Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Improving Indian Health Care in Washington State

December 14, 2018

SB 6032, Section 213 Chapter Laws of 2018

Improving Indian Health Care in Washington State

Washington State Health Care Authority

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Executive Summary

In 2018, the Washington State Legislature passed Senate Bill (SB) 6032, which included proviso language to establish the Governor's Indian Health Council. The council includes tribal leaders, urban Indian health leaders, representatives of the Governor's office, state agency leaders, and legislators to address issues in Washington State's Indian health care delivery system. This council convened on July 16, November 7 and 8, and December 6, and approved this report to the Governor and the Legislature during the December 6 meeting. As specified in the proviso, this report provides the following recommendations for the state:

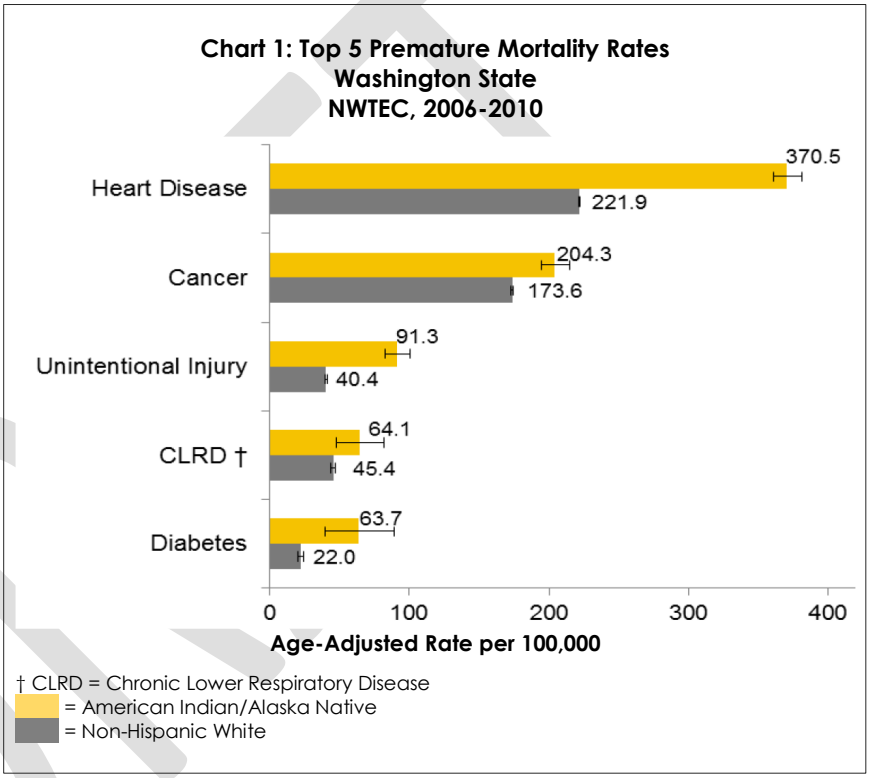
- Appropriate $366,000 for HCA to hire the four regional tribal liaisons as proposed in HCA decision package #37;
- Appropriate $150,000 for the Governor's Indian Health Council to complete the report with all of the analyses described in section 213(mmm) of SB 6032;
- Establish a reinvestment account into which the additional state savings due to the new 100 percent FMAP, less agreed upon administrative costs, will be appropriated and deposited (subject to federal appropriations).
- Establish the Governor's Indian Health Advisory Council to oversee the Indian Health Improvement Reinvestment Account and the Reinvestment Committee within the Advisory Council to determine how amounts will be expended from the Reinvestment Account.

Draft legislation and fiscal budget proposals to support the recommendations are in the appendices to this report.

Background

Health Disparities

American Indians/Alaska Natives (AI/ANs) in Washington State suffer some of the greatest health disparities of any racial/ethnic group.[1] Using state and tribal data, the Northwest Tribal Epidemiology Center (NWTEC) determined that the overall premature mortality rate for AI/AN for 2006 through 2010 was 71 percent higher than for non-Hispanic whites.[2] NWTEC also prepared Chart 1 with the top 5 premature mortality rates for AI/AN and non-Hispanic whites.[2] As shown in Chart 1, AI/ANs have significantly higher rates of premature death due to heart disease (67 percent higher), cancer (18 percent higher), unintentional injury (126 percent higher), chronic lower respiratory disease (41 percent higher), and diabetes (186 percent higher). Due to the complex analysis required to prepare these more complete data, the most recent NWTEC report is based on 2014 data. More recent state-only premature mortality data as published in the 2018 Washington State Health Assessment reflect similarly significant premature mortality rates for AI/ANs as compared to the other



[1] Notes on Data:

(a) There is no single source of health data on AI/ANs. Each tribe has its own data, which are reported to the Indian Health Service (IHS). Separately, the Washington Department of Health maintains vital statistics data, as well as sample-based data, such as the Healthy Youth Survey (HYS) and the Behavioral Risk Factor Surveillance System (BRFSS). A complete picture requires knowledge of, and work with, these diverse data sets.

(b) There is no single policy on how to identify AI/AN individuals. While tribes identify individuals as AI/AN even if they self-identify as two or more races, the state categorizes individuals who self-identify as two or more races into a separate "Two or More Races" category, leaving in the AI/AN category only those individuals who self-identify as AI/AN only. As a result, the state's data on the AI/AN population reflects less than half of the state's total AI/AN population.

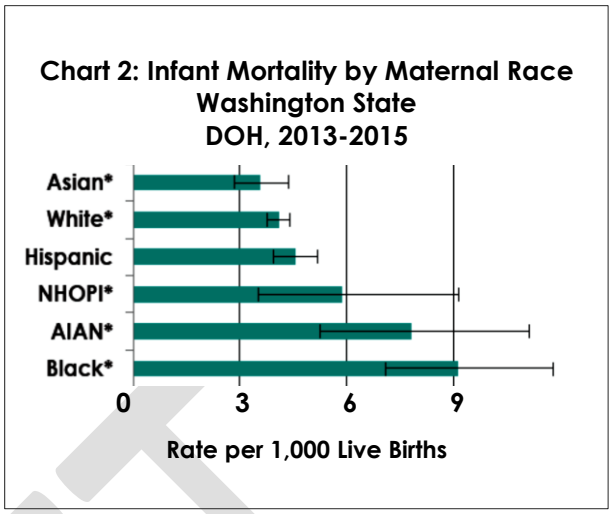
[2] Northwest Tribal Epidemiology Center (NWTEC). (2014). *American Indian and Alaska Native Community Health Profile - Washington*. Portland, Oregon: Northwest Portland Area Indian Health Board. Available at http://www.npaihb.org/idea-nw/.

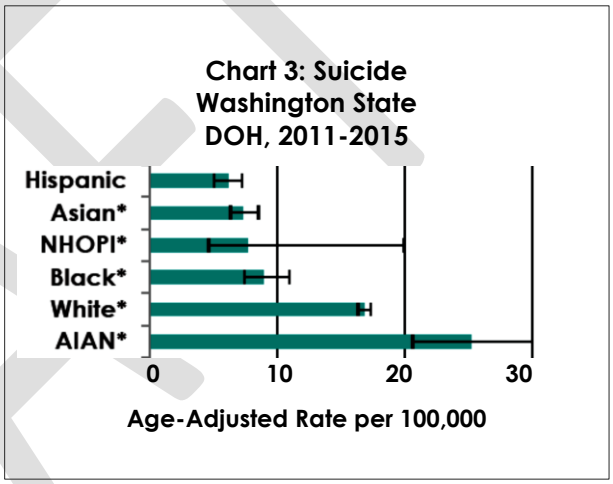
race categories – keeping in mind that the state's racial category data do not include individuals who self-identify with more than one racial category.[3]

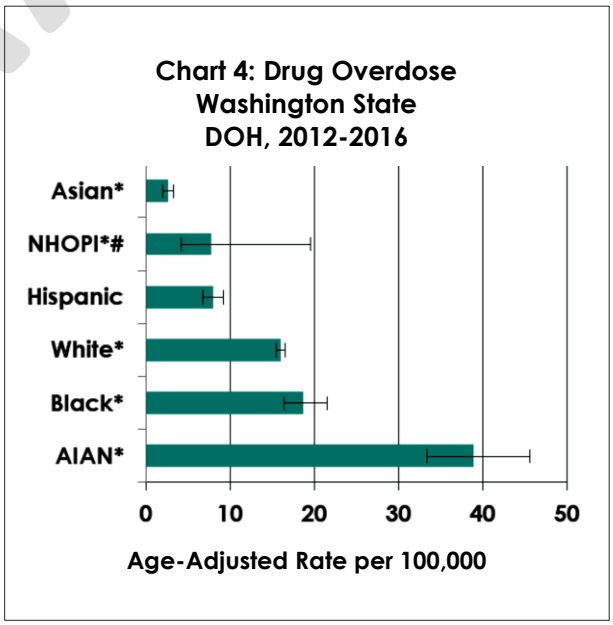
- Infant mortality rate for AI/AN mothers is nearly twice the rate for non-Hispanic white mothers (Chart 2).
- Completed suicide rate for AI/AN is much higher than for any other race (Chart 3).
- Drug overdose mortality rate for AI/AN is more than twice the rate for non-Hispanic whites (Chart 4).

The disparities continue across the spectrum of chronic diseases and mental illnesses. Compared to non-Hispanic whites, AI/ANs have significantly higher rates of:

- Asthma;
- Coronary heart disease and hypertension;
- Diabetes, pre-diabetes, and obesity;
- Dental caries in third grade;
- Poor mental health and youth depressive feelings;
- Adult and youth cigarette smoking and vaping; and
- Adult and youth cannabis use.[3]



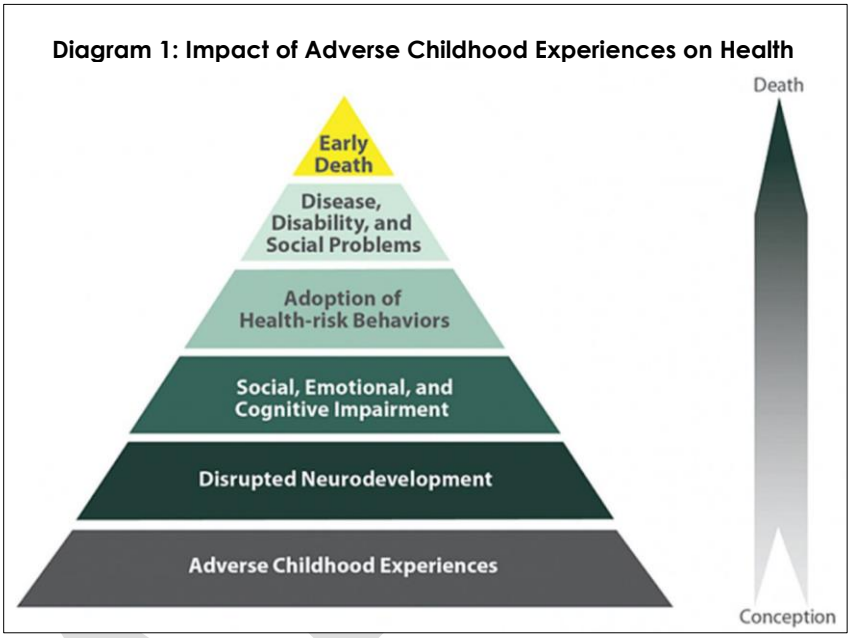




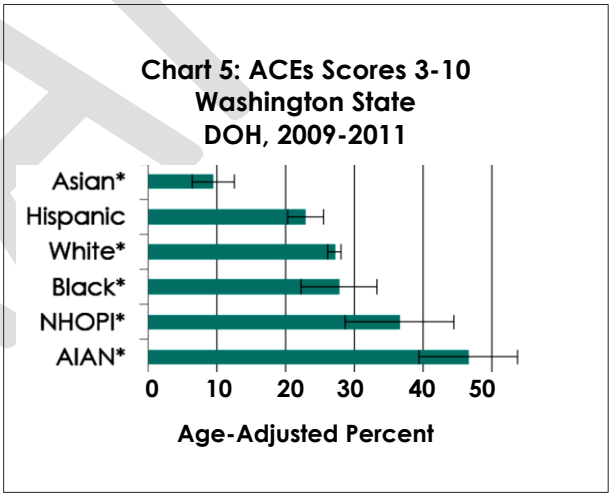
[3] DOH Pub 78945, available at http://www.doh.wa.gov/healthassessment.

Adverse Childhood Experiences and Historical Trauma

Higher rates of poor health and poor health outcomes – as reflected in the health disparities data – have been associated with higher rates of adverse childhood experiences (ACEs).[4] When ACEs disrupt neuro-development and impair social, emotional, and cognitive growth, individuals adopt health-risk behaviors that lead to disease, dis-ability, and social problems – resulting in premature mortality; see Diagram 1 for a visual representation.[4]



Measured by a 10 question screening tool, ACEs are various forms of childhood trauma in the home, including emotional, physical, or sexual abuse, neglect, and other household challenges during childhood. The ACEs score has been used as a measure of cumulative exposure to traumatic stress in childhood. As shown in Chart 5, AI/AN adults reported nearly twice the rate of 3+ ACEs compared to non-Hispanic white adults.[5] These data mean that between 39 percent and 54 percent of AI/AN adults reported childhood exposure to 3 or more traumatic family stressors, compared to 26 percent of non-Hispanic white adults.



In AI/AN communities, these disparately high rates of adverse childhood experiences are a direct result of historical trauma, which becomes intergenerational trauma through repeating cycles of ACEs over generations. Historical trauma refers to situations where a community experienced traumatic events, the events generated high levels of collective distress, and the events were

[4] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*(4), 245-258.
[5] DOH Pub 78945, available at http://www.doh.wa.gov/healthassessment.

perpetuated by outsiders with a destructive or genocidal intent.[6] One of the challenges in comprehending the impacts of historical trauma is the term "historical," because when it is heard people tend to think of something in the past. The effects of historical trauma, however, manifest in the everyday experience of AI/AN communities today – in the ways that they relate to one another, in their bodies, and in their daily thoughts. First studied in World War II holocaust survivors, historical trauma in AI/AN communities resulted from the legacy of genocide, a century of socio-cultural destruction through boarding schools, and continuing racial discrimination and socio-economic poverty.[7] Responses to historical trauma at the individual level may include post-traumatic stress disorder, guilt, anxiety, grief, and depressive symptoms; responses at the familial level may include impaired family communication and stress around parenting.[8] The burdens of historical trauma weigh heavily on AI/AN youth, with one in six thinking every day or several times a day about loss of trust, family, and respect.[9] More recently, historical trauma has been found to have epigenetic impacts across generations, as historical trauma and ACEs alter gene expression that is then biologically inherited by future generations.[10]

Limitations of Evidence-Based Practices

In the face of this historical/intergenerational trauma, adverse childhood experiences, and resulting health disparities, the quality of care that AI/ANs receive is "that much more important."[11] Yet, few research-based and evidence-based practices (EBPs) have been tested in tribal communities. Those that have been developed from AI/AN communities can be expensive to implement and maintain. Moreover, the diversity of tribal communities can limit the efficacy of EBPs, particularly if they were normed in such a way as to be particular to some tribal communities and cultures but not others.

Due to this diversity of tribal communities and cultures, the only way to ensure a high quality of services is through direct interaction with tribes and AI/AN communities to ensure that the practices are culturally appropriate.[12] This is true whether the practices are EBPs or promising

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[6] Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence*, *23*(3), 316–338.

[7] Wesley-Esquimaux, C. C., & Smolewski, M. (2004). *Historic Trauma and Aboriginal Healing*. Ottawa, Ontario: Aboriginal Healing Foundation.

[8] Yellow Horse Brave Heart, M., & DeBruyn, L. M. (1998). The American Indian Holocaust: Healing historical unresolved grief. American Indian and Alaska Native Mental Health Research, 8, 56–78.

[9] Whitbeck, L.B., Walls, M.L, Johnson, K.D., Morrisseau, A.D., McDougall, C.M. (2009). Depressed affect and historical loss among North American Indigenous adolescents. *American Indian and Alaska Native Mental Health Research*, *16*(3), 16-49.

[10] See, e.g., Kuzawa, C.W., Sweet, E. (2009). Epigenetics and the Embodiment of Race: Developmental Origins of U.S. Racial Disparities in Cardiovascular Health. *American Journal of Human Biology*, *21*(1):2–15; Bird, A. (2007). Perceptions of epigenetics. *Nature*, *447*, 396–398..

[11] Washington Health Alliance. (2014). *Disparities in Care 2014 Report*. Seattle, Washington. Available at https://wahealthalliance.org/alliance-reports-websites/alliance-reports/.

[12] Woolf, S., Grol, R., Hutchinson, A., Eccles, M., & Grimshaw, J. (1999). Potential benefits, limitations, and harms of clinical guidelines. *BMJ*, *318*(7182).

practices, because culture mediates health care.[13] For example, AI/AN cultures have a holistic and relationship-oriented view of health and well-being. As a result, treatments that focus only on parts of the individual without working on healing the family and the spirit will likely not be successful – even when they are evidence-based.[14] Without the flexibility to adapt EBPs or to implement promising practices, EBPs are likely to result in poor health outcomes. The only EBPs that are likely to result in better health outcomes are those based on the specific tribal community.

Examples of Proven Practices

"Family Spirit"[15] is a culturally tailored, evidence-based home-visiting model used by more than 100 tribal communities across the nation. This model addresses intergenerational behavioral health problems, applies local cultural assets, and overcomes deficits in the professional healthcare workforce in low-resource communities. Designed for, by, and with AI/AN families, community-based paraprofessionals deliver culturally appropriate behaviorally-focused interventions to support young parents from pregnancy through three years post-partum. A tribal community can link this program to other programs, such as Women, Infants, and Children (WIC), behavioral health, Head Start, Indian Child Welfare, domestic violence intervention, and substance use disorder programs.

"Pulling Together for Wellness"[16] is a comprehensive, culturally-grounded prevention framework based on a policy, systems, and environmental change approach. The framework was co-designed through the guidance of Washington tribal and urban Indian leaders with input from elders, youth, students, communities, program staff, and public health specialists. It adapts evidence-based practice by integrating western science and native ways of thinking. The approach uses the medicine wheel model - a holistic view of health including emotional, social, physical, and spiritual health. It honors the native values of the particular community seeking change, using a culturally appropriate and community-specific process to engage multiple sectors, including community members, in decision making. The Shoalwater Bay Indian Tribe adopted this framework to improve the health of tribal members for seven generations by embracing the traditions of their ancestors to change the norm. In recognition of their successful implementation, the Tribe received the Robert Wood Johnson Foundation Culture of Health prize in 2016.

The "Healing of the Canoe Project"[17] is a collaborative project between the Suquamish Tribe, the Port Gamble S'Klallam Tribe and the Alcohol and Drug Abuse Institute, University of Washington. Suquamish and Port Gamble S'Klallam both identified the prevention of youth substance abuse and

[13] Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, Illness and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research. *Annals of Internal Medicine*, *88*, 251-258.
[14] Larios, S., Wright, S., Jernstrom, A., Lebron, D., & Sorensen, J. (2011). Evidence-Based Practices, Attitudes, and Beliefs in Substance Abuse Treatment Programs Serving American Indians and Alaska Natives: A Qualitative Study. *Journal of Psychoactive Drugs*, *43*(4), 355-359.
[15] Family Spirit Home Visiting Program, Johns Hopkins University Center for American Indian Health. (2018). Available at http://caih.jhu.edu/programs/family-spirit/.
[16] Pulling Together for Wellness, American Indian Health Commission for Washington State. (2018). Available at https://aihc-wa.com/pulling-together-for-wellness/.
[17] Healing of the Canoe. (2018). Available at http://healingofthecanoe.org/.

the need for a sense of cultural belonging and cultural revitalization among youth as primary issues of community concern. The Healing of the Canoe partnership has sought to address these issues through a community based, culturally grounded prevention and intervention life skills curriculum for tribal youth that builds on the strengths and resources in the community. The Culturally Grounded Life Skills for Youth Curriculum uses the Canoe Journey as a metaphor, providing youth the skills needed to navigate their journey through life without being pulled off course by alcohol or drugs – with tribal culture, tradition and values as a compass to guide them, and an anchor to ground them. One key element of this program's success is the ability to adapt the "Healing of the Canoe Project" to different tribal communities and cultures.

"Nuka System of Care"[18] is a whole health care system (medical, dental, behavioral, traditional and health care support services) based on the recognition that the relationship between the primary care team and the client (also known as the customer-owner) is the single most important tool in managing chronic disease, controlling health care costs, and improving the overall wellness of a population. Recognizing that individuals are ultimately in control of their own lifestyle choices and health care decisions, Nuka focuses on understanding each customer-owner's unique story, values, and influencers, in an effort to engage them in their care and support long-term behavior change. Nuka also focuses on growing health professionals – encouraging medical assistants to become registered nurses, nurses to become advanced registered nurse practitioners (ARNPs), and ARNPs to become physicians through education scholarships. In recognition of their success with Nuka, the Southcentral Foundation received the Malcolm Baldridge National Quality Award in 2011 and 2017.

Barriers

Tribes and other Indian health care providers experience many barriers to providing culturally appropriate care. Burdensome reporting requirements and reimbursement processes impose administrative hurdles to financing and sustainability. Poor access to broadband internet and outdated computer and information systems interfere with the ability to use technology to improve care and to remotely report home care treatment hours on-site. All tribes and other Indian health care providers are considered health professional shortage areas, reflecting the challenges of recruiting and retaining health care professionals. Various loan repayment and forgiveness programs for health care professionals have mitigated – but not solved – the shortage of health care professionals at tribes and other Indian health care providers.

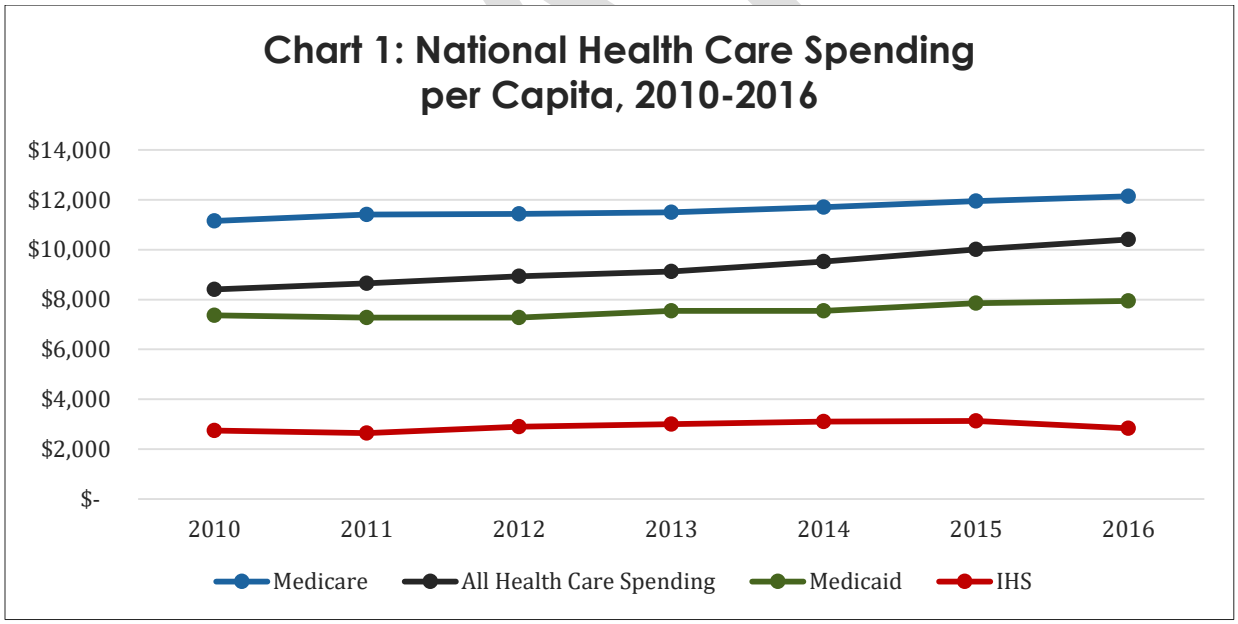
A bigger barrier – perhaps the biggest barrier – is the chronic underfunding of Indian health care nationwide.

[18] Nuka System of Care, Southcentral Foundation (2018). Available at https://scfnuka.com/.

Federal Funding Deficiencies for Indian Health Care

The health care delivery system for American Indians and Alaska Natives (AI/ANs) in the United States is complex and unique, resulting from treaty obligations, federal court cases, and federal laws.[19] Since 1955, Congress has funded health care delivery through the Indian Health Service (IHS), a federal agency within the U.S. Department of Health and Human Services. Originally an agency that provided health care and related services, IHS has only three service units remaining today in Washington State, providing health care services on three Indian reservations in eastern Washington. Under the Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), every tribe in Washington State has contracted to administer some or all of their health care programs funded through IHS. In addition, under the Indian Health Care Improvement Act (IHCIA), Congress authorized the establishment of urban Indian health programs (UIHPs) to serve AI/ANs in metropolitan areas to fulfill the special trust responsibility to AI/ANs who could not access health care from an IHS or tribal facility; the UIHPs in Washington operate in Seattle and Spokane. In 2018, Congress appropriated approximately $5.5 billion for all IHS-funded projects and programs.

Yet, Congress persistently underfunds health care for AI/ANs. For example, as shown in Chart 1, IHS per capita funding for health care delivery increased minimally from $2,741 in 2010 to $2,834 in 2016. With the growth in overall health care spending per capita from $8,411 to $10,410, the ratio



Data Sources: National Health Expenditure Accounts (NHEA) for All Health Care Spending per capita (Table 1) and Medicare and Medicaid spending per enrollee (Table 21); National Congress of American Indians Fiscal Year Indian Country Budget Requests: Healthcare for IHS spending per user.

[19] For a brief description of the history of the special trust responsibility to provide health care to American Indians and Alaska Natives, see Warne, D., and Frizzell, L.B. (2014). American Indian Health Policy: Historical Trends and Contemporary Issues. *American Journal of Public Health*, *104*(Suppl 3), S263–S267. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4035886/.

Table 1: Estimates of Annual Underfunding for AI/AN Health Care by Category					
	Medical and Non-Residential Behavioral Health Care	**Residential Behavioral Health Care, Long-Term Services, and School-Based Services**	**Dental Care**	**Public Health**	**Total**
National Per User Amounts					
National Health Expenditures (NHE)	$7,749	$1,329	$393	$255	$9,726
Less: Public and Private Insurance Payments	($1,937)	($598)	($39)	—	($2,574)
Less: IHS Funding[2]	($2,411)	($105)	($117)	($176)	($2,809)
Amount Underfunded	$3,400	$626	$236	$79	$4,341
Calculations of Total Underfunded Amounts = National Per User Amounts multiplied by:					
• 71,742[20] AI/AN Medicaid Enrollees	$243,922,800	$44,910,492	$16,931,112	$5,667,618	$311,432,022
• 206,860[21] AI/AN Individuals	$703,324,000	$129,494,360	$48,818,960	$16,341,940	$897,979,260

Data Sources: National Per User amounts from National Health Expenditure Accounts and the Indian Health Service as reported by IHS Indian Health Care Improvement Fund Workgroup; Washington State AI/AN Medicaid Enrollees from HCA; Washington State AI/AN Individuals from the American Community Survey, 2011-2015.

of IHS spending to overall spending actually declined from 33 percent in 2010 to 27 percent in 2016.

In June 2018, the IHS Indian Health Care Improvement Fund Workgroup issued an interim report on their attempt to establish a methodology for estimating the percentage of need currently met by IHS appropriations;[22] see Table 1 for data drawn from that report. Using the per capita amounts from that report along with the numbers of AI/AN Medicaid enrollees and AI/AN individuals in Washington State, we estimate in the last two lines of Table 1 the total amounts of funding needed

[20] HCA data: Total number of self-identified AI/AN Medicaid enrollees for October 2018.
[21] American Community Survey, 2011-2015: Total estimated population of AI/AN, alone or in combination, for Washington State.
[22] Data from Interim Report (June 2018) IHS Indian Health Care Improvement Fund Workgroup. Rockville, Maryland.

in Washington State to bring spending for AI/AN health care up to the average spent nationwide on health care for both populations – by category of services. As shown in Table 1, approximately $898 million per year of additional funding would be necessary to bring health care spending on all AI/ANs in the state up to the same level as what is spent on health care for all U.S. residents. These estimates do not take into account any additional funding that would be necessary to address the severe health disparities reflected above.

The public and private insurance payments shown in Table 1 reflect third party payments from Medicaid, Medicare, and commercial insurance. These payments result from federal requirements, particularly Medicaid requirements, to ensure payments to IHS and tribal health programs for services. In addition, under federal law, AI/ANs are required to apply for and use Medicaid and other coverage, when eligible, for care received outside of IHS-funded health programs. IHS is a payer of last resort, last in line even after Veterans Affairs health care payments. Consequently, tribes need the state as a partner to help fulfill the special trust responsibility.

New CMS Policy for Additional Medicaid Federal Match

Reflecting the treaty obligations and special trust responsibility, the Centers for Medicare and Medicaid Services (CMS) have historically paid 100 percent Federal Medical Assistance Percentage (FMAP) of the Medicaid payments to tribal and IHS providers for health care services to AI/AN Medicaid clients. With 100 percent FMAP, the state incurs no expense to the General Fund – State for Medicaid payments for services provided to AI/AN Medicaid enrollees by tribal and IHS facilities.

In February 2016, CMS issued a State Health Official (SHO) letter[23] announcing a regulatory change of interpretation. The SHO letter explained that the state can now receive 100 percent FMAP for Medicaid payments to non-IHS, non-tribal providers for health care services to AI/AN Medicaid clients. This 100 percent FMAP is only permitted if the services are covered by a written care coordination agreement between an IHS or tribal facility and a non-IHS, non-tribal provider, under which the IHS or tribal facility practitioner remains responsible for overseeing his or her AI/AN patient's care and the IHS or tribal facility retains control of the patient's medical record. To be eligible for 100 percent FMAP, a service must meet the following requirements:

1. The IHS or tribal facility practitioner provides a request for specific services (by electronic or other verifiable means) and relevant information about his or her AI/AN patient to the non-IHS/Tribal provider;
2. The non-IHS, non-tribal provider sends information about the care it provides to the AI/AN patient, including the results of any screening, diagnostic or treatment procedures, to the IHS or tribal facility practitioner;
3. The IHS or tribal facility practitioner continues to assume responsibility for the patient's care by assessing the information and taking appropriate action, including, when necessary, furnishing or requesting additional services; and

[23] State Health Official Letter #16-002, Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives, dated February 26, 2016.

4. The IHS or tribal facility incorporates the patient's information in the medical record through the Health Information Exchange or other agreed-upon means.

According to CMS, the purpose of the new 100 percent FMAP policy is to help states, IHS, and tribes to improve delivery systems for AI/ANs by increasing access to care, strengthening continuity of care, and improving population health.

In January 2017, CMS issued an FAQ[24] on the SHO letter. In the FAQ, CMS explained that the rate paid for the service provided under the care coordination agreement by the non-IHS, non-tribal facility must be the standard rate applicable to the service as billed. CMS also explained that a tribe's health clinic can be automatically considered a Medicaid federally qualified health center (FQHC) if the tribe opts for that designation. As an FQHC, the tribal clinic may contract with non-IHS, non-tribal providers to provide services outside the clinic's "four walls".

While the savings achieved from the new 100 percent FMAP interpretation accrue to the state, the required care coordination activities incur administrative costs to the IHS or tribal facility. Moreover, the SHO letter explicitly states that the state may not require tribes or IHS facilities to enter into such care coordination agreements or incur the administrative costs required to comply with the requirements for the new 100 percent FMAP.

<table>
<tr><th colspan="2">Illustrative Comparison</th></tr>
<tr><td>Without New 100 Percent FMAP:

Tribal clinic refers AI/AN Medicaid-enrolled patient to non-tribal specialist. Specialist assesses patient and bills HCA for $1,000. If the patient is covered by a Classic Medicaid program with 50 percent FMAP, the sources of funds for the $1,000 are:

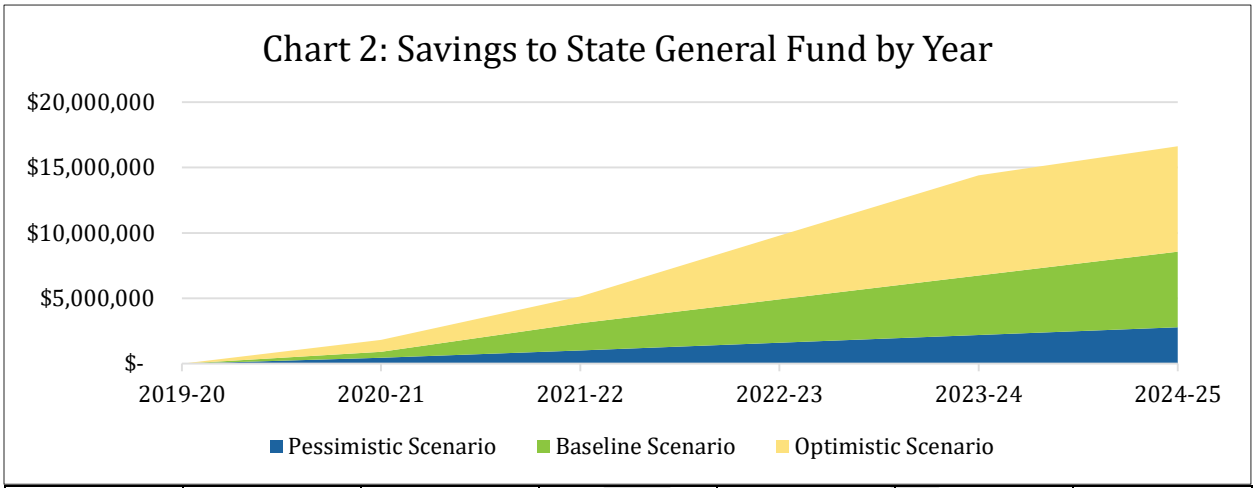
• State general fund: $500.
• Federal government: $500.</td><td>With New 100 Percent FMAP:

Tribal clinic enters into care coordination agreement with non-tribal specialist. Tribal clinic refers AI/AN Medicaid-enrolled patient to non-tribal specialist. Specialist assesses patient and sends medical records to tribal clinic. Specialist bills HCA for $1,000. Even if the patient is covered by a Classic Medicaid program with 50 percent FMAP, the new 100 percent FMAP would apply and the sources of funds for the $1,000 are:

• State general fund: $—.
• Federal government: $1,000.</td></tr>
<tr><td colspan="2">Compliance with the requirements for the new CMS policy for the new 100 percent FMAP results in a transfer of $500 in Medicaid costs from the state general fund to the federal government.</td></tr>
</table>

[24] Frequently-Asked Questions (FAQs) on Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives (SHO #16-002) dated January 18, 2017.

Estimates for Potential Savings to State General Fund



	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Pessimistic	$-	$455,095	$1,014,725	$1,604,995	$2,195,265	$2,785,534
Baseline	$-	$910,191	$2,081,717	$3,314,524	$4,547,331	$5,780,137
Optimistic	$-	$1,820,381	$5,141,201	$9,791,255	$14,400,751	$16,626,635
Data generated from 2017 HCA Medicaid claims applied to three penetration rate models.						

Using Washington State Medicaid data, HCA has prepared three projection scenarios – pessimistic, baseline, and optimistic – in Chart 2 of the amounts of additional savings to the state general fund that may be achieved as a result of the new 100 percent FMAP. To achieve these savings to the state general fund, tribes and IHS facilities will need to:

- Enter into an estimated 300 care coordination agreements with non-tribal, non-IHS providers;
- Develop processes and staffing to refer clients to non-tribal, non-IHS providers under these care coordination agreements;
- Develop processes and staffing to receive medical records from non-tribal, non-IHS providers and incorporate those records into the client medical records; and
- Ensure action is taken on the health information received from the non-tribal, non-IHS providers.

As explained above, the state may not require tribes or IHS facilities to engage in these activities that would generate savings to the state general fund – even as a condition for participating in the Medicaid program. More detailed information on the fiscal estimates are provided in Appendix A. To encourage tribes and other providers to enter into these arrangements, HCA could provide technical assistance to increase understanding of the benefits to the state and to the patients from entering into care coordination agreements with IHS facilities and tribal facilities.

The savings set forth in Chart 2, therefore, reflect two minimum investments out of the additional savings to the state general fund in order to achieve the three scenarios shown:

1. The state appropriates sufficient funding (estimated at $366,000 per state fiscal year) beginning in July 2019 for HCA to hire four regional tribal liaisons[25] to provide technical assistance to tribes, IHS facilities, and other providers throughout the state on the CMS requirements for the new 100 percent FMAP and monitoring for compliance with CMS requirements; and
2. The state provides a sufficient portion of the savings achieved from the new 100 percent FMAP to tribes and IHS facilities to cover their administrative costs for complying with the requirements for the new 100 percent FMAP (subject to federal appropriations).

More significant, as CMS wrote in the SHO letter, the new 100 percent FMAP is intended to help states, IHS, and tribes to improve delivery systems for AI/ANs by increasing access to care, strengthening continuity of care, and improving population health.

With so many AI/AN health disparities, the need to cover the administrative costs of IHS facilities and tribes, and ranges of potential new savings to the state general fund between $455,095 and $1,820,381 in state fiscal year 2020-2021 and between $2,785,534 and $16,626,635 in state fiscal year 2024-2025, this is an opportune moment for the state to create a mechanism to capture the savings to the state general fund due to the new 100 percent FMAP and reinvest it to increase access to care, strengthen continuity of care, and improve population health for AI/ANs throughout the state.

To achieve these goals, the state should establish the Indian Health Improvement Reinvestment Account. Savings from the new 100 percent FMAP, less administrative costs agreed upon by the state and tribes and urban Indian health programs, would be appropriated and deposited into this reinvestment account. To oversee the reinvestment account, the state should also establish the Governor's Indian Health Advisory Council, along with a committee of the advisory council members representing the tribes and urban Indian health programs. The advisory council committee would convene at least once a year to determine the amounts from the reinvestment account to invest in agreed upon target projects. The advisory council, including the committee, would convene at least once a year to conduct oversight of the reinvestment account and amounts spent from the account.

Recommendations

To improve Indian health care outcomes and begin to remedy long-standing health disparities, the Council makes the following recommendations:

A. Appropriate $366,000 per year for HCA Regional Tribal Liaisons. The state should appropriate funds for HCA to hire the four regional tribal liaisons as proposed in HCA decision package #37 to enable the state to begin work with the IHS facilities and tribes.

[25] See HCA decision package #37; during the tribal consultation with HCA on April 30, 2018, HCA and the tribes agreed for HCA to seek legislative approval for hiring four regional tribal liaisons.

B. **Establish the Governor's Indian Health Advisory Council.** The state should permanently establish the Governor's Indian Health Advisory Council, consisting of:
    - Voting members representing the tribes, urban Indian health programs, the governor's office, and the majority and minority caucuses of the House of Representatives and the Senate; and
    - Non-voting members representing the American Indian Health Commission for Washington State, the Northwest Portland Area Indian Health Board, the IHS Portland Area Office and Service Units, and the state agencies involved in health care.

    In addition, the state should establish the Reinvestment Committee of the Governor's Indian Health Advisory Council, consisting of the members of the Advisory Council representing the tribes and urban Indian health programs. The Advisory Council would be charged with overseeing the Indian Health Improvement Reinvestment Account (see Recommendation D) and related expenditures, and the Reinvestment Committee would be charged with determining which projects to spend the funds of the Reinvestment Account on (see Recommendation D) and in what amounts, with documentation and reporting guidance.
C. **Appropriate $150,000 for Governor's Indian Health Advisory Council for 2019-2020.** The state should appropriate funds for the 2019-2020 state fiscal year for the Governor's Indian Health Advisory Council, with support from the Health Care Authority and the American Indian Health Commission for Washington State, to complete the report with all of the analyses described in section 213(mmm) of SB 6032 and planning for oversight of the Indian Health Improvement Reinvestment Account (see Recommendation D).
D. **Establish the Indian Health Improvement Reinvestment Account for Appropriations of Additional State Savings**. The state should establish the Indian Health Improvement Reinvestment Account and appropriate and deposit into the account all of the savings due to the new 100 percent FMAP, subject to federal appropriations. To maintain fiscal neutrality to the state general fund, the administrative costs agreed upon by the state and the Reinvestment Committee of the Governor's Indian Health Advisory Council will be deducted from such appropriations and retained in the state general fund to cover such administrative costs. The state will work with the Reinvestment Committee to develop a system to track and report on additional state savings achieved due to the new 100 percent FMAP, administrative costs to support the achievement of the additional state savings due to the new 100 percent FMAP, and expenditures out of the Reinvestment Account for the projects and purposes determined by the Reinvestment Committee. The funds in the Reinvestment Account may only be spent on costs for projects that improve delivery systems for AI/ANs by increasing access to care, strengthening continuity of care, and improving population health. These costs include but are not limited to:
    - Expanding access to quality, culturally appropriate services for AI/AN individuals and their family members with disabilities, opioid use disorder, other substance use disorders, mental illness, and chronic diseases;
    - Tribal evaluation and treatment centers, tribal designated crisis responders (for Involuntary Treatment Act assessments), tribal crisis responders (for voluntary treatment), and tribal psychiatric services;

- Tracking system for FMAP savings;
- Third-party administrative entity for fee-for-service payments, provider referrals, care coordination with tribes, IHS facilities, and urban Indian health programs;
- Traditional healing services;
- Community health aide program and certification board;[26]
- Health information technology systems and data repositories;
- Capacity, infrastructure, and programming to address AI/AN health care delivery;
- Care coordination;
- Epidemiological services, public health services, and behavioral health prevention programs; and
- Other culturally appropriate health care services.

[26] See http://www.npaihb.org/download/authoring_project/native_dental_therapy_initiative/FINAL-CHAP-and-CHRP-Background-.pdf.

Appendix A: Fiscal Estimates

Providers (by Tax Identification Number), Contracts (Referrals between IHS or Tribal Facilities and Non-IHS, Non-Tribal Providers), and State General Fund Amounts by Region

	# of TINs	# of Contracts	2017 GF-S Amounts
Region: Central West (King, Kitsap, Jefferson, and Clallam counties)			
GF-S $200,000+	5	35	$ 4,538,617
GF-S $50,000-$200,000	16	79	$ 1,336,180
GF-S $10,000-$50,000	49	233	$ 1,085,279
Total	70	347	$ 4,687,616
Region: East (Spokane, Greater Columbia, and North Central regions)			
GF-S $200,000+	9	25	$ 3,663,791
GF-S $50,000-$200,000	24	61	$ 1,997,521
GF-S $10,000-$50,000	12	31	$ 259,439
Total	45	117	$ 5,920,752
Region: North Sound (North Sound region)			
GF-S $200,000+	4	22	$ 1,693,558
GF-S $50,000-$200,000	15	78	$ 1,364,530
GF-S $10,000-$50,000	55	235	$ 1,222,107
Total	74	335	$ 4,280,194
Region: Southwest (Pierce, Great Rivers, and Thurston-Mason regions)			
GF-S $200,000+	5	34	$ 217,265
GF-S $50,000-$200,000	21	111	$ 1,835,161
GF-S $10,000-$50,000	85	342	$ 1,810,347
Total	111	487	$ 3,862,772
Statewide GF-S Total for 2017			
GF-S $200,000+	**23**	**116**	**$ 10,113,230**
GF-S $50,000-$200,000	**76**	**329**	**$ 6,533,391**
GF-S $10,000-$50,000	**201**	**841**	**$ 4,377,172**
Total	**300**	**1286**	**$ 18,751,334**

Estimated Savings to State General Fund: Optimistic Scenario

	GF-S Savings: Optimistic Scenario					
	2019-20	**2020-21**	**2021-22**	**2022-23**	**2023-24**	**2024-25**
Region: Central West (King, Kitsap, Jefferson, and Clallam counties)						
GF-S $200,000+	$ -	$ 816,951	$ 1,838,140	$ 3,063,566	$ 4,084,755	$ 4,084,755
GF-S $50,000-$200,000	$ -	$ -	$ 213,789	$ 481,025	$ 801,708	$ 1,068,944
GF-S $10,000-$50,000	$ -	$ -	$ -	$ 151,939	$ 341,863	$ 569,771
Total	$ -	$ 816,951	$ 2,051,928	$ 3,696,530	$ 5,228,326	$ 5,723,470
Region: East (Spokane, Greater Columbia, and North Central regions)						
GF-S $200,000+	$ -	$ 659,482	$ 1,483,836	$ 2,473,059	$ 3,297,412	$ 3,297,412
GF-S $50,000-$200,000	$ -	$ -	$ 319,603	$ 719,107	$ 1,198,512	$ 1,598,017
GF-S $10,000-$50,000	$ -	$ -	$ -	$ 36,322	$ 81,723	$ 136,206
Total	$ -	$ 659,482	$ 1,803,439	$ 3,228,488	$ 4,577,648	$ 5,031,635
Region: North Sound (North Sound region)						
GF-S $200,000+	$ -	$ 304,840	$ 685,891	$ 1,143,151	$ 1,524,202	$ 1,524,202
GF-S $50,000-$200,000	$ -	$ -	$ 218,325	$ 491,231	$ 818,718	$ 1,091,624
GF-S $10,000-$50,000	$ -	$ -	$ -	$ 171,095	$ 384,964	$ 641,606
Total	$ -	$ 304,840	$ 904,216	$ 1,805,477	$ 2,727,883	$ 3,257,432
Region: Southwest (Pierce, Great Rivers, and Thurston-Mason regions)						
GF-S $200,000+	$ -	$ 39,108	$ 87,992	$ 146,654	$ 195,538	$ 195,538
GF-S $50,000-$200,000	$ -	$ -	$ 293,626	$ 660,658	$ 1,101,097	$ 1,468,129
GF-S $10,000-$50,000	$ -	$ -	$ -	$ 253,449	$ 570,259	$ 950,432
Total	$ -	$ 39,108	$ 381,618	$ 1,060,760	$ 1,866,894	$ 2,614,099
Statewide GF-S Total for 2017						
GF-S $200,000+	$ -	$ 1,820,381	$ 4,095,858	$ 6,826,431	$ 9,101,907	$ 9,101,907
GF-S $50,000-$200,000	$ -	$ -	$ 1,045,343	$ 2,352,021	$ 3,920,035	$ 5,226,713
GF-S $10,000-$50,000	$ -	$ -	$ -	$ 612,804	$ 1,378,809	$ 2,298,015
Total	$ -	$ 1,820,381	$ 5,141,201	$ 9,791,255	$ 14,400,751	$ 16,626,635
	Optimistic Scenario					
Contract Execution						
GF-S $200,000+	0%	20%	45%	75%	100%	100%
GF-S $50,000-$200,000	0%	0%	20%	45%	75%	100%
GF-S $10,000-$50,000	0%	0%	0%	20%	45%	75%
CMS Compliance						
GF-S $200,000+	0%	90%	90%	90%	90%	90%
GF-S $50,000-$200,000	0%	0%	80%	80%	80%	80%
GF-S $10,000-$50,000	0%	0%	0%	70%	70%	70%
Blended Success Rates						
GF-S $200,000+	0%	18%	41%	68%	90%	90%
GF-S $50,000-$200,000	0%	0%	16%	36%	60%	80%
GF-S $10,000-$50,000	0%	0%	0%	14%	32%	53%

Estimated Savings to State General Fund: Baseline Scenario

	GF-S Savings: Baseline Scenario					
	2019-20	**2020-21**	**2021-22**	**2022-23**	**2023-24**	**2024-25**
Region: Central West (King, Kitsap, Jefferson, and Clallam counties)						
GF-S $200,000+	$ -	$ 408,475	$ 816,951	$ 1,225,426	$ 1,633,902	$ 2,042,377
GF-S $50,000-$200,000	$ -	$ -	$ 53,447	$ 106,894	$ 160,342	$ 213,789
GF-S $10,000-$50,000	$ -	$ -	$ -	$ 15,194	$ 30,388	$ 45,582
Total	$ -	$ 408,475	$ 870,398	$ 1,347,515	$ 1,824,631	$ 2,301,748
Region: East (Spokane, Greater Columbia, and North Central regions)						
GF-S $200,000+	$ -	$ 329,741	$ 659,482	$ 989,224	$ 1,318,965	$ 1,648,706
GF-S $50,000-$200,000	$ -	$ -	$ 79,901	$ 159,802	$ 239,702	$ 319,603
GF-S $10,000-$50,000	$ -	$ -	$ -	$ 3,632	$ 7,264	$ 10,896
Total	$ -	$ 329,741	$ 739,383	$ 1,152,658	$ 1,565,932	$ 1,979,206
Region: North Sound (North Sound region)						
GF-S $200,000+	$ -	$ 152,420	$ 304,840	$ 457,261	$ 609,681	$ 762,101
GF-S $50,000-$200,000	$ -	$ -	$ 54,581	$ 109,162	$ 163,744	$ 218,325
GF-S $10,000-$50,000	$ -	$ -	$ -	$ 17,109	$ 34,219	$ 51,328
Total	$ -	$ 152,420	$ 359,422	$ 583,532	$ 807,643	$ 1,031,754
Region: Southwest (Pierce, Great Rivers, and Thurston-Mason regions)						
GF-S $200,000+	$ -	$ 19,554	$ 39,108	$ 58,662	$ 78,215	$ 97,769
GF-S $50,000-$200,000	$ -	$ -	$ 73,406	$ 146,813	$ 220,219	$ 293,626
GF-S $10,000-$50,000	$ -	$ -	$ -	$ 25,345	$ 50,690	$ 76,035
Total	$ -	$ 19,554	$ 112,514	$ 230,819	$ 349,124	$ 467,429
Statewide GF-S Total for 2017						
GF-S $200,000+	$ -	$ 910,191	$ 1,820,381	$ 2,730,572	$ 3,640,763	$ 4,550,954
GF-S $50,000-$200,000	$ -	$ -	$ 261,336	$ 522,671	$ 784,007	$ 1,045,343
GF-S $10,000-$50,000	$ -	$ -	$ -	$ 61,280	$ 122,561	$ 183,841
Total	$ -	$ 910,191	$ 2,081,717	$ 3,314,524	$ 4,547,331	$ 5,780,137
	Baseline Scenario					
Contract Execution						
GF-S $200,000+	0%	10%	20%	30%	40%	50%
GF-S $50,000-$200,000	0%	0%	5%	10%	15%	20%
GF-S $10,000-$50,000	0%	0%	0%	2%	4%	6%
CMS Compliance						
GF-S $200,000+	0%	90%	90%	90%	90%	90%
GF-S $50,000-$200,000	0%	0%	80%	80%	80%	80%
GF-S $10,000-$50,000	0%	0%	0%	70%	70%	70%
Blended Success Rates						
GF-S $200,000+	0%	9%	18%	27%	36%	45%
GF-S $50,000-$200,000	0%	0%	4%	8%	12%	16%
GF-S $10,000-$50,000	0%	0%	0%	1%	3%	4%

Estimated Savings to State General Fund: Pessimistic Scenario

	GF-S Savings: Baseline Scenario					
	2019-20	**2020-21**	**2021-22**	**2022-23**	**2023-24**	**2024-25**
Region: Central West (King, Kitsap, Jefferson, and Clallam counties)						
GF-S $200,000+	$ -	$ 204,238	$ 408,475	$ 612,713	$ 816,951	$ 1,021,189
GF-S $50,000-$200,000	$ -	$ -	$ 21,379	$ 42,758	$ 64,137	$ 85,516
GF-S $10,000-$50,000	$ -	$ -	$ -	$ 7,597	$ 15,194	$ 22,791
Total	$ -	$ 204,238	$ 429,854	$ 663,068	$ 896,282	$ 1,129,495
Region: East (Spokane, Greater Columbia, and North Central regions)						
GF-S $200,000+	$ -	$ 164,871	$ 329,741	$ 494,612	$ 659,482	$ 824,353
GF-S $50,000-$200,000	$ -	$ -	$ 31,960	$ 63,921	$ 95,881	$ 127,841
GF-S $10,000-$50,000	$ -	$ -	$ -	$ 1,816	$ 3,632	$ 5,448
Total	$ -	$ 164,871	$ 361,702	$ 560,349	$ 758,996	$ 957,643
Region: North Sound (North Sound region)						
GF-S $200,000+	$ -	$ 76,210	$ 152,420	$ 228,630	$ 304,840	$ 381,050
GF-S $50,000-$200,000	$ -	$ -	$ 21,832	$ 43,665	$ 65,497	$ 87,330
GF-S $10,000-$50,000	$ -	$ -	$ -	$ 8,555	$ 17,109	$ 25,664
Total	$ -	$ 76,210	$ 174,253	$ 280,850	$ 387,447	$ 494,045
Region: Southwest (Pierce, Great Rivers, and Thurston-Mason regions)						
GF-S $200,000+	$ -	$ 9,777	$ 19,554	$ 29,331	$ 39,108	$ 48,885
GF-S $50,000-$200,000	$ -	$ -	$ 29,363	$ 58,725	$ 88,088	$ 117,450
GF-S $10,000-$50,000	$ -	$ -	$ -	$ 12,672	$ 25,345	$ 38,017
Total	$ -	$ 9,777	$ 48,916	$ 100,728	$ 152,540	$ 204,352
Statewide GF-S Total for 2017						
GF-S $200,000+	$ -	$ 455,095	$ 910,191	$ 1,365,286	$ 1,820,381	$ 2,275,477
GF-S $50,000-$200,000	$ -	$ -	$ 104,534	$ 209,069	$ 313,603	$ 418,137
GF-S $10,000-$50,000	$ -	$ -	$ -	$ 30,640	$ 61,280	$ 91,921
Total	$ -	$ 455,095	$ 1,014,725	$ 1,604,995	$ 2,195,265	$ 2,785,534
	Pessimistic Scenario					
Contract Execution						
GF-S $200,000+	0%	5%	10%	15%	20%	25%
GF-S $50,000-$200,000	0%	0%	2%	4%	6%	8%
GF-S $10,000-$50,000	0%	0%	0%	1%	2%	3%
CMS Compliance						
GF-S $200,000+	0%	90%	90%	90%	90%	90%
GF-S $50,000-$200,000	0%	0%	80%	80%	80%	80%
GF-S $10,000-$50,000	0%	0%	0%	70%	70%	70%
Blended Success Rates						
GF-S $200,000+	0%	5%	9%	14%	18%	23%
GF-S $50,000-$200,000	0%	0%	2%	3%	5%	6%
GF-S $10,000-$50,000	0%	0%	0%	1%	1%	2%

Appendix B: Proposed Legislation

Washington Indian Health Care Improvement Act

AN ACT Relating to establishing the governor's Indian health advisory council and the Indian health improvement reinvestment account; reenacting and amending RCW 43.84.092; and adding a new chapter to Title 74 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** (1) The legislature finds that:

(a) As set forth in 25 U.S.C. Sec. 1602, it is the policy of the nation, in fulfillment of its special trust responsibilities and legal obligations to Indians, to:

(i) Ensure the highest possible health status for American Indians and Alaska Natives and to provide all resources necessary to effect that policy;

(ii) Raise the health status of American Indians and Alaska Natives to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives; and

(iii) Ensure tribal self-determination and maximum participation by American Indians and Alaska Natives in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of tribes and American Indian and Alaska Native communities;

(b) According to the northwest tribal epidemiology center and the department of health, American Indians and Alaska Natives in the state experience some of the greatest health disparities compared to other groups, from excessively high premature mortality rates to excessively high rates of chronic disease, mental illness, and substance use disorder;

(c) These health disparities are a direct result of historical trauma, leading to adverse childhood experiences across multiple generations, and of inadequate levels of federal funding to the Indian Health Service;

(d) Under recent guidance from the centers for medicare and medicaid services, the state has the opportunity to shift more of the cost of care for American Indian and Alaska Native medicaid enrollees from the state general fund to the federal government if all of the federal requirements are met; and

(e) The federal requirements to achieve this cost shift and obtain the additional federal funds place significant administrative burdens on Indian health service and tribal health facilities.

(2) The legislature, therefore, intends to:

(a) Establish that it is the policy of this state and the intent of this chapter, in fulfillment of the state's unique relationships and shared respect between sovereign governments, to:

(i) Recognize the United States' special trust responsibility to provide quality health care and allied health services to American Indians and Alaska Natives, including those individuals who are citizens of this state, as set forth in 25 U.S.C. Sec. 1602; and

(ii) Implement the national policies of Indian self-determination; and achieving the highest possible health status for American Indians and Alaska Natives.

(b) Provide resources necessary to effect this policy by establishing the Indian health improvement reinvestment account and, subject to federal appropriations, appropriating and depositing into the account all of the additional state savings, less agreed upon administrative costs to maintain fiscal neutrality to the state general fund, with such funds to be spent only on costs for projects that improve delivery systems for American Indians and Alaska Natives by increasing access to care, strengthening continuity of care, and improving population health;

(c) Establish the governor's Indian health advisory council to oversee the Indian health improvement reinvestment account and the reinvestment committee of the governor's Indian health advisory council to determine which projects to spend the reinvestment account funds on and in what amounts, with documentation and reporting guidance; and

(d) Appropriate funds for state fiscal year 2019-2020 to enable the health care authority to employ four regional tribal liaisons to begin work on achieving the new 100 percent FMAP and to enable the governor's Indian health advisory council to establish reporting and documentation requirements for amounts expended out of the Indian health improvement reinvestment account.

NEW SECTION. **Sec. 2.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Additional state savings" means the difference between (a) payments received from the centers for medicare and medicaid services due to the 100 percent federal medical assistance percentage applicable to referred services, and (b) payments that would otherwise be received from the centers for medicare and medicaid services due to the standard federal medical assistance percentage that would be otherwise applicable to the same services.

(2) "Advisory council" means the governor's Indian health advisory council established in section 3 of this chapter.

(3) "American Indian" or "Alaska Native" means any individual who is: (a) A member of a federally recognized tribe; or (b) eligible for the Indian health service.

(4) "Authority" means the health care authority.

(5) "Board" means the northwest Portland area Indian health board, an Oregon nonprofit corporation wholly controlled by the tribes in the states of Idaho, Oregon, and Washington.

(6) “Commission” means the American Indian health commission for Washington state, a Washington nonprofit corporation wholly controlled by the tribes and urban Indian health programs in the state.

(7) "Community health aide" means a tribal community health provider certified by a community health aide program of the Indian health service or one or more tribes or tribal organizations consistent with the provisions of 25 U.S.C. Sec. 1616l, who can perform a wide range of duties within the provider's scope of certified practice in health programs of a tribe, tribal organization, Indian health service facility, or urban Indian health program to improve access to culturally appropriate, quality care for American Indians and Alaska Natives and their families and communities.

(8) “IHS or tribal services” means medicaid-covered services which are provided to AI/AN individuals by an Indian health service facility, whether operated by the Indian health service or by a tribe or tribal organization pursuant to 42 U.S.C. Sec. 1396d, and eligible for the 100 percent federal medical assistance percentage applicable to such services under title IX of the social security act.

(9) "Fee-for-service" means the state's medicaid program for which payments are made under the state plan, without a managed care entity, in accordance with the fee-for-service payment methodology.

(10) "Indian health care provider" means a health care program operated by the Indian health service or by a tribe, tribal organization, or urban Indian organization as those terms are defined in 25 U.S.C. Sec. 1603.

(11) "Indian health service" means the federal agency within the United States department of health and human services.

(12) “Referred services” means medicaid-covered services, other than IHS or tribal services, which are provided to AI/AN individuals by referral from an Indian health service facility, whether operated by the Indian health service or a tribe or tribal organization pursuant to 42 U.S.C. Sec. 1396d, and

eligible for the 100 percent federal medical assistance percentage applicable to such services under title IX of the social security act.

(13) "Reinvestment account" means the Indian health improvement reinvestment account established in section 4(1) of this chapter.

(14) "Reinvestment committee" means the Indian health reinvestment account oversight committee established in section 4(5) of this chapter.

(15) "Target projects" means one or more projects that improve delivery systems for AI/ANs by increasing access to care, strengthening continuity of care, and improving population health, including but not limited to one or more of the following:

(a) Evaluation and treatment centers operated by one or more tribes or tribal organizations;

(b) A third-party administrative entity to provide, arrange, and make payment for services for American Indians and Alaska Natives enrolled in the state's medicaid fee-for-service program;

(c) Medicaid fee-for-service rate enhancement for providers who are trained in providing trauma-informed and culturally appropriate care to provide services to American Indians and Alaska Natives;

(d) Psychiatric services, including medication consultation, provided by child and adult psychiatrists, and psychiatrists certified in addiction or geriatric psychiatry;

(f) Licensing, training, and certification of designated crisis responders who are designated by the state of Washington in consultation with specific tribes;

(g) Traditional healing services;

(h) Development of a community health aide program, including a community health aide certification board for the state consistent with 25 U.S.C. Sec. 1616;

(i) Services of a community health aide program consistent with 25 U.S.C. Sec. 1616, including community health aides, community health practitioners, behavioral health aides, behavioral health practitioners, dental health aides, dental health aide therapists, and other types of aides for which certifications or standards are established and enforced by a community health aide program certification board operated by the Indian health service, one or more tribes, or a tribal organization;

(j) Health information technology capability within tribes and urban Indian health programs to assure the technological capacity to: (i) Produce sound evidence for Indian health care provider best practices; (ii) effectively coordinate care between Indian health care providers and non-Indian health care providers; (iii) provide interoperability with state claims and reportable data systems, such as for immunizations and reportable conditions; and (iv) support patient-centered medical home models, including sufficient resources to purchase and implement certified electronic health record systems, such as hardware, software, training, and staffing;

(k) Indian health care provider care coordination administrative duties to mitigate barriers to access to care for American Indians and Alaska Natives, with duties to include without limitation: (i)Follow-up of referred appointments; (ii) routine follow-up care for management of chronic disease; (iii) transportation; and (iv) increasing patient understanding of provider instructions;

(l) Indian epidemiology centers to create a system of epidemiological analysis that meets the needs of the state's American Indian and Alaska Native population; and

(m) Other health care services and public health services that contribute to reducing health inequities for American Indians and Alaska Natives in the state and increasing access to quality, culturally appropriate health care for American Indians and Alaska Natives in the state.

(16) ”Traditional healing services" means culturally appropriate healing methods developed and practiced by

generations of tribal healers who apply methods for physical, mental, and emotional healing. The array of practices provided by traditional healers must be in accordance with an individual tribe's established and accepted traditional healing practices.

(17) "Tribal organization" has the meaning set forth in 25 U.S.C. Sec. 5304.

(18) "Tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native claims settlement act (43 U.S.C. Sec. 1601 et seq.) which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(19) "Urban Indian" means any individual who resides in an urban center and is: (a) A member of a tribe terminated since 1940 and those tribes recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member; (b) an Eskimo or Aleut or other Alaska Native;(c) considered by the secretary of the interior to be an Indian for any purpose; or (d) considered by the United States secretary of health and human services to be an Indian for purposes of eligibility for Indian health services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

(20) "Urban Indian health program" means an urban Indian organization, as defined by 25 U.S.C. Sec. 1603(29), that is operating a facility delivering health care.

NEW SECTION. **Sec. 3.** (1) The governor's Indian health advisory council is established, consisting of:

(a) The following voting members:

(i) One representative from each tribe, designated by the tribal council, who is either the tribe's commission delegate or an individual specifically designated for this role, or his or her designee;

(ii) The chief operating officer of each urban Indian health program, or the urban Indian health program's commission delegate, or his or her designee;

(iii) One member from each of the two largest caucuses of the house of representatives, appointed by the speaker of the house of representatives;

(iv) One member from each of the two largest caucuses of the senate, appointed by the president of the senate; and

(v) One member representing the governor's office; and

(b) The following non-voting members:

(i) One tribal liaison from each of the following state agencies: The authority; the department of children, youth, and families; the department of commerce; the department of corrections; the department of health; the department of social and health services; the office of the insurance commissioner; the office of the superintendent of public instruction; and the Washington health benefit exchange;

(ii) The chief operating officer of each Indian health service area office and service unit, or his or her designee;

(iii) The executive director of the commission, or his or her designee; and

(iv) The executive director of the board, or his or her designee.

(2) With assistance from the authority and the commission, the advisory council will meet in a forum that offers both in-person and remote participation where everyone can hear and be heard at least three times per year when the legislature is not in session, with one meeting to be hosted by the authority and the other two meetings to be hosted by tribes or, if no tribe is able to host, by a member state agency, to:

(a) Create an action plan to raise the health status of American Indians and Alaska Natives to at least the levels set forth in the goals contained within the federal healthy people 2020 initiative or successor objectives;

(b) Address current or proposed policies or actions that have tribal implications and are not able to be resolved or addressed at the agency level;

(c) Facilitate educational training for agency leadership, staff, and legislators on the Indian health system and tribal sovereignty;

(d) Provide oversight of contracting and performance of service coordination organizations or service contracting entities as defined in RCW 70.320.010 in order to address their impacts on services to American Indians and Alaska Natives and relationships with Indian health care providers; and

(e) Provide oversight of the Indian health improvement reinvestment account established in section 4 of this chapter, ensuring sufficient documentation and/or reporting requirements for expenditures out of the reinvestment account to meet the requirements of this chapter.

(3) The governor's Indian health advisory council meetings, reports and recommendations, and other forms of collaboration support the consultation process but are not a substitute for the requirements for state agencies to conduct consultation or maintain government-to-government relationships with tribes under federal and state law.

NEW SECTION. **Sec. 4.** (1) The Indian health improvement reinvestment account is created in the state treasury.

(2) Moneys in the reinvestment account may not be expended for any purpose other than target projects.

(3) Beginning July 1, 2019, the additional state savings, less the state’s administrative costs as agreed upon by the state and the reinvestment committee, are appropriated and directed for deposit into the reinvestment account.

(4) The authority will work with the tribes and providers of referred services to develop a tracking and data reporting system to support the purposes of this chapter.

(5) The reinvestment committee is established, consisting of the following members of the advisory council:

(a) With voting rights on the reinvestment committee, every advisory council member who represents a tribe or an urban Indian health program; and

(b) With non-voting rights on the reinvestment committee, every advisory council member who represents a state agency, the Indian health service area office or a service unit, the commission, and the board.

(6) With assistance from the authority and the commission, the reinvestment committee will meet at least once per year to determine which target projects to invest the reinvestment account funds in and in what amounts.

(7) The authority will pursue additional state savings for medicaid managed care premiums on an actuarial basis and in consultation with tribes.

Sec. 5. RCW 43.84.092 and 2017 3rd sp.s. c 25 s 50, 2017 3rd sp.s. c 12 s 12, and 2017 c 290 s 8 are each reenacted and amended to read as follows:

(1) All earnings of investments of surplus balances in the state treasury shall be deposited to the treasury income account, which account is hereby established in the state treasury.

(2) The treasury income account shall be utilized to pay or receive funds associated with federal programs as required by the federal cash management improvement act of 1990. The treasury income account is subject in all respects to chapter 43.88 RCW, but no appropriation is required for refunds or allocations of interest earnings required by the cash management improvement act. Refunds of interest to the federal treasury required under the cash management improvement act fall under RCW 43.88.180 and shall not require appropriation. The office of financial management shall determine the amounts due to or from the federal government pursuant to the cash management improvement act. The office of financial management may direct

transfers of funds between accounts as deemed necessary to implement the provisions of the cash management improvement act, and this subsection. Refunds or allocations shall occur prior to the distributions of earnings set forth in subsection (4) of this section.

(3) Except for the provisions of RCW 43.84.160, the treasury income account may be utilized for the payment of purchased banking services on behalf of treasury funds including, but not limited to, depository, safekeeping, and disbursement functions for the state treasury and affected state agencies. The treasury income account is subject in all respects to chapter 43.88 RCW, but no appropriation is required for payments to financial institutions. Payments shall occur prior to distribution of earnings set forth in subsection (4) of this section.

(4) Monthly, the state treasurer shall distribute the earnings credited to the treasury income account. The state treasurer shall credit the general fund with all the earnings credited to the treasury income account except:

(a) The following accounts and funds shall receive their proportionate share of earnings based upon each account's and fund's average daily balance for the period: The aeronautics account, the aircraft search and rescue account, the Alaskan Way viaduct replacement project account, the brownfield redevelopment trust fund account, the budget stabilization account, the capital vessel replacement account, the capitol building construction account, the Cedar River channel construction and operation account, the Central Washington University capital projects account, the charitable, educational, penal and reformatory institutions account, the Chehalis basin account, the cleanup settlement account, the Columbia river basin water supply development account, the Columbia river basin taxable bond water supply development account, the Columbia river basin water supply revenue recovery account, the common school construction fund, the community forest trust account, the connecting Washington account, the county arterial preservation account, the county criminal justice assistance account, the deferred compensation administrative account, the deferred compensation principal

account, the department of licensing services account, the department of retirement systems expense account, the developmental disabilities community trust account, the diesel idle reduction account, the drinking water assistance account, the drinking water assistance administrative account, the early learning facilities development account, the early learning facilities revolving account, the Eastern Washington University capital projects account, the Interstate 405 express toll lanes operations account, the education construction fund, the education legacy trust account, the election account, the electric vehicle charging infrastructure account, the energy freedom account, the energy recovery act account, the essential rail assistance account, The Evergreen State College capital projects account, the federal forest revolving account, the ferry bond retirement fund, the freight mobility investment account, the freight mobility multimodal account, the grade crossing protective fund, the public health services account, ((~~the high capacity transportation account,~~)) the state higher education construction account, the higher education construction account, the highway bond retirement fund, the highway infrastructure account, the highway safety fund, the high occupancy toll lanes operations account, the hospital safety net assessment fund, the Indian health improvement reinvestment account, the Indian health improvement reinvestment matching account, the industrial insurance premium refund account, the judges' retirement account, the judicial retirement administrative account, the judicial retirement principal account, the local leasehold excise tax account, the local real estate excise tax account, the local sales and use tax account, the marine resources stewardship trust account, the medical aid account, the mobile home park relocation fund, the money-purchase retirement savings administrative account, the money-purchase retirement savings principal account, the motor vehicle fund, the motorcycle safety education account, the multimodal transportation account, the multiuse roadway safety account, the municipal criminal justice assistance account, the natural resources deposit account, the oyster reserve land account, the pension funding stabilization account, the perpetual surveillance and maintenance account, the pollution liability insurance agency underground storage tank revolving account, the public employees' retirement system plan account, the public

employees' retirement system combined plan and plan account, the public facilities construction loan revolving account beginning July 1, 2004, the public health supplemental account, the public works assistance account, the Puget Sound capital construction account, the Puget Sound ferry operations account, the Puget Sound taxpayer accountability account, the real estate appraiser commission account, the recreational vehicle account, the regional mobility grant program account, the resource management cost account, the rural arterial trust account, the rural mobility grant program account, the rural Washington loan fund, the sexual assault prevention and response account, the site closure account, the skilled nursing facility safety net trust fund, the small city pavement and sidewalk account, the special category C account, the special wildlife account, the state employees' insurance account, the state employees' insurance reserve account, the state investment board expense account, the state investment board commingled trust fund accounts, the state patrol highway account, the state route number 520 civil penalties account, the state route number 520 corridor account, the state wildlife account, the supplemental pension account, the Tacoma Narrows toll bridge account, the teachers' retirement system plan 1 account, the teachers' retirement system combined plan 2 and plan 3 account, the tobacco prevention and control account, the tobacco settlement account, the toll facility bond retirement account, the transportation 2003 account (nickel account), the transportation equipment fund, the transportation future funding program account, the transportation improvement account, the transportation improvement board bond retirement account, the transportation infrastructure account, the transportation partnership account, the traumatic brain injury account, the tuition recovery trust fund, the University of Washington bond retirement fund, the University of Washington building account, the volunteer firefighters' and reserve officers' relief and pension principal fund, the volunteer firefighters' and reserve officers' administrative fund, the Washington judicial retirement system account, the Washington law enforcement officers' and firefighters' system plan 1 retirement account, the Washington law enforcement officers' and firefighters' system plan 2 retirement account, the Washington public safety employees' plan 2 retirement account, the Washington school employees' retirement system combined plan 2

and 3 account, the Washington state health insurance pool account, the Washington state patrol retirement account, the Washington State University building account, the Washington State University bond retirement fund, the water pollution control revolving administration account, the water pollution control revolving fund, the Western Washington University capital projects account, the Yakima integrated plan implementation account, the Yakima integrated plan implementation revenue recovery account, and the Yakima integrated plan implementation taxable bond account. Earnings derived from investing balances of the agricultural permanent fund, the normal school permanent fund, the permanent common school fund, the scientific permanent fund, the state university permanent fund, and the state reclamation revolving account shall be allocated to their respective beneficiary accounts.

(b) Any state agency that has independent authority over accounts or funds not statutorily required to be held in the state treasury that deposits funds into a fund or account in the state treasury pursuant to an agreement with the office of the state treasurer shall receive its proportionate share of earnings based upon each account's or fund's average daily balance for the period.

(5) In conformance with Article II, section 37 of the state Constitution, no treasury accounts or funds shall be allocated earnings without the specific affirmative directive of this section.

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Proviso for the 2019-2020 Budget Legislation

(xxx) With $150,000 in general fund – state appropriations, by November 1, 2019, the governor's indian health advisory council, with assistance from the authority, will submit a report to the governor and the appropriate legislative committees with recommendations to raise the health status of American Indians and Alaska Natives throughout Washington state to at least the level set forth in the goals contained within the federal healthy people 2020 initiative or successor objectives, including draft legislation and fiscal budgets for:

(1) Developing model performance measures and risk adjustment methodologies for medicaid managed care value-based purchasing that account for the Indian health delivery system;

(2) Improving population health through tribally determined practices and resources such as the American Indian health commission for Washington state's "pulling together for wellness" framework;

(3) Developing written and technical assistance to support the incorporation of cultural awareness and of strategies to address historical trauma and intergenerational trauma in treatment planning for services covered by medicaid and other services provided by the state; and

(4) Other strategies to improve population health and increase access to quality health care for American Indians and Alaska Natives.