Overview of the Indian Health Care System

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TRIBAL ANALYSIS FOR WASHINGTON STATE HEALTH BENEFIT EXCHANGE & HEALTH CARE AUTHORITY
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American Indian Population & Health Status

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

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 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, its AI/AN uninsured rate is nearly twice the 13.4% rate for the entire state.

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. IHS also provides Contract Health Services (CHS) funding to Tribes that is used to pay for services that the IHS or tribal programs cannot directly provide to their tribal members.

Because the IHS’ 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.
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. ¹

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. ² 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 2008³,” 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.

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. Suicide is also much more common among AI/AN people than the general population.

**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**

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

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4 Chronic Disease Profile, Washington State Department of Health, December 2011, p. 7
• AI/AN infant’s experience 30% more birth defects
• 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.  

**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>
<thead>
<tr>
<th>Table 1</th>
<th>Washington 2009 ACS estimates</th>
<th>Total AIANs</th>
<th>Percent of total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-institutionalized</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>181,196</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-139 % FPL</td>
<td>58,511</td>
<td>32%</td>
<td></td>
</tr>
<tr>
<td>139-400</td>
<td>71,595</td>
<td>40%</td>
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<tr>
<td>400+</td>
<td>51,090</td>
<td>28%</td>
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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.

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

<table>
<thead>
<tr>
<th>Income Category</th>
<th>Total</th>
<th>Uninsured</th>
<th>Insured</th>
<th>% Uninsured</th>
<th>% Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>181,196</td>
<td>40,154</td>
<td>141,042</td>
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<td>78%</td>
</tr>
<tr>
<td>0-139</td>
<td>58,511</td>
<td>17,310</td>
<td>41,201</td>
<td>30%</td>
<td>70%</td>
</tr>
<tr>
<td>139-400</td>
<td>71,595</td>
<td>15,320</td>
<td>56,275</td>
<td>21%</td>
<td>79%</td>
</tr>
<tr>
<td>400+</td>
<td>51,090</td>
<td>7,524</td>
<td>43,566</td>
<td>15%</td>
<td>85%</td>
</tr>
</tbody>
</table>

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.

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...
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. Table 3 demonstrates the wide variation for three factors: Uninsured rate, Employer sponsored (ESI) rate, and percentage saying they have access to Indian Health Services (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 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. 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

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8 Fox, Edward and Verne Boerner, January 12, 2012; testimony to the Washington State House Health Appropriations Committee.
9 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. 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.

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 the IHS, 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**

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

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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.

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.12 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.13 The primary motivation for the transfer was to improve quality of medical

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13 The Department of Health, Education & Welfare was later reorganized as the Department of Health & Human Services (HHS).
services to American Indians through supervision by an agency with more administrative expertise and funding in health care.

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**

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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.  

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

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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. 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 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

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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%.

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.

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

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**  

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,

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enrollment, residence on tax-exempt land, ownership of restricted property, active participation, or other 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**

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.

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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. 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. 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. 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 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.

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

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.

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. The current rate is $294 per-counter, which is higher than FQHC or other professional rates.

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22 See Section 1932(h) of the Social Security Act.
23 See Section 1932(a)(2)(C) of the Social Security Act.
24 See Section 1905(l)(2) of the Social Security Act.
25 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.
26 States are required to specify the services that will be reimbursed using the IHS payment rate in their Medicaid State Plan.
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 health 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. 27

**Medicare Program 28**

The total number of AI/AN enrollees in the Medicare enrollment database between the years 1991 to 2007 was 280,419 nationally. 29 A match between the Medicare enrollment database and the IHS national 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. 30

[Graph: 80% of IHS and Tribal Users Eligible for Medicare are Enrolled]

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

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30 Ibid.
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.

- 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. 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). 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

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31 See Section 1861(aa)(4)(D) of the Social Security Act.
32 The FQHC benefit under Medicare was added effective October 1, 1991, when Section 1861(aa) of the Social Security Act was amended.
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. 33 Ten (56%) of the 18 BH sponsors are Washington tribes.

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. 34 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 35**

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

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33 BH enrollment and sponsorship data is for February 2012.
34 The Basic Health program’s enabling legislation and program design is found in Chapter 70.47 RCW.
35 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.
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.

<table>
<thead>
<tr>
<th>Tribe</th>
<th>Number of Clinics</th>
<th>Medicaid Programs</th>
<th>Medical</th>
<th>Dental</th>
<th>Drugs</th>
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</table>

Total Number of Tribes  | 28               | 14               | 23       | 13     | 27       | 26       | 10 |

Total Number of Programs| 61               | 34               | 25       | 14     | 33       | 31       | 19 | 156    |

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
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.

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. 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

<table>
<thead>
<tr>
<th>AIAN alone and in combination</th>
<th>Private Insurance</th>
<th>Public Insurance</th>
<th>Uninsured</th>
<th>IHS active users</th>
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<tr>
<td>78,675</td>
<td>46,576</td>
<td>23,445</td>
<td>14,948</td>
<td>17,196</td>
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</table>

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 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

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

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37 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.
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 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

<table>
<thead>
<tr>
<th>Active Users 2011</th>
<th>Medicaid Encounters</th>
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</thead>
<tbody>
<tr>
<td>Cowlitz</td>
<td>2,422</td>
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<tr>
<td>Lower Elwha</td>
<td>825</td>
</tr>
<tr>
<td>Samish Indian Nation Wellness</td>
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<tr>
<td>Suquamish Tribe Wellness Program</td>
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<td>Jamestown Family Health Clinic</td>
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<td>Kalispel Camas Center</td>
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<td>Tolt Community Clinic (Snoqualmie)</td>
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<td>Stillaguamish Tribal Health Clinic</td>
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<td>Sauk-Suiattle</td>
<td>64</td>
</tr>
<tr>
<td>Hoh</td>
<td>30</td>
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</table>

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).
<table>
<thead>
<tr>
<th>Tribe</th>
<th>User Population</th>
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## 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.