

Indian Health Care in Washington State

January 9, 2017



**American Indian Health Commission
for Washington State**

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Vicki Lowe***

***With assistance by:
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AGENDA



- I. Introductions
- II. Background on American Indian Health Commission for Washington State
- III. Purpose for Today's Meeting
 - Raise awareness of the importance of HCA-tribal collaboration
- IV. Why Collaborate?
 - A. Tribal sovereignty and federal trust responsibility
 - B. Government-to-government relations
 - C. Complex Indian health care delivery system
 - D. American Indian/Alaska Native (AI/AN) health disparities
 - E. Complex federal requirements
- V. Tribal Expertise, Challenges, and Concerns
- VI. How to Collaborate Effectively - Discussion?
- VII. Questions



I. BACKGROUND



BACKGROUND ON AMERICAN INDIAN HEALTH COMMISSION FOR WASHINGTON STATE

Created in 2003

Mission: *Improve the health of American Indians and Alaska Natives (AI/AN) through tribal-state collaboration on health policies and programs that will help decrease disparities*

Constituents: The Commission works with and on behalf of the 29 federally-recognized tribes and 2 urban Indian health programs in Washington State.

Commission Membership: Tribal Councils appoint delegates by Council resolution to represent their tribes on the Commission.



BACKGROUND ON AIHC: WORK WITH STATE AGENCIES

The Commission provides many health policy-related services under contracts with:



Washington State Department of Health



Washington State Health Care Authority



Washington Health Benefit Exchange



Office of the Insurance Commissioner



II. PURPOSE



Purpose for Today's Meeting

To raise awareness of the importance of HCA-tribal collaboration with the HCA Executive Leadership Team

- ❖ A few recent HCA missteps**
- ❖ Tribes have communicated some frustration**
- ❖ Many HCA-led changes taking place**



III. WHY COLLABORATE



A. TRIBAL SOVEREIGNTY, TREATIES, FEDERAL TRUST RESPONSIBILITY

U.S. RECOGNITION OF TRIBAL SOVEREIGNTY

Indian nations within the United States possess the inherent power to govern.

“The Indian nations had always been considered as distinct, independent, political communities, retaining their original natural rights, as the undisputed possessors of the soil, from time immemorial...”

– Worcester v. Georgia, 31 U.S. 515, 559 (1832)

As sovereign nations, Indian tribes operate full governments and often coordinate their services across multiple departments.



TREATIES WITH TRIBES IN WASHINGTON

**Treaty of
Medicine
Creek
(1854)**

**Nisqually, Puyallup, Squaxin Island,
Steilacoom, S'Homamish, Stehchass,
others**

Reservation, fishing, hunting,
pasturing (stallions for breeding only),
health care

**Treaty
of
Point
No
Point
(1855)**

**Jamestown S'Klallam, Port Gamble
S'Klallam, Lower Elwha Klallam,
Skokomish, others**

Reservation, fishing, hunting,
health care

**Treaty
with the
Yakama
(1855)**

**Yakama, Palouse, Piquouse, Wenatshapam,
Klikatat, Klinquit, Kow-was-say-ee, others**

Reservation with schools and fishery,
fishing, hunting, pasturing, **health care**

**Treaty with
the Nez
Perce
(1856)**

Nez Perce

Reservation with schools, fishing,
hunting, pasturing, **health care**

**Treaty
of Point
Elliott
(1855)**

Lummi, Suquamish, Tulalip (*Snohomish,
Skykomish, others*), **Swinomish,
Snoqualmie, Skagit, Duwamish, others**

Reservations, fishing, hunting,
health care

**Treaty
of
Neah
Bay
(1855)**

Makah

Reservation, fishing, whaling, sealing,
hunting, **health care**

**Treaty
of Walla
Walla
(1855)**

Umatilla, Walla Walla, Cayuses

Reservation, fishing, hunting, pasturing,
health care

**Quinault
Treaty
(1856)**

Quinault, Quileute

Reservation, fishing, hunting, pasturing
horses (stallions for breeding only),
health care

FEDERAL TRUST RESPONSIBILITY TO TRIBES

The federal government has a trust relationship with the tribes that is derived from treaties, statutes, and opinions from the Supreme Court.

The federal government has a legal obligation to protect tribal sovereignty and property.



See Worcester v. Georgia, 31 U.S. 515 (1832) and Cherokee Nation v. Georgia, 30 U.S. 1(1831).

STATUTE APPLIES FEDERAL TRUST RESPONSIBILITY TO PROVIDE CARE TO AI/ANS AND URBAN INDIANS



Section 3 of P.L. 94-437:

The Indian Health Care Improvement Act:

“...it is the policy of the Nation, in fulfillment of its special responsibilities and legal obligations to the American Indian people, to ensure the highest possible health status for Indians and urban Indians.”



SIMILAR RELATIONS: FEDERAL-STATE & FEDERAL-TRIBAL

Federalism – Governmental Relations between States and U.S.

“The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people.”

– U.S. Constitution, Tenth Amendment

Federal-Tribal Governmental Relations

“...the treaty was not a grant of rights to the Indians, but a grant of rights from them—a reservation of those not granted.”

– U.S. v. Winans, 198 U.S. 371 (1905)



B. GOVERNMENT-TO-GOVERNMENT RELATIONS

GOVERNMENT-TO-GOVERNMENT RELATIONS: FEDERAL-TRIBAL

- Executive Order 13175
- Various agency regulations



Brian Cladoosby, Chair Swinomish Tribe with
President Obama

GOVERNMENT-TO-GOVERNMENT RELATIONS: STATE-TRIBAL

Centennial Accord of 1989: Agreement between the State of Washington and the Tribes where each party “respects the sovereign status of the parties, enhances and improves communications between them, and facilitates the resolution of issues.”

Chapter 43.376 RCW: Law requires state agencies to “make reasonable efforts to collaborate with Indian tribes in the development of policies, agreements, and program implementation that directly affect Indian tribes...”



GOVERNMENT-TO-GOVERNMENT RELATIONS: TRIBAL CONSULTATION REQUIREMENTS

American Recovery & Reinvestment Act of 2009: Requires State Medicaid agencies to seek advice on a regular, ongoing basis from designees of Indian health programs (IHS, tribes, and urban Indian health programs) concerning Medicaid and CHIP matters that have a direct effect on AI/ANs or Indian health programs.

Chapter 43.376 RCW: Requires state agencies to “develop a consultation process that is used by the agency for issues involving specific tribes





C. COMPLEX INDIAN HEALTH CARE DELIVERY SYSTEM

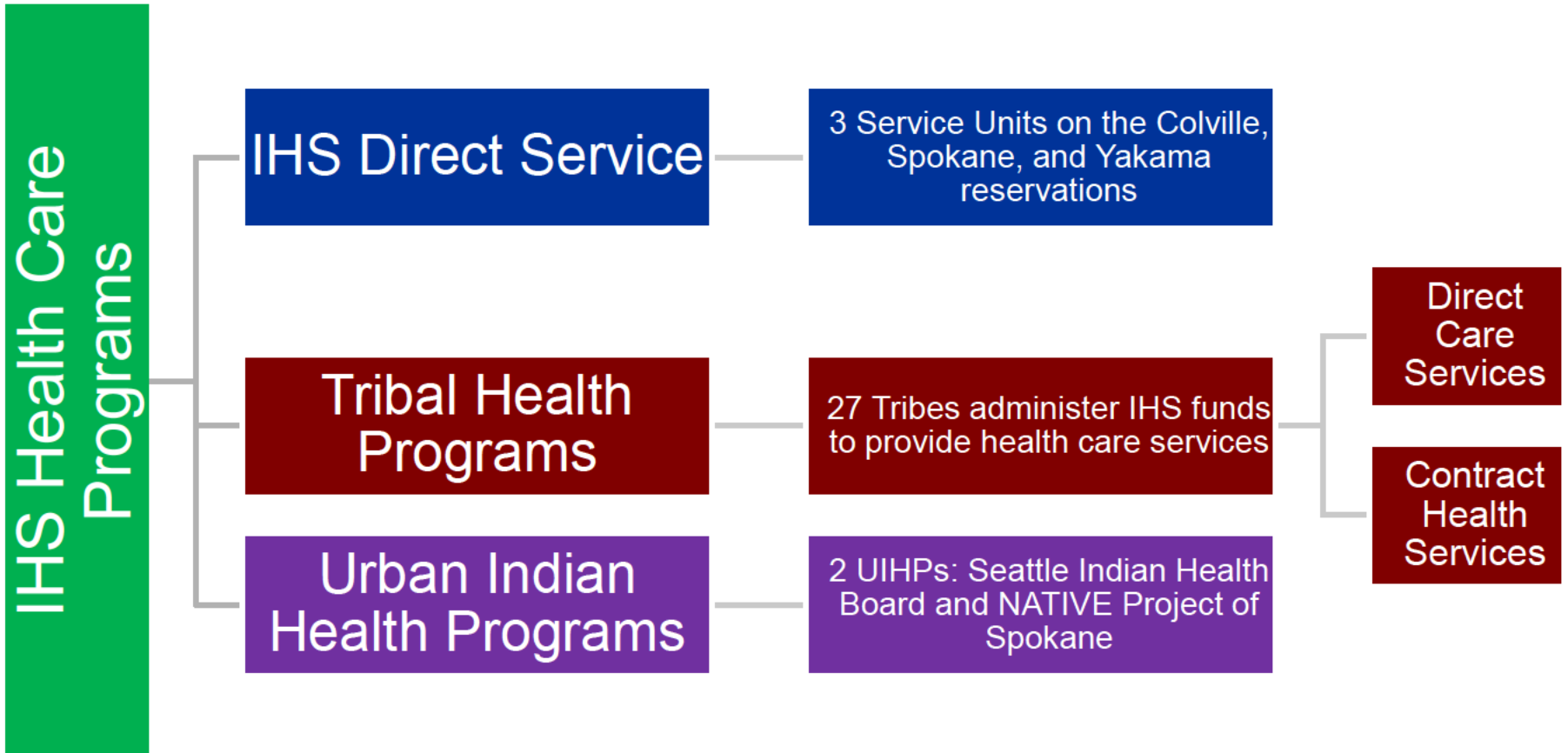


INDIAN HEALTH SERVICE (IHS)

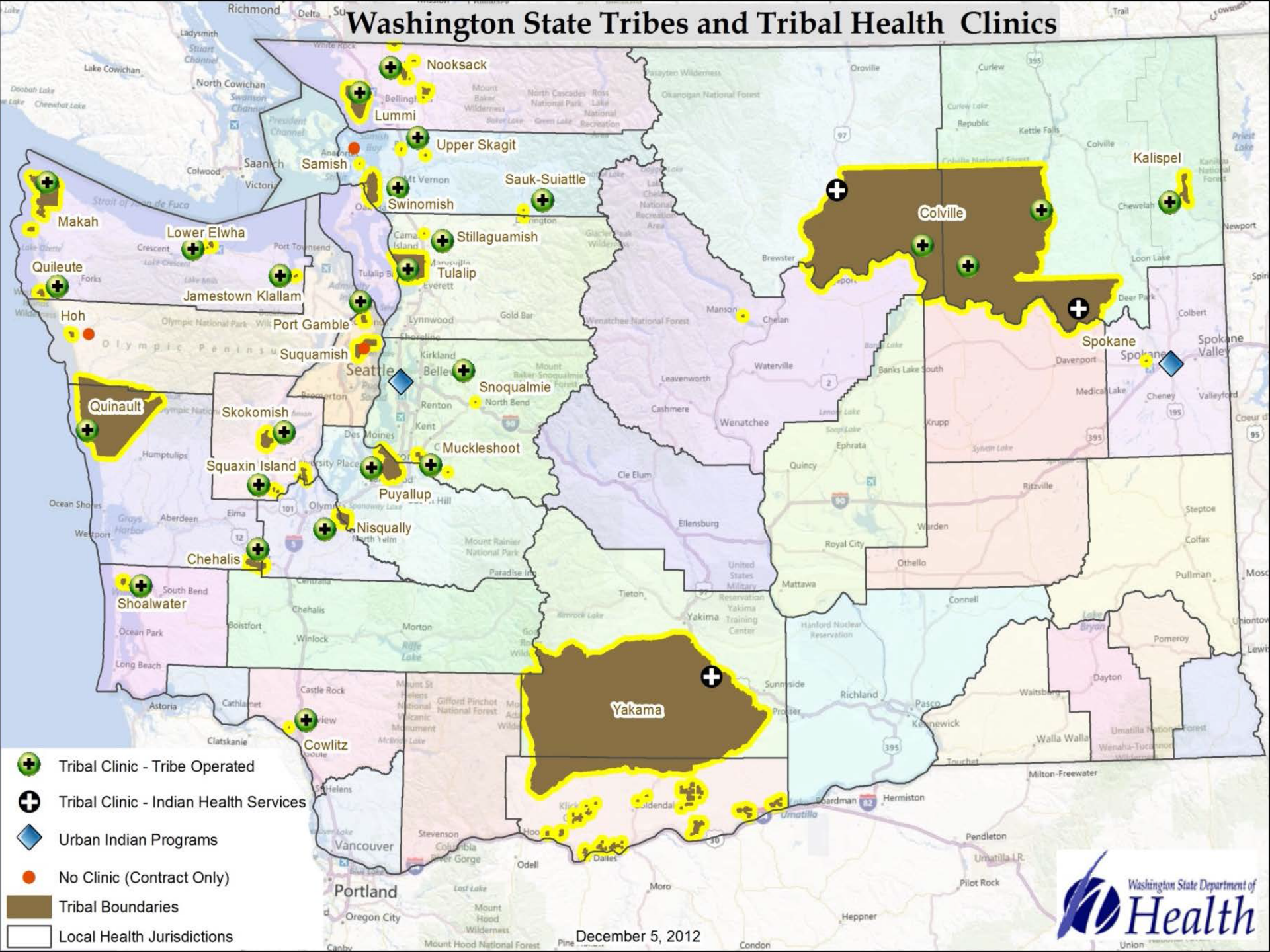
- **History:** Agency founded in 1955, but health care services provided through various federal agencies since the 1800s
- **Today:** Now in the Department of Health and Human Services, IHS is a sister agency to CMS
- **Function:** Coordinates the Congressional appropriations for health care to be provided to AI/ANs through three broad types of programs, with facilities located on or near Indian reservations or in certain urban areas
- **Eligibility:** Approximately 2.2 million eligible AI/ANs are eligible for care nationwide within the Indian health care delivery system, but eligibility varies depending on program and tribe









INDIAN HEALTH SERVICE (IHS)



Washington State Tribes and Tribal Health Clinics



-  Tribal Clinic - Tribe Operated
-  Tribal Clinic - Indian Health Services
-  Urban Indian Programs
-  No Clinic (Contract Only)
-  Tribal Boundaries
-  Local Health Jurisdictions

December 5, 2012



Contract Health Services (aka Purchased and Referred Care)

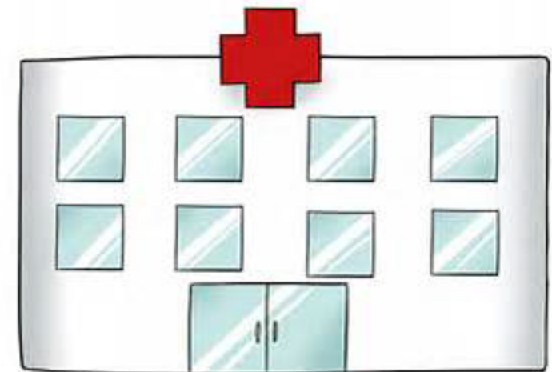
Indian Health Care Provider



- Health Care
- Mental Health
- Substance Use
- Dental

Referral & Coordination

Non-Indian Health Care Provider



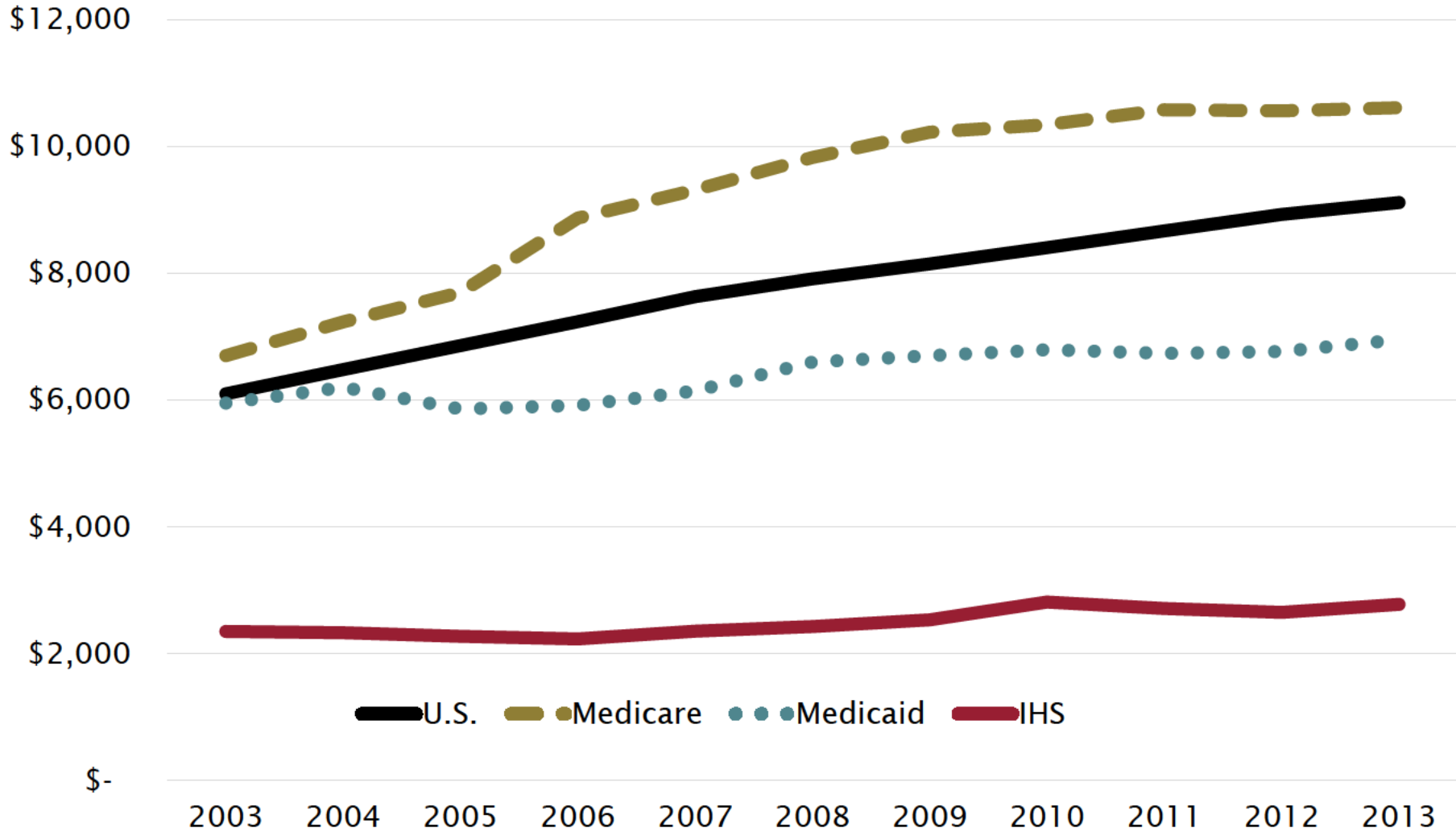
- Specialty Care
- Inpatient Care

IHS CHSDAs by County and RSA

	Clallam	Jefferson	Kitsap	Whatcom	Island	San Juan	Skagit	Snohomish	King	Pierce	Mason	Thurston	Grays Harbor	Pacific	Lewis	Wahkiakum	Cowlitz	Clark	Skamania	Chelan	Douglas	Grant	Okanogan	Ferry	Lincoln	Pend Oreille	Spokane	Stevens	Kittitas	Klickitat	Yakima	
	Peninsula RSA			North Sound RSA				RSA	RSA	M-T RSA	Timberlands RSA						SW RSA	North Central RSA					Spokane RSA			Gr. Columbia RSA						
Chehalis												x	x		x																	
Colville																					x	x	x	x	x	x						
Cowlitz									x	x		x			x	x	x	x	x													x
Hoh		x																														
Jamestown S'Klallam	x	x																														
Kalispel																																
Lower Elwha	x																															
Lummi				x																												
Makah	x																															
Muckleshoot									x	x																						
Nisqually										x		x																				
Nooksack				x																												
Port Gamble S'Klallam			x																													
Puyallup									x	x		x																				
Quileute	x	x																														
Quinault		x											x																			
Samish	x	x	x	x	x	x	x	x	x	x																						
Sauk-Suiattle							x	x																								
Shoalwater Bay														x																		
Skokomish											x																					
Snoqualmie				x				x	x	x																						
Spokane																									x	x			x			
Squaxin Island											x																					
Stillaguamish								x																								
Suquamish			x																													
Swinomish							x																									
Tulalip								x																								
Upper Skagit							x																									
Yakama															x				x												x	x

x = Tribal facility located in county/IHS service delivery area

NATIONAL HEALTH CARE SPENDING PER CAPITA



Source: Jessie Dean – Analysis of Centers for Medicare and Medicaid Services (CMS) National Health Expenditure Accounts (NHEA) and the Department of Health and Human Services (DHHS) Budgets in Brief.

Complex Payer Requirements for AI/ANs and Tribes

Federal government
fails to fund IHS
adequately



Federal government
requires AI/ANs to use
other resources first*



Tribes/UIHPs forced to
fill in the gaps



**42 CFR 136.61 – IHS is payer of last resort.*

EFFECTS OF UNDERFUNDING OF THE INDIAN HEALTH SERVICE

**Inadequate
funding
(56% level
of need)***

**Limited
access &
fragmented
care**

**Health
disparities**



D. AMERICAN INDIAN/ALASKA NATIVE (AI/AN) HEALTH DISPARITIES

WASHINGTON HEALTH ALLIANCE: DISPARITIES IN CARE REPORT 2014:



“American Indian/Alaska Native populations are disproportionately affected by diseases, such as cancer, heart disease, and diabetes. Furthermore, when looking at deaths in Washington state, American Indian/Alaska Native experience the highest age-adjusted death rates when compared to other racial and ethnic groups. *This makes the quality of care that they receive that much more important.*”
(emphasis added)

SELECT HEALTH DISPARITIES DATA FOR AI/ANS IN WA

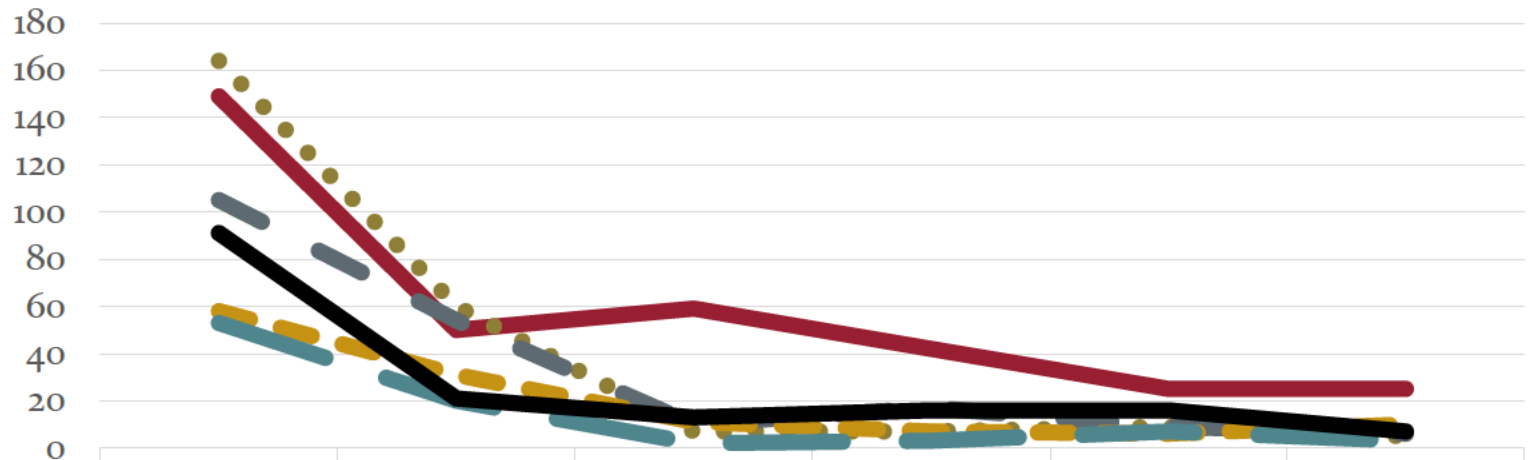
In Washington, the mortality rate for AI/ANs was 1,233.6 per 100,000. A rate about 71% higher than the rate for non-Hispanic whites.

Top 10 Leading Causes of Death

Heart Disease	19.3%
Cancer	19.2%
Unintentional Injury	12.6%
Diabetes	4.8%
Chronic Liver Disease	4.7%
Chronic Lower Respiratory Disease	4.5%
Stroke	3.9%
Suicide	3.2%
Alzheimer's Disease	2.4%
Influenza and Pneumonia	1.6%

Data Source: Northwest Portland Area Indian Health Board. American Indian & Alaska Native Community Health Profile – Washington. Portland, OR; Northwest Epidemiology Center, 2014 (WA State death certificates, 2006-2012, corrected for misclassified AI/AN race).

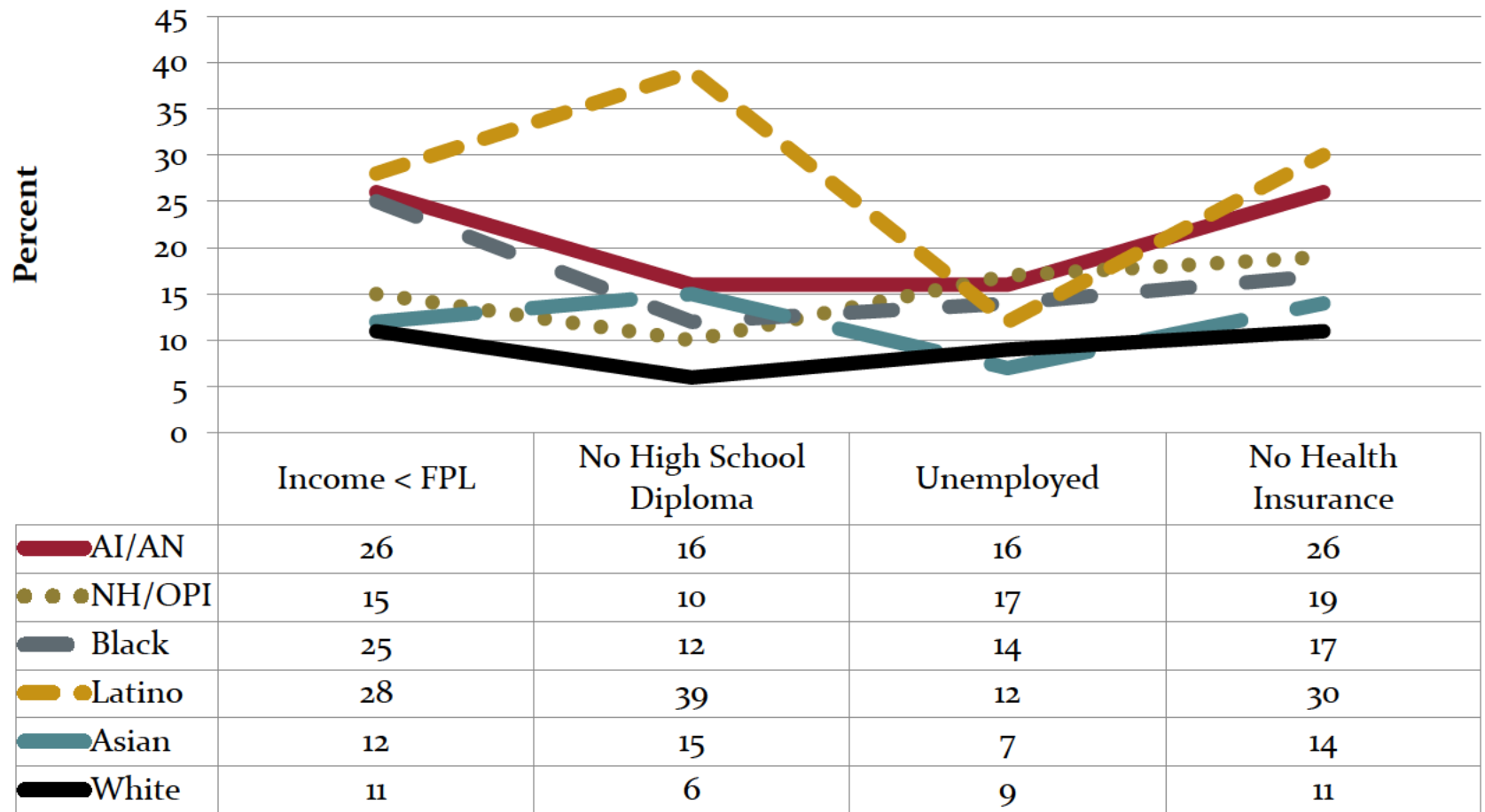
Premature Mortality Rates, Washington, 2013



	Coronary Heart Disease	Diabetes	Alcohol-Induced	Drug-Induced	Suicide	Motor Vehicle Crash
AI/AN	149	50	59	42	25	25
NH/OPI	164	60	7	7	9	5
Black	105	54	10	17	9	6
Latino	58	31	11	7	6	10
Asian	53	20	2	3	7	3
White	91	21	13	16	16	7

Source: Washington Department of Health. (2013). National Vital Statistics Report, 64(2).

Social Determinants of Health, Washington, 2013



Source: Washington Department of Health. (2013). National Vital Statistics Report, 64(2).



E. COMPLEX FEDERAL MEDICAID REQUIREMENTS APPLICABLE TO TRIBES AND AI/ANS

Tribal Sovereignty & Sovereign Immunity

Under federal law, Tribal governments are sovereign governments, like federal and state governments.

- Tribes and States are both sovereigns.
- Tribes are not subject to State law; States are not subject to Tribal law.

Tribal governments have sovereign immunity.

- Tribes are presumptively immune from state law.
- Tribes cannot be sued unless they consent to the lawsuit or they waive their sovereign immunity.



IHS is the Payer of Last Resort

Commercial Insurance

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graph TD; A[Commercial Insurance] --> B[Medicare]; B --> C[Medicaid]; C --> D[Indian Health Service];
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Medicare

Medicaid

Indian Health Service

See 42 C.F.R. 136.61.

HIPAA: PHI Disclosures to Tribal Governments

HIPAA (45 C.F.R. 164.512) provides that covered entities may disclose public health information (PHI), without written authorization of the individual, to a Tribe as either:

- A public health authority that is authorized by law to collect and receive such information for the purposes of preventing or controlling disease, etc., or
- A health oversight agency that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance.



IHS Encounter Rate & Federal Participation

IHS Direct facilities and Tribal 638 facilities that choose to be IHS facilities (as defined in the *1996 Memorandum of Agreement* between CMS (formerly HRSA) and IHS (MOA)) will receive the IHS Encounter Rate (currently \$350) for Medicaid-covered services provided to Medicaid enrollees. See MOA and Medicaid State Plan definition of encounter.

For Medicaid-covered services provided by IHS Direct facilities or Tribal 638 facilities to AI/AN Medicaid enrollees in fee-for-service, the Federal Medical Assistance Percentage (FMAP) is 100% (42 U.S.C. 1396d(b)).

- For comparison:
 - Medicaid Expansion FMAP: 100% until 2017, then declines to 90%
 - Presumptive SSI FMAP: 80% currently
 - Classic Medicaid/Other MAGI-Based Medicaid FMAP: 50% currently

Provider Enrollment: Licensing Exemption

Health care professionals employed by a Tribal health program are exempt from the licensing requirements of the state in which the services are performed, provided the health care professional is licensed in any state. (25 U.S. Code § 1621t)

- Similar to Veteran's Administration licensing requirements under 38 U.S. Code 7402



Provider Enrollment: Insurance & FTCA

Tribal health providers are covered by the Federal Tort Claims Act (FTCA)(25 C.F.R. Part 900)

- The federal government becomes responsible for the negligent or wrongful acts of Tribal health providers unless the claim is for:
 - On-the-job injuries which are covered by worker's comp
 - Breach of contract rather than a tort claim; or
 - Acts performed by employee outside the scope of emplo
- WACs 182-502-0006, -0010, -0012, -0016 reflect this.
- Tribal health providers are not required to obtain professional liability insurance or other insurance coverage for tort claims to the extent covered by FTCA.



MCO Contract Requirements

Each MCO contract with the State must require the MCO to:

- Demonstrate sufficient I/T/Us in network for MCO-enrolled AI/ANs to have timely access to Medicaid-covered managed care services from I/T/Us;
- Pay I/T/Us, whether contracted with the MCO or not, for Medicaid-covered managed care services provided to MCO-enrolled AI/ANs at a rate that is not less than the amount that would be payable to a contracted non-I/T/U provider;
- Make prompt payment to I/T/Us, whether contracted with MCO or not; and
- Pay I/T/Us that are FQHCs, whether contracted with the MCO or not, for Medicaid-covered managed care services provided to MCO-enrolled AI/ANs at a rate that is not less than the amount that would be payable to a contracted non-I/T/U FQHC (without affecting FQHC supplemental payments).

If the amount paid by the MCOs to a non-FQHC I/T/U is less than the IHS encounter rate, the Medicaid State Plan must provide for payment of the difference between the MCO rate and the IHS encounter rate.

See 42 U.S.C. 1396u-2(h)(2).

AI/AN Exemptions from Cost-Sharing

AI/ANs are exempt from:

- Medicaid premiums and cost-sharing (42 C.F.R. 447.56(a)(1)(x))
- CHIP premiums and cost-sharing (42 C.F.R. 457.125(b))
- Qualified Health Plan premiums and cost-sharing if:
 - a) Under 45 C.F.R. 155.350:
 - Household income is equal to or less than 300% of the federal poverty level, and
 - Verified membership in a Tribe; or
 - b) Under Section 1402(d)(2) of the Affordable Care Act:
 - They receive care through I/T/U or Purchased and Referred Care.

AI/AN Federal Rights and Medicaid Managed Care

AI/ANs have the right to exempt themselves from an MCO or PCCM program, if they choose, unless the MCO or PCCM is an I/T/U (42 C.F.R. 438.50(d)(2)).

AI/ANs enrolled in an MCO have the right to select an in-network I/T/U for primary care (42 U.S.C. 1396u-2(h)(1)).



III. TRIBAL EXPERTISE, CHALLENGES, & CONCERNS

TRIBAL EXPERTISE IN HEALTH CARE

- Providing care within a maze of federal and state regulation:
 - IHS funding is subject to many federal regulations, which differ between programs and between tribes; an IHS facility has different rules for eligibility, referrals and billing than a Tribal program or an UIHP.
 - Indian health care provider billing staff can educate non-Indian providers on how and when the different regulations apply.
- Creating and administering programs with limited funding:
 - Indian health care provider revenues come from discretionary IHS appropriations and third-party billing, including Medicaid, Medicare, and private insurance.
 - With persistent Congressional threats to appropriations and Congress's use of continuing resolutions instead of budgets, third party billing revenue has become a critical means for keeping Indian health care programs in existence.

TRIBAL EXPERTISE IN HEALTH CARE

- **Community Health Programs:**
 - Tribal health programs have utilized Community Health Nurses (CHNs) and Community Health Representatives (CHRs) for decades.
 - Home visiting, transportation to medical appointments, follow-up care from hospitalizations, prevention education, diabetes programs, walking and exercise programs help AI/ANs outside the clinical setting.
- **Social Determinants of Health:**
 - As governments, Tribes provide many governmental services to help address social determinants of health, including but not limited to housing, food banks, food vouchers, help with energy costs, employment services, education services, and case management.
- **Culturally Appropriate Services:**
 - Many Tribal clinics utilize traditional healers in their clinics but are unable to bill for their services. They provide them regardless of revenue as they know these services are important to the health of their people.

TRIBAL EXPERTISE IN HEALTH CARE

- **Best Practices: Creative solutions with limited funding**
 - Holistic health care from which others can learn
 - Wrap-around services that include physical, social, spiritual, and behavioral
 - Integrated behavioral and physical health care
 - Focus on population health through native public health practices

- **Other Common Tribal Priorities**
 - Sustainability
 - Prevention and wellness
 - Community connectedness
 - Culture



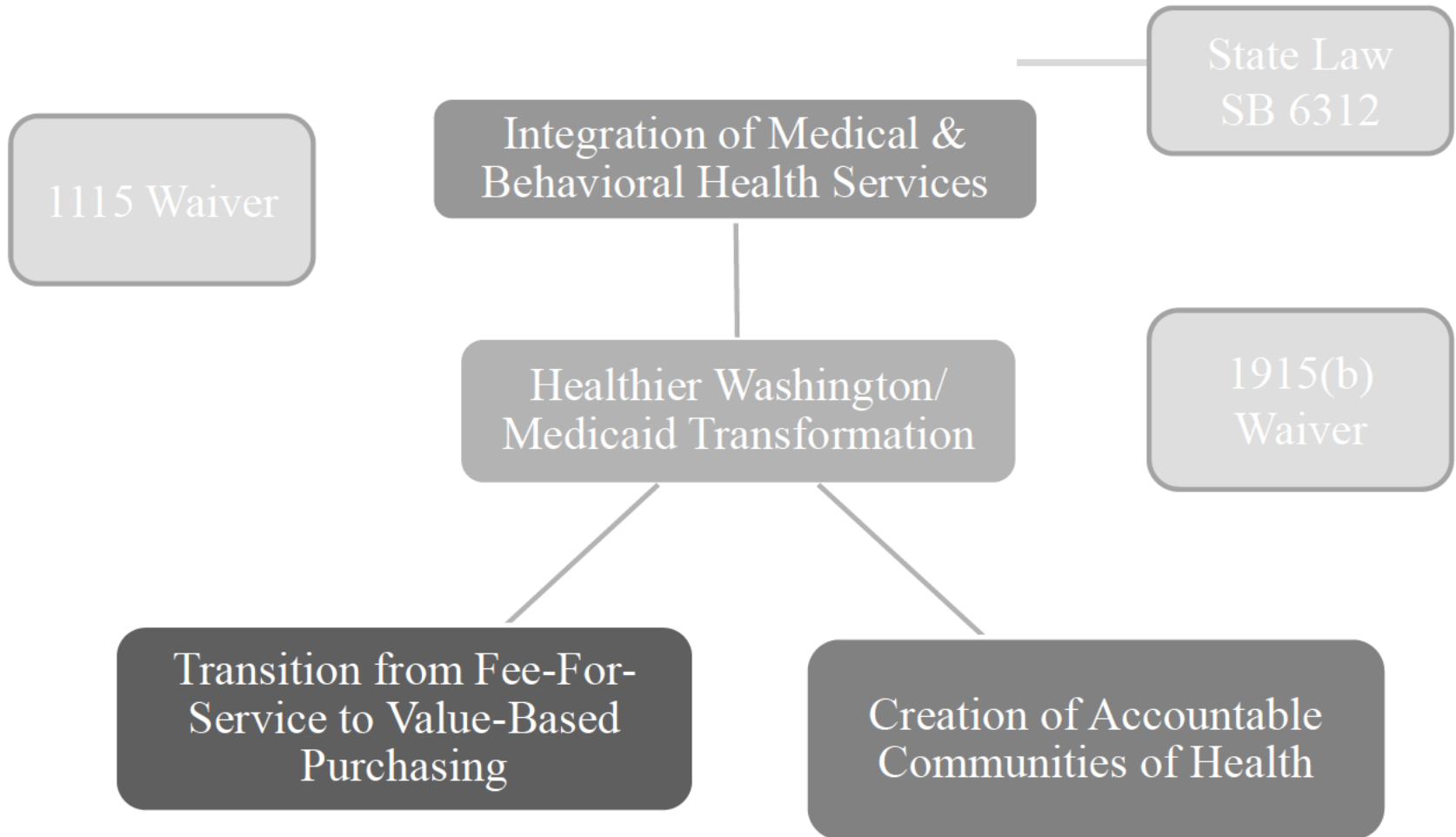
CHALLENGES IN INDIAN HEALTH CARE

- Provider Recruitment and Retention
 - Recently, one Tribe had a provider position vacant for 15 months
 - Common, persistent vacancies: oral health, maternal-infant health, long-term care

- Remote areas with few health care options
 - Lack of providers in rural communities
 - Transportation and child care becomes a barrier

- Cultural Barriers
 - Discrimination and distrust
 - Communication challenges
 - Lack of understanding of the Indian health care delivery system outside of Indian Country
 - AI/AN health literacy – AI/AN clients are used to IHS/Tribal clinics taking care of them and often don't know how to advocate for their own health

SOME TRIBAL CONCERNS



FINAL THOUGHT ON WHY WE NEED TO COLLABORATE



“There are always Tribal implications unless it turns out there are not.”

-- Stephen Kutz, Cowlitz Tribe

...and Tribes are the best source for whether a program, policy, or agreement will have Tribal implications.



IV. HOW TO COLLABORATE

How to Collaborate

What are your thoughts?



Thank you!



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