American Indian Health Commission for Washington State

"Improving Indian Health through Tribal-State Collaboration"

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Member Organizations:
Seattle Indian Health Board
NATIVE Project of Spokane

October 9, 2015

SENT VIA EMAIL: Victoria.Wachino1@cms.hhs.gov; kitty.marx@cms.hhs.gov

Victoria Wachino, Director
Center for Medicaid and CHIP Services (CMCS)
Centers for Medicare & Medicaid Services
Attn: CMS-2327-FC
P.O. Box 8016
Baltimore, MD 21244-8016

Re: AIHC Comments RE Washington State Medicaid Transformation Waiver Application

Dear Ms. Wachino:

The American Indian Health Commission for Washington State (AIHC), serving as an advocate for twenty-nine tribes and two urban Indian health organizations in Washington, is providing comments in response to the Washington Health Care Authority's (HCA) "Washington State Medicaid Transformation Waiver Application" submitted on August 24, 2015. We commend the HCA in their efforts to consult with tribes and urban Indian health programs in the development of the Global Waiver application and look forward to continuing a productive dialogue with the State of Washington. The importance of ongoing consultation is critical as these proposed changes to Medicaid will have significant implications for tribes, urban Indian health organizations (UIHOs), and American Indian/Alaska Native (AI/AN) enrollees.

The key components to transforming the state Medicaid system include financial and administrative integration of physical and behavioral health services through managed care organization (MCOs) and integration of mental health and substance abuse use disorder services through behavioral health organizations. While the application specifically states that AI/AN will be exempt from the managed care system, the State's transition to a value-based purchasing system and creation of Regional Accountable Communities of Health will undoubtedly impact Indian country. The AIHC, in partnership with the Northwest Portland Area Indian Health Board, have drafted AI/AN Special Standard Terms and Conditions (STCs) dated October 9, 2015. Implementation of these STCs will assist in mitigating potentially negative impacts of transformation activities upon the Indian health care delivery system. Further detailed analysis of these impacts were provided in the attached August 10, 2015 letter to the HCA.

Thank you for consideration of our comments regarding the HCA 1115 transformation wavier application. If you have questions regarding this proposed AI/AN section, please contact AIHC Executive Director, Vicki Lowe at vicki.lowe.aihc@outlook.com or 360-477-4522. We look forward to our continued partnership to ensure effective and meaningful tribal and urban Indian health program participation in the Plan's design and implementation.

E-mail AIHC.General.Delivery@outlook.com Website: www.aihc-wa.com
**Phone: 360-477-4522*

Sincerely,

Stephen Kutz, Chair
American Indian Health Commission for Washington State

Attachments

cc:
Kitty Marx, Director CMS Division of Tribal Affairs
Cecile Greenway, CMS Medicaid Region 10 Program Branch Manager
John Hammarlund, Regional Administrator, CMS Regions V and X
Priya Helweg, CMS Region X, Acting Native American Contact
Tribal Leaders
Tribal Health Directors
Urban Indian Health Organization Directors
AIHC Delegates
Nathan Johnson, HCA Policy Director
MaryAnn Lindeblad, HCA Medicaid Director
Jessie Dean, HCA Tribal Liaison
Joe Finkbonner, NPAIHB Executive Director
Jim Roberts, NPAIHB Policy Analyst
Heather Erb, AIHC Legal Consultant

AI/AN SPECIAL STANDARD TERMS AND CONDITIONS

Submitted on October 9, 2015

by the Northwest Portland Area Indian Health Board and the American Indian Health Commission for Washington State

1. State will comply with tribal consultation. The State will consult and collaborate with the twenty-nine tribes and two urban Indian health programs. In addition, the State will require all nine regional Accountable Communities of Health (ACHs) to adopt uniform consultation protocols for engaging with tribal governments and urban Indian health programs within their region.

2. State will enforce American Indians/Alaska Natives exclusion from mandatory managed care per 42 U.S.C. § 1396u-2(a)(2)(C). Individuals identified as American Indian/Alaska Native (AI/AN) shall be excluded from this demonstration unless an individual chooses to opt into the demonstration and access coverage pursuant to all the terms and conditions of this demonstration. Individuals who are AI/AN and who have not opted in to a managed care plan will receive the health benefits generally available to enrollees of the managed care plan in which they are enrolled.

3. State will preserve the fee-for-service system within Indian Health Programs. Indian health programs as defined by 25 U.S.C. 25 § 1603(12) shall continue to be eligible for fee-for-service reimbursement at the established Office of Management and Budget's federal encounter rate or the established FQHC rate. The State will ensure the transition to a value-based purchasing system will not negatively impact the fee-for-service system within Indian health programs. The State will establish a tribal coordinating entity who will make recommendations for maintaining the fee-for-service system (see Section 10 below).

4. State will enforce of ARRA 5006(a) Cost Sharing and Premium Protections. AI/AN individuals who receive services directly by an I/T/U or through referral under Purchased/Referred Care services shall not be imposed any enrollment fee, premiums, or similar charges if they are furnished an item or service by an I/T/U or through referral under CHS. Also, AI/AN will remain exempt from deductibles, copayment, coinsurance, cost sharing or similar charges. Payments to an I/T/U or a health care provider through referral under Purchased/Referred care services for services provided to an eligible AI/AN shall not be reduced by the amount of any enrollment fee, premium, deduction, copayment, or similar charges.

5. State will improve Managed Care Plan Network Adequacy, Contracting, Reimbursement, and Coordination of Care. The State will take the following steps to improve Managed Care network adequacy, contracting, reimbursement, and coordination of care:

    a. Require MCOs to offer contracts to all I/T/Us and use the Indian Addendum;

    b. Ensure MCO coordination of care and prior authorization requirements are consistent with I/T/U system's coordination of care requirements (e.g. referrals). Full faith and credit will be given for referrals from I/T/Us as if all I/T/U providers were authorized in any given managed care entity;

    c. Require MCOs to provide increased access to specialty and primary care;

d. Comply with 42 C.F.R. § 447.45 timely claims payment requirement; and ensure MCOs comply with § 447.46 timely claims payment requirements in order to improve the wraparound supplemental payment system;

e. Permit any Indian who is enrolled in a non-Indian managed care entity and eligible to receive services from a participating I/T/U provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services. ARRA 5006(d);

f. Require each managed care entity to demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers. ARRA 5006(d);

g. Require that I/T/U providers, whether participating in the network or not, be paid for covered Medicaid or CHIP managed care services provided to Indian enrollees who are eligible to receive services from such providers either (1) at a rate negotiated between the managed care entity and the I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider. ARRA 5006(d). See also, 25 U.S.C. § 1621e;

h. Provide that the managed care entity must make prompt payment to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under federal regulations at 42 C.F.R. sections 447.45 and 447.46.

i. Require MCOs participate in Indian health care delivery system training and tribal roundtables; and

j. Utilize the tribal assister program model used by the Washington Health Benefit Exchange and the Office of Insurance Commissioner to assist with coverage and access questions for AI/AN beneficiaries.

6. Plan for Improving Population Health. In forging a stronger link between public health and the delivery system, Washington plans to develop a state-wide strategy to improve population health, and more broadly infuse health equity and population health into delivery system and payment reforms. This plan shall recognize and allow the use of GPRA clinical quality measures or other Indian health performance measures to reduce duplication and administrative burden associated with over reporting by I/T/Us.

7. State will incorporate tribal centric behavioral health system with the medical and behavioral health integration set forth in state law and embraced in the Plan. The State and tribes have developed a tribal centric behavioral health system that should be incorporated into the overall integration of medical and behavioral health under the demonstration. In consultation with the tribes, the State will develop a one-year plan on how this integration will be achieved.

8. State will provide AI/AN Specific Provisions for Targeted Foundational Community Supports. The State will exempt AI/AN from the requirement to obtain Target Foundational Community Support services through the MCO system. In order to make these services effective and culturally competent for AI/AN, services should be obtained within their own communities when available. In addition to this exemption, the State will

a. allow tribes and urban Indian health organizations who have the capacity to provide these services to remain outside the managed care organizations and be reimbursed directly by the State; and

b. provide technical assistance to those tribes who do not yet have the capacity to provide Targeted Foundational Community Supports in order to ensure AI/AN have access to culturally competent services within their own communities.

9. State will develop ACHs in a manner that is parallel, complimentary, and coordinates with the Indian health care delivery system. The State will ensure the following:

   a. the design and implementation of Healthier Washington and ACHs meets the needs of the AI/AN communities in Washington state through I/T/U engagement and creation of a tribal coordinating entity (see Section 10 below); and

   b. all Regional ACH will receive training on the Indian health care delivery system with a particular focus on their local I/T/U systems and the needs of Tribal and urban Indian populations.

10. State will establish a Tribal/Urban Coordinating Entity. The State will create an entity that reflects the needs of the tribes and two urban Indian health organizations. This entity should be comprised of tribes, urban Indian health programs, and tribal organizations. The formation of tribal/urban entity will assist the State in the following:

    a. preserving the current Indian health care delivery system including the fee-for-service model and the encounter rate reimbursement;

    b. improving managed care organization compliance with federal legal protections for AI/AN and I/T/Us and improved coordination with the Indian health care delivery system;

    c. determination and implementation of transformation projects; and

    d. ensuring the regional accountable communities of health are designed and implemented in a parallel, complementary and coordinated manner with the Indian health care delivery system.

11. State will work with tribes to develop an uncompensated care waiver. The State shall work with tribes to develop an amendment to this Waiver to make supplemental payments that recognize the burden of uncompensated primary care provided by Indian Health Service (IHS) and tribal health facilities. Such services may include Medicaid optional services that may have been eliminated, or not included in the State's Alternative Benefit Plan or contain service limitations (e.g. number of visits per year) that restrict timely access to needed care to Medicaid enrollees.

American Indian Health Commission for Washington State

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Puyallup
Quileute
Quinault
Samish
Sauk-Suiattle
Shoalwater Bay
Skokomish
Snoqualmie
Spokane
Squaxin Island
Stillaguamish
Suquamish
Swinomish
Tulalip
Upper Skagit
Yakama
Member Organizations:
Seattle Indian Health Board
NATIVE Project of Spokane

August 10, 2015

Dorothy Teeter, Director
Washington State Health Care Authority
626 8th Avenue SE
P.O. Box 45502
Olympia, Washington 98504-5502

Re: AIHC Comments RE Washington State Medicaid Transformation Waiver Application

Dear Ms. Teeter:

The American Indian Health Commission for Washington State (AIHC), serving as an advocate for twenty-nine tribes and two urban Indian health organizations in Washington, is providing comments in response to the Health Care Authority's (HCA) "Washington State Medicaid Transformation Waiver Application" submitted for public comment on July 23, 2015. The purpose of this letter is to (1) identify tribal implications of the global waiver implementation; (2) provide recommendations for addressing American Indian/Alaska Native (AI/AN) issues within the application as well as draft AI/AN specific standard terms and conditions (STCs) for the upcoming waiver process (see attached); and (3) address state and federal consultation requirements for Waiver submissions. The AIHC requests the HCA to provide the following list of the tribal/urban implications for the global waiver as well as the attached AI/AN STCs for further input and consideration by the tribes and urban Indian health organizations (UIHOs) at the upcoming August 12, 2015 HCA Tribal Consultation.

I. Impacts of 1115 Medicaid Transformation Waiver Implementation upon Tribes and Urban Indian Organizations

As stated in the Medicaid Transformation Waiver Application, "transformation will have significant impacts on the Indian health care delivery system." Many of these impacts have the potential to provide significant benefits to Indian country including the provision of Long-Term Services and Supports (LTSS) to individuals at risk of utilizing additional intensive care and the provision of targeted foundational community supports.

However, several components of the waiver have implications for the Indian health care delivery system that require special attention in order to avoid unintended consequences. These potential effects include the following: (1) degradation of the fee-for-service system utilized by many AI/AN who also utilize the Indian health care delivery system; (2) ineffective and inefficient design and implementation of transformation projects by entities or organizations lacking knowledge and competence in the complex area of the Indian health care delivery system; and (3) lack of or inappropriate coordination of Regional Accountable Communities of Health (ACHs) with member tribes and urban Indian organizations.

E-mail AIHC.General.Delivery@outlook.com Website: www.aihc-wa.com
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A. Tribal/Urban Implications of Expansion of Managed Care on Indian Health Care Delivery System

HCA acknowledges within the application, "beneficiaries not receiving coverage through managed care will continue to receive services through the fee-for-service Medicaid program, and in the case of AI/AN population, through the Indian health system." However, the proposed transformation of the state Medicaid program will undoubtedly have direct and substantial impacts on the Indian health care delivery system. Medicaid coverage for AI/AN is a fundamental piece of the Indian health care delivery system, and any large scale efforts to change the statewide system will have repercussions for Tribes, urban Indian organizations, and the AI/AN population served by Medicaid. Excluding IHS funding, Medicaid is the largest public health insurance program for Indian people and the second largest source of health coverage altogether.[1] As of 2013, at least 29% of AI/AN are enrolled in Medicaid in Washington State.[2] With Medicaid Expansion, it is likely that this percentage is higher. The significance of Medicaid within Indian country is largely a result of the federal trust responsibility to provide health care. Indian Health Services is funded at 55% of the level of need. The Purchased and Referred Care (PRC) program (formerly known as Contract Health Services) where AI/AN access specialty care and inpatient services is severely underfunded. Federal law requires Indian health care providers to utilize all resources including Medicaid before accessing PRC funds. In order to address IHS funding shortfalls, Washington's Tribes have aggressively sought third party payment strategies. All but one of the Tribes have tribal health clinics contract with the state Medicaid agency to be providers to access Medicaid financing to help provide health services to tribal members.

As we have seen with the Regional Support Networks (RSN), expansion of managed care has caused further degradation of the fee-for-service reimbursement system that the Indian health care delivery system utilizes. While AI/AN can technically opt out of managed care, many have no choice but to receive critical services from the managed care system such as mental health services through the RSN. Since the Pacific Northwest does not have an IHS hospital, all inpatient care and the vast majority of specialty care comes from outside the Indian health care delivery system. According to the 2013 Tribal-Centric Behavioral Health Report to the Legislature, in 2011, 72% of AI/AN received mental health services through the RSN system.

The transition to managed care has created a severe lack of access to specialty and primary care for AI/AN who have the highest rate of chronic health conditions. The RSN system has had additional negative implications for Indian health care providers and AI/AN enrollees. The Tribal Centric Health Report described RSNs and tribes as having a "disjointed" relationship resulting in insufficient to no response whatsoever from designated mental health providers; lack of discharge coordination; lack of culturally responsive services; and disregard for tribal mental health professionals. In addition, the report recommended corrective actions and penalties for those RSNs who do not ensure that AI/AN consumers are afforded the same access, rights and benefits available to all other Medicaid beneficiaries.

Recommendations. The fee-for-service system in Indian country will remain substantially different from the HCA's proposed transformed Medicaid system which will be largely managed care. Nonetheless, health care delivery issues within the two systems will intersect as highlighted in the RSN example. Careful and thoughtful planning in coordination with tribal leaders and tribal health experts will avoid unnecessary

[1] Report to the Legislature, Tribal-Centric Behavioral Health Report, November 30, 2013.
[2] Tribal-Centric Behavioral Health Report.

and often costly negative impacts of poor implementation of systematic changes to the health care delivery system. As reported by the Tribal-Centric Behavioral Health Workgroup, ***"a Managed Care system without a requirement to acknowledge and constructively work with Tribal Governments cannot adequately respond to, and appropriately serve, American Indians and/or Alaskan Natives (AI/AN)."***[3]

HCA needs to take special measures to improve AI/AN access to primary and specialty care such as examining the potential benefits or "renting" a network for the fee-for-service system. In order to address the tribal implications of the managed care system, the AIHC recommends HCA develop, in coordination with the tribes and UIHOs, AI/AN specific STCs that require stronger enforcement of federal protections for AI/AN and Indian health services-operated programs, 638 tribal contracted an compacted programs and urban Indian health programs (I/T/Us) who interact with the managed care system. In addition, the attached AI/AN STCs provide for full faith and credit for referrals from I/T/Us as if all I/T/U providers were authorized in any given managed care entity.

The HCA should also implement the Tribal-Centric Behavioral Health Workgroup recommendations provided in the Tribal-Centric Behavioral Health Report. Specifically, the HCA should create a mechanism to coordinate planning activities between the workgroup, the State Health Care Innovation Plan (SHCIP) team, HCA staff, and the Behavioral Health and Service Integration Administration (BHSIA). Such coordination among the agencies and workgroups will reduce duplicative efforts and avoid the conflicting statements from various state agencies regarding implementation of the waiver.

B. Tribal/Urban Implications for Design and Implementation of Regional ACHs and Transformation Projects

Regional ACHs will be charged with several functions that will directly effect the tribes and UIHOs located within their geographical designations. These functions include selecting and implementing transformation projects in their region and facilitating the transition to a value-based purchasing system. Transformation projects include three major domains: (1) Health Systems Capacity Building; (2) Delivery System Transformation; and (3) Population Health Improvement.

Transformation projects will have significant impact on tribes and UIHOs who currently conduct many of these activities, some of which have been practiced for decades. Unique from any other provider in Washington State, tribal experience in these three specific areas is largely based on their multifaceted role of serving as police departments, court systems, schools, social service agencies, employers, public health departments, water and sewage departments, natural resources, and Indian health organizations providing medical, dental, mental health, and chemical dependency services. In addition, most all Indian health providers have expertise in performance measures that monitor population health outcomes. An added dimension to the Indian health system is the engagement of tribal governments with neighboring cities, counties, and regions when addressing health issues of their community and individual tribal members. Given the multi-layered system of Indian health, tribes should play a key role in the selection and implementation of these projects.

Another significant implication of these projects is that they are intended to address population health outcomes that are most prevalent in Indian country. According to the Department of Health's most recent report on "The Health of Washington State, "American Indians and Alaska Natives appear to have

[3] Tribal-Centric Behavioral Health Report.

poorest measures of health compared to other groups."[4] The report presents an alarming degree of health care disparities among AI/AN.[5] In almost every category of health risk, the AI/AN population had the highest rate of incidence, including the following:

Highest rate of smoking
Higher rate of obesity
Highest rates of disabilities
Highest rates of drug induced deaths
Highest rate of infant mortality
Highest rate of coronary heart disease
Highest rate of asthma
Highest rate of colorectal cancer
Highest rate of diabetes
Highest rate of stroke
Highest rate of suicide
Highest rate of alcohol and abuse disorders
Highest rate of poor mental health
Highest rate of adult tooth loss

During 2009–2011 combined, AI/AN had the highest age adjusted death rates—significantly higher than any other population.[6] Conversely, AI/AN during this same period had the shortest life expectancy of 72 years compared the overall population average of 80. Consistent with the spirit and intent of the Healthier Washington Initiative, the Department of Health has stated the following:

> Mortality rates and life expectancy can be improved by reducing specific causes of diseases and ***eliminating disparities***, as discussed in other chapters of this report. ***Some of the underlying causes of mortality are amenable to public health interventions.*** Chief among these are reducing tobacco use, unhealthy diets, physical inactivity, and excessive alcohol consumption.[7] *Emphasis added.*

In order to achieve the demonstration's goals of reducing the need for more intensive services and bringing spending growth below national trends, the State will need to specifically target the population with the highest rates of chronic conditions – the AI/AN population. The State will more effectively use limited resources by creating tribal/urban-led efforts to address these disparities and reduce costly medical interventions. Tribes and urban Indian health organizations are keenly aware of these staggering health care disparities and have been implementing intervention strategies for decades. These health care disparities and the complex legal framework of the Indian health system support the need for extensive tribal/urban engagement and the utilization of tribal/urban technical expertise in implementing these transformation activities.

Recommendations. The AIHC requests that specific measures to address the impacts outlined above be included in the waiver application. These measures should include at a minimum tribal/urban ACH(s) comprised of tribal representatives and tribal health experts to provide competent analysis,

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[4] T*he Health of Washington State*, 2007, General Health Status, Washington State Department of Health, section 2.1.1.

[5] *The Health of Washington State,* Washington State Department of Health, 2007 with updates from 2008-1014.

[6] *The Health of Washington State*, Mortality and Life Expectancy, Washington State Department of Health, 2013, p. 4-5.

[7] *The Health of Washington State*, Mortality and Life Expectancy, Washington State Department of Health, 2013, p. 4-5.

planning and technical assistance to assure that HCA adequately addresses the needs of AI/AN and the Indian health delivery system in Washington. The formation of tribal/urban ACH(s) will assist the State in (1) preservation of the current Indian health care delivery system including the Fee-for-Service Model and the encounter rate reimbursement; (2) improving managed care organization compliance with federal legal protections for AI/AN and I/T/Us and improved coordination with the Indian health care delivery system; (3) determination and implementation of transformation projects; and (4) ensuring the regional accountable communities of health are designed and implemented in a parallel, complementary and coordinated manner with the Indian health care delivery system.

Regional ACHs will need to be fully informed and educated about the Indian health care delivery system in order to effectively engage tribes and urban Indian organizations. In addition, the State should ensure that all Regional ACHs have membership from each of the tribes and urban Indian organizations within their designated areas. As sovereign entities, tribes should have the option of participating within their Regional ACHs.

C. Tribal/Urban Implications for Methodology for Incentive Payments to Providers and ACHs and Collection of Data

As part of the sustainability for the proposed transformation, the State of Washington intends to provide incentive payments to plans, providers, and community-based organizations. Section IV, Question 10 of the application addresses the methodology the State will use for establishing quality-based supplemental payments for high-performing ACHs and providers. The methodology will be based on common performance measures that apply across ACHs, MCOs and BHOs in support of State priorities. The State's integrated Client Database will be used to assess quality and cost metrics of the Demonstration's three initiatives.

Recommendations. First, the HCA should extend to tribes and UIHOs the same opportunity as other providers and ACHs to receive incentive payments for transformation activities and measurement of population health outcomes provided by Indian health care providers. Tribes and UIHOs have been providing the same proposed transformation activities with minimal levels of funding for many years. In addition, many tribes and UIHOs, unlike most providers, have monitored the quality of their clinical care through the comprehensive performance measures of the Government Performance and Results Act (GPRA). The goal of GPRA, much like Healthier Washington, is to improve health outcomes by promoting a strong focus on results, service, quality, and customer satisfaction. GPRA measures include clinical measures, such as various diabetes measures, cancer screening and others; quality of care; prevention, such as immunizations and injury prevention; and infrastructure, such as access to or improved sanitation facilities. Given the distinct components of the health care delivery system and disproportionate level of health care disparities within the AI/AN population, the HCA will need to coordinate with tribes and UIHOs to develop a separate methodology to determine supplemental payments to Indian health care providers. The State should ensure within the waiver that tribes and UIHOs will continue to use their own performance measuring methodologies and that the State will not impose any additional reporting requirements upon the tribes nor require participation in the value-based payment system.

D. Tribal/Urban Implications for Community Foundational Support System

Initiative three of the waiver application will provide foundational community supports to improve and maintain the health of vulnerable beneficiaries through supportive housing and supported

employment services. This initiative will have significant implications for tribes and UIHOs. The 2014 DOH Health of Washington State reports that AI/AN have the highest rate of poverty over any other population in Washington State. Indian health care providers are acutely aware of the impacts of homelessness and unemployment on the health of their patients and many times are working in conjunction with the tribal housing and local community housing programs to stabilize their patients living conditions. Conversely, many tribal housing programs are already providing similar supportive services to their residents.

Recommendations. Tribes and UIHOs can provide key strategies for effective implementation of Initiative 3 for the AI/AN population. One critical component of implementation will be ensuring that the reimbursement methodology is compatible with Indian country. The application states the cost of the benefit and delivery of services would be integrated into MCO and BHO rates. We are requesting that HCA provide an AI/AN exception to this provision.

II. Consultation and Notice Requirements

We appreciate the HCA's acknowledgement that the Global Medicaid Transformation Medicaid Waiver will have a significant impact on the Indian health care delivery system. However, the tribes and UIHOs have yet to receive notification regarding the anticipated impacts on tribes and urban Indian organizations as required by State Plan Amendment (SPA) Transmittal Number 11-025. We hope that this letter as well as earlier letters provided by AIHC and the Northwest Portland Area Indian Health Board provides some guidance as to what these tribal implications are.

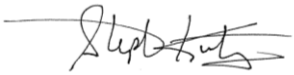
The HCA has held several tribal workgroup meetings in order to seek input into the draft waiver application. While these tribal workgroup meetings are important, they do not constitute consultation. While the tribes were given a high level introduction to the concept behind the global Waiver, tribes and UIHOs first consultation on Waiver Application will be occurring on August 12, 2015 with comments due on August 23, 2015. We understand the enormous undertaking of drafting such a waiver, but request that the HCA incorporate the comments provided by the tribes, UIHOs, AIHC and NPAIHB within the Global Waiver application and begin to further develop the proposed AI/AN STCs with input and consideration from the tribes and UIHOs.

III. Conclusion

Productive engagement with the tribes and urban Indian health organizations is essential to achieving the State's "triple aim" of improved health status, better care, and lower costs, by maximizing existing capacity and expertise and minimizing duplication of efforts. Recommendations for inclusion of the attached AI/AN STCs and formation of tribal/urban ACH(s) are based on three factors: (1) AI/AN have the highest level of health care disparities of any other population and that these disparities need to be addressed in order to improve population health outcomes; (2) the enormous operational and legal complexities of the Indian health care delivery system necessitates specific attention and utilization of tribal/urban technical expertise; and (3) the sovereign status of the 29 tribes and their government-to-government relationship with the State requires a higher level of coordination and consultation than with stakeholders. The examples of success in Indian country stem from tribes possessing full authority to determine and implement their own health care strategies. Conversely, failures and wasted state resources occur as the result of lack of seeking expertise from tribes and urban Indian organizations and providing tribal and urban opportunities to lead the way in improving health outcomes for their communities and AI/AN members.

We look forward to working with the State on implementation of the Global Transformation Medicaid Waiver and facilitating consultation with the tribes and UIHOs. If you have questions regarding this proposed AI/AN section, please contact AIHC Executive Director, Vicki Lowe at vicki.lowe.aihc@outlook.com or 360-477-4522. We look forward to our continued partnership to ensure effective and meaningful tribal and urban Indian health program participation in the Plan's design and implementation.

Sincerely,



Stephen Kutz, Chair
American Indian Health Commission for Washington State

Attachments

cc:
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