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Tribal/State Health Policymaking in the Northwest States of Oregon, Washington and Idaho: Institution Building for Policymaking.

Northwest Portland Area Indian Health Board

Please direct all correspondence to Edward J. Fox, Northwest Portland Area Indian Health Board, 520 SW Harrison St., Suite 335 Portland OR, 97201, 503-228-4185.

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State Tribal Health Policymaking in the Northwest States of Oregon, Washington and Idaho: Institution Building for Health Care Policymaking.

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Tribal Sovereignty

No discussion of policymaking in the United States begins with a discussion of sovereignty. To say the sovereignty of the United States is important in understanding its policymaking processes seems trivially true. U. S. sovereignty is taken for granted because it is unchallenged---not so with tribal sovereignty. The challenges to tribal sovereignty take place throughout all levels of government; in the U. S. Congress, in state legislatures, governors' offices, and county courthouses across the land. In the current resurgent period of state sovereignty, state leaders have found a receptive ear to their desire for greater autonomy. Tribal leaders, in contrast, spend more time defending sovereignty than any issue of policy they face. Unfortunately, much of the debate is spent on making up for the failure of the American educational system to put tribal sovereignty in its proper perspective for the American people. It is not the purpose of this paper to argue the legal basis of tribal sovereignty,[1] but only to note that it is as much the basis for policymaking for modern Indian leaders as it was for their ancestors in the first century of the U.S. Republic. Sovereignty is the foundation of tribal policymaking.

Tribal governments in the United States are in most cases elected governments and these elected and (in some cases) traditional leaders are the legitimate policymakers for tribes. Tribal leaders are not naïve politicians nor are they supplicants to richer political bodies: they are leaders of governments negotiating for fair agreements with other governments. They understand their demands are in competition with other demands and they are sophisticated negotiators who understand the nature of bargaining under budget constraints and competing priorities.

Indian Health Programs.

The federal obligation to provide health care services to American Indians/Alaska Natives is derived from treaties, legislation, court decisions, and executive orders. In exchange for land and other resources tribes often exacted promises of physician or medical services in treaties. This is often referred to as a treaty obligation or less precisely the trust responsibility of the federal government. The various Congresses and Presidents have followed the practice of making this a moral obligation to all tribes since many treaties were ignored by the U. S. Senate and never ratified and often land was simply expropriated without the legal cover of any contract or treaty. Indeed, all of the 556 tribes (including Alaska villages) in the United States and all American Indians/Alaska Natives consider the provision of health care services a moral as well as legal obligation of the United States. The Indian Health Service, an agency of the federal Department of Health and Human Services, is the source of most financing for Indian health programs. In FY 1998 the Indian Health Service budget of approximately $2 billion funded Indian health programs: those administered by the Indian Health Service in their hospitals and clinics and through tribal programs. As U. S. and state Citizens, American Indians/Alaska Natives are also eligible for other public health programs including Medicaid and Medicare if they meet the entitlement criteria. An

[1] Charles Wilkinson, American Indians, Time, and the Law. New Haven: Yale University Press, 1987.

estimated $300 to $500 million is expended on services for Medicaid recipients who are American Indians/Alaska Natives. Medicare serves very few (about 30,000) American Indians/Alaska Natives.[2]

Three Trends Impacting Indian Health Programs

Three significant trends have radically changed health care policymaking for tribes in the Northwest and tribes nationwide.

- The first is the growing number of tribes who administer their health programs.
- The second is the chronic underfunding of the Indian Health Service (IHS) budget that has traditionally provided nearly all funding for Indian health programs.
- The third is the increased importance of state health policy decisions on Indian health programs.

Each of these trends impacts the others. For example, the trend toward tribal control of health programs has made tribes keenly aware of the federal budget shortfall and able to respond with their new management flexibility they are positioned access state health programs, most notably state Medicaid programs. As a result of these challenges and opportunities, Northwest tribes are now more actively involved in state health policymaking.

P.L. 638 Compacting and Contracting: Tribal Administration and Policymaking of Indian Health Programs.

Since the passage of P. L. 93-638, the Indian Self Determination and Education Assistance Act in 1976 Indian health programs have gone from a fully federal public health program with financing, administration, and policymaking centrally directed from the Indian Health Service headquarters in Rockville, MD to one where nearly half of all expenditures are controlled by tribal health programs. If one were looking at current trends to predict the future of Indian health programs the experience of Portland Area tribes would suggest that in the near future the majority of the health programs funded by the Indian Health Service budget will be tribally administered. In FY 1998 fully 2/3 of the Portland Area Office of the Indian Health Service expenditures fund tribal health programs. Only 7 service units remain under IHS control; four in Washington at Yakama, Wellpinit (Spokane and Kalispel tribes), Nespelem (Colville Tribe), Neah Bay (Makah Tribe), Ft. Hall (Shoshone-Bannock), Idaho, and Warm Springs and Chemawa (mainly for the Chemawa School) in Oregon. Tribal control has resulted in programs that are flexible and unbound from many of the rules and regulations of the Indian Health Service. This flexibility has furthered the tendency of Northwest tribes to look to each other rather than the IHS headquarters in Rockville, Maryland for policymaking leadership. One could also observe that tribes in the remaining Indian Health Service programs have become more active in the policymaking area as a result of the increased

[2] The bureaucratic impediments to billing faced by tribal and Indian Health Service clinics inhibit their ability to bill Medicare Part B, thus preventing many clinics from receiving payment from the Medicare program and reducing the incentive for eligibles to enroll in Medicare.

activism of compacted and contracting tribes. This is in part because all tribes contract at least part of their former Indian Health Service provided health services.

Chronic Underfunding of Indian Health Service Budgets Since 1994

A second trend has had a profound impact on Indian health programs. Unlike Medicare and Medicaid, Indian health programs are not entitlement programs. Indian Health Service funding depends on an annual appropriation. In the current political push for balanced budgets and deficit reduction paid by discretionary programs the IHS budget has been largely frozen despite of a growing Indian population and medical inflation.

The Compounding Effect of Multi-year Funding Shortfalls

Table 1 demonstrates the loss of real resources in the health services account due to increases that have been inadequate to pay for cost increases due to inflation (medical and general) and population growth (averaging 2.38% over this time period and 2% for FY 1999). The loss over the past seven years is estimated at $1.219 billion. This estimate is based on a simple model that applies the medical rate of inflation to 75% of the health services account budget and the general inflation rate is applied to the remaining 25%.

Table 1 Indian Health Services Account FY 1993-1999

Year	Approved Health Services Budget	Budget With Inflation and Growth Adjustment	Real Resource Loss
	(facilities not included)		(000s)
1993	$ 1,524,990	$ 1,555,824	$ 30,834
1994	1,646,088	1,673,320	27,232
1995	1,707,092	1,784,212	77,120
1996	1,745,309	1,899,331	154,022
1997	1,807,269	2,008,581	201,312
1998	1,841,074	2,138,557	297,483
1999	1,844,000	2,275,001	431,001
Total Real Resources Lost FY 1993-1999			$ 1,219,004

If the Health Services account had received full funding for inflation in each budget beginning with FY 1993 the FY 1999 appropriation for the core program (the health services account) of the Indian Health Service would be $2.275 billion not $1.844 billion.[3] $431 million is the additional amount tribes would have to operate complete programs. This funding could be used to provide or purchase many services such as preventive care, mammograms, or to recruit and retain staff. Increased collections have restored a small fraction of these lost revenues. Despite the federal obligation to provide health care to American Indians/Alaska Natives, tribes have had to divert their own source funds to health programs to make up the deficit resulting in these chronic shortfalls. Some Northwest tribes and Wisconsin tribes have reported that nearly one third of all medical expenditures are funded with own source funds. This trend toward

[3] This information is taken from the Northwest Portland Area Indian Health Board's Analysis and Recommendations of the FY 1999 Indian Health Service Budget, February 19, 1998.

frozen budgets continues. Tribes were surprised when in FY 1999 the President proposed a budget increase of just 0.9% for the health services account of the Indian Health Service a figure that proved to be lower than the amount proposed by the Congress. If the Medicaid program had seen similar budget constraint over the past seven years well over $200 billion dollars in federal debt would have been erased!

The Increased Importance of State Health Policy Decisions

In a response to a flat IHS budget and facilitated by the flexibility arising from self-determination contracting and compacting,[4] tribal programs have developed more aggressive management of their financing. Since an estimated one-quarter of the non-elderly Indian population lives under the poverty level many are eligible for state Medicaid programs. The Medicaid program has become an important source of funds for Indian health programs. In the Northwest 20% to 40% of revenues for Indian health programs is derived from Medicaid payments from states. In recent years these amounts leveled off and since the passage of welfare reform declined slightly. The Northwest states of Oregon and Washington were among the first to utilize managed care for their Medicaid population and tribes have had to respond to the challenges this presents to their health programs.

The Tribal Response: Institutionalizing Tribal-State Meetings on Health Care Issues

Northwest tribes in Oregon, Washington and Idaho have responded to the devolution of health care policymaking by engaging states in regularly scheduled meetings to discuss health care issues. Tribes that traditionally focused their attention on the Portland Area Office of the Indian Health Service or the national IHS headquarters in Rockville, Maryland and other agencies in Washington, DC now devote substantial resources to tracking state health care policy.

Establishing true government-to-government relationships with federally recognized tribes is a relatively new concept for states. Since the federal government is the entity responsible for treaty obligations and legislation guaranteeing Indian health services tribes themselves have only reluctantly and at times only tentatively engaged states in discussions on health policy. Many IHS and tribal health programs have experienced negative unintended consequences of state health reform policies developed and adopted without tribal input. Most tribes realize that state, as well as federal, health policy directly affects funding and services available to American Indians and Alaska Natives, but individual tribes have difficulty in accessing, analyzing and effectively responding to state-level policy making given extremely limited staff resources. Northwest tribes have

[4]Contracting refers to the tribal assumption of a health program(s) under Title I of P.L. 638, the Indian Self-Determination and Education Assistance Act. Compacting, authorized under Title III is a more complete takeover of the responsibility for health programs from the Indian Health Service. Self-Determination is the term used to describe the tribal assumption of program responsibilities from federal agencies.

a tradition of working together through Indian organizations in many policy areas and health policy is no exception.

In Washington, Oregon and Idaho the states and the tribes have benefited from the existence of tribal organizations that bring state and tribal concerns together in forums that are part of the policymaking process. One such organization is the Northwest Portland Area Indian Health Board. While these groups do not replace the direct government-to-government relationship between each tribe and the state, they act to focus issues and identify productive solutions.

The Northwest Portland Area Indian Health Board

The tribes of Idaho, Oregon and Washington have long recognized the need to work together on intergovernmental health policymaking. To this end, in 1972, they formed the Northwest Portland Area Indian Health Board (NPAIHB or Board), to assist member tribes to improve their health status and quality of life. The stability of the Board is reflected in the fact that over the last 24 years it has had only two chairs. The Board does not provide any medical services.

The NPAIHB is a tribal organization as defined by P.L.93-638 and a 501 (3) c non-profit organization that represents 40 of the 41 Federally, recognized tribes in Oregon, Washington, and Idaho. The governing body of each member tribe selects a delegate to sit on the Board. Quarterly meetings provide tribal delegates with an opportunity to discuss national and regional health issues and make policy decisions. The Board maintains offices in Portland, Oregon with a staff of thirty and a FY 1998 budget of over $2.5 million headed by an Executive Director who answers directly to a five-person Executive Committee elected by the Board. The overall mission of the Board is to assist member tribes to improve the health status and quality of life of Indian people. The focus of the Board for most of its history has been on the federal government and on the policies of the Indian Health Service.

The mission of the Board is described as:

- Providing a forum for unified Northwest tribal positions on health issues
- Building effective partnerships between Northwest tribes and the Indian Health Service
- Advocating for health policy that protects tribal interests at the federal, state, and local level
- Building tribal capacity to address health issues
- Developing and providing support for health promotion/disease prevention programs
- Developing epidemiology, research, information systems, and data analysis capacity

In 1994 the Board recognized the need to develop expertise in intergovernmental relations with states. Most significantly it developed a position for a policy analyst who

would assist tribes in each of its three states to proactively track tribal/state health policy issues. Under the direction of the board's executive director the policy analyst was instructed to assist the ongoing efforts of the Washington State tribes through the American Indian Health Commission for Washington State. Additionally, the policy analyst would seek to establish regular meetings between state tribes in Oregon and Idaho. This task was accomplished in Oregon and Idaho (described below). In Washington the Board played a supportive role as well, but tribes had a larger role in developing a tribal organization for regular meetings. The Board was later asked to facilitate the American Indian Health Commission meetings as it does for Oregon and Idaho. The policy analyst and a 1/2-time secretary provide most of the staff support for tribal/state health meetings. In addition, however, tribal staff devote countless hours to workgroups and in preparation for meetings and decisions on health policy issues.

The Board is actively involved in state health policy issues. Although most state specific discussions take place in the state meetings described below, the Board regularly schedules state issues on the agenda of its quarterly meetings. In addition, the committees of the Board regularly discuss state health policy issues. The Board's Tribal Health Director's Consortium meets the day prior to the Board's quarterly meetings and has on many occasion discussed state issues that are common to all three states. Since tribal health directors have the responsibility for the viability of their health programs they are keenly aware of the importance and impact of state decisions on their programs. In many cases state issues are first raised with the Board's Tribal Health Directors' Consortium and if the issue deserves their attention a workgroup or staff report is requested to work on the issue. Alternatively, the issue is deferred to state-tribal forums and reports from the state discussions are later report to the Consortium.

Interaction with Other Regional and National Indian Organizations

The Northwest Portland Area Indian Health Board also takes issues to a political body that serves tribes in the Northwest, the Affiliated Tribes of Northwest Indians (ATNI) and its national counterpart the National Congress of American Indians (NCAI). The Board staffs ATNI's health committee and is regularly invited to present health care updates to the full session of ATNI's regular meetings. ATNI in turn takes issues raised by its health committee to the National Congress of American Indians (NCAI) and the National Indian Health Board (NIHB). There have been cases where resolutions dealing with proposals to reform Medicaid have been developed in state meetings and taken forward to the regional ATNI meetings and then brought to the national meetings of the NIHB and NCAI. The Board is a very active member of each of these organizations. The interaction with ATNI and NCAI is critical to effective policymaking because these two organizations are composed of elected tribal leaders with the authority to approved positions raised by the Northwest Portland Area Indian Health Board and the various state meetings. In this way there is a link that runs from local health issues all the way to the national level with tribes and elected tribal officials involved in every level of policymaking. The legitimacy of the more informal policy discussions in state meetings depends on this process.

The Development of State-Tribal Meetings on Health Care Policy

Oregon

Oregon tribes have enjoyed relatively good relations with the State of Oregon, but before the rise in importance of the Medicaid program health was not a regular matter of joint concern. The impetus for tribal state meetings in Oregon was the start up of the State's 1115a waiver in FY 1994. This Health Care Financing Administration waiver gave the state broad flexibility in administering its Medicaid program through the Oregon Health Plan (OHP). Unfortunately for tribes, the OHP was developed without tribal input. Its implementation threatened American Indians/Alaska Natives with the loss of their medical home at an Indian health program because of its requirement that participants choose a managed care plan in order to see any provider. The OHP also placed the viability of Indian health programs in jeopardy since they would no longer be able to bill the state for services provided to American Indians/Alaska Natives who had been enrolled or automatically assigned to a managed care plan. Since American Indians/Alaska Natives are entitled to services many continued to receive some of their services at an Indian health program. Prior to managed care an Indian health program was paid for providing services to a Medicaid patient on a fee for service basis. Indian health programs would now be providing services without reimbursement to patients enrolled in managed care plans. In 1994 a crisis atmosphere pervaded several meetings held to address these concerns.

A March 1995 meeting of Oregon Tribes and the state Department of Human Resources (DHR) resulted in a commitment from the DHR Director to appoint a single point of contact within the Department for the purpose of facilitating quarterly meetings on health and related issues. Since that meeting Oregon tribes have met quarterly without exception. In the first two years all meetings were held in Salem, Oregon at the DHR building, but beginning in October 1998 these meetings have also been held at tribal locations. The Oregon meetings are well attended (a routine May 1 meeting at the Siletz tribe was attended by all 9 Oregon tribes). Most attendees are program staff and tribal health directors, but occasionally a tribal council member participates.

The meetings have accomplished a great deal in three years. The greatest accomplishment has been involving tribes at an early stage in health policymaking. Tribes are now briefed annually on DHR budget development, on the development of changes to the Medicaid program and recently on the development of the Children's Health Insurance Program. The state provides reimbursement to tribal representatives for travel expenses related to quarterly meeting attendance (Idaho and Washington do not).

Idaho

Establishing meetings in Idaho was more difficult than Oregon. The state has traditionally had more contentious relations with tribes than the states of Oregon and Washington. In 1995 a regional meeting sponsored by the Department of Health and

Human Services provided some impetus for the state meetings that would follow. The March meeting, hosted by HHS Assistant Secretary for Health Dr. Philip Lee, was attended by only one representative from Idaho compared to over 10 each from the states of Alaska, California, Washington and Oregon. Idaho tribes resolved to engage the state in regular interactions on health care issues. The policy analyst for the Northwest Portland Area Indian Health Board initiated the invitations for a follow-up meeting which was held on August 7, 1995. Attending the first meeting were: The Director of the Region X office of the Department of Health and Human Services, the Area Director of the Indian Health Service, the Executive Director of NPAIHB and representatives of nearly all Idaho Tribes. As in Oregon the Idaho tribes and the State of Idaho department of Health and Welfare have meet quarterly without exception. The most recent meeting on August 7, 1998 was held at the Ft. Hall Reservation in Idaho and marked the completion of three years of productive interaction with the state.

The Idaho meetings have resulted in a real change in health policymaking in the state. The State now makes it a practice to include a tribal representative in all committees developing changes to the Medicaid program and recently the Children's Health Insurance Program. A tribal representative has a permanent place on the state's Medicaid Advisory Committee (the practice in Oregon and Washington as well).

Washington State

Two Washington State groups are described in detail as examples of more mature forms of tribal state forums– the American Indian Health Commission (AIHC) and the Indian Policy Advisory Committee (IPAC). AIHC is a tribally driven group interacting with all levels of government. IPAC is a Washington State Department of Social and Health Services (DSHS)' supported advisory committee.

The American Indian Health Commission

The American Indian Health Commission for Washington State (AIHC) was created in 1994. The original intent of AIHC (The Commission) was to "guide the implementation of the Washington Health Services Act of 1993" by seeking unity and guiding "the collective needs of Tribal governments and other American Indian organizations to assure quality and comprehensive health care to all American Indians and Alaska Natives in Washington State".[5] The purpose of AIHC was to: provide collective communications with the state through position papers and other authorized correspondence; monitor and disseminate information regarding the activities and issues raised through the governor's office and state agencies; and establish task forces to address specific issues and assure appropriate and timely reports on the activities of the task forces to their constituents. To accomplish this, five responsibilities were described: identify issues which apply to tribes and advocate for approaches and strategies which address the concerns of Tribal/Indian providers; coordinate integrated policy analysis and develop recommendations;

[5] American Indian Health Commission, October 12, 1994.

disseminate information and materials resulting from AIHC and task forces; solicit and collect information from state for review, response and dissemination as necessary; advocate for education and training of state and tribal policy staff regarding the basis of tribal sovereignty and the right of American Indians/Alaska Natives to a minimum level of quality health services.

The process for creating the AIHC began with a grant from the Washington State Department of Health's Office of Rural and Community Health to the Squaxin Island Tribe. The grant was to organize and host an event in August 1994 called the "Tribal Leaders Health Summit." The Squaxin Island Tribe assembled a team from several tribes to identify key issues and plan the three-day agenda. To provide tribal representatives with adequate information, the team drafted issue papers and recommendations that were released prior to the summit. To ensure decisions could be made at the summit, key state agency directors were invited to participate. The governor also attended. 15 of the 26 federally recognized tribes sent delegates, as did 4 of the 8 unrecognized tribes and 8 American Indian organizations. At the summit, the position papers were presented to the general assembly and then discussed in small caucuses. The following day, the revised papers were presented to the general assembly for discussion, revision and adoption. The final agenda item was to decide on next steps. At that time it was apparent that the state health policy issues confronting tribes would require a ongoing tribal effort. "Probably one of the most crucial strategic planning concepts...was to develop a policy level advisory group. This group would not circumvent the sovereign authority of the tribal governments but would provide a forum... to communicate their views and concerns that pertain to health care."[6] Information about the summit, along with the position papers was sent to each tribe in the state. A cover letter was included from Ron Allen, the Tribal Chairman of the Jamestown S'Klallam Tribe. The letter asked each tribe to review and comment on the position papers and called for tribal resolutions supporting the American Indian Health Commission.

The initial AIHC meeting was held on October 12, 1994. The first issue discussed was whether the group should be an advisory committee or a stand-alone commission. The group decided to be a stand-alone commission with the core formed by individuals officially delegated from each tribe.[7] Officers were elected at the next meeting in November and issues such as the upcoming state legislative agenda, work on the Health Data Plan and the by-laws were discussed.[8]

AIHC by-laws were developed over a period of nine months before being adopted in June 1995. Perhaps the most difficult issue to resolve was commission membership. At the time there were 26 federally recognized tribes in the state and up to 9 additional tribes seeking recognition or re-recognition. Two Indian Health Service funded urban Indian health programs also existed – one in Seattle and one in Spokane. While membership for

[6] Memo. Molly Aalbue, Squaxin Island Planner to Tribal Leaders, "Report on Tribal Leaders Summit - August 1994.
[7] American Indian Inter-Tribal and Organizations Meeting Washington State Health Plan and Issues, October 12, 1994.
[8] American Indian Health Commission, Meeting Minutes, November 21, 1994.

each of the federally recognized tribes was never in question, membership for unrecognized tribes was opposed for a variety of reasons. Eventually the by-laws solved the problem by allowing 6 "at-large" seats -- a seat for each of the urban Indian programs and up to four seats "to provide for representation for individual American Indian and Alaska Native people within Washington State."[9] Each at-large seat is filled by majority vote of tribal delegates. For a tribal delegate to be seated, the tribal council must pass a resolution supporting AIHC and naming a specific individual as a delegate to represent them. Currently 14 tribes have delegates seated, but all tribes receive agendas and are welcome to attend meetings and participate in discussions. Several state agencies have appointed individuals to act as liaisons to AIHC. These individuals regularly attend Commission meetings as guests.

The AIHC meets about quarterly with meeting dates set at the previous meeting. Agendas are mailed or faxed 20 days before the meetings. The chair sets the agenda and then the group determines actions or activities. Until recently the Jamestown S'Klallam Tribe has produced and mailed meeting agendas, however the task is currently being done through the Northwest Portland Area Indian Health Board. Agenda items tend to minimize reports and attempt to focus on creating and promoting opportunities for tribes to improve health services or funding. Some opportunities are for each tribe to consider, while others are for all tribes and or American Indians/Alaska Natives statewide. An example of the former was Medicaid administrative matching funds program. Medical Assistance outreach staff provided information at an AIHC meeting about two programs which would provide a tribe with additional funding for outreach and administrative matching funds for Medicaid clients. Information included how to access the program, the relative merits and an example of an existing tribal program. AIHC also sent this information to tribes not attending the meeting. It was then up to each tribe to decide if they wanted to pursue the funding option or not. An example of the latter, statewide opportunities, is the work being done by the AIHC on a state American Indian Children's Health Insurance Program (CHIP). When tribes realized Washington would not be developing a CHIP plan, AIHC, with assistance from the Northwest Portland Area Indian Health Board, decided to work with the state and HCFA to explore a CHIP program for Indian children. Through AIHC research and meetings with the state and HCFA a framework for the program was drafted and approved by AIHC. AIHC is continuing to work with the state to create an appropriate statewide program for American Indian and Alaska Native children.

The AIHC Chair presides over each meeting. A roll call is done to determine if a quorum is present. Written minutes are reviewed, revised if necessary and approved. The agenda is reviewed and modified if needed. Discussions are open and are brought to a conclusion by the Chair. Simple parliamentary procedures are used for formal actions or approvals. When state agencies or other groups request a representative from the AIHC, the chair asks for volunteers from the members present. AIHC has set up special committees or task forces to deal with specific time limited issues. For example, a data committee was constituted to assist the state draft plans for how an American Indian

[9] By-Laws for the American Indian Health Commission for Washington State (adopted June 1, 1995)

health data clearinghouse might work. Most business is conducted at the meetings with follow-up done by the Chair, the coordinating organization or delegated volunteer.

The authority of the AIHC comes from the tribes. This autonomy has resulted in a great deal of flexibility and efficiency but requires effective leadership and tribal support – both philosophical and financial. Financial support for the AIHC has largely come from the tribes themselves as in-kind staff time and travel. The Department of Health's Office of Rural and Community Health has provided grant support, through several tribes, which has funded two of the three Tribal Leaders Health Summits and several projects. The Office of Rural and Community Health also directly funded an ambitious effort called "The American Indian Health Care Delivery Plan" which was published in June 1997. Although this plan is not technically a policy document, it catalogues crucial information about the Indian health system in Washington State and provides tribal/state recommendations for improvements. The process used to develop the plan is a model for tribal/state joint ventures. Key to this process was the AIHC, which interviewed staff, recommended appointments to the steering committee and reviewed the document and issues that arose at all stages of development. The AIHC has now prioritized and selected key recommendations to implement.

In 1997, tribal and state participation in AIHC seemed to be waning. The consensus of internal tribal discussions was that, to some extent, the group had lost focus and that sustaining this type of effort exclusively and indefinitely on a volunteer basis was extremely difficult. Fortunately, the Department of Health had budgeted a small amount of carry over funding for American Indian specific work. In September, the AIHC Executive Committee met with Department of Health and Northwest Portland Area Indian Health Board staff to explore ways to strengthen the AIHC as well as meet an important Department of Health goal – implementing recommendations from the American Indian Health Care Delivery Plan. Four options were discussed: hire a 0.5 FTE through the Department; develop an IPA-type agreement with a Department epidemiologist; assemble a multi-disciplinary group; contract with the AIHC through a member tribe. [10] The last option was agreed upon because it would allow staffing support for AIHC as well as provide a work focus, once priority recommendations were selected. The Department contracted with the Jamestown S'Klallam Tribe, which then sub-contracted with the Northwest Portland Area Indian Health Board. The scope of the 18 month contract was to: identify and implement priority recommendations from the 1997 American Indian Health Care Delivery Plan; update the plan for 1999; secure additional funding for continues development and implementation of the plan.[11]

In August 1998 Washington tribes were informed that due to budget constraints, funding used to support the American Indian Health Commission and its work on the American Indian Health Care Delivery Plan would not be included in the Department's budget request for the next biennial budget. This will be another difficult challenge and somewhat politically sensitive issue for the Commission to address.

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[10] Draft Minutes, American Indian Health Commission Executive Committee, September 9, 1997.
[11] American Indian Health Care Delivery Plan Workplan for American Indian Health Commission, January 20, 1998.

Since the first Tribal Leaders Health Summit, Washington State tribes have realized that impacting state health policy requires relationships with multiple state agencies and branches of government. Early in the development of the AIHC, tribes tried to map out how relationships would work. It was clear that in addition to establishing relationships with the legislature and governors office that there were at least five other state agencies (Health Policy Board, Health Care Authority, Insurance Commissioners Office, Department of Health and Department of Social and Health Services) with responsibilities for setting key state health policy through administrative codes and agency policies. The flexibility of the AIHC has allowed tribes to enter into a dialogue with any level of state/local government or their administrative agencies. For example, AIHC has worked with the state Department of Health on a variety of public health issues and now has begun to work with local county health departments through their association of public health officials. In fact, several tribal/county "partnership" projects have occurred including the development of a county/tribal public health memorandum of understanding which coordinates public health jurisdictions and local services.

DSHS has also assigned a staff person to act as a liaison for Native American/Alaska Native issues. This liaison remains actively involved with the AIHC and has been instrumental in resolving (and preventing) a variety of tribal/state policy problems. Perhaps key to this effectiveness has been the liaison's dual role of not only acting as a communication conduit for policy development, but also actually working with tribes to operationalize policies at the tribal health program level.

The Indian Policy Advisory Committee

The Indian Policy Advisory Committee (IPAC) is a standing committee of the Department of Social and Health Services (DSHS) and has existed in its current form since 1990. Its mission is to "review, advise and monitor all Department of Social and Health Service policy that will effect the quality of social and health status of all American Indian and Alaska Natives within Washington State".[12]

In 1978 DSHS established the Office of Indian Affairs as a part of the Division of Legislative and Community Affairs. By 1990, a variety of serious problems had arisen between the tribes and DSHS, probably due to an ineffective tribal consultation process. Although DSHS did consult with individuals who were American Indians or Alaska Natives, individuals were selected by DSHS and were not necessarily familiar with or representing the views of a tribal government. To improve the situation, the Indian Health Service through an Interagency Personnel Agreement (IPA) loaned a well-respected Indian leader to DSHS for two years. Under his direction, the Indian Policy Support Staff (IPSS) was created to replace the Office of Indian Affairs. The mission of IPSS is "to promote communications between the Department of Social and Health

[12] By-laws for the Indian Policy Advisory Committee to Washington State Department of Social and Health Services, 1996.

Services programs and all Indian people, while recognizing our unique government-to-government relationships." [13]

The Secretary of Social and Health Services under administrative policy 7.01 authorizes both IPSS and its advisory committee, IPAC. This policy charges IPSS staff "with the overall coordination, monitoring and assessment of department relationships with American Indian governments, communities and participants." IPAC is established "to ensure implementation of this policy, continued exchange of information and resolution of issues with Indian tribes and organizations." Administrative policy 7.01 goes through a sunset review every other year. On alternate years, each DSHS division submits a service plan for tribes as well as American Indian communities and DSHS program participants.

A fundamental change occurred in 1990 that was central to improving tribal communication and consultation. DSHS requested that each tribe and Indian organization designate their own delegate to IPAC. Prior to 1990, the DSHS Secretary appointed IPAC members. From 1990 to 1996, tribes identified their own delegates, but the Secretary still officially appointed IPAC members. In 1996, IPAC revised their by-laws and modeled themselves more closely to the AIHC. Responsibility for committee appointments changed from the DSHS secretary to tribes and tribal delegates. Currently, 17 of the 27 federally recognized tribes have submitted resolutions identifying delegates to be seated on IPAC. There are also 6 at-large members who are filled in the same way as the AIHC (approval by tribal delegates).

Also added in the 1996 by-laws change was IPAC's ability to establish committees and task forces (previously there had only been an executive committee). Following the by-law changes the group did go ahead and establish 7 new committees, each of which related directly to a DSHS division. The committees were: legislative; children and family services & juvenile rehabilitation; area on aging; health and rehabilitation; economic services and medical assistance; management services and community relations; family policy. IPAC is supported by a staff of 9 under the Office of Indian Policy and Support Services (IPSS). DSHS also reimburses IPAC members for travel expenses.

IPAC frequently focuses on social service and welfare issues, but it has played an important role in discussions on health issues relating to mental health and drug and alcohol policy. In several instances it worked closely with the NPAIHB and the American Indian Health Commission for Washington State on specific health issues.

[13] IPSS mission statement, July 17, 1995.

The Accomplishments of Tribal-State Meetings on Health Care Issues

Medicaid Managed Care

The history of the development of the American Indian Health Commission and the formation of the regularly scheduled state meetings in Oregon and Idaho adumbrated above all noted the role of the implementation of Medicaid Managed Care in precipitating greater tribal state interaction. Indian health programs perceived a grave threat to their operating budgets and their patient caseloads from managed care programs that excluded Indian health programs. The Oregon and Washington plans' early implementation resulted in the default assignment of many American Indian/Alaska Native patients to managed care plans. This meant Indian health programs were not paid for American Indians/Alaska Natives enrolled in managed care plans that continued to receive services at their programs.

Integrating Indian health programs into state managed care programs is not easy. The first step was educating state health officials on the nature of Indian health programs. Tribal representatives argued that Indian health programs are managed care programs. Initially, state officials may have perceived Indian health programs as no different than the larger community of fee-for-service providers that were seen as the cause of large budget-busting cost increases for the Medicaid program of the early 1990s. Tribal health representatives made the case that Indian health programs are, in fact, managed care plans albeit of a different nature than the plans being implemented by states. Indian health programs operate with fixed annual budgets and their programs are designed with this in mind (similar to the British Health Service model of global budgeting, guaranteed health services for a defined population, and public provision of most non-specialist services). State officials learned that Indian health programs have long used gatekeepers to screen requests for services and required pre-authorization of expensive services; two features of the new state Medicaid managed care plans. In addition, tribal health programs rationed care long before Oregon received approval for its putatively 'first in the nation' rationing plan. Once state officials learned about how tribes managed health care expenses, State Medicaid Directors were more willing to work out arrangements to exempt American Indians/Alaska Natives and allow payments to be made to Indian health programs.

A content analysis of agendas for all state/tribal meetings since January 1995 reveals Medicaid and implementation of Medicaid managed care as the number one agenda item. State Medicaid Directors attended well over half of all meetings held during the period January 1995 and August 1998. In July of 1997 Medicaid directors from Idaho, Washington and Oregon (in addition California was invited) were invited to present their views of tribal/state health policy issues at a quarterly Board meeting. The issues raised concerning Medicaid managed care included developing;

- procedures to exempt American Indian/Alaska Natives,
- billing processes to ensure payment to Indian health programs,

- processes for allowing American Indians/Alaska Natives to choose to enroll in Indian health programs and to choose to 'opt out' of managed care plans and
- enrollment and billing guides to reflect these arrangements.

Other health issues

Public Health

It was understood by most that once state meetings were initiated they would address the full range of state/tribal health issues. Some health issues have involved other levels of government besides the state including counties for public health issues and often the federal government. The top state public health official for each state has attended each state's meeting for the purpose of reviewing the state's public health program and at times to discuss a particular public health issue. In Washington State the development of a document known as the Public Health Improvement Plan raised many issues of concern to tribes. Tribal representation was included in the development of the plan that raised issues about the relationship at tribal, county and state public health jurisdictions. Tribes argued for acknowledgement of Tribal Health Districts on a par with other Public Health Districts (usually counties or multi-county jurisdictions governed by county supervisors/councilors). Tribes also argued for a share of state funding being disbursed to address public health concerns including funds for capacity assessment. In Oregon the Health Division and tribes worked out an acceptable policy for distribution of health promotion and education funding made possible from a new tax on tobacco.

Implementation of December 19, 1996 Memorandum of Agreement Between the Indian Health Service and the Health Care Financing Administration.

In 1997 tribes and states spent a great deal of effort in a tripartite negotiation over the implementation of a Memorandum of Agreement that essentially extended the 100% Federal Medical Assistance Percentage (FMAP) to tribal health programs. The agreement would allow states to be reimbursed for all costs of providing care to American Indians/Alaska Natives who received services in any Indian health program be it tribal or Indian Health Service operated. Federal, state, and tribal representatives bargained over the details of a fairly simple agreement signed on December 19, 1996 for nearly a year before most details were worked out in the Northwest. An informal workgroup did most of the work, but state meetings were used as sounding boards for developing tribal consensus positions and for final agreements between state and federal officials.

Children's Health Insurance Program

The Children's Health Insurance Program authorized by the 1997 Budget Reconciliation Act requires states to describe how they will meet the needs of poor American Indian/Alaska Native children. The Health Care Financing Administration has

encouraged states to meet with tribes to assess how to best meet the needs of poor Indian children. In Oregon and Idaho the quarterly health meetings provided a ready forum for the state to engage in meaningful consultation with tribes on the Children's Health Insurance Program.

In Idaho the state discussed the program at state meetings shortly after passage of the act and requested that tribes provide a representative to a workgroup that was developing the Children's Health Insurance Program for Idaho. That representative reports back to the quarterly meetings on progress of the workgroup and receives input from the tribes attending the meeting. In Oregon the state also used the quarterly meetings to receive input on the development of its state Children's Health Insurance Program. Tribes were able early on to point out needed provisions to meet the needs of Indian health programs and American Indians/Alaska Natives. When the Washington State legislature rejected participating in Children's Health Insurance Program funding in 1998, tribes entered into a negotiation with the state on developing an Indian-only Children's Health Insurance Program. The American Indian Health Commission facilitated those negotiations by discussing the potential for an Indian-only plan at a meeting and establishing a workgroup to work on the issue.

Micellaneous Health Issues

A review of the meetings agendas over the past four years reveals a broad range of issues including: developing a mechanism for new tobacco prevention funds in Oregon, developing an agenda for a state/tribal leaders health summit in Washington, reports from tribal representatives on state committees developing proposals for waivers to the state Medicaid program in Idaho. In addition, the Northwest Portland Area Indian Health Board has made presentations to the state meetings on its various project including: The Northwest Tribal Welfare Information Project, the HIV/STD Project Red Talon, the Health Professionals Recruitment and Retention Project, the Women's Health Promotion Project, the Graduate Health Professions Project, the Epidemiology Center, and the Western Tobacco Project. The virtue of having regular forums for discussing health issues is that tribes and states now have the expectation that any health issue that may impact Indian health programs will be brought before these forums. In addition, the meetings serve an educational purpose for all involved as each party, the state and the tribes, takes the opportunity to present information about their own programs and planned activities.

Insuring Communication between States and Tribes

This paper has painted a picture of a fairly simple process between states and tribes. As any student of bureaucratic decision-making knows, too often administrators and program staff can easily stray from legitimate authority and go beyond their own

authority in making decisions. The antidote for this well-known tendency is the frequent and extensive communication of the discussions of health issues and proposed agreements to tribal leaders who have the authority to make decisions. The need for insuring this legitimacy is critical to the long-term success of state-tribal interactions. Staff should never succumb to the temptation of making decisions they have no authority to make.

The Northwest Portland Area Indian Health Board is the common carrier of the information for tribes in the states of Oregon, Idaho, and Washington. This organization includes information on tribal/state policy issues, discussions, and decisions in its weekly mailing to tribes. Time sensitive material is often faxed to tribal leaders. The states continue to mail official communication directly to tribes, but the Board often provides a brief analysis of official state communication to tribes (and a duplicate mailing of the state communication is attached to the analysis). The weekly mailing goes to tribal chairs, tribal health directors and delegates to the Northwest Portland Area Indian Health Board. In addition, Board delegates learn of issues raised in the state meetings at the Board's quarterly meetings.

The Northwest Portland Area Indian Health Board also maintains information regarding the state quarterly meetings and the American Indian Health Commission for Washington State on its Website.[14] The dates, times and locations of tribal/state meetings are posted well in advance of meetings. When possible meeting agendas are also posted.

The Board also prepares meeting minutes for the American Indian Health Commission for Washington states as part of the duties performed under the contract with the Jamestown S'Klallam tribe (and funded by the state Department of Health). Meeting minutes have also been provided for the Idaho meetings. In Oregon the Northwest Portland Area Indian Health Board is negotiating with the state for some funding to provide fuller support for the quarterly meetings including minutes and payment for some meeting expenses.

The Future of Institutions for Tribal/State Health Care Policymaking

There is no consensus yet in the Northwest on how best to foster the interaction required for successful state/tribal health policymaking, but in each state a process is in place for tribes to have regular contact with state policymakers. Regular meetings are now taken for granted by states and tribes alike. However, one should expect that the organizational forms will evolve over time, however Tribes in the Northwest no longer call emergency sessions to address a policy crisis for health issues. Unlike many parts of the country where state/tribal health care issues have no forum, Northwest tribes have begun the

[14] The Northwest Portland Area Indian Health Board website address is www.npaihb.org and the legislation webpage address is www.npaihb.org/legis.html.

development of a stable and ongoing policy process that strives for positive outcomes, and promises a fair hearing for issues raised by both states and tribes.[15]

Tribes and states are engaged in long term discussions and often bargaining over how the interests of both can be accommodated. Students of the American federal system and American public policy would do well to add this relatively recent policymaking phenomenon to their picture of American federalism and policymaking. Many of the generalizations and observations of state and federal policymaking may apply to a process that includes tribes in the policymaking mix. Jurisdictional issues are likely to be paramount and sometimes contentious, but periods of rather settled views of responsibilities may also be evident since cooperation is generally more productive than conflict.

With familiarity has come trust and knowledge of the many instances when the interests of tribes and states are mutual. The tangible accomplishments of the current mechanisms of regular meetings for health care policymaking suggests an optimistic evaluation that Northwest tribes and states have begun a new era in policymaking that should survive after current political actors have moved on. Future tribal leaders, governors and legislators are likely to gain confidence in a process of consultation and cooperation, which avoids policy conflict and produces policy results.

[15] States and Tribes: Building New Traditions. The National Conference of State Legislators, 1996. A survey of state committee leaders and tribal leaders found that few had ever met with states on health care issues and none reported regular state-tribal health care meetings.