

An Action Plan from the Urban Indian Health Summit

# Actualizing Health Care Reform for Urban Indians



Robert Wood Johnson Foundation

# Acknowledgements

The Seattle Indian Health Board would like to thank the Robert Wood Johnson Foundation for its sponsorship of the Urban Indian Health Summit and production of this report.

The Seattle Indian Health Board would also like to thank the urban Indian health organizations, the National Council of Urban Indian Health and other attendees of the Urban Indian Health Summit for their participation in this important event.

Finally, the Seattle Indian Health Board would like to acknowledge and thank the Planning Committee for its support and guidance with the Urban Indian Health Summit.

- D'Shane Barnett
- Jami Bartgis
- Jacob Bernal
- Jyl Marden
- Donna Polk-Primm
- Ramona Valdez
- Phyllis Wolfe

**Recommended Citation:** Urban Indian Health Institute, Seattle Indian Health Board. *Actualizing Health Care Reform for Urban Indians: An Action Plan From the Urban Indian Health Summit*. Seattle: Urban Indian Health Institute, April 2011.

# Executive Summary

This report serves as a Call for Action that outlines strategies to ensure the success of health care reform for urban Indians. It is intended to prompt an ongoing discussion that is responsive to feedback from urban Indians, the organizations that serve them, urban Indian health care professionals, practitioners and others. Because the federal government is a partner in the delivery of health care services and programs to urban Indians and their communities, guidance and involvement from federal partners is fundamental to the success of this Call for Action. We hope that the federal government will work with us to implement this Call for Action and develop ongoing strategies for the implementation of health care reform for urban Indian communities.

The Patient Protection and Affordable Care Act (ACA) is transforming health care delivery and access. As changes are implemented, health professionals are working to stay informed and involved. Urban Indian health professionals are no different. Passage of ACA marked two significant changes for urban Indian health. First, the law alters the way direct medical care services are provided and how these services will be financed. Second, permanent reauthorization of the Indian Health Care Improvement Act is embedded in the new law, making urban Indians a permanent part of the Indian Health Service (IHS) for the first time through the inclusion of authorization of Title V, health care for urban Indians.

With all of these changes, urban Indian health organizations and their partners recognize the importance of becoming informed, engaged and active in health care reform. In an effort to support these aims, the Seattle Indian Health Board hosted an Urban Indian Health Summit on January 13, 2011, in Washington, D.C. Urban Indian health organizations, policy-makers, federal partners, community advocates, private foundations, researchers and leaders in the field all gathered for this important event, which was sponsored by the Robert Wood Johnson Foundation. They addressed issues tied to the success of health care reform and its promise to help urban Indians who experience severe health disparities.

Following the summit, on Friday, January 14, 2011, urban Indian health organizations reconvened to discuss the outcomes of the summit and formulate a Call for Action that outlines strategies to ensure the success of reform for urban Indians. The Call for Action includes the following insights and recommendations for federal partners to ensure the success of health care reform for urban Indians.

**Workforce development** plays an essential role in the effort to reform health care and will increase health care access for urban Indians.

- **Resources:** Develop and strengthen new and existing education loan repayment programs for providers committed to serving urban Indians.
- **Advocacy:** Support and encourage placement of American Indian and Alaska Native National Health Service Corps providers at urban Indian health organizations.
- **Education:** Establish communication pathways to support and educate urban Indian health organizations about ways to partner with the National Health Service Corps and other manpower training programs to address unmet service needs.

Understanding the value of the **Federally Qualified Health Center** designation and the differences among reimbursement options associated with that designation is critical to the success of many urban Indian health organizations.

- **Recognition:** Recognize those urban Indian health organizations that are Federally Qualified Health Centers as a solution to the primary care shortage as “essential community providers.”

The complexities of **Medicaid and Medicare** provisions could act as a barrier to implementation.

- **Education:** Provide technical assistance to urban Indian health organizations on how to become involved in health insurance exchanges.
- **Advocacy:** Ensure urban Indian health organizations are eligible for the option to receive the IHS all-inclusive rate for Medicare and Medicaid.
- **Recognition:** Develop a mechanism to assure conferring directly with urban Indian health organizations is possible.
- **Recognition:** Department of Health and Human Services (HHS) could mandate that eligible “essential community providers,” including urban Indian health organizations, be designated as a provider in all health plan networks recognized under state-specific exchanges.
- **Recognition:** HHS, in its role in helping states conduct the development of state-specific exchanges, should require that health plans participating in exchanges demonstrate their ability to assure culturally competent health care for American Indian populations, both tribal and urban.

Understanding the **complexities and implications of ACA** is critical to the success of implementing health care reform for urban Indians.

- **Education:** Provide targeted assistance to assure that urban Indian health organizations are aware of and prepared to implement health reform strategies.
- **Advocacy:** Ensure access to Regional Extension Centers to assist with analysis of electronic needs to meet both electronic health record requirements for meaningful use and to facilitate transition to electronic management, billing, reporting, etc. as reform implementation evolves.
- **Recognition:** Include urban Indian health organizations as eligible entities for reform grants and contracts.
- **Recognition:** Promote engagement by local and state planning councils and agencies charged with implementing reforms on a local, regional or state basis.
- **Recognition:** Require that the needs of urban Indians are addressed in local and state plans for reform implementation.

**Developing partnerships** with local, regional, national and tribal entities is critical for urban Indian health organizations to ensure opportunities are made available to urban Indians.

- **Recognition:** Include urban Indian health organizations in efforts to implement health care reform.
- **Recognition:** Ask state and regional planners how they currently or intend to address health reform implementation for urban Indians.

- **Advocacy:** Upon request, assist in making connections to initiate partnership discussions at the state, local and regional levels.
- **Recognition:** Include urban Indian health organizations in local, state and regional workshops, seminars and other gatherings to inform and help keep these organizations abreast of plans as they are developed.
- **Recognition:** IHS should work in partnership with urban Indian health organizations to address the reality that urban Indian health is for the first time statutorily recognized and considered a permanent part of IHS. This is a historic confirmation of the legal and legislative legacy used to justify health services for urban Indians.

Urban Indian health organizations must be **strategically positioned** to make the most out of health care reform.

- **Advocacy:** IHS should protect funding for outreach and referral to urban Indian health organizations. Nonclinical urban Indian health organizations play a critical role in providing essential enabling services. With the focus of ACA on insurance and payment for direct care, special attention must be given to support these essential services.
- **Recognition:** Examine and support the role that drug and alcohol programs, such as those sponsored by the National Institute on Alcohol Abuse and Alcoholism, play in the urban Indian health care reform discussion.
- **Advocacy:** IHS could serve as an advocate for urban Indian health organizations in working with the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services (HHS), other federal agencies, and tribes.

There are inconsistencies in **how urban Indians are defined** in policy and programs. The definition of urban Indian affects a person's eligibility to receive Indian-specific benefits (e.g., waivers from cost sharing).

- **Recognition:** Confer with urban Indian health organization to ensure the definition of urban Indians meets organizational needs.
- **Recognition:** Resolve conflicting definitions of urban Indian in ACA.
- **Recognition:** Ensure there are no conflicting definitions of urban Indian used by government agencies.

Clearly, government leaders are just beginning to implement provisions of health insurance reform. However, it is essential that urban Indian health organizations interact early, frequently and continually with those responsible for reform implementation in order to share in the benefits promised by reform. The Urban Indian Health Summit started this dialogue and the Call for Action intends to ensure urban Indians are not forgotten.

## Table of Contents

|   |           |
|---|-----------|
| <b>Executive Summary</b> .....  | <b>i</b>  |
| <b>Purpose of This Call for Action</b> .....                                      | <b>1</b>  |
| <b>Introduction</b> .....   | <b>2</b>  |
| <b>Overview of Efforts to Address Health Service Gaps for Urban Indians</b> ..... | <b>3</b>  |
| <b>Overview of Health Care Reform As It Relates to Urban Indians</b> .....        | <b>4</b>  |
| <b>Summit Planning Committee</b> .....  | <b>6</b>  |
| <b>Focus Areas</b> .....  | <b>6</b>  |
| <b>Call for Action</b> .....  | <b>6</b>  |
| <b>Implementation</b> .....   | <b>7</b>  |
| Workforce Development .....   | 7         |
| Federal Employees Health Benefits Program .....                                   | 8         |
| Federally Qualified Health Center .....   | 8         |
| Medicaid and Medicare .....   | 8         |
| Traditional Healing .....   | 9         |
| <b>Resources and Strategies</b> .....   | <b>10</b> |
| Complexities and Implications of ACA .....  | 10        |
| Developing Partnerships .....   | 11        |
| Strategic Positioning .....   | 11        |
| <b>Definitions and Standards</b> .....  | <b>12</b> |
| Defining Urban Indian .....   | 12        |
| <b>Next Steps</b> .....   | <b>13</b> |
| <b>Appendix A: Brief History of Urban Indians</b> .....                           | <b>14</b> |
| <b>Appendix B: Urban Indian Health Organizations</b> .....                        | <b>15</b> |
| <b>Appendix C: Materials From the Summit</b> .....                                | <b>17</b> |
| <b>Appendix D: Healthy Government Benchmark Table</b> .....                       | <b>18</b> |

## Purpose of This Call for Action

This report is a Call for Action that outlines strategies to ensure the success of health care reform for urban Indians. While this Call for Action focuses specifically on health reform initiatives, the Conferring Policy for Urban Indian Health Programs under development will require greater communication to address the other priority areas. This report will be complementary to and coordinated with the policy under development.

The Call for Action is intended to prompt an ongoing discussion that is responsive to feedback from urban Indians, the organizations that serve them, urban Indian health care professionals, practitioners and others. Changes in health outcomes of urban Indians will be examined regularly, and modifications to this Call for Action will be made to ensure continuous improvement in services and outcomes.

The federal government is a partner in the delivery of health care services and programs to urban Indians and their communities. Its guidance and involvement is fundamental to the success of this Call for Action. We hope that the federal government will work with us to implement this Call for Action and develop ongoing strategies for the implementation of health care reform for urban Indian communities.

## Introduction

The health reform law is transforming health care delivery and access. As the federal government implements these changes, health professionals are working to stay informed and involved. Urban Indian health professionals are no different.

Passage of the Patient Protection and Affordable Care Act (ACA), marked two significant changes for urban Indian health. First, the law alters the way direct medical care services are provided and how these services will be financed. Second, lawmakers embedded a permanent reauthorization of the Indian Health Care Improvement Act that includes authorization of Title V, health care for urban Indians, making urban Indians a permanent part of the Indian Health Service (IHS) for the first time.

Urban Indian health organizations and their partners are now required to become informed, engaged and active in health care reform. In an effort to support these aims, the Seattle Indian Health Board hosted an Urban Indian Health Summit on January 13, 2011, in Washington, D.C. Urban Indian health organizations, policy-makers, federal partners, community advocates, private foundations, researchers and leaders in the field all gathered for this important event, which was sponsored by the Robert Wood Johnson Foundation. They addressed issues tied to the success of health care reform and its promise to help urban Indians who experience severe health disparities.

The summit described the complexities of urban Indian health, including issues related to the provision of culturally tailored services, mixed funding, data standards and definitions. Presenters detailed the challenges faced while demonstrating their capacity to serve the urban Indian community in thoughtful and creative ways. Leaders representing all sectors of health care, from policy to service delivery, discussed strategies and methods to successfully address the changes occurring as a result of the implementation of ACA.

There was also a pre-summit health reform training on Wednesday, January 12, 2011, conducted in partnership with the National Council of Urban Indian Health. This one-day meeting helped inform urban Indian health organizations about how ACA is designed to affect the provision and financing of medical care.

Following the summit, on Friday, January 14, 2011, urban Indian health organizations reconvened to discuss the outcomes of the summit and formulate a Call for Action that outlines strategies to ensure the success of reform for urban Indians.

Clearly, government leaders are just beginning to implement provisions of health insurance reform. However, it is essential that urban Indian health organizations interact early, frequently and continually with those responsible for reform implementation in order to share in the benefits promised by reform. The summit started this dialogue and the Call for Action intends to ensure urban Indians are not forgotten.

### > Attendees of the Urban Indian Health Summit





## Overview of Efforts to Address Health Service Gaps for Urban Indians

American Indians and Alaska Natives living in cities suffer from some of the worst health problems in the nation. Parallel to poor health outcomes, urban Indians are suffering from high rates of poverty, single parenthood, unemployment, disability and inadequate education far above those of other Americans. Many believe limited or no access to comprehensive health care services is a major contributor to poor outcomes for this population.

The IHS, a division of the U.S. Department of Health and Human Services (HHS), is charged with executing the federal trust obligation for American Indian and Alaska Native health. The trust obligation is a historical federal responsibility derived from political and judicial processes by which the federal government assumed responsibility for Indians and certain obligations on their behalf. Health is a cornerstone application of this responsibility.

The government defined the scope of this national commitment in 1976 with the Indian Health Care Improvement Act (P.L. 94-437, as amended). As previously mentioned, when President Obama signed ACA into law, it included the permanent reauthorization of the Indian Health Care Improvement Act, including the authorization of Title V. Urban Indians are for the first time statutorily recognized and considered a permanent part of IHS. This is a historic confirmation of the legal and legislative legacy used to justify health services for urban Indians.

Title V of the Indian Health Care Improvement Act authorizes the Urban Indian Health Program within IHS to provide grants and contracts to nonprofit Indian health organizations in 34 designated metropolitan areas throughout the nation. The Indian Health Care Improvement Act specifies that organizations that contract with IHS must attempt to improve access to health care for Indian people. This authority is crafted under the auspices of the national Indian policy of “self-determination without termination.” Under this policy, Congress gives broad discretion to Indian tribal councils

and to governing boards of nonprofit organizations to operate and manage programs and services to meet the IHS goal of raising the health status of Indians to parity with other Americans.

American Indian and Alaska Native health care is a separate, noticeably different system from the traditional health care model. It is built on a community and public health foundation and relies on understanding local needs and designing programs and services specific to these identified problems. When developing the provision of urban Indian health services, Congress considered core issues of cost, quality and culturally appropriate services, as well as issues of mobility, historical trauma and grave health disparities.

A look back at the history of American Indian and Alaska Native health care illustrates some of the legal and geographic challenges that remain unresolved. In 1970, President Richard Nixon sent a “Special Message to the Congress on Indian Affairs” denouncing the policy of Indian assimilation through termination and relocation and launching a new era of “Indian self-determination without termination.” In spite of this change, Congress has thus far not been able to adequately provide the necessary resources to effectively implement this policy. The result has been an ongoing struggle to get both Congress and the White House to live up to this commitment.

Currently, IHS is the federal agency responsible for delivering health care to American Indians and Alaska Natives who live on or near Indian reservations or in Alaska Native villages. Urban Indians, often descendants of those displaced by relocation and other federal policies, face numerous barriers to accessing IHS programs or tribally run health services, including geographic inaccessibility and eligibility restrictions. Using only 1 percent of the IHS budget, the 34 nonprofit, IHS-contracted urban Indian health organizations partly remedy this situation by providing assistance with health care access. (For more information on these urban Indian health organizations, see Appendix B.)

Attempts to limit or abolish federal services to American Indians and Alaska Natives in cities were seen in 2006, 2007 and 2008, when funding for urban

Indian health was eliminated in the president's budget. Simultaneously, the Department of Justice challenged the legitimacy of urban Indians to receive assistance and further threatened the future of urban Indian health. Despite the reinsertion of urban Indian health funding, attacks such as the elimination of provisions of health care services to urban Indians demonstrate a need for constant education and reminders of the promises made in centuries past to the nation's first people in exchange for their land and resources.

In an effort to help educate the broader public on the plight of urban Indians, the Seattle Indian Health Board's Urban Indian Health Institute partnered with the Robert Wood Johnson Foundation, the nation's largest philanthropic organization devoted to improving health and health care, to establish an Urban Indian Health Commission in 2005. The commission consisted of experts who merged their scientific, cultural and policy expertise with the aim to provide outreach and education on urban Indian health issues. The commission's report, "Invisible Tribes: Urban Indians and Their Health in a Changing World," focused on the topics of cardiovascular disease, diabetes and depression. It drew broad attention to urban Indian health needs and disparities, as well as the unique role and strengths of urban Indian health organizations in responding to their communities' needs. The commission's report was widely received and resulted in expanded opportunities for advancement.

## Overview of Health Care Reform As It Relates to Urban Indians

There are numerous ways ACA will impact the lives of urban Indian people. Appendix C of this report contains a selection of resources that provide more detailed information on how the specific provisions of the law will impact urban Indians.

This report advances previous work by highlighting the concerns and needs of those who will ultimately be responsible for the implementation of the law. Through the efforts of the Urban Indian Health Summit and this Call for Action, urban Indian health organizations have identified the barriers to implementing health care reform, as well as the strategies needed for success.

ACA has significant Indian-specific provisions, in the form of both protections and benefits. As a primary gateway for health care for urban Indians, urban Indian health organizations must be intimately involved in the implementation of health care reform in order to take advantage of the protections and benefits outlined in the law.

Urban Indian health organizations are in a unique position. Their standing within IHS has been mostly outside of the general planning and management practices of the agency, which focuses the bulk of its

> **Urban Indian Health Organizations Panel, Urban Indian Health Summit**

*Pictured left to right:*

**Jacob Bernal**, Tucson Indian Center

**Rodney Stapp**, Urban Inter-Tribal Center of Texas

**Donna Polk-Primm**, Nebraska Urban Indian Health Coalition, Inc.

**Jerilyn Church**, American Indian Health and Family Services

**Jackie Mercer**, Native American Rehabilitation Association of the Northwest, Inc.





> **Health Reform Planning Panel, Urban Indian Health Summit**

*Pictured left to right:*

**Mat Kendall**, *Office of the National Coordinator for Health IT*

**Yvette Roubideaux**, *Indian Health Service*

**Teresa Nino**, *Centers for Medicare and Medicaid Services Office of External Affairs and Beneficiary Services*

**Mayra Alvarez**, *HHS Office of Health Reform*

attention and resources on federally recognized Indian tribes and those living on or near Indian reservations. This focus leaves urban Indian health organizations without a clear direction with defined goals pertinent to their needs.

The original design of urban Indian health organizations, including the scope of care and methods of assistance, was driven by local planning and organized to meet defined needs. Most of these organizations have relied on financial support from non-Indian-specific federal, state and local contract and grant entities intended to assist those with limited income and, in the case of health care, those mostly uninsured or underinsured. Data shows, however, that urban Indians experience more severe health and social disparities than other populations in the same geographic locations. Resources to meet the identified needs have never been sufficient. IHS itself devotes just 1 percent of its annual budget appropriated by Congress to serve urban Indians.

In 1990, urban Indian health organizations became eligible for Federally Qualified Health Center status in an effort to enhance financing from Medicaid and Medicare payment. Unfortunately, not all urban Indian health organizations qualified for this status due to limited service capacity. Few of these organizations have succeeded in becoming part of the Bureau of Primary Health Care's community health center program, although many are applying under the new start initiative.

The focus of reform on health insurance fails to recognize the unique nature of urban Indian health. Not all services offered by urban Indian health organizations qualify for reimbursement. For example, traditional health practices are an essential component in the care of urban Indians, yet these tribal and cultural practices are not included in payment menus. The broader scope of the IHS allows for more intensive case management, community health aides, community health education, outreach and case finding, and the multitude of public health-oriented services not often included in mainstream medicine. Because of the reluctance of many urban Indians to seek health care, the need for a more direct approach to support health among urban Indians is needed. Many of these practices are now being viewed in the context of the "medical home model." The hallmark of urban Indian health organizations is their ability to reach out to communities and encourage early contact with the medical establishment with community-based support—yielding remarkably positive results at a reasonable cost.

The patchwork nature of urban Indian health financing broadens the scope of care offered to the community. This approach has benefits and detriments. It demands strong financial systems, good data management, and flexible reporting capabilities. The creation of such a system positions urban Indian health organizations well for taking advantage of reform initiatives as they are implemented.



## Summit Planning Committee

In October of 2010, a planning committee met in an effort to help ensure the summit was reflective of the priorities of the urban Indian community. This committee included executive directors from a wide range of urban Indian health organizations, national and regional organizations that provide services to urban Indian health organizations, and the Urban Indian Health Program of IHS. (See Appendix C for a complete planning committee description.) Planning committee members met face to face and conducted numerous conference calls to ensure the content of the summit would meet the needs of attendees.

### Focus Areas

In trying to grasp the enormity of the challenges urban Indian health organizations face amidst reform, the Summit Planning Committee identified three critical areas of focus: 1) implementation, 2) resources and strategies, and 3) definitions and standards. In an effort to facilitate small group discussion and support coverage of these critical areas, participants self-selected into one of these three areas during the follow-up meeting to flesh out action steps and continuing concerns.

## Call for Action

The following section outlines the Call for Action, developed from outcomes of the follow-up meeting. The Call for Action is divided into three topic areas, which correspond to the three areas of focus identified by the Summit Planning Committee. Each area of focus is further divided into key issues identified by the group participants, outlined below:

### Implementation

- Workforce Development
- Federal Employee Health Benefits Program
- Federally Qualified Health Centers
- Medicaid and Medicare
- Traditional Healing

### Resources and Strategies

- Complexities and Implications of ACA
- Developing Partnerships
- Strategic Positioning

### Definitions and Standards

- Defining Urban Indian

Several audiences are identified in the action plan steps: federal partners, urban Indian health organizations, national and regional organizations serving urban Indian health organizations, and private foundations and funders. Action plan steps are listed according to the applicable audience for each item.

### > Question and Answer Session

Jerilyn Church,  
*American Indian Health  
and Family Services*



## Implementation

The focus of the implementation breakout session was on identifying and discussing the needs and gaps related to the implementation of ACA. Based on the information gathered at the pre-summit and summit, participants were asked to describe their areas of concern. Topics included participation in the health insurance exchange, employer issues, the Title V funding formula and resource allocation policy. Participants were encouraged to identify unique issues related to dual funding, grants, contracts and other specific issues related to being an urban Indian health organization that need to be considered and highlighted for effective implementation of ACA.

## WORKFORCE DEVELOPMENT

Workforce development will play an essential role in the effort to reform health care and increase health care access for urban Indians. Focusing on increasing the number of health care providers in the workforce, summit participants identified strategies to meet this need.

### Action for Federal Partners:

- Develop and strengthen new and existing education loan repayment programs for providers committed to serving urban Indians.
- Develop outreach programs to support pathways in health education, starting with parents of young children and continuing through job placement and loan repayment options.
- Develop mechanisms to prioritize urban Indian health organizations as sites for provider placement from the National Health Service Corps or other manpower training opportunities.
- Support and encourage placement of American Indian and Alaska Native National Health Service Corps providers at urban Indian health organizations.

- Create and support opportunities for sharing National Health Service Corps providers between urban Indian health organizations and surrounding tribal organizations or community health centers.
- Establish communication pathways to support and educate urban Indian health organizations in ways they can partner with the National Health Service Corps and other manpower training programs to address unmet service needs.

### Action for Urban Indian Health Organizations:

- Develop partnerships with local universities to support relationship building, mentoring opportunities and job placement programs for American Indian graduates.
- Network with local tribes, community health centers and others to determine if sharing National Health Service Corps providers is possible.
- Develop relationships with National Health Service Corps representatives to ensure there is a careful review of their application.

### Action for National and Regional Organizations Serving Urban Indian Health Organizations:

- Establish a network to share information on successes and lessons learned in working with the National Health Service Corps and other manpower development programs.

### Action for Private Foundations and Funders:

- Assess existing scholarship activities to determine if resources are reaching urban Indian students.
- Increase funding mechanisms based on the needs of the population, not on population size.
- Develop outreach programs to educate, encourage and support urban Indian college students applying for scholarships.

## FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

ACA outlines provisions for urban Indian health organizations that previously had not been available, such as access to the Federal Employees Health Benefits Program. Understanding the costs associated with the Federal Employees Health Benefits Program is critical in determining if there are benefits for urban Indian health organizations.

### Action for National and Regional Organizations Serving Urban Indian Health Organizations:

- Present a webinar with information on cost and benefit assessment.

### Action for Urban Indian Health Organizations:

- Participate in discussions at the national and local levels to determine if the Federal Employees Health Benefits Program is a viable option for employee health benefits.

## FEDERALLY QUALIFIED HEALTH CENTER

Primary care providers play a critical role in implementing ACA. In the Omnibus Reconciliation Act of 1993, Title V programs were added to the list of specific programs automatically eligible for Federally Qualified Health Center designation. Currently, 45 percent of urban Indian health organizations are Federally Qualified Health Centers. Understanding the value of Federally Qualified Health Center designation and the differences between reimbursement options associated with that designation is critical to the success of many urban Indian health organizations.

### Action for Federal Partners:

- Those urban Indian health organizations that are Federally Qualified Health Centers should be recognized as a solution to the primary care shortage as “essential community providers.”

### Action for Urban Indian Health Organizations:

- Urban Indian health organizations without Federally Qualified Health Center designation should actively pursue this important distinction.

### Action for National and Regional Organizations Serving Urban Indian Health Organizations:

- Provide education on designation of a Federally Qualified Health Center and the difference between reimbursement options.

## MEDICAID AND MEDICARE

The complexities of Medicaid and Medicare provisions could act as a barrier to implementation.

### Action for Federal and State Partners:

- Provide technical assistance to urban Indian health organizations on how to become involved in health insurance exchanges.
- Ensure urban Indian health organizations are identified as “essential community providers.”
- Ensure urban Indian health organizations are eligible to receive the IHS all-inclusive rate for Medicare and Medicaid.
- Support relationships between states and urban Indian health organizations.
- Support a more direct relationship between CMS and urban Indian health organizations.
- Develop a mechanism to assure conferring directly with urban Indian health organizations is possible.
- HHS could mandate that eligible “essential community providers,” including urban Indian health organizations, be designated as a provider in all health plan networks recognized under state-specific exchanges.

- HHS, in its role in helping states conduct the development of state-specific exchanges, should require that health plans participating in exchanges demonstrate their ability to assure culturally competent health care for American Indian populations, both tribal and urban.

#### Action for Urban Indian Health Organizations:

- Contact and network with state or HHS planners for health insurance exchanges to gain awareness of the requirements to participate in implementation.
- Promote prevention efforts as a critical component of health care reform.
- Oppose Medicaid block grants to states, a harmful funding mechanism that could seriously damage funding for urban Indian health organizations, especially in states where urban Indians are invisible and continue to be ignored.
- Explore the option to qualify for payment under the HHS/IHS Memorandum of Understanding, which would allow urban Indian health organizations to be paid under the all-inclusive rate payment system offered to the IHS and tribes.

## TRADITIONAL HEALING

Traditional healing is a fundamental, culturally competent service provided by urban Indian health organizations. Organizations should promote the inclusion of traditional medicine as a valued and essential service under reform.

#### Action for National and Regional Organizations Serving Urban Indian Health Organizations:

- Assess traditional health service provisions at urban Indian health organizations to determine whether they meet appropriate standards for reimbursement under reform.
- Create a workgroup or taskforce to investigate whether standards for the credentialing and privileging of traditional practitioners is achievable.



> **Health Disparities Reform Panel, Urban Indian Health Summit**  
**John Ruffin, Ph.D.,**  
*National Institute on Minority Health and Health Disparities*



## Resources and Strategies

The resources and strategies breakout session focused on identifying mechanisms to ensure urban Indian health organizations have the information and support needed to take advantage of the many new resources and opportunities that will be made available during the coming years. This session also focused on building partnerships and developing strategies to best position urban Indian health organizations to make the most of health care reform.

## COMPLEXITIES AND IMPLICATIONS OF ACA

Understanding the complexities and implications of ACA is critical to the success of implementing health care reform for urban Indians. Resources and strategies are necessary to ensure urban Indian health organizations are informed and fully equipped to actively participate in health care reform.

### Action for Federal Partners:

- Provide targeted assistance to assure that urban Indian health organizations are aware of and prepared for implementing health reform strategies.
- Ensure access to Regional Extension Centers to assist with analysis of electronic needs to meet both electronic health record requirements for meaningful use and to facilitate transition to electronic management, billing, reporting, etc. as reform implementation evolves.
- Include urban Indian health organizations as eligible entities for reform grants and contracts.
- Promote engagement by local and state planning councils and agencies charged with implementing reforms on a local, regional or state basis.
- Require that the needs of urban Indians are addressed in local and state plans for reform implementation.

### Action for Urban Indian Health Organizations:

- Investigate and engage in local, regional and national efforts to educate and inform communities on efforts to implement health care reform.
- Conduct meetings with staff and communities about ACA and how it impacts urban Indian health organizations.
- Educate the community about the importance of insurance, as well as expanded eligibility for Medicaid and other programs created under health reform. Build agency capacity to ensure that individuals eligible for these programs enroll.
- Analyze and understand the proper qualifications needed to meet the definition of “medical home.”
- Assure the standards are met to be an “essential community provider.”

### Action for National and Regional Organizations Serving Urban Indian Health Organizations:

- Develop a user-friendly, Web-based resource to ensure recognition as the one authoritative source of vetted information and resources.
- Assist urban Indian health organizations in understanding the implications of policy and actions required to meet implementation of policies.
- Provide guidance on action steps that urban Indian health organizations must take to further their efforts to successfully implement health care reform.
- Engage with urban Indian health organizations to ensure communication methodology is effective.
- Develop a communication plan and training for urban Indian health organizations to conduct community town hall meetings.
- Assist urban Indian health organizations in developing an education component to understand health insurance and why it is needed.



### Action for Private Foundations and Funders:

- Assess portfolio for grants in which urban Indian health organizations might be eligible for funding support.
- Increase funding mechanisms based on the needs of the population, not on population size.
- Reach out to and educate urban Indian health organizations about funding opportunities.

## DEVELOPING PARTNERSHIPS

Urban Indian health organizations work in a wide variety of networks. Developing partnerships with local, regional, national and tribal entities is critical to ensure opportunities are made available to urban Indians.

### Action for Federal Partners:

- Include urban Indian health organizations in efforts to implement health care reform.
- Ask state and regional planners how they currently or intend to address health reform implementation for urban Indians.
- Upon request, assist in making connections to initiate partnership discussions at the state, local and regional levels.
- Include urban Indian health organizations in local, state and regional workshops, seminars and other gatherings to inform and help keep these organizations abreast of plans as they are developed.
- IHS should work in partnership with urban Indian health organizations to address the reality that urban Indian health is for the first time statutorily recognized and considered a permanent part of IHS. This is a historic confirmation of the legal and legislative legacy used to justify health services for urban Indians.

### Action for Urban Indian Health Organizations:

- Develop a consensus position on health reform.
- Develop a matrix of urban Indian health organizations' skills, expertise and partners that can help provide support to other urban Indian health organizations (e.g., electronic health records, meaningful use).

### Action for National and Regional Organizations Serving Urban Indian Health Organizations:

- Facilitate local, regional, national and tribal partnerships with urban Indian health organizations.

## STRATEGIC POSITIONING

Urban Indian health organizations must be strategically positioned to make the most out of health care reform.

### Action for Federal Partners:

- IHS should protect funding for outreach and referral to urban Indian health organizations. Nonclinical urban Indian health organizations play a critical role in providing essential enabling services. With the focus of ACA on insurance and payment for direct care, special attention must be given to support these essential services.
- Examine and support the role that drug and alcohol programs, such as those sponsored by the National Institute on Alcohol Abuse and Alcoholism, play in the urban Indian health care reform discussion.
- IHS plays a central role in the existence of urban Indian health organizations. Urban Indian health organizations benefit IHS by providing direct care and support services to the majority of American Indians and Alaska Natives. IHS undoubtedly would like to see the strengthening and growth of urban Indian health organizations. For this to be a reality, IHS could serve as an advocate for urban Indian health organizations in working with CMS, HHS, other federal agencies and tribes.

### Action for Urban Indian Health Organizations:

- Define and articulate a relationship with the tribes.
- Outreach and referral projects should consider working with a local clinical provider to ensure clients are able to benefit from the provisions in health care reform.

### Action for National and Regional Organizations Serving Urban Indian Health Organizations:

- Recommend alternative strategies to address a need for urban Indians in the event a provision is not implemented.
- Identify and develop a comprehensive communication strategy, which could include a searchable website and a policy blog.
- Develop a website to provide information about legislative members along with their contact information for each urban Indian health organization area.
- Conduct regular meetings and conference calls to provide urban Indian health organizations with updates on the implementation of health care reform.

## Definitions and Standards

This breakout session discussed issues and challenges related to the implementation of definitions and standards associated with ACA. Participants focused their discussion on the confusion resulting from the multiple definitions of urban Indian used in ACA and how that confusion harms or benefits urban Indian health organizations.

## DEFINING URBAN INDIAN

There are inconsistencies in how urban Indians are defined in policy and programs. The definition of urban Indian affects a person's eligibility to receive Indian-specific benefits (e.g., waivers from cost sharing). Much of the debate has been about legal versus political definitions of urban Indian. Oftentimes, these definitions are used to limit who can access services and resources.

### Action for Federal Partners:

- Confer with urban Indian health organization to ensure the definition of urban Indians meets organizational needs.
- Resolve conflicting definitions of urban Indian in ACA.
- Ensure there are no conflicting definitions of urban Indian used by government agencies.

### Action for Urban Indian Health Organizations:

- Increase awareness of the differences of the legal definition of urban Indian compared to how each individual urban Indian health organization may define the term.
- Define and describe how and why an urban Indian health organization defines urban Indian.
- Assess the benefits and risks of defining urban Indian.

### Action for National and Regional Organizations Serving Urban Indian Health Organizations:

- Catalogue the differences in how urban Indian is defined and how that definition is used throughout the urban Indian landscape.
- Catalogue how various definitions of urban Indian are used to exclude members of the Indian community.

## Next Steps

The purpose of this report is multifold: to highlight key barriers faced by urban Indian health organizations, identify opportunities to remove those obstacles, and ensure ACA can successfully improve health care access for the 67 percent of American Indians and Alaska Natives who reside in urban areas.

This Call for Action is intended to prompt an ongoing discussion with urban Indians, the organizations that serve them, urban Indian health care professionals, practitioners and others. Changes in health outcomes of urban Indians will be regularly examined and modifications to this Call for Action will be made to ensure continuous improvement in services and outcomes. This Call for Action can also be used as a benchmark to determine if efforts to support the implementation of ACA among urban Indian communities are sufficient, and to measure and monitor changes over time. For that to be a reality, facilitated conversation must continue. This Call for Action can be used as a framework to guide that discussion, and resources are required to ensure these critical discussions continue.

The federal government, funding agencies, urban Indian health organizations and agencies that serve them are all partners in the delivery of health care services and programs to urban Indians and their communities. The guidance and involvement of these partners is fundamental to the success of this Call for Action. We hope that all partners will work with us to implement this Call for Action and develop ongoing strategies for the implementation of health care reform for urban Indian communities.



> **Participants of the Urban Indian Health Summit**  
*Pictured left to right:*  
**Donna Keeler**, South Dakota Urban Indian Health  
**Ralph Forquera**, Seattle Indian Health Board  
**Donna Polk-Primm**, Nebraska Urban Indian Health Coalition, Inc.

## Appendix A: Brief History of Urban Indians

Nearly seven out of 10 American Indians and Alaska Natives live in or near cities and their numbers are growing. Many live in extreme poverty, poor health, and cultural isolation far from reservation-based health services, which can scarcely afford more patients. In one sense, these 2.8 million urban Indians are America's largest and most vulnerable tribe.

The United States has a unique relationship with American Indians that imposes a duty of responsibility that exceeds those offered to other citizens. Simply stated, tribes exchanged their land and their vast resources for federal promises of a better life and better health. Because of those promises, most Americans live on what was once Indian land. The passage of time has not erased these promises, nor the people to whom they were made.

Since the signing of treaties with American Indian and Alaska Native tribes, the United States government has struggled to find a suitable means of performing this duty, and its periodic efforts to terminate the promises brought great harm to Indian societies.

The struggle over Indian rights has led to a dynamic history, vacillating between Indian recognition and independence to plans for assimilation and tribal termination. In fact, between 1953 and 1961, a policy of relocation and termination dominated Indian Country. Congressional acts terminated the political standing of 109 tribes, thrusting tribal members into American cities with yet more promises that have not been fulfilled. This era brought tens of thousands of Indians to American cities sending most into urban poverty.

By 1970, Congress began to recognize their failed policies had created a new community of urban Indians confronted by social, economic, cultural and environmental challenges that threatened their health and well-being. In a special message prepared for the Congress, then President Richard Nixon called for a change in policy to one of self-determination without termination repudiating the policy of the 1950s and recognizing an obligation to assist urban Indians. Thus,

a special initiative was added to the 1976 Indian Health Care Improvement Act that created a discrete contract program to build health capacity for urban Indians.

But in spite of this authority, resources necessary to help improve the health of urban Indians remains inadequate. IHS focuses its attention on Indians who are living on or near Indian reservations and who are members of federally recognized Indian tribes. Many urban Indians have lost this distinction as a result of the termination actions during the 1950s leaving them with limited options and a declining health status.

American Indians and Alaska Natives living in cities suffer from poverty, single parenthood, unemployment, disability and inadequate education at rates far above those of other Americans. These and other risk factors have contributed to a health crisis in this population despite an ongoing national effort to eliminate health care disparities across all races and ethnicities.

- The rate of alcohol-induced deaths among urban American Indians and Alaska Natives is nearly three times greater than that of the U.S. urban population (16.1 per 100,000 compared to 5.5 per 100,000).<sup>1</sup>
- The urban Indian death rate due to chronic liver disease and cirrhosis is more than twice that of the U.S. urban population (21.6 per 100,000 compared to 9.0 per 100,000).<sup>1</sup>
- The urban Indian death rate due to diabetes is 28.8 per 100,000 compared to 21.7 per 100,000 among the U.S. urban population.<sup>1</sup>
- The urban Indian death rate due to accidents is 37.8 per 100,000 compared to 30.5 per 100,000 among the U.S. urban population.<sup>1</sup>
- The urban Indian infant mortality rate is 8.1 per 1,000 births compared to 6.0 per 1,000 among the U.S. urban population.<sup>2</sup>
- According to self-reported health data, 43.2% of urban American Indians and Alaska Natives report one or more days of poor mental health within the last 30 days, compared to 36.9% for U.S. urban population.<sup>3</sup>

- Cardiovascular disease was virtually unheard of among American Indians and Alaska Natives as recently as 40 years ago. Now it is their leading cause of death.<sup>1</sup>
- Federal Indian health policy directs the bulk of its funds and attention toward members of federally recognized tribes living on or near reservations. Just 1 percent of the U.S. Indian Health Service's \$4.05 billion annual budget goes to the 34 local health organizations serving urban Indians.
- According to self-reported health data, 25.7% of urban American Indians and Alaska Natives report not having health insurance in the past 12 months, compared to approximately 17.4% of the U.S. urban population.<sup>3</sup>

<sup>1</sup> U.S. Centers for Health Statistics, UIHO Service Areas, United States, 2002-2006

<sup>2</sup> U.S. Centers for Health Statistics, UIHO Service Areas, United States, 2001-2005

<sup>3</sup> BRFSS, UIHO Service Areas, United States, 2005-2009

## Appendix B: Urban Indian Health Organizations

Urban Indian health organizations are community-based, non-profit agencies that provide targeted health care services. Many are partially funded through the authority of Title V of the Indian Health Care Improvement Act (P.L. 94-437, as amended).

### Funding

Under Title V, contractors are required to be non-profit corporations, Indian-governed, and eligible to qualify for other non-Indian grants and contracts. IHS contracts with 34 independent urban Indian health organizations located in 19 states and reaching nearly 60,000 low income urban Indians annually. Urban Indian health organizations funded under Title V became eligible for Federally Qualified Health Center status for Medicaid and Medicare purposes. In amendments to the Indian Health Care Improvement Act in 1988, the IHS was given granting authority for urban Indian organizations making them eligible for special initiatives funded by the Congress. Urban Indian health organizations were also included in the 1997 Balanced Budget Act that created a special diabetes initiative for American Indians and Alaska Natives. However, the Congress appropriates just 1 percent of its annual funding for Indian health to assist urban Indians, a practice that has persisted since 1979 in spite of considerable growth in the urban Indian population.

### Important Historical Policies

Self-determination without termination is the current overarching policy for Indian affairs. This policy endorses local development of health and related assistance for urban Indians by seeking ways to be inclusive of local participation in the planning, implementation, management, and operation of community-based services.



## Services

The services offered by the urban Indian health organizations vary from outreach, referral and case management programs to primary health care. Many of those with primary health care services offer medical and dental care, as well as lab, pharmacy, nutrition and mental health services. The culturally competent care of these organizations is important, and the 34 urban Indian health organizations have important historical experience in understanding and addressing the unique health needs of their urban Indian communities.

Urban Indians represent a more transient, dispersed and both culturally and historically diverse population than reservation communities. Essentially, they live in a community of tribal people, outside of the usual definition of a geographically defined home. This lack of a geographically defined, culturally homogeneous community creates challenges for those serving urban Indians. Given the mobility and fractionalization of urban Indians, the 34 federally recognized urban Indian health organizations offer the best care possible for this vulnerable population. Addressing the health of urban Indian populations is difficult due to their geographic dispersal and small numbers compared to the total population in these areas. Mobility has proven to be a daunting challenge; many American Indians and Alaska Natives must leave their urban home due to lack of resources and travel to their reservation to access health care. Once there, they may need to wait six months to re-establish residency and be eligible for care. At this point, they are placed on a waiting list, prolonging their care for many months, possibly years.

While culturally focused programs and cost-saving preventative medicine are essential to improve urban Indian health, funding instability and challenges to providing care are at odds with it. Indeed, the urban Indian health system needs to grow, both in its current locations as well as in places where urban Indian health care is now unavailable. The largest urban Indian health organizations offer primary medical and dental care operations; however, with the exception of some contracted specialty care services for diabetes, such as foot care and eye exams, there are no hospital or specialty care services directly connected to these institutions.

Perhaps more importantly, currently there is no universal system of data collection available, which weakens our understanding and documents threats that may influence access to timely and quality care. National reporting on the health status of urban Indians is critical for the creation of programs and services that will effectively reach and serve the population. Without accurate data on urban Indians, policy will not be informed, resulting in inappropriate or limited funding for programs and services for this population. If programs or services are ineffective in reaching urban Indians, the health status of this population will continue to spiral downward, health disparities will increase and ultimately the programs will fail the people who need these services most.

Research has shown that tailoring health care to meet the culturally specific needs of a community is essential to the effectiveness of the service. For example, minority patients who receive treatment in culturally focused programs respond better to preventive medicine and are more likely to seek out health care services. Traditional healing is one element of a culturally focused program among urban Indians. Whether incorporating herbal remedies, sweat lodges, customary health practices or spiritual healing into health care, the appreciation of cultural beliefs improves the quality of medical care as well as patient response to urban Indian health care.

Community services are another element of a culturally balanced program. Urban Indian health organizations may transmit cultural communications about upcoming pow-wows, health events or other group activities. The facility itself often serves as a safe-space for urban Indians to congregate, celebrate and share.

The scope of services of individual urban Indian health organizations varies greatly. Although the future vision for urban Indian health organizations includes the ability to provide comprehensive services, they currently offer three types of service designs: the outreach and referral design, limited services design and the comprehensive services design.

## OUTREACH AND REFERRAL DESIGN

- Urban Indian health organizations that use the outreach and referral design do not provide medical services on-site. They offer health and awareness activities and education services on-site, referring people elsewhere for medical services. Urban Indian health organizations may or may not pay for the medical service referral, depending on resources available.

## LIMITED SERVICES DESIGN

- Urban Indian health organizations that use the limited service design provide some medical services on-site while other services are referred out. Types of on-site medical services offered vary from organization to organization. Similar to the outreach and referral design, urban Indian health organizations may or may not pay for the medical service referral, depending on resources available.

## COMPREHENSIVE SERVICES DESIGN

- Urban Indian health organizations that use the comprehensive services design provide most medical services on-site. If the medical services are not available on-site, the organization may provide for a medical service referral.

Most urban Indian health organizations provide substance abuse prevention activities, while a few house both residential and outpatient substance abuse treatment programs. Some have additional programs, such as the Seattle Indian Health Board in Seattle, Washington, which operates a family medicine residency-training program, offers a community health center and manages the Urban Indian Health Institute.

## Appendix C: Materials From the Summit

Additional materials from the Urban Indian Health Summit can be found on the website, [www.uihi.org/summit](http://www.uihi.org/summit).

Materials include:

- Urban Indian Health Summit agenda
- Pre- and post summit agendas
- Archived excerpts from panel presentations
- Photos from the Urban Indian Health Summit
- Speaker biographies
- Planning committee membership list
- Links to additional resources that address provisions of ACA affecting urban Indians

## Appendix D: Healthy Government Benchmark Table

The following benchmark table is a draft document. It serves as an example of one approach that can be used to determine if efforts to support the implementation of ACA among urban Indian communities are sufficient, and to measure and monitor changes over time. To support this approach, we recommend

the creation of a workgroup with representation from federal partners, urban Indian health organizations, national and regional organizations serving urban Indian health organizations and private foundations and funders. Workgroup members can provide guidance on the establishment of baseline measures and measureable outcomes. Further research and data collection efforts can then be implemented to inform these baseline measurements and monitor target achievements and progress over time.

### Acronym Key

|             |  |               |  |
|-------------|--|---------------|--|
| <b>ACA</b>  | Patient Protection and Affordable Care Act   | <b>IHS</b>    | Indian Health Service  |
| <b>AIAN</b> | American Indian Alaskan Native               | <b>NIAAA</b>  | National Institute on Alcohol Abuse and Alcoholism                   |
| <b>CMS</b>  | Centers for Medicare and Medicaid            | <b>ONC</b>    | Office of the National Coordinator for Health Information Technology |
| <b>EHR</b>  | Electronic Health Record                     | <b>OPA</b>    | Office of Price Administration                                       |
| <b>FQHC</b> | Federally Qualified Health Center            | <b>SAMHSA</b> | Substance Abuse and Mental Health Services Administration            |
| <b>HHS</b>  | Department of Health and Human Services      | <b>UIHO</b>   | Urban Indian Health Organization                                     |
| <b>HRSA</b> | Health Resources and Services Administration |               |  |

| IMPLEMENTATION        |   |                |                 |  |  |
|-----------------------|---|----------------|-----------------|--|--|
| Workforce Development |   |                |                 |  |  |
| Action Number         | Action  | Type of Action | Agency Involved | Baseline   | Target   |
| <b>I-1</b>            | Develop and strengthen new and existing education loan repayment programs for providers committed to serving urban Indians.   | Resources      | HHS             | Number of urban Indian-serving loan repayment providers                                      | Increase number of providers serving UIHOs through loan repayment programs by 50%                                |
| <b>I-2</b>            | Develop outreach programs to support pathways in health education, starting with parents of young children and continuing through job placement and loan repayment options. | Resources      | HHS             | Number of health education pathway programs for urban Indians                                | Increase the number of health education pathway programs for urban Indians by 20%                                |
| <b>I-3</b>            | Develop mechanisms to prioritize UIHOs as sites for provider placement from the National Health Service Corps or other manpower training opportunities.                     | Advocacy       | HHS             | Number of UIHOs with Commissioned Corps Providers  | Increase the number of UIHOs with Commissioned Corps Providers by 10%  |
| <b>I-4</b>            | Support and encourage placement of AIAN National Health Service Corps (providers at UIHOs).   | Advocacy       | HHS             | Number of UIHOs with AIAN Commissioned Corps Providers                                       | Increase the number of UIHOs with AIAN Commissioned Corps Providers by 5%  |
| <b>I-5</b>            | Create and support opportunities for sharing National Health Service Corps providers between UIHOs and surrounding tribal organizations or community health centers.        | Educate        | HHS             | Number of UIHOs and tribes collaborating to support and utilize Commissioned Corps Providers | Increase the number of UIHOs and tribes collaborating to support and utilize Commissioned Corps Providers by 10% |



| Action Number                            | Action  | Type of Action | Agency Involved | Baseline  | Target  |
|--|---|----------------|-----------------|---|---|
| <b>I-6</b>                               | Establish communication pathways to support and educate UIHOs about how they can partner with the National Health Service Corps and other manpower training programs to address unmet service needs.  | Educate        | HHS             | Number of UIHOs participating in educational sessions for informational sharing | Increase the number of UIHOs with Commissioned Corps Providers by 10%   |
| <b>Federally Qualified Health Center</b> |   |                |                 |   |   |
| <b>I-7</b>                               | Those UIHOs who are FQHCs should be recognized as a solution for primary care shortage as essential community providers.  | Recognition    | HRSA            | Number of FQHC UIHOs identified as essential community providers                | 100% of FQHC UIHOs identified as essential community providers  |
| <b>Medicaid and Medicare</b>             |   |                |                 |   |   |
| <b>I-8</b>                               | Provide technical assistance to UIHOs on how to become involved in health insurance exchanges.  | Educate        | HHS             | Number of UIHOs involved in health insurance exchanges                          | 100% of eligible UIHOs to be involved in health insurance exchanges   |
| <b>I-9</b>                               | Ensure UIHOs are identified as “essential community providers.”   | Advocacy       | CMS             | Number of FQHC UIHOs identified as essential community providers                | 100% of FQHC UIHOs are identified as essential community providers  |
| <b>I-10</b>                              | Ensure UIHOs are eligible for the option to receive the IHS all-inclusive rate for Medicare and Medicaid.   | Advocacy       | CMS             | Number of UIHOs receiving IHS all-inclusive rate                                | 100% of eligible UIHOs receive IHS all-inclusive rate   |
| <b>I-11</b>                              | Support relationships between states and UIHOs.   | Advocacy       | CMS             | Number of UIHOs with formal relationships with states                           | Increase the number of UIHOs with formal relationships with states by 50%   |
| <b>I-12</b>                              | Support a more direct relationship between CMS and UIHOs.   | Advocacy       | CMS             | Not yet performed   | Establish a formal consultation process between UIHOs and CMS   |
| <b>I-13</b>                              | Develop a mechanism to assure conferring with UIHOs directly is possible.   | Recognition    | HHS             | Not yet performed   | Establish a formal consultation process between UIHOs and all HHS operating divisions   |
| <b>I-14</b>                              | HHS could mandate that eligible “essential community providers” be designated as a provider in all health plan networks recognized under state-specific exchange, of which UIHOs are included.  | Recognition    | HHS             | Not yet performed   | Establish a formal policy to mandate that eligible “essential community providers” be designated as a provider in all health plan networks recognized under state-specific exchange   |
| <b>I-15</b>                              | HHS, in its role in helping states conduct the development of state-specific exchanges, should require that health plans participating in the exchange demonstrate their ability to assure culturally competent health care for American Indian populations, both tribal and urban. | Recognition    | HHS             | Not yet performed   | Establish and implement a process and policy to ensure health plans participating in the exchange demonstrate their ability to assure culturally competent health care for American Indian populations, both tribal and urban |

## RESOURCES AND STRATEGIES

### Complexities and Implications of ACA

| Action Number           | Action  | Type of Action | Agency Involved | Baseline  | Target   |
|-------------------------|---|----------------|-----------------|---|--|
| <b>RS-1</b>             | Provide targeted assistance to assure that UIHOs are aware of and prepared for implementing health reform strategies.   | Educate        | HHS             | Number of HHS educational efforts to reach UIHOs  | 100% of UIHOs participate in HHS educational efforts related to ACA  |
| <b>RS-2</b>             | Ensure access to Regional Extension Centers to assist with analysis of electronic needs to meet both EHR requirements for meaningful use and to facilitate transition to items such as electronic management, billing and reporting as reform implementation evolves. | Advocacy       | OPA, ONC        | Number of UIHOs with access to Regional Extension Centers                                     | 100% of UIHOs coordinates with a Regional Extension Centers  |
| <b>RS-3</b>             | Include UIHOs as eligible entities for reform grants and contracts.   | Recognition    | HHS             | Number grants and contracts with language to include UIHOs                                    | Increase the number of grants and contracts with language to include UIHOs by 100%.                                |
| <b>RS-4</b>             | Promote engagement by local and state planning councils and agencies charged with implementing reforms on a local, regional or state basis.   | Recognition    | HHS             | Number of UIHOs engaged with planning councils and agencies charged with implementing reforms | Increase the number of UIHOs engaged with planning councils and agencies charged with implementing reforms by 100% |
| <b>RS-5</b>             | Require that the needs of urban Indians are addressed in local, state plans for reform implementation.  | Recognition    | HHS             | Not yet performed   | 100% of UIHOs provide description of needs through a needs assessment  |
| Developing Partnerships |   |                |                 |   |  |
| <b>RS-6</b>             | Include UIHOs in efforts to implement health care reform.   | Recognition    | HHS             | Not yet performed   | Convene 2-4 meetings annually with UIHO leadership to assess progress towards implementation of ACA                |
| <b>RS-7</b>             | Inquire with state and regional planners on how they intend to or currently are addressing health reform implementation for urban Indians.  | Recognition    | HHS             | Not yet performed   | 100% of states and regional planners to develop and present strategies to include urban Indians                    |
| <b>RS-8</b>             | Upon request, assist in making connections to initiate partnership discussions at the state, local and regional levels.   | Advocacy       | HHS             | Not yet performed   | Carry out 100% of requests to make connections to develop partnerships at the state, local and regional levels     |
| <b>RS-9</b>             | Include UIHOs in local, state and regional workshops, seminars and other gatherings to inform and help keep UIHOs abreast of plans as they are developed.   | Recognition    | HHS             | Number of UIHOs participating in educational sessions or any forum of informational sharing   | 100% of UIHOs engaged with planning councils and agencies charged with implementing reforms                        |

| Action Number                             | Action  | Type of Action | Agency Involved | Baseline  | Target   |
|---|---|----------------|-----------------|---|--|
| <b>RS-10</b>                              | IHS should work in partnership with UIHOs to address the reality that urban Indian health is for the first time statutorily recognized and considered a permanent part of IHS. This is a historic confirmation of the legal and legislative legacy used to justify health services for urban Indians. | Recognition    | IHS             | Not yet performed   | Establish a mechanism between IHS and UIHOs for consultation and partnership                                     |
| <b>Strategic Positioning Partnerships</b> |   |                |                 |   |  |
| <b>RS-11</b>                              | IHS should protect funding for outreach and referral UIHOs. Non-clinical UIHOs play a critical role in providing essential enabling services. With the focus of ACA on insurance and payment for direct care, special attention must be made to support these essential services.                     | Advocacy       | IHS             | Number of non-clinical UIHOs and their funding level                          | Maintain the number of non-clinical UIHOs and their funding  |
| <b>RS-12</b>                              | Examine and support the role that drug and alcohol programs, such as those sponsored by NIAAA, fit into the urban Indian health care reform discussion.   | Recognition    | IHS, SAMHSA     | Number of UIHOs with NIAAA or stand-alone programs and their funding level    | Increase the number of NIAAA UIHOs participating in discussions related to health care reform                    |
| <b>RS-13</b>                              | IHS should serve as an advocate for UIHOs in working with CMS, HHS, other federal agencies and tribes.  | Advocacy       | IHS, HHS        | Number of UIHOs with formal relationships with CMS, HHS or other agencies     | Increase the number of UIHOs with formal relationships with CMS, HHS or other agencies                           |
| <b>DEFINITIONS AND STANDARDS</b>          |   |                |                 |   |  |
| <b>Defining Urban Indian</b>              |   |                |                 |   |  |
| <b>DS-1</b>                               | Confer with UIHOs to ensure the definition of urban Indians meets organizational needs.   | Recognition    | HHS, IHS        | Not yet performed   | Convene 1-2 annual meetings with IHS, HHS and UIHOs to discuss definitions and eligibility                       |
| <b>DS-2</b>                               | Resolve conflicting definitions of urban Indian in ACA.   | Recognition    | HHS, IHS        | Number of conflicting definitions of urban Indian in ACA                      | Reduce definition of urban Indian in ACA to one definition, agreed upon by UIHO leadership                       |
| <b>DS-3</b>                               | Ensure there are no conflicting definitions of urban Indian used by government agencies.  | Recognition    | HHS, IHS        | Number of conflicting definitions of urban Indian used by government agencies | Reduce definition of urban Indian used by any government agency to one definition agreed upon by UIHO leadership |

