Washington State Health Care Authority

Centennial Accord Report

Tribal Health Programs and Services for American Indian & Alaskan Natives

May 2012

2012 REPORT
2010-2012 GOALS AND DESIRED OUTCOMES

Services to Washington State Recognized Tribes and American Indians and Alaskan Natives

MAY 2012

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EXECUTIVE SUMMARY

The Health Care Authority (HCA) provides this report of the efforts and activities regarding Medicaid and health services for programs and contracts for Washington State American Indian/Alaskan Native (AI/AN) clients and with Tribal and Urban Indian facilities. This report identifies goals and activities from the 2010-2012 biennium.

HCA has met with tribes and tribal representatives in a variety of forums to identify issues, and establish goals based on the identified needs of tribal programs and communities. Over the past year, staff have met with tribal leaders and representatives, tribal clinic directors, the Indian Policy Advisory Council IPAC), the American Indian Health Commission (AIHC), Northwest Portland Area Indian Health Board (NPAIHB)–health director's meetings, held tribal work groups, and participated at regional tribal coordinating council meetings. In addition, HCA has provided technical assistance trainings as requested by tribal representatives and tribal leaders. In all forums with tribes, staff have identified tribal concerns and have coordinated the resolution of operational and policy concerns that are within the purview of the administration. The agency programs include;

- Basic Health
- Health Technology Assessment Program
- Health Insurance Partnership
- Medicaid
- Prescription Drug Program
- Public Employees Benefits Program
- Uniform Medical Plan
- Washington Health Program

Introduction

The mission of HCA is to promote access to quality health care for Washington's most vulnerable residents. To address the issues identified by the tribes, HCA has integrated the following goals: increase collaboration and communications, distributed responsibilities of government to government collaborations throughout HCA, promoted HCA programs for which tribes may receive reimbursement for the services provided for eligible clients at tribal facilities and maintained tribal program reimbursements.

The HCFA (now CMS) and IHS Memorandum of Agreement defines the relationship between the Medicaid program and federally recognized tribes in Washington State for direct health services or contracts for other Medicaid programs. This federal policy defines a special relationship between federally recognized tribes, IHS and CMS. Eligibility for special Medicaid reimbursement rates require tribal programs to meet federal IHS eligibility criteria in addition to the State Medicaid program criteria. Non-

federally recognized tribes and urban programs do not meet the eligibility criteria through IHS, but are eligible to provide services as state approved health providers.

The Centennial Accord requires the collaboration with tribes and American Indian organizations in the development of plans and processes to ensure the delivery of necessary health services to American Indians in their communities. In addition, federal Health and Human Services (HHS) policies require collaboration by consulting or seeking advisement from tribal health programs identified on the Indian Health Service (IHS) list. HCA staff have taken the opportunity to meet with tribal representatives in forums such as the Indian Policy Advisory Council, the American Indian Health Commission, Northwest Portland Area Indian Health Board Quarterly Board meetings and HRSA/ workgroup meetings. HCA also receives input on issues from individual contact with tribal leaders and representatives. HCA has also provided forums and workgroups to obtain input and guidance regarding development of the health Exchange Board, and implementation plans for Medicaid expansion in 2014.

Consultations

HCA utilizes various venues and methods to address consultation. In addition to the Centennial Accord, HCA is also required to consult with tribal and urban health programs in an advisory capacity under CMS policy for tribal communications as it relates to state plan amendments, waivers and pilot and demonstration projects. The requirements, as defined by HHS/CMS, have distinctly different levels of communication and options than with the previous administration. CMS consultation requires a direct contact with tribal health programs and a general understanding of how policy change impacts tribal and urban Indian health programs, and AI/ANs in the state. DSHS consultation requirements are a more formal government to government discussion with tribal leaders or their representatives. HCA has incorporated the HHS requirement for seeking advisement of tribal health programs into the administrative process for State Plan Amendments by issuing a letter to all tribal leaders and sending copies of the Dear Tribal Leader letter to health facility directors, health administrators and program managers. The letter explains the purpose of the SPA and the expected changes to covered services, possible iHCAct to tribal health programs and also expected iHCActs to American Indian/ Alaskan Native clients. The SPA letter incorporates a timeline that allows each tribal leader to request a consultation or the tribal program manager time to submit comment.

HCA has participated in many informal consultations, and workgroups in order to meet and discuss policy issues that affect a select native community or communities and tribes in Washington through the American Indian Health Commission and “Dear Tribal Leader” letters. HCA has established a monthly workgroup in partnership with the AIHC to provide a forum to identify and clarify policy for tribal facilities. This is defined in the draft of the new HCA consultation policy. As a result of huge budget deficits and program cuts, HCA has made communication on budget changes a priority with tribal leadership and program staff due to the unique relationship with tribes and the importance of federal and state reimbursement from publicly funded health programs to

tribal health budgets. HCA had also initiated discussion on a tribal health homes and am working with tribal representatives to develop recommendations and components to be included. On March 15, 2012, the Exchange became an independent 11-member governing board appointed by the Governor.

Priority Activities

HCA Health Benefit Exchange
HCA received a $128 million federal Level II Exchange Establishment Grant to develop and implement the state's Health Benefit Exchange. Through the exchange residents can receive help to find, coHCAre, and enroll in health care coverage in 2014. Washington is only the second state in the nation to qualify for the Level II Exchange grant. Integrated into the grant was a request for tribal specific funding in which to incorporate the needs of tribal health programs and urban AI/ ANs.

HCA Tribal Consultation on the Waiver Bridge Funding for Basic Health
Meetings with tribal representatives were held regarding the approved Bridge Waiver, that provided federal match for the Basic Health program. Two workgroups were formed with the AIHC to assist the department in defining documentation needs for AI/AN's to qualify for the exemptions identified in the waiver and a workgroup to assist in development of a balance payment for tribal facilities billing managed care organizations as primary payer.

Tribal Behavioral Health Redesign
With the separation of Behavioral Health Services from the HCA the Tribal Behavioral health redesign stayed with DSHS. HCA utilized funding from two grant sources to fund a contract with the NPAIHB to provide an analysis of the Tribal behavioral health resources used by tribes and assist in the identification of services and resource gaps. The work of the Board was shared with the tribes, tribal leaders, AIHC and the DSHS/Indian Policy Advisory Council. HCA will continue to participate in the continuing policy work.

Funding

ProviderOne Implementation
HCA has provided ongoing training and technical assistance to tribes to support the billing for publicly funded treatment services provided at tribal facilities for eligible DSHS clients. The administration has worked to extend reimbursement opportunities to tribal programs for services to non-natives within policy and funding limitations.

As the new ProviderOne billing system was implemented, HCA has provided ongoing communication and technical assistance to tribal facilities and providers to keep tribal staff and leadership apprised of the ongoing status of ProviderOne updates and needed tribal staff participation. HCA completed 4 tribal specific trainings via webinar in order to allow increased participation by tribal staff. In order to align tribal programs with other

Medicaid providers, ProviderOne will convert tribal billing to the standard use of medical code billing in October 2012.

Health Care Services

HCA has continued to work with the tribes in achieving policy clarification and reimbursement to tribal programs for Medicaid, CHIP, and state funded programs. For the purposes of the Healthy Options program in Clallam county a meeting with the Clallam county tribes was scheduled upon the determination of the county becoming a mandatory enrollment county for Medicaid and CHIP clients. Tribes and clients eligible for managed care placement in the county would be highly iHCActed by the change. A more thorough evaluation of the MCO's capacity is occurring. Meetings are being scheduled to assist in mitigation strategies for each tribe.

Medicaid Administrative Match (MAM)

HCA formally submitted a Tribal MAM Cost Allocation Plan (CAP) to CMS in April. HCA staff and tribes have over the course of several meetings and developed a final CAP that has been submitted CMS. HCA will continue to work with tribes once the plan is formally approved by CMS. HCA was able to request a contract extension for the tribes currently contracting with HCA until the plan is formally accepted by CMS.

First Steps/Maternity Support Services

Data presented by DOH in 2006 to the AIHC and HCA identified a significant increase in infant mortality rates for AI/AN infants in Washington State. It is the only population in which infant mortality is increasing instead of decreasing. Although the First Steps and Maternity Support Services programs have had a 50% budget reduction due to state budget cuts, program participated on a Maternal Child Health workgroup in collaboration with the American Indian Health Commission. As a result of the data analysis of the at risk population, AI/AN has been identified as a risk factor for eligibility for First Steps services. Budget changes have required services to be more highly prioritized toward eligible clients.

Tribal Eligibility Determination Project

The Port Gamble S'Klallam Tribe is one of the first self governance tribes in Washington, fully exercising control over their resources. As a tribal sovereign government, the Port Gamble S'Klallam Tribe provides comprehensive services to its members on the Port Gamble S'Klallam Reservation and in the surrounding Kitsap County area. Among these are services specific to the social, emotional, spiritual and physical well being of all community members.

The pilot went live January 1, 2010. The project has announced resounding success in proving access to tribal clients. A formal review of the project was completed in 2011 in order to evaluate the possible expansion of the pilot to other interested tribes. CMS has approved the expansion to other tribes, but approval to extend contracts to other tribes has not been received from the Administration for Children and Families (ACF). HCA in partnership with DSHS/ Economic Services Administration is working to facilitate the

opportunity for other tribes as preparation for the expanded Medicaid religability that is to occur in 2014.

Tribal Exemption from Medicaid Service Reductions

As a result of the budget reductions and subsequent reduction in Medicaid covered services, tribes made a formal request of the administration to request an exemption for tribal programs receiving 100 percent federal match in Medicaid reimbursements. The Social Security Act authorizes multiple waiver and demonstration authorities to allow states flexibility in operating Medicaid programs. Each authority has a distinct purpose, and distinct requirements. As a state waiver would not meet the federal rules for "budget neutrality", the state requested technical assistance from CMS in respect to the government to government relationship with tribes. Washington is working with the State of Oregon in developing parallel exemptions for Washington and Oregon tribal facilities that receive 100 percent federal match.

Washington Bridge Waiver

Washington State has received approval of its request for a Medicaid waiver that will let the state and federal government share the cost of the Basic Health plan and the Medical Care Services program for Disability Lifeline and the Alcohol Drug Addiction Treatment Support Act. The transition to National Health Care Reform and the iHCAct to AI/ AN and tribal programs as a result of the Bridge Waiver required several consultations with tribes in WA. As a result topic specific workgroups emerged as a requirement of implementation. A workgroup to identify the documentation needs for AI/ANs exemption from premiums and co-pays and the payment process for tribal facilities to receive the balance of a OMB/ IHS encounter rate for services provided by a tribal clinic for AI/AN in a managed care plan. Both workgroups will address changes needed to ensure the state is in compliance with federal policy.

Action Plan

The primary goal in development of the HCA Centennial Accord plan is to increase communication with the tribes, identify policy, resource and reimbursement issues, and provide appropriate technical assistance as requested by tribes. Tribes have expressed the need for increased resources to provide health services. HCA recognizes the need to assist the tribes in accessing state and federal resources to assist tribal programs in addressing health equity issues in their communities. Among the most important issues raised by tribal representatives are increased government to government relations, tribal consultations, and direct policy planning.

In order to respond to tribal concerns in a more collaborative manner, workgroups are created as the forum for resolution of identified issues. In 2011, issues identified were requests for consultation on several management and administrative changes that were out of the purview of tribal consultation, i.e. legislative budget decisions, DSHS consolidation due to budget cuts and departmental directives as a result of federal policy requirements. As a consolidated HCA there have been a great increase in communications regarding the state budget process and changes communicated directly to tribal leadership and health program directors. A monthly workgroup was

established in collaboration with the AIHC that incorporated all HCA programs in participation. The agendas for the workgroup are developed jointly with the executive director of the commission. As issues are identified use of issue focused, time-limited workgroup subcommittees are created to resolve issues or develop proposals for resolution.

A Tribal-Centric Mental Health Redesign workgroup was created while the DBHR was merged under HCA. A contract with NPAIHB was initiated while the services were merged. The DSHS secretary has requested a re-initiation of the workgroup under DSHS. HCA has committed to work closely and provide identified technical assistance to the redesign workgroup.

Challenges

Federal Medicaid rules require comparability and state-wideness. This challenges the administration's ability to be flexible on a tribe by tribe basis. All state plan amendments must be shared with tribes for comment although the administration has limited purview on implementation of program creation and reductions imposed by the administration. This often places the administration in a disingenuous position when the administration requests advise and comment from tribal leaders, but are restricted from accommodation of tribal specific concerns. To address this a standing agenda item ion the AIHC –HCA workgroup is sharing of any emerging State Plan Amendments or pending legislative initiatives.

Federal rules and the infrastructure of HCA have created the need for a variety of approaches to government to government relations with tribal health programs. HCA's action plan contains issues identified by the tribes and tribal representatives through various forums. Statewide issues have been identified and brought forward by direct communication to the Assistant Secretary and Division Directors. Identification of tribal concerns has occurred during tribal workgroups, forums, conversations and consultation as well as direct communication from tribal representatives and leaders.

Tribal concerns are being addressed with statewide workgroups and consultations with HCA administration. Health Care Services has utilized issue/topic specific workgroups to clarify policy, develop cost allocation plans, and to strategize access through clarification of federal policy.

Collaboration Projects

As HCA moves forward in collaboration with tribes, the administration aims to increase the number of Medicaid programs tribes have core provider agreements for. The administration views the tribes as partners in providing valuable health services to our Washington State clients. The goal of HCA is to be a primary partner with tribes to address the health equity issues of American Indian/Alaskan Natives in Washington State. To that end HCA collaborates with other state health organizations to increase resources and develop strategies in partnership with tribes.

Current projects within the HCA and in collaboration with other administrations;

Bridge Waiver Implementation- Receipt of federal match for Basic Health clients and Medical Care Services

Behavioral Health Redesign- Work with tribes to access needed State Behavioral health resources needed by tribes. Brainstorm around identified service gaps, needs, and identification of access points for new Medicaid clients. Partnering with ADSA/DBHR.

Port Gamble Eligibility Pilot- Creates a tribal CSO to increase access to services for eligible tribal clients. Pilot is in the final stages with the evaluation pending. Partnering with the Economic Services Administration

Tribal Health Home Develop a tribal specific Health Home model to address the unique cultural aspects of care coordination and the convoluted health funding and regulations for IHS and Medicaid.

Health Benefit Exchange- Now their own entity. While a part of HCA two tribal representatives selected by the AIHC were placed on the Exchange Board to represent tribal interests. The unique policy needs of tribes and urban Indians were identified in partnership with HCA through a planning grant developed by the AIHC. AIHC was funded for $378,565 to provide the WHBEB with the tools and expertise needed to assure HBE policy and administrative issues related to AI/AN and the Indian health delivery system are appropriately addressed in the design and implementation of the HBE as they prepare for Exchange certification. Legislature requires the Board to develop a consultation policy with the AIHC.

Medicaid Expansion Workgroups – With the implementation of National Health Care Reform is the expansion of Medicaid eligibility. This could mean up to 30,000 newly eligible AI/ AN Medicaid clients in Washington State. Separate from the issues involving development of an Insurance Exchange, Medicaid Expansion has many unique requirements for tribes and AI/ AN's. To address the issues as systems and policy are developed in Washington, delegates from the AIHC are participating

CENNTENNIAL ACCORD UPDATED STATE FISCAL YEAR REPORT,GOALS AND DESIRED OUTCOMES

1. **Statistics on American Indian- community and participant populations, numbers of American Indian participants served statewide in SFY 2011**

	Adult			Children			Total		
PROGRAM ELIGIBILITY CATEGORIES	**Fee For Service**	Managed Care	Total Eligible	**Fee For Service**	Managed Care	Total Eligible	**Fee For Service**	Managed Care	Total Eligible
AHK - Children's Health Insurance	22	8	30	1,068	265	1,333	1,090	273	1,363
AHK - Medicaid CN Foster Care & Adop. Support Children	141	0	141	1,885	4	1,889	2,026	4	2,030
AHK - Medicaid CN Mandatory Children	448	84	532	8,875	2,673	11,548	9,323	2,757	12,080
AHK - Medicaid CN Optional Children	120	43	163	4,638	1,305	5,943	4,758	1,348	6,106
AHK - Non-Citizen Children	3	0	3	45	0	45	48	0	48
Invol. Psych. Treat.	27	0	27	2	0	2	29	0	29
Medicaid Alien Emergency Medical	2	0	2	0	0	0	2	0	2
Medicaid CN Blind/Disabled (SSI Related)- Dual	1,366	2	1,368	0	0	0	1,366	2	1,368
Medicaid CN Blind/Disabled (SSI Related)-NON Dual	4,425	140	4,565	655	2	657	5,080	142	5,222
Medicaid CN Elderly-Dual	1,204	10	1,214	0	0	0	1,204	10	1,214
Medicaid CN Elderly - NON Dual	83	0	83	0	0	0	83	0	83
Medicaid CN Family Medical	6,941	1,448	8,389	7,305	2,922	10,227	14,246	4,370	18,616
Medicaid CN Family Planning - Postpartum	1,289	0	1,289	2	0	2	1,291	0	1,291
Medicaid CN Health Care for Workers with Disabilities- Dual	22	0	22	0	0	0	22	0	22
Medicaid CN HC for Workers Non dual with Disabilities	8	0	8	0	0	0	8	0	8
Medicaid CN Pregnant Women	1,715	231	1,946	100	4	104	1,815	235	2,050
Medicaid CN Women w/ Breast& Cerv. Cancer	36	0	36	0	0	0	36	0	36
Medicaid Family Planning- Take Charge	1,002	0	1,002	187	0	187	1,189	0	1,189

Medicaid MN Blind/Disabled (SSI Related) Non dual	253	0	253	0	0	0	253	0	253
Medicaid MN Blind/Disabled (SSI Related) Dual	199	0	199	0	0	0	199	0	199
Medicaid MN Elderly	164	0	164	0	0	0	164	0	164
Medicaid MN Others (Pregnant Women & Children)	9	0	9	24	0	24	33	0	33
Medicaid/Medicare Cost Sharing (Partial Duals)	1,212	1	1,213	0	0	0	1,212	1	1,213
MCS - DL	1,348	755	2,103	0	0	0	1,348	755	2,103
MCS - ADATSA	1,141	0	1,141	5	0	5	1,146	0	1,146
Title XXI Non-Citizen Pregnant Women	14	0	14	0	0	0	14	0	14
Voluntary Treatment - Psychiatric	9	0	9	0	0	0	9	0	9
Total MAA	**23,203**	**2,722**	**25,925**	**24,791**	**7,175**	**31,966**	**47,994**	**9,897**	**57,891**
Total MAA less FP	**20,912**	**2,722**	**23,634**	**24,602**	**7,175**	**31,777**	**45,514**	**9,897**	**55,411**
Apple Health for Kids	**734**	**135**	**869**	**16,511**	**4,247**	**20,758**	**17,245**	**4,382**	**21,627**

- State-only clients are DL only, and do not include ADATSA or state-paid family planning-only clients.
- The tribal clinic data is pulled using the tribal facility billing.
- The statewide total is based on a data pull using the “04” race code from the HCA Medicaid Management Information System (MMIS) ProviderOne.

Tribal Facility Client Population

# AI/ AN Clients	Distinct Clients-	Medical FFS	PCCM	Total
AVG	20,857	19,670	11,193	51,720

AI/Tribal Facility Expenditures - SFY 2011

# AI/ AN Clients	Medicaid Encounter	Medical FFS	Pharmacy D claims	State-only	PCCM	Total
Total	$47,720,574	$4,280,957	$2,498,569	$1,565,296	$217,092	$56,282,488

GOALS AND OBJECTIVES	ACTIONS	MEASUREMENTS	TARGET DATE	CURRENT STATUS
1. Work with ESA to integrate tribal identifiers into ACES	1. workgroup participation-inclusion of identified tribes for Medicaid expansion	Increase identification of eligible AI/AN clients.	March 31, 2013	In workgroup process.
2. Work with tribes to identify documents needed for Bridge Waiver & NHR for exemption of cost sharing for eligible AI/AN	2. Sent to CMS recommendations for Medicaid and Exchange alignment.	Legislation proposed or passed.	July 30,2013	In process.

2. **Descriptions of American Indian employment patterns as they relate to: affirmative action, participant populations, at-risk populations and other service delivery considerations.**

AFFIRMATIVE ACTION GOALS HEALTH CARE AUTHORITY
Native American Employees – 2011

Org Unit	EM OD	HCA OAS	HCA DLS	HCA DRF	HCA DHS	HCA ESS	HCA DSM	PEBB	Total
# of Employees	1	16	35	129	72	254	197		958
# AI/AN staff	0	1	0	2	0	7	0	5	15

For **SFY 2011**, HCA had a total of **15** AI/AN staff. This represented **.64%** of the total 958 HCA HQ staff.

Tribal specific positions:

Native Health Program Manager/ Tribal liaison /100%
Tribal/DOH Medicaid Administrative Match Program Manager/ 50%
Primary Care Case Manager/ 15%
Health Disparity Reduction Manager / 15%

GOALS AND OBJECTIVES	ACTIONS	MEASUREMENTS	TARGET DATE	CURRENT STATUS
Involve HCA HR department to ensure efforts are made to recruit and hire AI/AN staff reflective of the service population.	Take steps to recruit AI/AN persons for HCA staff openings. Outreach through tribal communications for open staff positions.	Number of AI /AN applicants will increase.	Ongoing	Coordinate with the DSHS Diversity Affairs office for employment outreach. Distribute all staff announcements through tribal communication channels. Goal iHCActed by hiring freezes and layoffs.

3. Tribal Agreements & Contracts in effect. (Any local-state agreements, protocols, or other similar documents in effect).

HCA has numerous core provider Agreements and contracts with tribes for services being reimbursed to tribal facilities and Urban Indian programs. The following tables identify the various Medicaid, state funded health programs and grants as monitored and managed by HCA Divisions. In addition 1 pilot was implemented– the Port Gamble CSO pilot.

With the economy impacting tribal health program budgets and increased demand for health services- tribal programs have been impacted with many reductions but have increased in the number of clients eligible for services.

Medical/Health Programs		
	SFY 2010	SFY 2011
Administrative Match (admin)	12	9
Ambulance(admin)	3	4
Basic Health –Tribal sponsors		10
Basic Health –Tribal members Jan-Jun 2011- Avg/mo		870**
Basic Health –Tribal members Range		874-854**
Dental	22	15
DME	1	1
MSS/ICM	6	6
Medical services	28	29 clinics
		27 tribes
Optometry	2	2
PCCM contracts	18	15
PEBB - Tribal sponsors		4
PEBB - Tribal members, AVG		302**
PEBB - Tribal members, Range		231 – 370**
Tribal 340B Pharmacy (active)	10	10
Take Charge	2	2
Transportation*(admin)	14	14

*Subcontracts to tribes through HCA contactors

** Monthly enrollment varies due to eligibility

GOALS AND OBJECTIVES	ACTIONS	MEASUREMENTS	TARGET DATE	CURRENT STATUS
Transition tribal programs to use of CPT/HCPC codes in P1 claiming	Meet with tribes and AIHC to plan transition and identify training needs.		October 1, 2012	Planning
Continue to promote Medicaid and state health plan participation.	Work on a tribe-by-tribe basis to promote CPA and /contracts as appropriate and statewide forums as needed	Number of agreements and contracts will increase.	March 31, 2014	Ongoing.

4. Method and frequency of communication with tribal governments, landless tribes and off-reservation American Indian organizations for purposes of information sharing, joint planning, and problem solving, including a current listing of all department and American Indian contact people.

Daily, HCA staff communicate by phone, email, or in person with staff from one or more of the following:

I/T/U clinics
Tribal clinic & program staff
Tribal leadership and administrators
Portland IHS Area Office
Northwest Portland Area Indian Health Board (NPAIHB)
American Indian Health Commission of Washington State (AIHC)
Indian Policy Advisory Committee (IPAC)

- HCA has prioritized budget communications with tribal leadership, clinic representatives and program staff. Regular communication on the Governor's proposed budget and legislative budgets were shared immediately with tribal leaders and tribal health administrators.
- HCA staff attend, present and actively participates at AIHC, NPAIHB, and at IPAC meetings and workgroups as requested.
- Tribal Council Chairs and I/T/U Health and Clinic Directors receive mailings and e-mails of proposed changes to the Washington Administrative Code (WAC), billing instructions, and other policy changes. These notices allow the tribes an opportunity to provide input to the change process.
- HCA staff coordinates efforts with other state agency staff who work with Indian health programs and Indian people, including Indian Policy and Support Services (IPSS), the Department of Health (DOH), Children's Administration (CA), the Health Care Authority (HCA), Economic Services, and Aging and Disability Services.
- HCA staff coordinates efforts with federal agencies including the Centers for Medicare and Medicaid Services (CMS) and the Indian Health Service (IHS).

The HCA Primary AI/AN contact is:

Deborah A. Sosa,
Native Health Program Manager
Health Care Authority- Health Care Policy
P.O. Box 45502, Olympia, WA 98504-5502
Phone: 360.725.1649 Fax: 360.586.9551 Email: sosada@dshs.wa.gov

GOALS AND OBJECTIVES	ACTIONS	MEASUREMENTS	TARGET DATE	CURRENT STATUS
Maintain communication with federally recognized tribal governments, non-federally recognized tribes, and AI/AN organizations for information sharing, consultation, joint planning, and problem solving.	Maintain contact lists of Indian Health Service, Tribal, and Urban Indian (I/T/U) clinics.	Listing of I/T/U clinic contacts will be available for administrative staff.	March 31, 2012	Currently being maintained. Ongoing.
	Liaison will attend and present at American Indian Health Commission (AIHC), Indian Policy Advisory Committee (IPAC), and other committees as requested.	Liaison will be on agendas or attendance list of AIHC, IPAC, or other committees as requested.	March 31, 2014	Liaisons or program experts participate as requested. Ongoing.
Increase communication via availability of HCA tribal documents, resources, administrative policies, and contracts via the internet.	HCA tribal web page will be created as a resource for AI/AN clients, tribal administration, and HCA staff as resources allow	Hit counter on website and registration sign-up for notification of updates to website.	Sept 30, 2013	Planning

5. Descriptions of how American Indian participants and community needs relevant to specific program and Indian policy objectives have been met, or not met, and how is the administration is working toward developing a positive working relationship by implementation of the plan.

Federal rules and the infrastructure of HCA have created the need for a variety of approaches to government to government relations with the tribes. Communications are needed at policy and operations levels. HCA's action plan contains issues identified by the tribes, and tribal representatives through various forums. Operational issues have been identified and brought forward by direct communication to the Assistant Secretary, Division Directors and through the monthly workgroup and AIHC meeting. Identification of tribal concerns has occurred during tribal workgroups, forums, conversations and consultation. HCA does not provide direct client health services but facilitates payment of services for eligible clients. To support participant and community needs HCA provides technical assistance to tribal facilities, and facilitation of available contracts for HCA program participation.

A major work has been facilitation of AIHC involvement with planning for the Health Benefit Exchange (HBE) for Washington and incorporating the identified needs of the unique tribal health network and policy. The overarching goal of the proposal was to provide the Washington Health Benefit Exchange Board (WHBEB) with the tools and expertise needed to assure HBE policy and administrative issues related to AI/AN and the Indian health delivery system are appropriately addressed in the design and implementation of the HBE as they prepare for Exchange certification. This goal aligns with four of the eleven Exchange Establishment Core Areas. Core areas are identified for each goal.

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

The AHIC proposal is for 18-months – May 2012 through October 2013. The tasks will be completed no later the September 2013, which is

HCA has collaborated with the AIHC to develop a consultation policy, and communication process reflective of the needs to address operations and policy development in an ongoing collaborative model. Communication protocols have been developed in order for HCA to be in compliance with federal CMS requirements for consultation and to seek advisement from tribal health programs and tribal representatives. In addition to monthly workgroups the following forums were held with tribes:

Consultations, Roundtables & Forums

State-wide Formal Consultation has not been requested by any tribe during SFY 2011. CMS policy does require the offer of consultation with tribes on CMS waivers and SPA's that affect tribal health programs.

> **June 29, 2011- Bridge Waiver Definition** - Conference Call was held with AIHC workgroup to discussion Waiver submission language to CMS on WA states recommended definition of Indian.
>
> **July 12, 2011- Conference Call -Definition of Ai/AN Under the Transitional Bridge Waiver**
>
> **November 28, 2011- Tribal Budget Meeting**- Discussed proposed Governor's budget and possible impacts to tribal health programs if implemented.
>
> **June 29, 2011** – **Proposed State Budget-** Videoconferences with tribes and stakeholders on the budget and the session

HCA believes it has established a positive working relationship with tribal health representatives and planners and that maintenance of a positive working relationship is an ongoing process.

GOALS AND OBJECTIVES	ACTIONS	MEASUREMENTS	TARGET DATE	CURRENT STATUS
Identify needs of AI/AN clients and communities and evaluate if current programs and policies meet the need.	Provide information on HCA programs and pilots to tribal health planning staff.	Agenda items for workgroup.	Ongoing	Ongoing
Research & incorporate issues as identified and applicable by IPAC, AIHC, NPAIHB, HCA/AIHC workgroup and direct communication from tribal representatives.	Participate on workgroups, provide/facilitate technical assistance, or organize trainings as needed.	Meeting minutes for organizations, workgroups, and trainings. IPAC meetings AIHC meetings Workgroup meetings	March 31, 2012 Ongoing.	Ongoing.
Improve HCA's ability to have meaningful government to government discussions with the tribes.	Develop HCA tribal administrative policy that includes federal waiver consultation requirements.	Policy document and evaluation tool that program	May 25, 2012 .	In draft.

		managers would use to evaluate when consultation was necessary, what level and how to initiate.		
Increase knowledge of program managers and executive leadership of HCA Federal & State policy.	Incorporation of New Gov't to Gov't bill into HCA training calendar for identified staff.		March 31, 2010 Ongoing.	As requested

6. **Descriptions of outstanding issues and gaps in services. Suggest recommendations for meeting needs and resolving outstanding issues, and translate those needs into specific performance expectations which can be implemented, monitored, and evaluated.**

HCA has utilized a workgroup process, formal consultations and educational roundtables to address issues and gaps. The primary forum for discussion and resolution of issues has been HCA tribal workgroups, the AIHC and the HCA / HCA monthly workgroup.

All remaining matrices items have been moved to the Behavioral Health System Re-Design Workgroup incorporated into the IPAC –ADSA subcommittee.

The following is a summary listing of the current active issues. Identification of issues and prioritization of new issues is ongoing. Prioritization is decided by consensus of tribal representatives.

TOP ACTIVE ISSUES

DATE ON MATRIX	ISSUE	ACTION	ACTIVITY/ MEASUREMENTS	LEAD	TARGET UPDATE DUE DATE	CURRENT STATUS
March 2011	Identify where tribes and AI/ AN will be impacted and policy guidance is needed in Exchange planning	AIHC to receive grant funding based on State level 2 application for the Health Benefit Exchange	AIHC request submitted with State application	HCA/ Exchange Brad Finnegan	May 2012	AIHC was funded for $378,565
March 2012	Exchange- Brad Finnegan	Execute contract	1) maximize grant resources 2) prepare for AI/AN enrollment in the HBE; 3) assure Tribal and urban Indian programs in-network provider issues are addressed; 4) develop an HBE Tribal Consultation policy.	AIHC	July 1, 2013	October 2013

March 2012	Identify where tribes and AI/ AN will be impacted in Medicaid expansion activities	Coordinate with AIHC for participation to review proposed policy	Tribal guidance is incorporated into implementation plans	AIHC	June 1, 2012	October 2013
June 29, 2011	Definition of Indian for the Bridge waiver and Exchange	Develop definition with AIHC representatives	Submit language to CMS	HCA	July 1, 2013	Oct 2013
May 31, 2012	Tribal MH redesign	Provide TA to ADSA/ DBHR	Participate in workgroups and provide research as requested.	OIP	TBD	Initiating 18June 2012

7. Description of how the administration will facilitate training of HCA staff on major principles of federal American Indian law:

HCA has instituted tribal specific training as it relates to the mission and work of the agency. Due to staff cuts, loss of training coordinator, reduction in, training budget and increase demand of qualified staff. Trainings been severely reduced for SFY 2010-2011.

History of Indian Health & Medicaid	1
Hitchhikers' Guide to Indian Country	0
Evaluating Policy for Impact to Tribes	0

GOALS AND OBJECTIVES	ACTIONS	MEASUREMENTS	TARGET DATE	CURRENT STATUS
Increase trainings.	Trainings	. Trainings held	March 2014	Increased trainings will occur if funding and staffing become available
Provision of TA for new staff needing tribal training	TA provided on an individual basis based on need.	TA provided when requested	March 2014	As needed

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