funded in the Interior Appropriations Bill with funds transferred to HHS after appropriated). These line items include: Hospitals

and Clinics, by far the largest line item, Dental, Mental Health, Alcohol and Substance Abuse, Public Health Nursing, Health Education, Contract Health, and Contract Support Costs. In a typical year each line item is given varying increases and seldom is an across the board increase given to the line items of the Health Service Budget (the other items that comprise the overall budget for IHS are known as the Facilities Budget and its increase varies greatly from year to year).

Although not complicated, is also not easy to readily determine how much a Tribe can expect to receive in its annual funding increase. Since some years a line item like dental might increase 5% when another line item like alcohol and substance abuse might only increase 1% it is the sum total of all the increases that ultimately determines how much the increase in funding will be for a given tribe.

In the current fiscal year, for example, despite a 2% increase in overall funding for the IHS budget, Washington Tribes are very likely to get less than 1% increase for several reasons. The main reason is the facilities budget percentage increase is larger than the health services budget and none of the facilities construction funding is coming to Washington State in this fiscal year. Secondly, since a number of new facilities are opening in 2012 their need for new staffing directs over 50% of the annual increase to just 5 health programs in the nation. Thus, a 1% increase is predicted for Washington tribes to cover new patients and medical inflation of about 5.5%.

Washington Tribal Health Funding Provided by the Indian Health Service – FY 2011	
Health Service Accounts Only	**Amt**
Hospitals & Health Clinics	$ 40,699,594
Dental Services	$ 4,160,713
Mental Health	$ 2,080,929
Alcohol & Substance Abuse	$ 7,656,448
Contract Health Services	$ 47,193,873
Public Health Nursing	$ 1,595,947
Health Education	$ 448,095
Community Hlth Representatives	$ 3,168,540
Contract Support Cost	$ 21,435,472
Urban Indian Health Programs	$ 4,602,162
Total Health Services Funding Received from IHS (Does not include Facilities Program Funds)	**$ 133,041,773**

Typically tribal priorities are different than national priorities and it is very common for a Tribe to move money from one line item to another to meet its own priorities. In actuality, however, it is more accurate to say that tribes direct non-IHS funds from Medicaid or Medicare payment to these 'higher priority' areas of their health program.

Dental is a good example of how this takes place at any tribe with its own dental program. The dental line item in the IHS budget is famously underfunded. Dental services, however, are highly valued by tribes. The value of dental health in overall health is well-recognized and unlike other programs such as alcohol treatment and mental health therapy, dental services enjoy a near 100% success rate in solving the health problem presented. Tribal councils are typically satisfied that their dental programs are successful. Whenever a Tribe takes over its health program from IHS it inevitably expands dental health. In order to do so it is necessary to do one or both of two things:

1. Redirect some funding from other line items to Dental. For example, rather than buy dental services it usually makes sense to hire a dentist and dental hygienist, if possible, and start a dental program.
2. Direct 3rd party payments from Medicaid, Medicare or private health insurance paid 'medical services' to the dental program.

Following is an example: A Tribe with between 1,000 and 2,000 active users is likely to receive between $100,000 and $150, 000 from IHS to provide dental services. Unfortunately, the Tribe's dental program provides about $600,000 in dental services (that is, the billed amount for services is $600,000). Thankfully, 35% or more of these services are delivered to Medicaid patients at the rate of $294 per encounter. This generates about $200,000 in payments. Since the Tribe operates its own program it is

also able to absorb the $200,000 in uncollected bills that are considered tribal 'write-offs' by Indian programs. That is, a cost is calculated for each service provided to an eligible Indian patient, but that patient is not charged for these dental services.

	Income	Income			Cost of Dental Services	Net deficit
IHS budget item (distributed with all other line items to the tribe)	Medicaid	All other sources: Tribal Funds, Private insurance, and self-pay		Value of services according to standard charges	Actual cost of providing services	
$118,000	$200,000	$100,000	$418,000	$618,000		$200,000
Bottom Line			$418,000		$518,000	-($100,000)

Although dental is the line item that is underfunded the most, all the line items are underfunded and they have similar financing characteristics. The Tribe provides as much services as it can from other sources of income and forgone 'charges.' Medicaid payments are of critical importance, and the very limited payments from private insurances and own-source Tribal funds.

Urban Indian Health Programs [16]

According to U.S. Census Bureau data, over half of all AI/AN people live in urban areas. The 20 cities with the largest urban Indian populations in 2000, listed in order of the number of American Indians and Alaska Natives, are: New York, Los Angeles, Phoenix, Anchorage, Tulsa, Oklahoma City, Albuquerque, Tucson, Chicago, San Antonio, Houston, Minneapolis, San Diego, Denver, San Jose, Fresno, Mesa, Dallas, Seattle, and Portland.

As described above, the federal government has a trust responsibility, based on treaty obligations and federal statutes to provide health care to members of federally recognized Indian tribes. Historically the IHS discharge of this trust responsibility on Indian people's behalf has focused on Tribes and hospitals and clinics run by IHS or by Tribes which are located primarily on reservations in rural areas.

As the urban Indian population increased, in part due to government relocation programs, the need for health services for urban Indians also became apparent. Several cities, particularly designated relocation sites developed in the 1970s, independently developed health services for urban Indians. IHS, with funds from the Office of Economic Opportunity, provided its first direct support for urban Indian health clinics in 1972 in Minneapolis, Rapid City, and Seattle. The IHCIA included the creation of the urban Indian health program under Title V.

While IHS CHS funding support Tribes and IHS operated programs, eligibility for services delivered does not extend to all AI/AN people. It is limited to "… *persons of Indian descent belonging to the Indian community served by the local facilities and program*." These include an individual *"… regarded as an Indian by the community in which he/she lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation, or other*

[16] Source: Forquera, Ralph. *Urban Indian Health* Issue Brief. Seattle Indian Health Board, for Kaiser Family Foundation. (2001). Washington State Department of Health & American Indian Health Commission, "*American Indian Health Care Delivery Plan 2010-2013*", (August 2009)

relevant factors." Eligibility for CHS purchased services from non-IHS or tribal programs is more restrictive. IHS eligibility rules limit the IHS service population to about 1.5 million of the 2.5 to 4.1 million individuals who identify themselves solely or partially as AI or AN people. The effect of these eligibility rules is to exclude many urban Indians from services provided through IHS or tribal facilities or purchased from non-tribal, private sector providers through the CHS program.

Although urban Indians generally lack access to care at IHS or tribal facilities, IHS does administer a program targeted at urban Indians. The program was first authorized in Title V of the IHCIA. The Congressional rationale for the program was in part to address the failure of former federal Indian policies and programs on the reservations that encouraged thousands of Indians to seek a better way of life in the cities. Unfortunately, the same policies and programs that failed to provide Indians with an improved lifestyle on the reservation also failed to provide them with the vital skills necessary to succeed in the cities.

The Title V program is intended to make outpatient health services accessible to urban Indians, either directly or by referral. These services are provided through non-profit organizations, controlled by urban Indians, which receive funds under contract with IHS. Urban Indian organizations commonly supplement this funding with revenues from other sources, such as Medicaid and Medicare payments, private insurance reimbursements, and support from localities and private foundations. Despite the change in demographics of the American Indian population, funding for urban Indian health has remained at about 1.0 % of IHS's annual appropriation since 1979.

Unlike tribal and IHS tribal clinics where services are free to the eligible Indian client, medical and dental services at urban Indian programs are provided on a sliding fee basis. The scope of services at urban Indian programs is restricted to primary care. Referrals for inpatient hospital care, specialty services, diagnostics, etc., are at the client's expense. Efforts are made to mitigate these expenses through negotiations and other arrangements. Of the urban Indian programs that provide medical care, several function as "safety net" clinics for the uninsured similar to federally qualified health centers (FQHC).

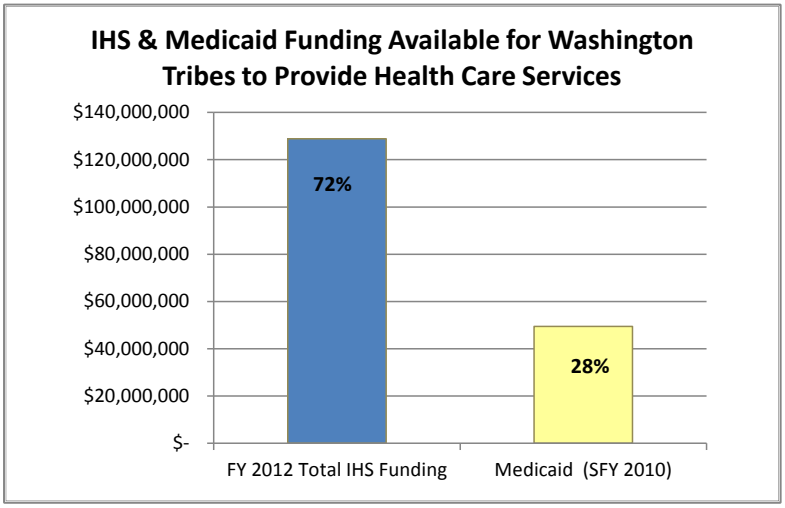
Medicaid Program [17]

Washington's Medicaid program currently covers some 1.1 million people, about 15 % of all Washington residence and nearly one-half of all children. While there are not complete counts of AI/AN enrollment due to self-reporting, an estimated 40,000 AI/AN people are currently enrolled in Medicaid.

Medicaid is second largest source of coverage for AI/AN people, and, excluding IHS funding, is the largest public health insurance program for Indian people. While published data is not available, the 2005 GAO study and tribal participation in Medicaid would suggest that Medicaid is the largest third-party sources for Washington's tribal health programs, and that Medicare is another federal funding source. In their 2005 study, GAO visited 13 tribal facilities. They found that reimbursements from private health insurance and federal health insurance programs, such as Medicare and Medicaid, were an important source of funding for the services each facility offered. While the amount of reimbursements that facilities obtained varied, Medicaid revenue accounted for about one-quarter (range from 2% to 49%) of budgeted direct service revenue for health clinics. In Washington, all tribes with health clinics also contract with the state Medicaid agency.

[17] Sources: Smith, Vernon, et.al., "*Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends*", Kaiser Family Foundation (October 2011). Kaiser Family Foundation, "*Medicaid At A Glance*" (June 2010).

Since its inception in 1965, Medicaid has improved access to care for low-income people, paid a large share of the nation's bill for nursing homes and other long-term care, and supported the safety-net hospitals and health centers that serve low-income and uninsured people. The Medicaid program funds 16% of all personal health spending in the U.S.



Medicaid is a federal-state partnership. The federal government and the states share the cost of Medicaid, and states design and administer their own Medicaid programs within broad federal rules.

Under current law, to qualify for Medicaid, a person must meet financial criteria and belong to one of the "categorically eligible" groups: children; parents with dependent children; pregnant women; people with severe disabilities; and seniors. States must cover individuals in these groups up to specified income thresholds and cannot limit enrollment or establish a waiting list. Non-disabled adults without dependent children are "categorically" excluded from Medicaid by federal law unless the state has a waiver or uses state-only dollars to cover them. Finally, among Medicaid's elderly and disabled enrollees, there are more than 8 million individuals who also have Medicare coverage. Many states including Washington also cover the "medically needy," categorically eligible individuals who exceed Medicaid's financial criteria but have high medical costs.

Many states, including Washington, have expanded Medicaid beyond federal minimum standards, mostly for children. Washington's *Apple Health for Kids*, which is jointly funded by Medicaid and Children's Health Insurance Program (CHIP), covers children in families with incomes up to 300 % of the FPL.

Under the ACA, beginning in 2014, nearly everyone under age 65 with income up to 138% of the FPL will be eligible for Medicaid. Categorical restrictions will be eliminated for this population. These changes establish Medicaid as the coverage pathway for low-income people in the national framework for near-universal coverage laid out in the health reform law. Medicaid eligibility rules for the elderly and disabled will not change under health reform. As described above, over 17,000 AI/AN uninsured adults with incomes below 138% of the FPL will be eligible for health coverage through the Medicaid expansion.

Medicaid covers a wide range of benefits to meet the diverse and often complex needs of the populations it serves. In addition to acute health services, Medicaid covers a broad array of long-term services that Medicare and most private insurance exclude or narrowly limit. Medicaid enrollees receive their care mostly from private providers, and two-thirds receive at least some of their care in managed care arrangements. Medicaid programs are generally required to cover: (a) inpatient and outpatient hospital services; (b) physician, midwife, and nurse practitioner services; (c) laboratory and x-ray services; (d) nursing facility and home health care for individuals age 21+; (e) early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21; (f) family planning services and supplies; and (g) rural health clinic/federally qualified health center services.

In addition, states can elect to offer many "optional" services, such as prescription drugs, dental care, mental health and chemical dependency services, durable medical equipment, and personal care services.

All Medicaid services, including those considered optional for adults, must be covered for children. Medicaid assists Medicare/Medicaid eligibles with their Medicare premiums and cost-sharing and covers key benefits not covered by Medicare, especially long-term care.

Generally, the same Medicaid benefits must be covered for all Medicaid enrollees statewide. However, states have some authority to provide some groups with more limited benefits modeled on specified "benchmark" plans, and to cover different benefits for different enrollees. Premiums are prohibited and cost-sharing tightly is limited for beneficiaries with income below 150% FPL. Less restrictive rules apply for others, but no beneficiaries can be required to pay more than 5% of their income for premiums and cost-sharing.

The role that Medicaid plays to support AI/AN health has been strengthened overtime by Congress, HHS and the state. The IHCIA of 1976 allowed IHS and tribal health programs to begin billing Medicaid for services provided to AI/AN people. Normally, the federal Medicaid program requires states to provide dollars to match federal funds to finance the program. AI/AN health care, however, has traditionally been the responsibility of the federal government. The IHCIA authorized the Centers for Medicare and Medicaid Services (CMS) to pay IHS and states 100 % of the Medicaid-enrolled AI/AN enrollees through use of the federal medical assistance percentage (FMAP), thereby relieving the states of much of the financial responsibility for these services. [18] In the CMS/IHS 1996 memorandum of agreement (MOA), CMS affirmed that the 100% FMAP applied to services provided by IHS and by 638 tribally-operated programs. The 100% is in recognition of the federal trust responsibilities to Tribes. It also provides an incentive for states to actively work with Tribes to enroll AI/AN people in Medicaid.

To date, CMS and the Courts have interpreted that the Section 1905(b) 100 % FMAP only applies to services directly provided by tribal and IHS hospitals and clinics. The state is reimbursed at its "regular" FMAP (currently 50.00% for Washington) for services provided by non-native programs (e.g., community hospitals) to AI/AN patients.

Over time, states have introduced cost-sharing to promote more appropriate use of health care and to have beneficiaries share in the cost of their health care. Federal law prohibits point-of-service costs (copayments, deductible, co-insurance) to be imposed on AI/AN Medicaid or CHIP beneficiaries when they receive services at tribal, IHS or urban Indian operated programs, or when they receive services that were referred by that program. [19] Washington has expanded this exemption to apply to all Medicaid and CHIP services received by AI/AN beneficiaries, regardless of the place of service.

States are able to impose premiums on higher income Medicaid beneficiaries and children enrolled in CHIP. However, federal law prohibits premium requirements for AI/AN beneficiaries who receive services from tribal or Indian health services. [20] Again, Washington has had a long standing policy that all AI/AN beneficiaries are exempt from any premium requirements, regardless of the place of service.

States have been moving away from traditional fee-for-services (FFS) to managed care organization delivery systems to improve care coordination, implement quality improvement initiatives, implement payment reforms, reduce the growth rate in health care costs and gain budget predictability. All but three states have Medicaid managed care arrangements. Nationally, two-third of Medicaid beneficiaries receive their medical care through managed care organization. Washington has recently engaged in a

18 See Section 1905(b) of the Social Security Act.
19 See Section 1916(j) of the Social Security Act.
20 See Section 1916A(b)(3(vii) of the Social Security Act.

new procurement for July 2012 that will result in all but dual Medicare/Medicaid beneficiaries and certain non-citizen children being enrolled in managed care organization.

With the expansion of managed care, federal law now requires managed care entities serving AI/AN enrollees to include tribal or urban Indian program primary care providers and allow AI/AN members to choose the Indian health care provider as their primary care provider. [21] Additionally, contracts with managed care entities must demonstrate that access to Indian health care providers is sufficient for AI/AN enrollees to receive services. Washington's managed care contracts require participating health carriers to contract with any tribal, IHS or urban Indian health program that wants to participate in their provider network.

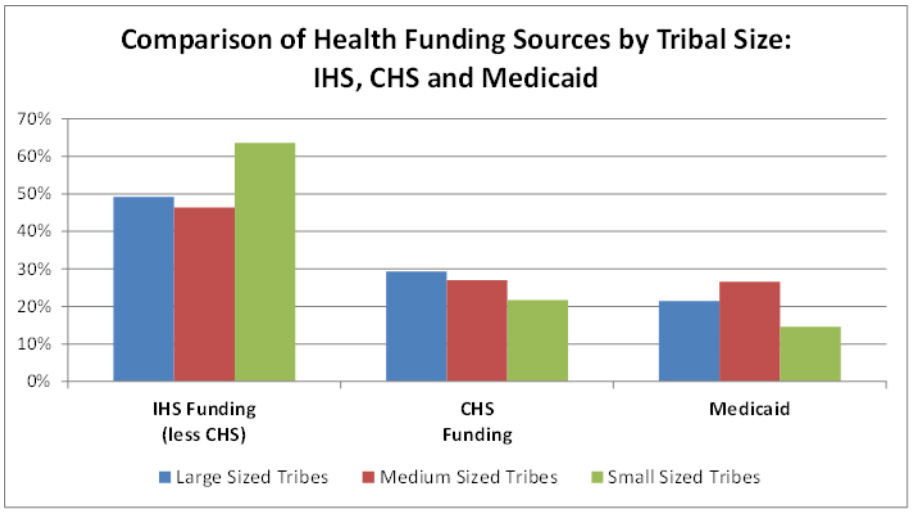
Federal law allows states to require that certain Medicaid beneficiaries enroll in managed care to receive their medical care. However, the law exempts certain groups, including children with special health care needs and dual Medicare/Medicaid beneficiaries. The law prohibits requiring enrollment for AI/AN unless the entity is an IHS provider, tribal health providers or urban Indian health providers. [22] As part of Washington's government-to-government relationship, the Medicaid program has had a long standing policy of not requiring AI/AN beneficiaries to enroll in managed care under any circumstances. AI/AN people may, however, voluntarily elect to enroll in managed care (so-called "opt in provisions").

State Medicaid programs have a strong financial incentive to facilitate the use of IHS or tribally-operated health facilities by Medicaid AI/AN beneficiaries. As described above, the federal matching rate for state expenditures in such cases is 100 %. The need to sustain an IHS and tribally-run health care infrastructure has a number of policy implications.

Given Medicaid's growing role in financing tribal health care, reimbursement rates have become more important. Medicaid law was amended in 1990 to define tribal programs and urban Indian health programs to be FQHCs. [23] This allows tribal and urban Indian clinics to be paid on a cost-related reimbursement system, resulting in higher payments than would be received by physicians and other health professionals. [24]

The CMS 1996 MOA also affirmed that, like IHS operated facilities, 638 tribal clinics could: (1) continue to operate as a FQHC under the state plan and receive the FQHC reimbursement rate; (2) if it so qualifies, operate as any other provider type recognized under the state plan and receive that respective reimbursement rate; or (3) choose to be designated as an IHS provider. If the facility chooses to be designated as an IHS provider for purposes of the payment policy and the MOA, it will receive the IHS encounter payment rate for services to AI/ANs. However at state option, the IHS encounter rate may not be available for services to non-Indian Medicaid beneficiaries because a state will not receive 100 % FMAP for services to non-Indians. Washington's Medicaid program pays tribal programs at the same rate for both AI/AN and non-native Medicaid clients.

[21] See Section 1932(h) of the Social Security Act.
[22] See Section 1932(a)(2)(C) of the Social Security Act.
[23] See Section 1905(l)(2) of the Social Security Act.
[24] Of note, Congress amended federal law to allow states to reimburse FQHCs and rural health clinics under a cost-related system, which would be different and most often lower than a cost-based system (see Section 1902(bb) of the Social Security Act.



The IHS encounter rate is an outpatient, per-visit rate which includes all on-site laboratory and x-ray services, as well as all medical supplies incidental to the services provided to the client during the visit. The Federal Office of Management and Budget (OMB) publishes the encounter rate in the Federal Register each fall; the rate is retroactive to the first of the year. The rate is paid for services provided to Medicaid and CHIP beneficiaries, but not to other state-only programs such as Medical Care Services. The rate is paid to tribal and IHS operated programs. In general, it is paid for physician related services, dental care, PT/OT/ST therapies, mental health and chemical dependency services. [25] The current rate is $294 per-counter, which is higher than FQHC or other professional rates.

To date, all of Washington's tribal health clinics have elected to be reimbursed under the IHS payment rate for medical, dental and behavioral health services covered under that payment rate. Other services, such as pharmacy and therapy services are reimbursed at the regular Medicaid professional rates.

The 1996 CMS/IHS MOA also reaffirmed IHCIA provisions that IHS and tribal operated facilities would be eligible for reimbursement for Medicaid services provided under a state plan so long as it meets all the conditions and requirements generally applicable to such facilities under the Medicaid statute. It does not, however, need to be licensed by the state. While not specifically referenced in the MOA, tribal health professionals also did not have to be licensed by the state in which the program is located so long as the professional has a valid license in another state and is practicing within the scope of that license.

Historically, federal law required that the FQHCs in managed care provider networks be paid the same amount for a Medicaid member as the FQHC would be paid for a Medicaid beneficiary in the fee-for-service system. Recent law now also requires that Non-FQHC Indian heath care providers under managed care be paid by the managed care entity or the State for services provided to AI/AN beneficiaries, at a rate that is at least equal to what the provider would be paid under the State plan. [26]

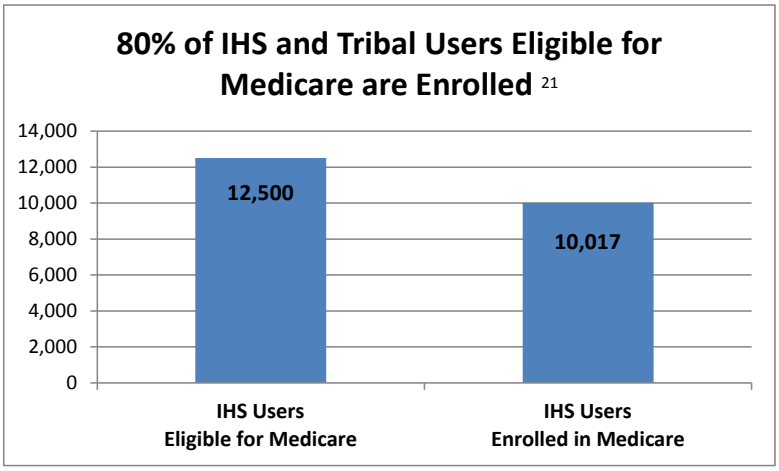
Medicare Program [27]

The total number of AI/AN enrollees in the Medicare enrollment database between the years 1991 to 2007 was 280,419 nationally.[28] A match between the Medicare enrollment database and the IHS national

[25] States are required to specify the services that will be reimbursed using the IHS payment rate in their Medicaid State Plan.
[26] See Section 1932(h)(2)(C)(ii) of the Social Security Act.
[27] Source: Kaiser Family Foundation, "*Medicare At A Glance*" (November 2011).
[28] "American Indian and Alaska Native Medicare Program Statistics", California Rural Indian Health Board, 2006, prepared for the Centers for Medicare & Medicaid Services Tribal Technical Advisory Committee.

patient registry file indicates that 113,517 are enrolled in Medicare and receive their health care from IHS and Tribal health system programs.

According to three-year ACS estimate for 2008-2010, some 17,700 AI/AN people residing in Washington are enrolled in Medicare. In terms of Medicare enrollment within the tribal health system, data analysis indicates that approximately 12,500 individuals are eligible for Medicare within the Portland Area (Idaho, Oregon, and Washington). A similar data match between Medicare enrollment and IHS patient files indicates that 80% (10,017 people) of AI/AN who are eligible for Medicare are enrolled and receive care from the IHS and Tribal health system.[29]



Created in 1965, Medicare is the federal health insurance program for all people age 65 and older, regardless of income or medical history. It now covers 49 million Americans. Most people age 65 and older are entitled to Medicare Part A if they or their spouse are eligible for Social Security payments and have made payroll tax contributions for 10 or more years. Medicare was expanded in 1972 to include people under age 65 with permanent disabilities. Nonelderly people who receive Social Security Disability Insurance (SSDI) generally become eligible for Medicare after a two-year waiting period, while those diagnosed with end-stage renal disease (ESRD) and amyotrophic lateral sclerosis (ALS) become eligible for Medicare with no waiting period.

Medicare is organized into four parts:

- Part A covers inpatient hospital stays, skilled nursing facility stays, home health visits (also covered under Part B), and hospice care, and accounts for 31% of benefit spending in 2011. Part A benefits are subject to a deductible ($1,156 in 2012) and coinsurance.

- Part B covers physician visits, outpatient services, preventive services, and home health visits. Part B benefits are subject to a deductible ($140 in 2012), and cost sharing generally applies for most Part B benefits.

- Part C refers to the Medicare Advantage program, through which beneficiaries can enroll in a private health plan, such as a health maintenance organization (HMO), and receive all Medicare-covered benefits. Nearly 12 million beneficiaries (25% of all beneficiaries) are enrolled in a Medicare Advantage plan in 2011.

[29] Ibid.

- Part D is the voluntary, subsidized outpatient prescription drug benefit, with additional subsidies for beneficiaries with low incomes and modest assets. The Part D benefit is offered through private plans that contract with Medicare. More than 29 million beneficiaries are enrolled in a Medicare Part D plan in 2011.

Medicare provides protection against the costs of many health care services, but has relatively high deductibles and cost-sharing requirements, no limit on out-of-pocket spending, and (until 2020) a coverage gap ("doughnut hole") in the prescription drug benefit. Medicare also does not pay for many services needed by elderly and disabled beneficiaries, such as long-term care, or dental services. Many beneficiaries have some form of supplemental insurance to help with Medicare's cost-sharing requirements and fill in the benefit gaps.

Under Medicare, tribal and urban Indian health programs are defined as FQHC providers when they attest to meet FQHC standards. [30] FQHC services are covered when furnished to a Medicare beneficiary at the FQHC, the beneficiary's place of residence, or elsewhere (e.g., at the scene of an accident). [31] A FQHC generally provide the following services: (a) Physician related services; (b) Nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services (c) Visiting nurse services to the homebound in an area where the CMS has determined that there is a shortage of Home Health Agencies; (d) Otherwise covered drugs that are furnished by, and incident to, services of a FQHC provider; and (f) Outpatient diabetes self-management training and medical nutrition therapy for beneficiaries with diabetes or renal disease. FQHCs also furnish preventive primary health services when furnished by or under the direct supervision of a physician, NP, PA, CNM, CP, or CSW.

FQHCs, including tribal and urban Indian health programs, are reimbursed on a cost-based reimbursement basis, with a rural and urban upper payment limit. The upper payment limit is increased annually by the applicable Medicare Economic Index. Unlike Medicaid, Medicare has a 20% coinsurance payment for all Medicare beneficiaries and 62.5 % copayment for outpatient mental health treatment limitation.

The ACA included new Medicare provisions to help tribal programs. Payment limits are set for hospitals billing Tribes or urban Indian programs for services provided to AI/AN Medicare beneficiaries. Under legislation enacted in 2005 and effective June 2007, tribal, IHS, and urban Indian programs are to pay no more than "Medicare-like" rates for referred services (in-patient) furnished by Medicare-participating hospitals. This provision essentially places a limit the amount that hospitals can charge Tribes and tribal programs for inpatient services provided to tribal members.

Basic Health Program

In response to IHS underfunding and a policy goal of promoting health insurance, Washington's Tribes have actively participated in the state's BH program. Nearly one-quarter of BH enrollees have financial sponsorship in order to be able to afford coverage. Some 912 (9.9%) of BH's 9,179 sponsored enrollees are covered through tribal sponsorship. [32] Ten (56%) of the 18 BH sponsors are Washington tribes.

[30] See Section 1861(aa)(4)(D) of the Social Security Act.
[31] The FQHC benefit under Medicare was added effective October 1, 1991, when Section 1861(aa) of the Social Security Act was amended.
[32] BH enrollment and sponsorship data is for February 2012.

BH provides coverage to low-income individuals with household incomes up to 200% if FPL who are not otherwise eligible for Medicare, Medicaid or Apple Health for Kids. [33] Unlike Medicare or Medicaid, coverage is only offered through health carriers. BH benefit coverage is similar to the ACA essential health benefit requirements. Prior to January 2011, BH was only financed by individual enrollees through premiums and by state funds. In January 2011, HCA obtained a federal "Transitional Bridge" demonstration waiver that converted BH to a Medicaid financed program with the federal government contributing 50% of the state subsidy. The waiver will last until 2014, when most existing BH enrollees will be eligible for coverage under the Medicaid expansion, and the remainder will be eligible for coverage through the state's Health Benefit Exchange or federal BH option.

Prior to the waiver, all AI/AN enrollees were subject to the same premium and point-of-services cost-sharing requirements as non-natives. Under the Transitional Bridge waiver, AI/AN enrollees are treated like Medicaid beneficiaries and are not subject to premium or cost-sharing requirements. BH plans receive a higher payment for AI/AN enrollees to off-set the cost of no cost-sharing.

Washington's Tribal Health Care Delivery System [34]

Washington's tribal delivery system is statewide and provides care to AI/AN people residing in both rural and urban areas. Currently, 28 of the 29 tribes have clinics that provide medical or behavioral health services. Twenty-five (89%) of the tribal programs are self-governance, three (11%) tribes have IHS operated clinics and two of these Tribes also have 638 operated clinics.

Based on Medicaid contract data, there are 61 clinic sites across the state (see table on following page). These clinics are contracted to provide 156 medical and behavioral health services. Of key importance to the Health Benefit Exchange, there are 34 tribal medical clinics. In addition to providing primary care, 22 of the medical clinics also provide dental care, 12 provide pharmacy services, 19 provide mental health treatment and 15 provide chemical dependency services. Some of these clinics also provide optometry and optical services, maternity support services, and audiology. In addition to the medical clinics, 18 Tribes also have separate sites that provide mental health and behavioral health services at 23 locations.

Sub-specialty care is sometimes offered by in-house medical staff, but more typically it is provided by contract employees or referral through the tribe's contract health program detailed below. Human resources is an issue for Tribe's who report long delays in filling vacancies for medical staff, particularly Medical Doctors (MDs), Advanced Registered Nurse Practitioners (ARNPs), Physician's Assistants (PAs) and Dentists (DDS). Dental Care funding from the IHS is funded far below the level of need and sustaining a dental program requires funds from other sources.

With the exception of a handful of health programs, Washington States Indian health programs are overwhelming programs that see Indian patients with a small percentage of Non-Indian patients. Metrics for comparing programs are not easily available as reporting has only recently been a requirement of the non-IHS programs. Patient visits, for example, are not routinely published and require inquiry to each program for permission to report. Medicaid encounters are available but are skewed by a handful of outliers with behavioral health programs. IHS active user populations are also available and useful for

[33] The Basic Health program's enabling legislation and program design is found in Chapter 70.47 RCW.

[34] Source: Data for this section is from Washington's Medicaid program and from the Northwest Portland Area Indian Health Board. The number of clinics is from the Medicaid ProviderOne system's listing of contract providers. In order to be included on this listing, the entity must be a tribal or IHS operated facility and listed on the IHS facilities list.

depicting the potential size of a program's Indian patients, but this does not give information about intensity or volume of services provided to the 'active users.'

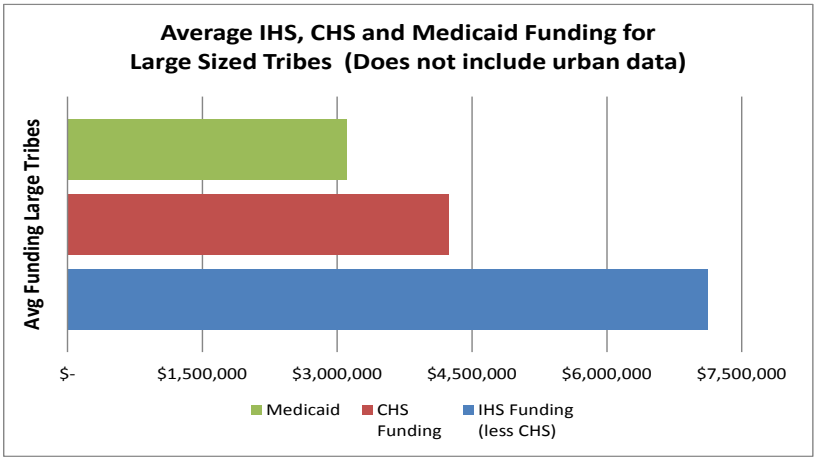
Policymaking, particularly for the non-IHS programs is local, not system-wide, with a great deal of autonomy for both the compacted and contracted programs (described below) and system wide policymaking is in most cases optional except where federal law and regulations apply.

Administration is clearly not system-wide for the non-IHS programs with each program maintaining not only its own administrative system (including human resources), but its own judicial system supported by tribal sovereignty-again within federal law and regulation.

Medicaid Tribal Health Programs (IHS Recognized)											
	Tribe	Government Status	Compact Title V	Number of Clinics	Medicaid Programs						
					Medical	Dental	Drugs	Mental Health	Chem. Depend	Other	Total
1	Chehalis	638		2	1	1		1	1	2	6
2	Colville	IHS/638		5	4	3	2	2	3	3	17
3	Cowlitz	638	V	3	2			2	2		6
4	Hoh										
5	Jamestown S'Klallam	638	V	2	1	1		1	1		4
6	Kalispel	638	V	2	1	1	1	2	1		6
7	Lower Elwha S'Klallam	638	V	2	2	1		1	1	1	6
8	Lummi	638	V	4	2	1	1	2	1		7
9	Makah	638	V	3	1	1	1	1	1	1	6
10	Muckleshoot	638	V	2	1	1	1	1	1	1	6
11	Nisqually	638	V	1	1	1	1	1	1		5
12	Nooksack	638		2	1	1		2	1		5
13	Port Gamble S'Klallam	638	V	2	1	1		1	1	1	5
14	Puyallup	638		3	1	1	1	1	1		5
15	Quileute	638		1	1	1		1	1	1	5
16	Quinault	638	V	1	1	1	1	1	1		5
17	Samish	638		1	1						1
18	Sauk-Suiattle	638		1				1	1		2
19	Shoalwater Bay	638	V	1	1	1		1	1		4
20	Skokomish	638	V	1	1	1		1	1		4
21	Snoqualmie	638		3	2			1	1		4
22	Spokane	IHS/638		2	1	1	1	1			4
23	Squaxin Island	638	V	2	1	1	1	1	1		5
24	Suquamish	638	V	1				1	1		2
25	Stillaguamish	638		3	1	1	1	1	3		7
26	Swinomish	638	V	4	1	1		1	1	2	6
27	Tulalip	638	V	4	1	1	1	2	1	4	10
28	Upper Skagit Total	638		1	1	1		1	1		4
29	Yakama	his		2	2	1	1	1	1	3	9
	Total Number of Programs			**61**	**34**	**25**	**14**	**33**	**31**	**19**	**156**
	Total Number of Tribes	**28**	**16**		**26**	**23**	**13**	**27**	**26**	**10**	

Large Indian Health Programs

1. Yakama
2. Colville
3. Puyallup
4. Tulalip
5. Muckleshoot
6. Lummi
7. Quinault
8. Seattle Indian Health Board
9. Native Project, Spokane



Each of these seven tribes has at least 2,500 active IHS users. The two Urban Indian Health programs (Seattle Indian Health Board and the Native Project) are as big as the average size of this group of larger Indian health programs.

Three of these programs (Colville, Yakama and Quinault) are rural health programs that are more typical of IHS programs nationally. They are more than an hour from a tertiary care hospital, they have more difficulty recruiting staff, and they share the social and economic difficulties that face rural American generally and rural Indian health programs specifically; jobs are scarce, economic development more difficult than in urban areas, incomes are low, educational achievement lags, and health status suffers, in part due to these economic conditions.

The four remaining large tribal (not IHS or Urban) programs (Lummi, Puyallup, Muckleshoot, and Tulalip) are in more urban settings with some advantages and a different set of challenges. Economic development and proximity to advanced medical centers along the I-5 corridor has improved the life chances of tribal members and attracted not only more seeking tribal membership, but more AIANs from other tribes seeking economic opportunity, and often health care services.

Although this trend toward more 'in migration' has abetted somewhat in recent years the three Seattle Metropolitan Area tribes, Muckleshoot in King County, Puyallup in Pierce County, and Tulalip in Snohomish County have not received funding increases needed to meet the growth in Indian patients who are eligible for health care services at these sites. The IHS has documented that two of these three programs are funded at less than 35% of the estimated funding requirement for a basic level of health care services.[35] Each of Seattle Metropolitan Area tribes have funded (usually with own source tribal funds) large capital and staffing investments over the past 15 years to increase services, but as the IHS data demonstrates the need has outpaced the investment.

Health Insurance Status of AIANs in Seattle Area

AIAN alone and in combination	Private Insurance	Public Insurance	Uninsured	IHS active users
78,675	46,576	23,445	14,948	17,196

Nearly 80,000 AI/AN people live in the Seattle Metropolitan Area. Over 17,000 were considered active users of the three Indian health programs in 2011. Since about 40,000 AI/AN people in the metropolitan

[35] Federal Disparity Index, Accessed from ihs.gov on February 24, 2012.

area have private health insurance it is likely that many have non-Indian health program providers. Unfortunately, 21,000 are uninsured.

Washington's Urban Indian Health Programs [36]

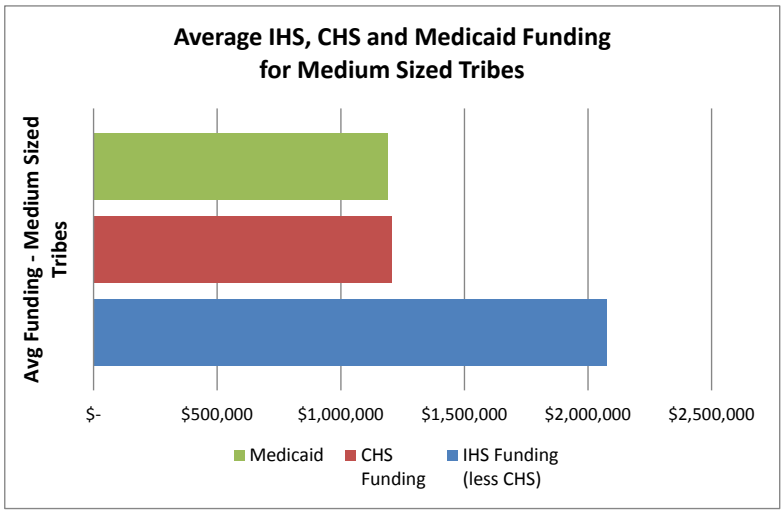
Washington has two urban Indian health programs, located in Seattle and Spokane. In addition to primary care and referral services, the Seattle clinic provides dental care, mental health, chemical dependency services and maternity support services. The Spokane clinic is solely medical care. Given that nearly 50% of AI/AN people reside in urban centers, the two urban programs and several I-5 corridor tribes have the role in providing primary care and behavioral health to these people.

The two urban programs are considered FQHCs for Medicaid programmatic and reimbursement purposes. As such they receive the cost-related encounter payments for services provided to Medicaid clients and the regular professional rate for non-Medicaid clients. The state is not able to claim the 100% FMAP rate for any services provided by the urban clinics.

The Seattle Indian Health Board sees many of the uninsured described in the above table that, together with those AI/ANs with Medicaid and many non-Indians, make up their patient mix in one of the state's largest Indian health programs. In Spokane this same mix of patients is seen at the Native Project's health program in Spokane. Both of these programs receive partial funding as Indian Health Service Title V (of the Indian Health Care Improvement Act) Urban Indian Health programs (2 of 35 in the nation).

Medium-sized Indian health programs

1. Sophie Trettevick Indian Health Center (Makah)
2. David C. Wynecoop Memorial Clinic (Spokane)
3. Port Gamble S'Klallam Tribal Clinic
4. Nisqually Tribal Health Clinic
5. Swinomish Health Center
6. Chehalis Tribal Wellness Center
7. Nooksack Community Clinic

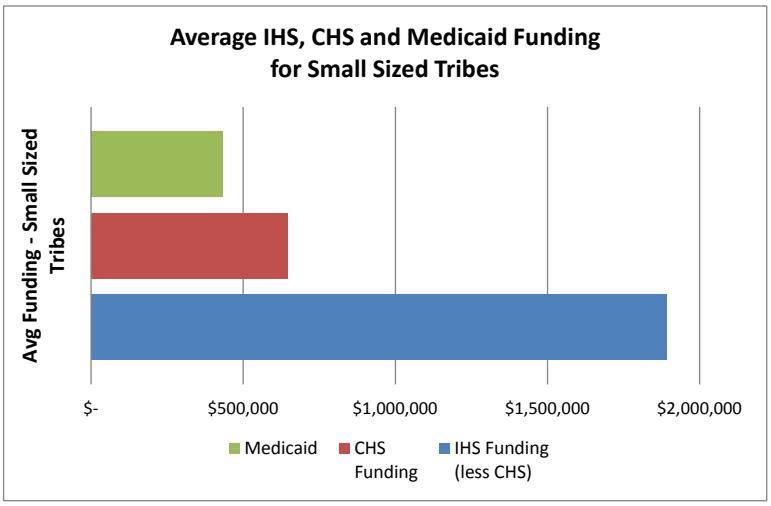


This group of seven Indian health programs have between 1,000 and 2,200 active IHS users. Each serves mainly Indian patients. All provide medical, dental and behavioral health services on site with their own staff and some contracted staff. Each of the programs is at least somewhat distant to the demands faced by the more urban Indian health programs of the Seattle area. The IHS operated Spokane health program is located on the Spokane Reservation, which is at times difficult to reach for the large Indian population of the City of Spokane. Nooksack, Makah, and Spokane are more rural than the others with Makah a classically rural health program with the attendant difficulties in replacing medical staff, with higher costs generally and specifically the high cost to transport patients to specialty care and hospital care. The four more urban health programs, with the exception of Nooksack are the smallest of the medium-sized program and still struggle with staffing despite their

[36] Source: Data for this section is from Washington's Medicaid program. The number of clinics is from the Medicaid ProviderOne system's listing of contract providers.

location in more urban counties with large medical communities and easier access to specialty and tertiary hospital care.

The smaller Indian health programs



1. Sally Selvidge Clinic, (Squaxin Island)
2. Skokomish Health Center
3. Quileute Health Clinic
4. Upper Skagit Tribal Clinic
5. Shoalwater Bay Wellness Center

These five programs range from 400 to 900 IHS active users. Although small, their health programs are comprehensive and very similar to the medium sized group. All have access to an Indian dental program (Upper Skagit through a tribal consortium), a robust behavioral health program and a solid primary care program with an efficient and effective referral network for specialty and hospital care. Their smaller size is, in part a reflection of the fact that they are all more rural than average and have not had the demands of population expansion due to 'in migration' of IHS-eligible Indian patients. Quileute is extremely rural and shares the same issues faced by the Makah health program in terms of high costs especially of transportation to specialty and hospital care.

The innovative (hard to categorize) health programs

	Active Users 2011	Medicaid Encounters
Cowlitz	2,422	2,823
Lower Elwha	825	5,688
Samish Indian Nation Wellness	571	217
Suquamish Tribe Wellness Program	550	743
Jamestown Family Health Clinic	459	5,116
Kalispel Camas Center	451	830
Tolt Community Clinic (Snoqualmie)	307	3,508
Stillaguamish Tribal Health Clinic	149	43,586
Sauk-Suiattle	64	596
Hoh	30	

Four programs with many Non-Indian patients

Three of these programs (Jamestown S'Klallam, Lower Elwha S'Klallam, Stillaguamish) are distinguished by the large number of non-Indian patients, nearly all Medicaid that make up their patient mix. The Stillaguamish behavioral health program accounts for over 70% of all non-Indian Medicaid patients and payments in the state. Jamestown and Lower Elwha serve their communities by providing access to primary (and some specialty) services to Medicaid Indian and non-Indian patients. Similarly the Snoqualmie Tribe provides mainly behavioral health services to both Indian and Non-Indian patients. The four programs account for over 90% of payments to non-Indians by the state's Medicaid program.

Two Programs that purchase health insurance rather than maintain a primary care program

Samish and Suquamish do not have a comprehensive health program with direct care services across the spectrum, rather they use the contract health care program to purchase health insurance and provide behavioral health services on site.

The Hoh Tribe is currently developing its onsite health program. It is an extremely rural and very small program with just 30 active IHS users.

Cowlitz Tribe's Innovation: A dispersed multi-site health program

The Cowlitz Tribe is the fastest growing Indian health program in the state over the past 3 years (in terms of IHS active users) having doubled in size of users. The tribe provides direct health care services in a modest, but newly constructed clinic in Longview, WA. The tribe has perhaps the most dispersed membership of the State's Tribes with Contract Health Service Delivery Areas from the heart of Metropolitan Seattle (and a behavioral health program in the cities of Vancouver and Seattle) to counties in Eastern Washington along the Columbia River.

Indian health programs by Indian Health Service funding authority: "Direct Service" (IHS), "Contracting" (P.L. 93-638 Title I), and "Compacting " (P. L. 93-638 Title V)---also known as the Indian Health Service, Tribal, Urban (I/T/U) programs with both P.L. 93-638 Title I and Title V considered Tribal.

- Three tribes, Spokane, Colville, and Yakama, are IHS "Direct Service" health programs, with both Colville and Yakama also operating smaller clinics under P.L. 93-638 authority.
- Sixteen Tribes are Indian Self-Determination and Education Assistance Act (ISDEAA) Title V "Compacting" health programs. Compacted Tribes have the right to purchase some of their services from IHS (e.g., Information Technology) and the right to contract for the services of IHS medical staff (as does the Port Gamble S'Klallam Tribe).
- Ten Tribes are P.L. 93-638 Title I "Compacted" Tribes who all operate nearly all their programs under contracts with the Indian Health Services.
- Two Urban Indian Health Programs operate under Title V of the Indian Health Improvement Act (IHCIA).
- Washington Tribes have access to several behavioral health residential treatment centers operated both by the IHS (a youth IHS Youth Regional Treatment Center: *Healing Lodge of the Seven Nations* in Spokane) and Tribes (detailed elsewhere in this paper).

Tribe	User Population	Medicaid Encounters
Yakama	12,523	5,284
Colville Tribal Clinic	8,289	10,483
Takopid Indian Health Center (Puyallup Tribal Health)	7,814	8,967
Tulalip Health Clinic	4,878	9,007
Muckleshoot Tribe Health & Wellness Center	4,498	1,864
Lummi Tribal Health Center	4,424	12,923
Roger Saux Health Center	2,502	1,174
Cowlitz Indian Tribal Health Services	2,344	2,823
Sophie Trettevick Indian Health Center (Makah)	2,154	2,192
David C. Wynecoop Memorial Clinic (Spokane)	1,637	2,136
Port Gamble S'Klallam Tribal Clinic	1,584	4,253
Nisqually Tribal Health Clinic	1,341	794
Swinomish Health Center	1,247	1,360
Chehalis Tribal Wellness Center	1,194	1,694
Nooksack Community Clinic	1,004	9,851
Lower Elwha Clallam Medical Clinic	825	5,688
Sally Selvidge Clinic , Squaxin Island)	814	4,876
Skokomish Health Center	772	1,449
Quileute Health Clinic	666	2,013
Samish Indian Nation Wellness Program	571	217
Suquamish Tribe Wellness Program	550	743
Upper Skagit Tribal Clinic	540	230
Jamestown Family Health Clinic	459	5,116
Kalispel Camas Center for Community Health	451	830
Shoalwater Bay Wellness Center	434	746
Tolt Community Clinic (Snoqualmie Tribe)	307	3,508
Stillaguamish Tribal Health Clinic	149	43,586
Sauk Suiattle	64	596
Total	**6,4035**	**144,403**

IHS Active User Population	2009	2010	2011	2011 v. 2009	2010 v 2011	
Yakama	12,111	12,523	12,629	104.3%	100.8%	1
Colville	8,288	8,289	8,384	101.2%	101.1%	2
Puyallup	7,977	7,814	7,773	97.4%	99.5%	3
Tulalip	4,599	4,878	5,021	109.2%	102.9%	4
Muckleshoot	4,272	4,498	4,402	103.0%	97.9%	5
Lummi	3,981	4,424	4,361	109.5%	98.6%	6
Quinault	2,493	2,502	2,511	100.7%	100.4%	7
Cowlitz	1,186	2,344	2,422	204.2%	103.3%	8
Makah	2,013	2,154	2,244	111.5%	104.2%	9
Nisqually	1,339	1,341	1,715	128.1%	127.9%	10
Spokane	1,781	1,637	1,628	91.4%	99.5%	11
Port Gamble	1,522	1,584	1,531	100.6%	96.7%	12
Chehalis	1,199	1,194	1,245	103.8%	104.3%	13
Swinomish	1,183	1,247	1,233	104.2%	98.9%	14
Nooksack	994	1,004	1,086	109.3%	108.2%	15
Lower Elwha	748	825	856	114.4%	103.8%	16
Skokomish	811	772	853	105.2%	110.5%	17
Squaxin Island	747	814	795	106.4%	97.7%	18
Quileute	630	666	674	107.0%	101.2%	19
Samish	461	571	593	128.6%	103.9%	20
Suquamish	336	550	542	161.3%	98.5%	21
Upper Skagit	411	540	517	125.8%	95.7%	22
Shoalwater Bay	431	434	419	97.2%	96.5%	23
Snoqualmie	190	307	249	131.1%	81.1%	24
Stillaguamish	125	149	125	100.0%	83.9%	25
Kalispel	270	451	469	25.6%	15.3%	26
Jamestown S'Klallam	397	459	558	14.6%	12.6%	27
Sauk-Suiattle	73	64	48	65.8%	75.0%	28
Hoh	28	33	30	107.1%	90.9%	29
Total	**60,596**	**64,068**	**64,013**	**105.6%**	**99.9%**	

Conclusion

The Tribes and urban Indian health programs are the essential community providers for Washington's AI/AN population. In spite of limits on IHS-CHS funding, the Tribes have built a capacity to serve Indian people through the development of some 34 medical clinics, two urban clinics and 18 other behavioral health sites. With the estimated expansion of coverage for some 41,000 AI/AN people through the ACA, these clinics will be the key health homes and essential community providers for Indian people. Given that all of the clinics have existing Medicaid contracts, it is likely that some tribal clinics will also elect to contract with EBE with QHP to serve non-native people in their services areas.

SECTION THREE: AI/AN Provisions in ACA and Indian Health Care Improvement Act

The Patient Protection and Affordable Care Act (ACA) includes a number of provisions to improve the health of American Indians (AI) and Alaska Natives (AN) and to support the Indian health systems participation in the ACA health benefit exchanges (HBE) and Medicaid expansion in 2014. The ACA also reauthorizes and amends The Indian Health Care Improvement Act (IHCIA), which includes specific tribal program provisions designed to support the Indian health system's participation in Medicare, Medicaid, Children's Health Insurance Program (CHIP) and the ACA HBE. Following is a summary of the provisions that apply specifically to HBE. [37] These are requirements that Washington's Health Benefit Exchange Board will need to address in the implementation of Washington's HBE.

The ACA has specific provisions designed to promote AI/AN participation in states or the federally administered HBEs.

AI/AN Cost-Sharing Exemption. Section 1402(d) and 2901(a) of the ACA places limitations on AI/AN enrollees point-of-service cost-sharing (i.e., copayments, co-insurance and deductible) requirements in the qualified health plan (QHP) benefit designs. AI/AN people in households with incomes up to 300 % of the FPL are exempted from any cost-sharing requirements in the HBE individual market. AI/AN people with incomes above 300 % of FPL are subject to the same cost-sharing as non-natives. Section 1402(d) also affirms that AI/AN people are exempted from the QHP cost-sharing requirements and are to be "… treated qualified as an eligible insured."

Tribal Program Cost-Sharing Provisions. Section 1402(d)(2) adds other cost-sharing protections for Indian health programs, including urban Indian programs, by prohibiting QHPs from reducing payments to these programs to off-set the cost of the AI/AN cost-sharing exemption. HHS is responsible for paying the QHP for any such costs associated with the exemption.

AI/AN Exemption from Health Insurance Penalties. Section 1501(b) amends the Internal Revenue Code to require that U.S. citizens and lawful legal residents have health insurance coverage. Persons failing to have health coverage after January 2014 will be subject to a fine that will be collected through the federal income tax obligations set forth in the Code. Section 1501(e) exempts certain persons from the penalty, including a member of an Indian Tribe (as defined 6 in section 45A(c)(6)). The law exempts members of Indian Tribes on the basis of the federal trust relationship.

AI/AN Monthly Enrollment Periods. Section 1311(e)(5) requires that there be annual open enrollment periods for individuals that operate on a calendar year basis. Section 1311(e)(5)(D) gives AI/AN applicant's special monthly enrollment periods to prompt enrollment in the HBE. The HHS proposed rule further defines this provision to mean that an AI/AN may enroll in a QHP or change from one QHP to another 1 time per month (45 155.420(d)(8)).

Payer of Last Resort. Section 2901(b) states that health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations (defined in section 4 of the

[37] The following summary is based on: Northwest Portland Area Indian Health Board's XXX summary of the Indian provisions in the Patient Protection and Affordable Care Act; National Indian Health Board (NIHB) and Tribal Technical Assistance Group's (TTAG) October 31, 2011, letter to the Centers for Medicare and Medicaid Services (CMS) on their proposed rules establishing the health benefits exchange and qualified health plans; The Department of Health and Human Services (HHS) proposed to establish the health benefit exchanges and qualified health plans (Federal Register Vol. 76, No.136 (July 15, 2011); and the Congressional Research Services (CRS) March 30, 2011, report (R1152) titled "Indian Health Care Improvement Act Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)"

Indian Health Care Improvement Act (25 U.S.C. 1603)) shall be the payer of last resort for services provided by these programs to AI/AN individual's eligible for services through these programs

In addition to the specific Indian provisions in the law, the ACA prescribes other HBE requirements that directly impact AI/AN enrollment in the HBE and tribal program participation in the HBE. These include:

HBE Consultation. Section 1311(d)(6) requires that HBE consult with stakeholders relevant to the implementation and administration of the Exchange. HHS rules require the HBE have on-going consultation with specified entities, including Federally-recognized tribe(s) as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a, located within the Exchange's geographic area (45 CFR 155.130(f)). The rule's preamble goes on to say that HHS encourages HBE to have ongoing consultation with tribal health programs and urban Indian programs. Washington's exchange law also specifically requires the HBE Board to consult with the American Indian Health Commission (RCW 43.71.020(9)).

Premium Payments. Section 1312(b) of the ACA states that a qualified individual enrolled in a QHP may pay any applicable premium directly to the QHP insurer. HHS rules expand this provision to Tribes. 45 CFR 155.240(b) states, "… *The Exchange may permit Indian tribes, tribal organizations and urban Indian organizations to pay QHP premiums on behalf of qualified individuals, including aggregate payments, subject to terms and conditions determined by the Exchange*."

Navigator Program. Section 1311(i) requires HBEs to have a program that awards grants to entities that serve as a "navigator." These entities are to: conduct public education activities to inform persons of the availability of HBE QHPs; provide "impartial" information on enrollment in QHP; provider information on the availability of premium tax credits; facilitate enrollment in QHP; and, provide referral to applicable office of health insurance assistance or insurance ombudsman or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage. While the statute does not specifically define who may be a navigator, the HHS rule lists entities eligible to be a navigator. This includes " … *Indian tribes, tribal organizations, urban Indian organizations …*" (45 CFR 155.210.b(2)(viii)).

Outreach and Education. HHS rules require state's HBE to engage in set of activities to assist persons to enroll in the exchange and make informed choices of their QHP, including call centers, Internet website, Exchange calculator, and consumer assistance. 45 CFR 155.205(e) specifically requires that the HBE must conduct outreach and education activities to educate consumers about the HBE and to encourage their participation. While not specifically referencing AI/AN people of Tribes, the rule preamble encourages HBEs to conduct outreach "broadly" and to target hard to reach populations and populations with health disparities due to "… low literacy, race, color, national origin, or disability, including mental illnesses and substance use disorders." This would clearly include AI/AN persons residing on reservation land and urban areas.

Program Essential Community Provider Status. Section 1311 of the ACA sets forth the requirements for state HBEs. Section 1311(c) requires HHS to establish minimum certification criteria for health plans to QHPs in the HBE. Subsection 1301(c)(1)(C) requires that QHPS must contract with "essential community providers that *" …serve predominately low-income, medically-underserved individuals."* While essential community providers are not specifically listed in law, the ACA does say that these providers are health care providers defined in Section 340B(a)(4) of the Public Health Service Act and providers described in Section 1927(c)(1)(D)(i)(IV) of the Social Security Act (SSA). Section 340B(a)(4) defines these providers in Section 1905(l)(2)(B) of SSA to be federal qualified health centers (FQHC)

and includes, " …. *an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services*." Thus, tribal health programs and urban Indian health programs are HBE essential community providers

QHP Essential Community Provider Requirements. Subsection 1301(c)(1)(C) and 45 CFR 156.235 requires that QHPS must include " … *within the provider network of the QHP a sufficient number of essential community providers, where available, that serve predominantly low-income, medically underserved individuals*. " The rule does not define what constitutes a sufficient number of essential community providers. However, the pre-amble notes that states may elect to adopt a "blanket" contract requirement the QHP issuers would be required to offer contracts to all essential community providers (e.g., any-willing provider).

Essential Community Provider Payment Requirements. As acknowledged in the proposed ACA rules, there are two provisions regarding payment of essential community providers and payment of Federally Qualified Health Centers (FQHCs) that may conflict. Section 1311(c)(2) states that nothing shall be construed to require a QHP to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of the plan. This requirement may conflict with Section 1302(g), which requires that a QHP issuer reimburse FQHCs at each facility's Medicaid prospective payment system (PPS) rate. The FQHC Medicaid PPS rates are facility specific rates paid on a per encounter basis, and they may be higher than the rates that a QHP issuer pays to other contracted providers for similar services. The HHS rule (45 CFR 156.235(e)) requires QHPs to pay FQHCs for services covered by a QHP at " … the amount of payment that would have been paid to the center under section 1902(bb) of the Act ..." The rule goes on to say, "*Nothing would preclude a QHP issuer and federally-qualified health center from mutually agreeing upon payment rates other than those that would have been paid to the center under section 1902(bb) of the Act, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in paragraph (d) of this section.*" These payment provisions would apply to tribal programs that meet FQHC requirements.

Special Indian Contracting Requirements. While not specifically addressed in the ACA, HHS is inviting comments on other federal requirements that must be made when contracting with Indian providers. These include: the Anti-Deficiency Act, the Indian Self-Determination and Education Assistance Act, the Indian Health Care Improvement Act, the Federal Tort Claims Act, and the Federal Medical Care Recovery Act. As noted in the HHS rule pre-amble, " …*Indian health providers serve a specific population in accordance to these and other federal laws*."

The ACA further prompts the goal of improving health care for the AI/AN population by permanently re-authorizing IHCIA. Prior to ACA, IHCIA was last fully reauthorized by the Indian Health Amendments of 1992. The Act authorizes many specific IHS activities, it sets out the national policy for health services administered to Indians, and it states the federal goal for the health condition of the IHS service population, which is to "assure the highest possible health status for Indians and urban Indians." IHCIA also authorizes direct collections from Medicare, Medicaid, and other third-party insurers for AI/ANs receiving services at facilities operated by the tribal program. IHCIA also gives IHS authority to grant funding to urban Indian organizations to provide health care services to urban Indians, and establishes substance abuse treatment programs, Indian health professions recruitment programs, and many other programs.

The reauthorized IHCIA includes a set of provisions assist tribal programs participating in federal programs, including the ACA HBE, that are intended to support tribal capacity to service AI/AN people.

Tribal and Urban Indian Program Licensing Requirements. Section 408(a)(2) of IHCIA requires that federal health care programs accept an entity operated by IHS, Tribes or urban Indian organizations as a provider eligible to receive payments, on the same basis as other qualified providers, if it meets the applicable licensure requirements for its provider type, regardless of whether the facility obtains the applicable license. This licensing requirement applies to providers working at Indian entities, and prohibits providers and entities that are excluded from receiving reimbursements from other federal programs from receiving reimbursements from Indian entities. These licensing exemption provisions also apply to tribal programs that contract with HBE QHPs.

Tribal Provider Licensing Requirements. To increase clinical recruitment and retention, Section 221 of the IHCIA provides that licensed health professionals that are employed by a tribal health program are exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). These provisions apply to professionals working for tribal programs that are QHP providers.

Tribal Program Payments. Section 206 of the IHCIA provides requires that all Indian health providers have the right to recover from third party payers, including insurance companies up to the reasonable charges billed for providing health services or, if higher, the highest amount the insurer would pay to other providers to the extent that the patient or another provider would be eligible for such recoveries. This section also states that no law of any State or provision of any contract shall prevent or hinder this right of recovery. This requirement applies whether or not there is a contract between the insurance company and the Indian health provider. HHS proposed rule pre-amble states that the payment requirements under section 206 of IHCIA apply to QHP issuers, as well as to any insurer, employee benefit plan or other third party payer.

As part of Washington's HBE implementation, the Legislature enacted and is proposing several policy directives for the Health Benefits Exchange Board that have a direct bearing on AI/AN peoples access care through the HBE and tribal programs to be QHP care providers. These include:

WHBE Tribal Consultation. Consistent with federal HBE requirements, Washington's exchange law specifically requires the Board to consult with the American Indian Health Commission (RCW 43.71.020(9)).

Sponsorship. E2SHB 2319, enacted during the 2012 legislative session, directs the Board to establish rules or policies that permit city and county governments, Indian tribes, tribal organizations, urban Indian organizations, private foundations, and other entities to pay premiums on behalf of qualified individuals (ESHB 2319, Sec.4(3)). As described above, the ability for tribes, tribal organizations and urban Indian organizations to pay QHP premiums on behalf of qualified individual is specifically prescribed in HHS federal EHB rules. The inclusion of other entities in proposed state law is consistent with long-standing financial sponsorship options in Washington's Basic Health and Apple Health for Kids programs.

Essential Community Providers. E2SHB 2319 affirms federal requirements that tribal programs and urban Indian health programs are HBE essential community providers (E2SHB 2319, Sec.8(1)(c)). This requirement also re-affirms state policy that health plans regulated by the State Insurance Commission under Chapter 48 RCW require plans to contact with tribal programs. The rule

specifically states, *"… To provide adequate choice to covered AI/AN persons, health carriers must maintain arrangements that ensure that AI/AN members have access to Indian health care services and facilities that are part of the Indian health system. Carriers are not responsible for credentialing providers and facilities that are part of the Indian health system."*

In summary, the ACA and IHCIA sets forth a set of HBE requirements that are intended to ensure the AI/AN people are able to obtain affordable health care coverage. These include provisions to reduce the cost of HBE coverage, ability to enroll in the HBE in a timely manner, support in obtaining coverage through the HBE navigator program, and outreach and education to Tribes to so that they can actively enroll their people into the HBE. The two federal laws prescribe that tribal and urban Indian health programs should be QHP essential community providers to serve AI/AN people who are often low-income, medically-underserved individuals. The ACA also recognizes the government-to-government relationship between Tribes and the HBE governance entities through the implementation of a consultation policy. State laws re-enforce these requirements by directing the HBE to establish a finance sponsorship program so that Tribes, urban Indian health programs, local governments and foundations can assist low-income people to purchase care through the HBE; reaffirmations that tribal and urban Indian health programs are critical essential community providers; and, requires ongoing consultation with Tribes through the AHIC.

SECTION FOUR: Key Tribal Focus Areas for HBE

As described above, the HCA contracted with AIHC to prepare a report on Washington's Tribes and Indian health care system to guide the WHBEB in developing a HBE that meets federal and state AI/AN requirements. The contract also provided financing for AIHC to develop a proposal for Washington's Level 2 Establishment Grant request that would prescribe projects and tasks that AHIC would conduct to assist the WHBEB in developing the HBE components to ensure the AI/AN people would be able to enroll and purchase affordable health care coverage through the HBE and tribal essential community providers.

The overarching goal of this proposal is to provide the WHBEB with the tools and expertise needed to assure HBE policy and administrative issues related to AI/AN and the Indian health delivery system are appropriately addressed in the design and implementation of the HBE as they prepare for Exchange certification. This goal aligns with four of the eleven Exchange Establishment Core Areas. Core areas are identified for each goal.

Based on its Preliminary Analysis Report and Tribal HBE Assessment submitted previously to the HCA, AIHC has developed four strategic issue areas on which to focus in order to reach the goal stated above: 1) maximize grant resources through effective project management and operation; 2) prepare for successful AI/AN enrollment in the HBE; 3) assure Tribal and urban Indian programs in-network provider issues are appropriately addressed; and, 4) facilitate the development of an HBE Tribal Consultation policy.

Under each issue area, objectives are included that will assure each issue area statement is addressed.

ISSUE ONE: Maximize grant resources through effective project management and operation

Funding will be required for coordinating the objectives, tasks and activities under this proposal. It is important for the WHBEB to work with AIHC in order to successfully facilitate a collective voice and input from 29 federally-recognized Tribes and 2 urban Indian health organizations. As a trusted Tribal source, AIHC serves as a convener where Tribes and urban programs can provide feedback on key HBE components on which AIHC is working and assure the work between AIHC and the WHBEB remains tribally-driven. A project coordinator will be hired to meet the objectives under this issue area.

Objective 1.1 Develop an overall project work plan

Tasks:

- Project Coordinator will work with the WHBEB, consultants and AHIC Executive Director to develop a timeline for accomplishing the objectives outlined in this proposal. The work plan will include activities, responsible parties, and partners to engage, start and end dates, benchmarks, and deliverables for each

Objective 1.2 Direct the overall operations of this project

Tasks:

- Oversee implementation of project activities and work plan
- Coordinate with the HCA, WHBEB, and other agencies, Tribes and urban programs
- Develop documents, materials and presentations
- Conduct meetings

- Design and direct the gathering, tabulating and interpreting of required data;
- Conduct program evaluation and assure required reports/documentation are submitted to the HCA as identified

Objective 1.3 Convene the appropriate Tribal experts necessary for each specific technical, policy and product component of the HBE design and implementation related to AI/AN and I/T/Us and the issues identified in this proposal

Tasks:

- AIHC to serve as primary contact for WHBEB as further collaborative work is accomplished.
- Develop pool of technical and policy experts within Tribes/urban programs to support the design and implementation of AI/AN HBE components.
- Facilitate teams to work with WHBEB, Office of the Insurance Commission (OIC) and HCA (state Medicaid program) on specific components within this proposal at appropriate times throughout the grant cycle.

ISSUE TWO: Prepare for successful AI/AN enrollment in the HBE

One of the primary goals of this Tribal-focused work is to assure the most successful AI/AN enrollment rates in the HBE beginning on October 1, 2013. As described above some 23,000 uninsured AI/AN adults will be eligible for health insurance through Washington's HBE. Many challenges exist to enrolling AI/AN, which were described in the Statement of Need of this proposal. Incentives, outreach, and easy access are all critical to assisting Indian people in enrollment into qualified health plans for which they are eligible. The accomplishment of the objectives under this issue area will increase the ability for AI/AN to access coverage through the newly establish HBE. There are key ACA provisions within the ACA that will help facilitate AI/AN enrollment into qualified health plans but further work to ensure the success of these provisions will need to be accomplished.

Exchange Core Areas

#2: Stakeholder Consultation
#10: Providing Assistance to Individuals and Small Businesses
#11: Business Operations of the Exchange

Objective 2.1 Provide technical assistance in development of Exchange Call Center

As described in the Section 3 of this report, the AI/AN provisions within the ACA are numerous. Not only will Call Center staff need to understand how to work with AI/AN people (tribal competencies) but will also need to be able to understand all the provisions that impact AI/AN enrollment and have the ability to describe and implement them through clear and simple explanations and guidance.

Tasks:

- Determine call capacities on Tribal reservations and in urban areas.
- Identify tribal-specific issues that should be considered by Call Center; develop plan to address.
- Develop AI/AN requirements in collaboration with WHBEB and Medicaid staff and the HBE Call Center.
- Identify special circumstances for AI/AN; develop training curriculum and program for call center employees on Indian health; develop quality assurance process for call center employees in collaboration with WHBEB and Call Center.

- Work with WHBEB to designate an Indian health expert at Call Center who is empowered to resolve problems, answer questions, keep a list of FAQs, and work with tribal and urban Indian programs, HBE QHPs and others on issues that relate to AI/AN provisions and Tribal and urban Indian health systems.

Objective 2.2 Develop model for Tribal Sponsorship of qualified health plan premiums for AI/AN

Recently adopted federal rules allow tribal entities to pay HBE premiums on behalf of their members (45 CFR 155.240(d)). Washington has enacted law that, "*The board shall establish rules or policies that permit city and county governments, Indian tribes, tribal organizations, urban Indian organizations, private foundations, and other entities to pay premiums on behalf of qualified individuals."*

Tasks:

- Work with WHBEB and other stakeholders to design and implement E2SHB 2319 premium sponsorship program for Tribes, urban Indian health programs and other entities.
- Provide Tribes and urban Indian programs with information and methods for creating capacity for sponsoring premiums for individuals.
- Work with WHBEB policy staff to assure capacity for on-line payments.
- Review existing Basic Health program sponsorship to serve as model for developing HBE sponsorship program.

Objective 2.3 Develop and finance a Tribal Education & Outreach program in coordination with the Northwest Portland Area Indian Health Board (NPAIHB)

A comprehensive education program is needed to raise awareness and prepare Tribes, tribal leaders and urban Indian health programs for the HBE implementation. Tribal and community leaders, as well as health directors and health decision-makers, will play a significant role in promoting AI/AN enrollment in the HBE. Based on outreach conducted in AIHC's preliminary work during the winter of 2012, it is apparent that many Tribes are not yet aware of the HBE and the positive impacts it could have on Tribal health. The education program will employ resources that NPAIHB is developing nationally for Tribes across the county and then tailor them specifically to Washington.

A Tribal Assister program is a critical element in the successful enrollment of AI/AN into qualified health plans within the HBE. By developing an assister model(s), Tribes and urban programs will have a tool from which to develop community-specific approaches to benefits enrollment. The model will need to be able to serve IHS Tribes, 638 Tribes and urban Indian programs, which is essential for successful enrollment of AI/AN people in the HBE. The Tribal Assister program is a critical component in the enrollment of AI/AN people because of the historical federal responsibility for tribal health care and absence of online capability among low-income tribal members. There will be further enrollment challenges for the Tribes because Indian people are exempt from insurance penalty provisions and the historical responsibility of IHS to provide funding for tribal health care. The Tribal Assister program will be compliance with federal requirements for the HBE Navigator, state consumer protection requirements, and Title XIX Medicaid program. The program, will serve as a model for WHBEB to build their HBE navigator program.

Tasks:

- Develop tribal-appropriate education curriculum and materials.
- Conduct presentations at each of the 29 Tribal communities and 2 urban Indian health programs.
- Conduct meeting with Tribal leaders and WHBEB on key policy issues affecting tribal member enrollment in the HBE and participation of tribal programs in QHP networks.

- Develop a Tribal Assister model(s) that is tribally and culturally-appropriate and that could be used as a tool for each of Washington's 29 Tribes and 2 urban Indian health programs.
- Work with WHBEB to develop a training model for Tribal Assisters that is tribally/culturally appropriate and that is consistent with federal requirements for the HBE Navigator program and federal Medicaid/CHIP programs.
- Facilitate input from Tribes and urban Indian programs on both the Assister model and training curriculum.
- Research opportunities for funding the assister program in Tribal communities.

Objective 2.4 Provide technical assistance to HBE policy and program staff in assuring AI/AN and Indian health delivery system provisions are addressed and included the HBE website portal and call center.

There are many provisions and issues related to AI/AN enrollment qualified health plans in the HBE. AIHC will create a pool of Tribal technical experts to work in teams with the WHBEB policy and program staff and their HBE IT consultants as the HBE is further designed and developed to develop the functionality to address AI/AN provisions. While other issues may arise and will be addressed as this technical work moves forward, the following tasks have been identified under this objective to be accomplished.

Tasks:

- Provide technical assistance on the IT design requirements for the HBE's on-line website to support AI/AN enrollment; this will include the ability to pass AI/AN membership information to QHPs and BH plans for cost-sharing and tribal essential community provider enrollment.
- Work with WHBEB and state's Medicaid program to develop the definition of AI/AN people and method to document AI/AN status; the definition and document requirements will need to be the same for HBE and Medicaid; if possible, the requirements should also be the same for Oregon and Idaho.
- Work with WHBEB to develop QHP requirement that tribal programs be the default choice for tribal members enrolled in their plan.

ISSUE THREE: Assure Tribes & Urban Indian Health Programs are QHP In-Network Providers

Exchange Core Areas

2: Stakeholder Consultation
9: Health Insurance Market Reforms
11: Business Operations of the Exchange

Objective 3.1 Work with WHBEB and OIC to have Tribes/Urban Programs defined as essential community providers

The ACA requires that a health plan's network include essential community providers who provide care to predominantly low-income and medically-underserved populations to be certified as QHP. E2SHB 2319 also requires that Tribal and urban Indian health programs be considered essential community providers and be included in QHP provider networks.

Tasks:

- Consistent with federal and E2SHB 2319 requirements, AIHC will work with the OIC and Washington Association of Community and Migrant Center (WACMHC) and health plans to define Washington's essential community provider definition.

Objective 3.2: Work with WHBEB and OIC to develop QHP provider contract requirements for essential community providers consistent with federal and state laws.

An important issue with respect to including essential community providers in QHP provider networks is establishing a "sufficient number" of essential community provider participation in QHPs. The ACA does not require QHP issuers to contract with "all" and "any willing" provider.

Tasks:

- Prepare documentation that sets forth ACA, IHCIA and state QHP requirements for contracting with tribal and urban Indian health programs.
- With WHBEB, OIC and other entities, develop essential community provider network standards.

Objective 3.3 Work with WHBEB and OIC to develop a standard contract addendum containing all conditions that would assist QHP issuers when contracting with Indian health providers

Tasks:

- In coordination with NPAIHB and the Center for Medicare & Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG), develop an "Indian addendum" for the WHBEB to facilitate the identification and enforcement of Indian-specific provisions of Federal law and rules.
- Assure addendum contains all federal and state requirements that would apply to QHP issuers and tribal programs when contracting with Indian health providers.
- Address issues such as, but not limited to, Indian Health Care Improvement Act licensing requirement, Federal Torts Claims Act provisions, tribal employment provisions, Indian cost-sharing and existing Medicaid and OIC "any willing provider" requirements that apply to tribal programs.

Objective 3.4 Work with WHBEB and OIC to develop QHP payment requirements for essential community providers

Federal rules (45 CFR 156.235(e)) requires QHPs to pay FQHCs for services covered by a QHP at " … the amount of payment that would have been paid to the center under section 1902(bb) of the Act ..." The rule goes on to say, "*Nothing would preclude a QHP issuer and federally-qualified health center from mutually agreeing upon payment rates other than those that would have been paid to the center under section 1902(bb) of the Act, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in paragraph (d) of this section.*" These payment provisions would apply to tribal programs that meet FQHC requirements. The HBE requirements will need to be harmonized with Medicaid payment requirements because Washington's tribes are paid at the IHS encounter rate.

Section 206 of the IHCIA provides requirements that all Indian health providers have the right to recover from third party payers, including insurance companies up to the reasonable charges billed for providing health services or, if higher, the highest amount the insurer would pay to other providers to the extent that the patient or another provider would be eligible for such recoveries. This section also states that no law of any State or provision of any contract shall prevent or hinder this right of recovery. This requirement applies whether or not there is a contract between the insurance company and the Indian health provider. HHS proposed rule pre-amble states that the payment requirements under section 206 of IHCIA apply to QHP issuers, as well as to any insurer, employee benefit plan or other third party payer.

Tasks:

- Work with WHBEB, OIC and WACMHC to develop federally-required payment rates for essential community providers.

ISSUE FOUR: Facilitate the development of a Tribal Consultation Process for the Washington State Health Benefits Exchange Board

Exchange Core Areas

#2: Stakeholder Consultation

In the July 15, 2011 proposed rules for Establishment of Exchanges and QHPs, under Subpart B, f, Stakeholder Consultation, a certain group of stakeholders are identified, groups that Exchanges are required to consult with. These groups include, *"federally recognized tribe(s) as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a, located within the Exchange's geographic area."* It goes on to say that, *"Exchanges must engage in regular and meaningful consultation and collaboration with such tribes and their tribal officials on all Exchange policies that have tribal implications. We encourage Exchanges to also seek input from all Tribal organizations and urban Indian organizations. . .we encourage States to develop a tribal consultation policy that is approved by the State, the Exchange and Tribes."* This commitment is also made at the state level in recognition, not only of the federal government-to-government responsibility but the state-tribal relationship, as well. RCW 43.71.020(9) states that, *"In recognition of the government-to-government relationship between the state of Washington and the federally recognized tribes in the state of Washington, the board shall consult with the American Indian Health Commission."*

Tasks:

- AIHC to work with WHBEB to develop a Tribal consultation plan, identify issues in which consultation is required.
- Conduct policy analysis on issues requiring consultation.
- Through a consultation process facilitated by AIHC, obtain an approved policy that meets Washington Centennial Accord and RCW 43.71.020(9) requirements.
- Develop process for identifying issues that will require consultation vs. technical assistance from AIHC.