**AMERICAN INDIAN HEALTH COMMISSION FOR WASHINGTON STATE**
**2017-2018 AIHC Policy/Project Work**

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| Legislation Requirement for Use of the Washington State Indian Health Care Provider Addendum | Indian Addendums provide the federal requirements under the Patient Protection and Affordable Care Act (ACA) and the Indian Health Care Improvement Act (IHCIA) for issuers (health insurance companies) when contracting with Indian health care providers (I/T/Us). Currently, the Federal marketplace, and both Minnesota and Oregon Exchanges require the use of an Indian Addendum when contracting with Indian health care providers. The State of Washington currently has no such requirement. Issuers are merely "…encouraged to use the current version of the Washington State Indian Health Care Provider Addendum as posted on http://www.aihc-wa.com, to supplement the existing contracts when contracting with an Indian health care provider." (WAC 284-43-222(5)(b)). | • Request that OIC, WHBE, HCA and Governor's Policy Office support legislation that would require issuers to use the Washington State Model Indian Health Care Provider Addendum when contracting with Indian providers.<br>• Obtain legislation in the 2016 legislative session that will require issuers to use the Washington State Model Indian Health Care Provider Addendum when contracting with Indian providers. | Lead: Heather Erb, Partners: Tribes, AIHC | **Complete for Medicaid – Tribal Centric Health Plan Memorandum of Agreement**<br><br>**Creation of model Indian Health language for State based universal health plans.**<br><br>**Not funded/ No momentum for QHP, Employer based plans and other private plans.** |
| Medicaid Managed Care Indian Provider Requirements | Amend the Apple Health managed care contract to require that issuers offer network contracts to all Indian health care providers in their service area. This is the same requirement that QHP issuers have in the Washington State and federal Exchanges.<br><br>Under federal law (42 U.S.C 1396u-2(a)(2)(C)), American Indians/Alaska Natives (AI/AN) are exempt from having to enroll in managed care. The Healthy Options contract requires that AI/AN enrolled in Apple Health have access to Indian health care providers even if the provider is not a network contractor. Apple Health plans are also required to reimburse Indian health care providers for services provided to AI/ANenrollees even if the provider does not have a network contract. Of the over 30,000 AI/AN enrolled in Medicaid, it is estimated that only 10 percent are in managed care. Those AI/AN not enrolled in managed care receive coverage through the Medicaid fee-for-services (FFS) system. | • Amend the Apple Health managed care contract to require that issuers offer network contracts to all Indian health care providers in their service area. This is the same requirement that QHP issuers have in the Washington State and federal Exchanges.<br>• Amend the Apple Health managed care contract to require issuers to use the Washington State model Indian Health Care Provider Addendum when contracting with Indian providers to ensure they comply with federal laws governing contracting with Indian providers. This is the same requirement that QHP issuers have in and federal Exchanges. | Lead: Heather Erb Partners: HCA, AIHC | **Complete- Tribal Centric Health Plan Memorandum of Agreement signed by the State (Health Care Authority) July of 2017**<br><br>+ Indian Health Care 101 Training to each of the Medicaid Managed Care plans<br>Native Perspectives in ACEs training – twice to Coordinated Care |
| AI/AN Provider Access and Indian | Currently, 638 tribal compact/contract tribes, Indian Health Service sites, and Urban Indian health programs (I/T/Us) face many challenges in ensuring that health insurance issuers are properly complying with | • As Indian health care providers move forward with the implementation of the ACA and stronger protection in IHCIA, they will need clear guidance as to what steps to take | Lead: Heather Erb Partners: | **Partially funded- need for ongoing work**<br>4/25/2018- Tribal/Insurance Carriers Health Fair and Roundtable |

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| Health Care Provider Protections | the (1) payment and referral process; and (2) provider and facility licensure exceptions in the Indian Health Care Improvement Act (IHCIA) and the Patient Protection and Affordable Care Act (ACA). | when issuers fail to comply with the state and federal law. By partnering with the OIC the AIHC can provide ongoing training and education to issuers and providers regarding the specific American Indian and Alaska Native (AI/AN) protections and federal rules for interacting with Indian health care providers. Lastly, it will be important for both Indian health care providers and insurance issuers to understand which state and federal agencies are responsible for enforcing these rules. | OIC/AIHC | |
| State Health Care Innovation Plan (SHCIP) System Transformation – Tribal Centric Health Home Model | On July 21, 2014, the Washington State Health Care Authority (HCA) submitted a $92.4 million State Innovation Models (SIM) grant application to the federal Center for Medicare and Medicaid Innovation (CMMI) to implement a State Health Care Innovation Plan (SHCIP). The plan was developed through a CMMI Pre-Testing Award to Washington in April 2013 to develop a 5-year SCHIP. The purpose of SIM grant is to finance state efforts to test whether new payment and service delivery models will improve "… health, improve health care, and lower costs for a state's citizens through a sustainable model of multi-payer payment and delivery reform. Washington's SCHIP was developed with input from some 1,100 communities, health care providers, and stakeholders. Washington's Tribes and AIHC also provided input into developing the plan that included a Tribal Consultation with HCA. The state anticipates hearing about the plan award by the end of October 2014, with implementation beginning by January 2015. | • Conduct a programmatic and financial study to develop a Tribal centric health home model that would service both persons with chronic conditions and those at-risk of needing inpatient or outpatient specialty services. The model would be based in part on the Medicaid health home model, IHS health home and NCQA patient-centered medical home standards. If still available, planning activities funding will be sought from CMS.<br>• If feasible, Tribes may participate in pilots to implement and test the Tribal centric health home model. | Lead:<br>Roger Gantz;<br>Partners:<br>HCA, AIHC | **CHANGED PRIORITIES: The State went on to develop the Healthier Washington Initiative with funds and created regional Accountable Communities of Health (ACH) and move to value based payments. Although there was Tribal UIHP representation on HILN and engagement with Tribes and UIHPs, the State never clearly understood the difficulties forcing the Indian Health Care Delivery system into their regional ACHs. Lack of appropriate Tribal representation on ACH Boards continues to be a problem, concerns about a new payment model impacting Tribal clinic budgets,** |
| Uniform Washington State Tribal Consultation Policies | Tribal leaders currently have numerous tribal consultation policies to familiarize themselves with. Often these policies have lacked clarity on (1) what issues require consultation; (2) the process for notifying tribes, (3) the requirements for consultation; and (4) the difference between consultation versus collaboration. | Tribal consultation that truly respects the government-to-government relationship with tribes provides (1) clear expectations regarding when to consult; (2) proper tribal leader notification; (3) the opportunity for tribes to initiate consultation; (4) requirements for people with the authority to act to be present; and (5) requirements to comply with the Centennial Accord of 1989 and R.C.W. 43.376. AIHC recommends that agencies propose to the tribes for their approval consultation policies modeled after the Washington Health Benefit Exchange Tribal Consultation Policy | Lead:<br>Heather Erb<br>Partners:<br>HCA, DOH, OIC | **Unfunded- Partially complete**<br>DOH consultation policy updated;<br>OIC policy update in in process- signed June 2016<br>HCA to be updated in 2017- still working on |

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| | | since this policy was not drafted by the agency but rather from the tribal perspective to address the issues outlined above. | | |
| Tribal Assister Program | The Tribal Get Covered Workgroup formed under Level 2 Establishment Grant through the WHBE, continued under two more grants. The TGCWG began April of 2013. From April through September of 2013, the group met twice monthly through webinar to prepare Tribal Assisters to enroll Washington State AI/AN through the Washington HealthPlanfinder (HFP). In addition to these meetings, the AIHC worked with the WHBE to create and implement training for Tribal Assisters to pass the exam and gain access into the HPF which allows them to partner (connect) with accounts and help process the applications and manage these accounts. October 1st, 2013 to June 1, 2016, this group met weekly, to help provide support for enrollment issues. The AIHC worked closely with the WHBE and the HCA to help Tribal Assisters work through their enrollment issues and create systems and processes to resolve these issues. There are still some technical issues with application and need for ongoing training for new Tribal Assisters are hired as well as working to resolve sponsorship issues in the HPF system. The AIHC has also created an online manual to aid Tribal and Urban Health program staff as well as other individual's signing AI/AN's up for coverage. | • Continue TGCWG webinars once or twice per month<br>• Quarterly in person meetings for Tribal Assisters to share best practices<br>• Continue Certification training for new or recertifying Tribal Assisters<br>• Continue updating online manual | Lead:<br>Vicki Lowe<br>Partners:<br>WAHBE, HCA, NPAIHB, IHS | **Partially Funded/ Ongoing need to continue work**<br>Tribal Assister certification/training and monthly meetings taken over by WAHBE<br><br>9/13/2017 and 4/21/17 Tribal Assister In-Person Training funded by WACMHC<br><br>4/25/18 Tribal Assister In-Person Training funded by MCOs<br><br>No funds to update manual |
| Coverage for Dual Eligible AI/AN | Under the Affordable Care Act (ACA), Medicaid expansion changed how most Washington State citizens sign up for medical coverage. It also changes and simplifies Medicaid eligibility requirements by adopting modified adjusted gross income (MAGI) standards. The HPF was to be the access point for all medically related Medicaid programs. Citizens, who are aged, blind or disabled, are not eligible for coverage under the Medicaid expansion group standards. They are eligible under the older guidelines, known as "Classic Medicaid". The application for "Classic Medicaid" coverage is not in the Healthplanfinder; it still within the DSHS ACES eligibility system and can be accessed through the Washington Connections online application or by filling out a paper application and taking to the DSHS Community Service Office (CSO). Eligibility for this coverage includes stringent income limits and asset requirements that are not | • Grant Partnership with OIC to utilize the TGCWG to increase outreach and enrollment in "Classic Medicaid to the AI/AN population.<br>• Improve the process for AI/AN and others to be enrollment in the non-MAGI Aged, Blind & Disabled (ABD) Medicaid program. | Lead:<br>Vicki Lowe<br>Partners:<br>OIC, HCA, DSHS | **Through partnership with AIHC, OIC/SHIBA Program created relationship with Tribes across the state and are train SHIBA volunteers on several reservations.** |

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| | part of the Medicaid MAGI expansion rules. Beginning October 1, 2013, if an aged, blind or disabled person with Medicare started an application in the Healthplanfinder, they were to be referred to the DSHS website and have part of their application pre-populated. This interface has never worked right. In addition, DSHS CSO workers were told they were no longer to help with Medicaid applications and In Person Assisters, including Tribal Assisters, were not expected to or trained to help with the Classic Medicaid application. | | | |
| Implement Medicaid Tribal Centric Behavioral Health System Recommendations | Medicaid enrolled American Indian/Alaska Natives (AI/AN) have a significantly higher incidence of mental illness diagnoses than Medicaid non-natives. Across all ages, AI/AN enrollees have a 67 % higher incidence of mental illness diagnoses than non-natives enrollees. This is reflected in mental health prescription drug utilization, with AI/AN enrollees having 47% higher usage than non-natives.<br><br>Diagnoses of mental illness for AI/AN children was 125% higher than for non-native children. AI/AN children also have an 84% higher usage of being prescribed psychotropic medications than non-native children. AI/AN Medicaid enrollees have a significant higher need for chemical dependency treatment services than non-natives. Across all ages, AI/AN have a 155% higher incident diagnosed mental illness than non-natives. Medicaid eligible AI/AN children and seniors have over twice the need than non-natives. | Require DSHS to implement and include the 2SSB 5732 report recommendations into the new Behavioral Health Organization (BHO) contracts. Federal Medicaid law prohibits Medicaid programs from requiring AI/AN to enrollees in managed care. The Indian Health Care Improvement Act gives Indian health care providers the right to be reimbursed for services provided to AI/AN patients even when the program is a non-network provider. To address these federal requirements, AI/AN and their non-native clinic family members have direct access to Medicaid mental health services from Tribal programs without having to go through the RSN referral process. Under the existing chemical dependency fee-for-service system, AI/AN also have direct access to Tribal chemical dependency programs. DSHS should be required to continue to allow Medicaid AI/AN enrollees and their non-native clinical family members to have direct access to Tribal medical health and chemical dependency services without having to be referred through BHOs. | Lead:<br>Vicki Lowe<br>Partners:<br>DSHS, HCA, AIHC | **Funded through budget proviso that created Governor's Indian Health Council, legislation and a report to show how maximizing federal funds into the State can bring funds to expand the specialty network while maintaining budget neutrality.** Maintaining the FFS system while allowing AI/ANs to opt into managed care where needed. SUD services carved out of integration 4/2016 with plan to carve out MH services by 7/2017. Working with Tribes, HCA, DBHR and NPAIHB to create a Tribal FFS program that will support an adequate network and address the requests made to the legislature in December 2013 TCBH Report. Need more funding to continue**.** Implementation of HB 1388 has helped. |
| Maternal and Infant Health Strategic Plan Implementation: Reduction of Native American Maternal and Infant Health Disparities | The AIHC Maternal and Infant Health (MIH) Strategic Plan was developed in 2010 and widely distributed beginning in early 2011 to State and Tribal leaders. The plan outlines a clear methodology, including evidence based and best practices, with a budget attached, to address the severe MIH disparities among American Indian women and infants in Washington State.<br>It is a mutual goal of our state governor, in the "Results Washington" plan, and the AIHC, to reduce low birth weight and infant mortality. | • State Agencies, including the Department of Health, the Health Care Authority, and the Department of Social and Health Services will engage in meaningful dialogue with the AIHC to plan for the funding of the initiatives and programs outlined in the budget section of the Strategic Plan, to reduce the Maternal and Infant Health disparities in American Indian women and infants in Washington State and improve the health of our communities. | Lead:<br>Cindy Gamble/Jan Olmstead<br>Partners:<br>DOH, HCA, WIC, DSHS, MSS | **No movement** on coordination of comprehensive funding plan with health agencies based MIH Strategic Plan.<br>**Progress**: funding of the WIC research project, collaboration on the AIHC Maternal Infant Early Childhood Home Visiting summits, DOH and AIHC collaboration on Results WA, Community Health |

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| | | | | Representatives accepted as a billable provider type for MSS First Steps team, the PRAMS project, and support offered as requested to Tribes/UIHOs working on MIH projects. DOH provides funds to AIHC to: provide technical assistance to Tribes/UIHPs and to work with DOH and other health agencies on MIH related strategies and interventions.<br><br>The **additional request for $150,000 to update the MIH Strategic Plan remains** unfunded. |
| Need for Data and Data Access: Pregnancy Risk Assessment Monitoring System Survey (PRAMS) | The PRAMS survey is one of our best sources for maternal and infant health data on American Indian women and infants here in Washington State. Response rates are declining. We require reliable data to develop appropriate and effective plans to reduce maternal and infant health disparities, to measure our progress, to identify trends, and to implement effective maternal and infant health programs. | • Washington State DOH will engage with the AIHC, Tribes, and Urban Indian Health Organizations to plan for and execute a PRAMS survey of 100% of the self-identified American Indian (eligible) mothers and fathers in Washington State.<br>• Washington State will collaborate with AIHC to determine a funding strategy for the survey to help reduce the American Indian maternal and infant health disparities and in so doing, help build healthy communities.<br>• Funding to promote PRAMS survey to AI/AN mothers.<br>• Washington State will collaborate with AIHC to make the PRAMS data easily accessible to our Tribes and Urban Indian Health Organizations. | Lead: Cindy Gamble/Jan Olmstead Partners: DOH, AIHC | **There is still a need for an additional PRAMS survey. Initial discussions with MIH and PRAMS DOH staff.**<br><br>**Unfunded, Cost undetermined** |
| Hepatitis C Research, Outreach, and Education | Hepatitis C affects American Indian people in disproportionate numbers to the general population. This disease is underdiagnosed, and costly in terms of human lives and productivity and in treatment dollars. The data shows that between 2009 and 2011 there was a 137% increase in Hep C in Native Americans. Many Tribal Providers say that | • The State should engage with AIHC, Tribes, and UIHO's to investigate the true scope of the Hepatitis C issue in Indian Country; identify funding options to conduct an education campaign for patients and providers about Hepatitis C, including how Hep C affects pregnant women, newborns, | Lead: Jan Olmstead/Wendy Stevens Partners: DOH, AIHC | **Unfunded. Continuing request Cost undetermined** |

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| | they are facing "epidemic proportions" in their clinics. The cost of treating just one Hep C patient seriously impacts Tribal Health funding (CHS) dollars and could precipitate a "priority one" status. | and breast feeding; information about the new treatment options available; and connecting Tribal providers to the free screening kits through DOH and educate them on the Patient Assistance Programs for financial assistance with the appropriate medications for their patients.<br>• Hire Consultant to coordinate efforts surrounding Hepatitis C with AIHC, NPAIHB and WA DOH | | |
| Public Health Emergency Preparedness Funding | The first year that PHEPR funds were available to Washington State tribes (2003 – 2004), the Tribes, the Washington State Department of Health (DOH), the Northwest Portland Area Indian Health Board and the American Indian Health Commission agreed to use a funding methodology similar to that used for tribal tobacco cessation funds to distribute the PHEPR funds. The DOH adopted this recommendation and the formula has been used since then to allocate available funds to Tribes.<br>Methodology<br>Funding was split into two categories<br>- Category 1: Approximately 75% of the total available funds distributed to all 29 federally recognized tribes<br>- Category 2: Approximately 25% of the total available fund distributed to 26 tribes that had tribally operated clinics<br>For Category 1 funds, 30% was distributed equally to all tribes and 70% was distributed proportionally based on the most recent available IHS user population for each tribe.<br>For Category 2 funds, 50% was distributed equally to all tribes and 50% was distributed proportionally based on the most recent available HIS user population for each tribe. | • Agree to reallocate funds that are not contracted by Tribes towards benefiting all Tribes' efforts to strengthen their capacity to prepare and respond to public health emergencies. (For example, training, exercises, technical assistance, etc.)<br>• Consider modifying the funding allocation formula. | Lead:<br>Lou Schmitz<br>Partners:<br>DOH, Tribes, AIHC | **Completed-** February 8, 2016, DOH announced preservation for any funds that are allocated for Tribes, but not contracted for the contract year 2016-17. Funds were set aside for Tribes and Indian organizations to submit applications for special projects completed by June 30, 2017. Announcement was made July 7, 2016, application deadline was August 31, 2016. DOH will convene a review panel to select projects for funding. Once the process is complete, Tribes will be able to assess this new approach to tribal PHEPR funds.<br><br>Tribes stated the preservation of non-contracted funds was the first priority, and they will address the funding allocation formula review after the non-contracted funds issue is resolved. |
| Improve immunizations rates in Tribal and Urban Indian communities by addressing vaccine | American Indians and Alaska Natives are impacted the most by illnesses that could have been prevented through proper immunizations. This has raised concerns about vaccine hesitancy among health care workers and the implications for Tribal and Urban Indian communities. AIHC and the Tribal Health Immunizations Workgroup (THIW) conducted an assessment in 2012 on tribal health | • Develop immunization policy to address health care worker vaccine hesitancy using PES approach, including<br>• Conducing a comprehensive review and analysis focused on long term solutions for sustainable health care worker immunizations policies using a policy, environment, and systems approach, | Lead:<br>Jan Ward Olmstead/<br>Partners:<br>DOH, AIHC, NPAIHB, IHS | 2017 DOH Funded: Feasibility of Tribal Immunization Summit& identify potential source of funding current |

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| hesitancy by health care workers. | care workers knowledge, attitudes and practices. The AIHC Tribal Health Immunizations workgroup prioritized its recommendations and has established a work plan to address Tribal and Urban Indian community vaccine hesitancy. | • Engaging the Tribal Health Immunization Workgroup to review and bring forward recommendation to AIHC<br>• Working with Tribes/Urban Indian Clinics to implement the immunization policy.<br>• Develop Tribal and Urban Indian specific educational materials regarding vaccine hesitancy, including:<br>• Materials for multiple audiences, e.g., health care workers, community members, etc.<br>• Engaging the Tribal Health Immunizations Workgroup to create, review and bring recommendations to the AIHC<br><br>• Engaging Tribal leaders' immunizations promotional campaign, "I'm immunized; how about you?" Participate in development of immunizations promotional campaign.<br>• Convene Tribal and Urban Indian Immunization Summit in 2015 in partnership with Tribes, UIHOs, NPAIHB, IHS, DOH Immunizations and others.<br>• Establish Summit Planning Committee<br>• Identify funds | | Group Health Foundation (GHF) supported day-long Tribal Immunization work session to identify tribal coalition priorities<br><br>**2018-19 Funded:**<br>GHF funding for Immunizations Coalition Development<br><br>DOH provided funding to support:<br><br>• 2015 MIH/Youth Summit to include HPV education focus,<br>• Convening Immunization workgroup, current<br>• convening tribal workgroup/coalition, site visits and participation in state initiatives<br><br>**Ongoing request:**<br>Fund Immunizations Report: health care worker vaccine hesitancy recommendations. |
| Healthy Communities: *Pulling Together for Wellness*, framework. | The American Indian Health Commission (AIHC) has facilitated the development of a Tribal/Urban Indian-driven *Healthy Communities* framework. The framework focuses on a comprehensive prevention strategy integrating Native and western knowledge to reduce risk factors for chronic disease among American Indians and Alaska Natives (AI/AN) in Washington State. This model utilizes a Policy, Environment, Systems (PES) change approach and incorporates | • Support the Healthy Tribal and Urban Indian Communities: *Pulling Together for Wellness* framework.<br>• Integrate concepts and principles of the Healthy Tribal and Urban Indian Communities: *Pulling Together for Wellness* framework in planning processes to address chronic disease prevention through a policy, environment and systems approach.<br>• Partner with Tribes and Urban Indian programs to seek funding to implement the framework. | Lead:<br>Jan Ward Olmstead<br>Partners:<br>AIHC, Tribes, DOH | **AIHC and DOH continue to jointly seek funding for demonstration project**.<br><br>Continuing effort to seek demonstration project funding. |

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| | cultural appropriate strategies designed for Tribal and Urban Indian communities. | • Obtain funding for demonstration project: 2 Tribes, 1 Urban Indian Organization, Northwest Indian College and AIHC. | | |
| Nutritional Program for Woman, Infants and Children (WIC) | The American Indian Health Commission Maternal-Infant Health Strategic Plan documents and addresses the material and infant health disparities in Washington's AI/AN pregnant women and their infants and also identified opportunities for change. The plan includes best and promising practices and programs to help address these disparities. The WIC Nutrition Program is one of the established programs that Tribal leaders asked to be addressed in the strategic plan by developing and implementing strategies to improve AI/AN access and Tribal Health program ability to provide WIC services. The WIC Nutrition Program is collaborating with AIHC to identify barriers to participation in WIC among AI/AN pregnant women and their children. Together we are working to develop Tribally-driven strategies to enhance eservices to the Tribes and Urban Indian health organizations. The collaboration effort is in direct response to concerns over high infant mortality and morbidity experience in Tribal Communities. | • Improve American Indian/Alaska Native (AI/AN) access to WIC services through a tribally-driven process to determine barriers and concerns.<br>• Further goals of the WIC Program in the access to food, breastfeeding, health education and information and referral to other programs & services for the AI/AN population.<br>• To determine and advocate for culturally relevant and Tribal Community accessible programs and services. | Lead:<br>Cindy Gamble<br>Partners:<br>Tribes, WIC, AIHC | **Funded** |
| Maternal Infant Early Childhood Home Visiting | AIHC is working with the Department of Early Learning and Department of Health to ensure the promotion of health and the state home visiting structure includes Home Visiting programs is that are culturally appropriate and effective in tribal and urban Indian setting. | • Identify the needs and capacity in Tribes and Urban Indian settings<br>• Develop culturally appropriate home visiting options<br>• Add to the national collective pool of home visiting knowledge regarding Tribal/Urban home visiting practices.<br>• Co-Sponsor annual Home Visiting Summit<br>• Provide TA to the Tribal Home Visiting Demonstration Project<br>• Collaboration with HV partners in development of statewide services. | Lead:<br>Jan Olmstead<br>Partners:<br>Tribes, DEL, DOH, AIHC | **Funded** |