



# *American Indian Health Commission for Washington State*

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## **Meeting Minutes May 14, 2004 Seattle Indian Health Board**

### **Welcome**

AIHC Secretary Whitney Jones (Squaxin Island Tribe) opened the meeting on behalf of AIHC Chair Marilyn Scott (Upper Skagit Tribe), who was on her way to the meeting.

### **Invocation**

Dennis Jones (Spokane Tribe) delivered an invocation.

### **Roll Call**

Due to traffic difficulties that had prevented some AIHC members from arriving on time, the roll call was postponed until 10:45. Whitney Jones conducted roll call at that time, and a quorum was established. Sheryl Fryberg (Tulalip Tribes) and Freida Eng (Nisqually Tribe) requested that AIHC e-mail them delegate resolutions for follow-up with their tribal councils.

### **Review of Minutes**

Jim Sherrill (Chehalis Tribe) made a motion to approve the March 14, 2004 minutes (*Handout 1*). Dennis Jones seconded the motion. The March 14, 2004 minutes were approved.

### **Review Agenda**

Jim Sherrill said that AIHC should schedule time to discuss concerns regarding upcoming Medicaid changes on mental health services which will go into effect in October. This item will be placed on the July agenda and AIHC Director Becky Johnston will provide tribes with information on this issue.

Whitney Jones and Becky Johnston reviewed changes to the draft agenda (*Handout 2*). Colleen Cawston, Director of DSHS-IPSS, would be replaced by Doug North and Tiffany Villanes. Danette Ives would not be available to provide the COPES update.

### **DSHS Consultation Issue**

IPSS Regions 4 and 5 Manager Doug North stated that IPAC would be considering a consultation policy for DSHS. About four years ago, IPAC drafted a policy statement as part of WorkFirst planning, but it never advanced past the consultation stage. The IPAC executive committee met recently and decided to revisit the issue. IPAC will discuss the issue at its July meeting and try to formalize a plan at its October meeting on how to finalize the draft policy, – IPAC about 4 years ago drafted a consultation policy statement but it never made it past draft. Whitney Jones requested that AIHC delegates be provided the opportunity to comment on the draft. Tiffany Villanes, IPSS, said that she would follow up with Becky Johnston to distribute the draft.

Tiffany said that Colleen Cawston met with Secretary Braddock on Monday to discuss the ongoing conversations regarding the one facility/one rate policy for non-Native Medicaid billings. She said that the Secretary has agreed that there is a need for a consultation session to make sure that everyone is on the same page. Colleen will take the lead and will start the process for scheduling a late summer meeting (due to other scheduling conflicts, such as the canoe journey). Jim Sherrill asked whether the meeting

will be to receive bad news or whether there will be a chance to avert the bad news. Marilyn Scott said that the consultation will be government-to-government. Becky Johnston outlined the letter that AIHC sent to the Secretary requesting consultation and said that she believes that he is committed to hearing from tribes before making a policy decision on the encounter rate for non-Natives.

### **Title XIX Billing for Non-Natives**

Cecile Greenway (Lower Elwha Tribe) opened the discussion by stating that Lower Elwha several years ago decided to open up alcohol/substance abuse services to non-Natives because of IHS funding shortfalls and local issues regarding access to care. The Tribe decided to serve non-Natives to ensure that tribal members would receive care while the alcohol/substance abuse treatment remained fiscally viable. The county had approached the Tribe to provide care to non-Natives because the only other chemical dependency provider in the county was closing. The Tribe has been billing DASA the encounter rate for both natives and non-Natives under an agreement, and this has allowed the Tribe's program to grow from one to six providers. This year, the Tribe didn't get its DASA contract until after the start of the fiscal year, and was told by the regional DASA administrator that the state would no longer provide the state match for non-Native TANF patients. (The Tribe had been providing the state match for non-TANF patients, while the state had been providing the match for TANF patients.) In January, DASA Director Ken Stark sent a letter to the Tribe stating that it had erred in failing to notify the Tribe about the state's decision ahead of time. For Clallam County, the Tribe is the only chemical dependency provider that accepts Medicaid. If the Tribe stopped serving non-Natives, the nearest provider would be Sequim, which would create a major transportation issue. The state's decision dramatically impacts treatment services for everyone. The Tribe has had subsequent meetings with Ken Stark, but there has been no resolution of the issue. One billing dilemma is that there are different definitions of Native versus non-Native in IHS and CMS regulations. Another major issue is that the process for policy changes hasn't been followed because there has been no public hearing. Cecile said that it is important to have the appropriate level of discussion on this issue, and she isn't sure how many other tribes know about this problem.

Cecile said that MAA is listed as the lead Medicaid agency within the state plan so there is a disconnect between who can set the encounter rate policy. She doesn't see anything in the state plan that would indicate that DASA can set the policy unilaterally. She said that the state does have the ability not to pay the encounter rate under the CMS-IHS MOU, but the question is who can set the policy, how it can be set, and when it can be set. – MAA is listed as lead agency on Medicaid so there is a disconnect in terms of who can set this policy.

Marilyn Scott requested that any DASA representatives at the meeting come forward. DASA Tribal Liaison Sandra Mena and DASA Regional Representative John Taylor were in attendance. John said that Ken Stark would like any AIHC and tribal comments or questions to be put in writing because the issue is broader than DASA. Rod Smith (Puyallup Tribe) said that Ken Stark starts to set policy himself when he wants to change things and that tribes have had problems with him for years. He said that tribes need to drive to Olympia and have a powwow on this issue.

Marsha Crane (Shoalwater Bay Tribe) said that Shoalwater is not invested in the DASA issue but it is very concerned about the trend on non-Native billing that seems to be emerging without any input or upfront information. The Tribe serves non-Natives due to a lack of Medicaid providers in Pacific County. These services have become an economic enterprise and the decision to build a new clinic was based on third party reimbursement projections. Shoalwater provides medical and dental services for people who cannot find services anywhere else in the county, and about half of the Tribe's patients are non-Native. We provide medical and dental services for the people who can find services anywhere else in the new county. If the encounter rate policy changes, it will seriously impact the Tribe's ability to provide services and complete and pay for its clinic building.

Cecile said that Lower Elwha also is completing new construction based on reimbursement estimates. She was contacted by DSHS Children's Administration to see if the Tribe would provide Medicaid services for child care. They don't want to do it until encounter rate issue is resolved.

Tom Ashley (Stilligumish Tribe) said that the same issue has been going on for more than a year and that he believes that DASA has been more responsive than the Mental Health Division. Mental Health has told him that he can't do things but provided him with no written backup information. Stilligumish recently constructed a new methadone facility, and the Tribe's entire funding stream might go away without any consultation or written justification. The Tribal Council is extremely concerned. The non-Native community keeps asking for services, and the Tribe has taken the position that it is not country within a county that doesn't serve community members.

Marilyn said that she has heard from a lot of tribal representatives on this issue. She said that the state had been working with tribes and tribal leaders but that the work doesn't always get down to the lower levels. Some decisions rely on local level relations. She stated that AIHC's role is to be the liaison on the tribal side for health care services. When an issue like this comes up, AIHC's role is to bring the issue forward, clarify the problems, then facilitate a consultation with the decision-makers. Tiffany and Doug reiterated Secretary Braddock's commitment to consultation. Marilyn said that the Secretary will be making one decision and that individual divisions won't be able to issue policy in the meantime.

Marsha requested that a portion of a November 8 letter from CMS official Linda Ruiz to Shoalwater be read into the record. The letter states: "Tribes and states have asked if a state Medicaid program can pay two rates for the same services at a single facility: one rate for the service when furnished to AI/AN patients (for which the state received federal matching at the 100 FMAP), and a separate rate for non-AI/AN patients (for which the state received federal matching at the regular FMAP). CMS' position is that this is not legally permissible because states cannot make payments or set rates based on the race of beneficiaries, nor are they allowed to pay two different rates for the same service. This position remains in effect."

Marilyn said that this issue first was raised with DASA about five years ago and that similar problems cropped up then.

Jim Roberts (NPAIHB) said that the Board would help with policy guidance. Marilyn said that AIHC will take the lead on coordinating this issue because it is a tribal-state matter but that would like to get assistance from NPAIHB on related CMS and federal issues.

Chuck Wagner (Suquamish Tribe) said that Tribes need resolution of the issue if there is a consultation because things have been going on for five years. Marilyn said that we need written policy after the consultation so that policy won't change when people leave their jobs.

Rod Smith said that Ken Stark has said in public and in private that he doesn't agree with the state Medicaid program as being a pass-through of federal funds. This issue is none of his business and that he is tired of people introducing their own biases into the tribal-state-federal relationship. – Ken Stark in private and public doesn't agree with the pass-through of federal funds. This is none of his business and he's tired of people introducing their own biases into the relationship with state and federal governments.

Marilyn closed the discussion by stating that AIHC has clear direction to follow up and requested that AIHC members and tribal governments participate in the consultation process.

### **Tribal FQHC Issues**

Shulamit Decktor, consultant to the NPAIHB, made a presentation on Federal Qualified Health Centers (FQHC) and how tribes can become FQHCs for Medicare and Medicaid (*Handout 3*). Tribal 638 clinics are considered FQHC look-alikes and tribes can apply for FQHC status through a simple written request.

There are two separate funding streams – one for Medicare and one for Medicaid. The Medicaid FQHC is a fallback position within the IHS-CMS MOU and one that most tribes won't want to consider.

Marsha said that she had asked Region X staff if tribes had to be FQHCs for both Medicare and Medicaid or if they could be an FQHC for just one, and was told that they would have to do both. Shulamit said that the information was incorrect and that Lower Elwha has been a Medicare-only FQHC since the late 1990's. She also stated that the cost reports for Medicare FQHCs are easy because the rate is capitated, which means that tribes also need to show that they had \$98 worth of cost.

Shulamit said that background information on Medicaid FQHCs will be good for the upcoming consultation on non-Native billing issues. Under BIPA, Congress changed the way the Medicaid FQHC rate is paid. She believes that tribes can show that their costs are higher than the CMS rate, especially for tribes with small facilities. She is analyzing this issue for Port Gamble and thinks that their cost will be \$230 or higher. The sticking point is political in that states are able to capitate the rate for Medicaid FQHCs at 100% reasonable cost reimbursement. – this provides information which will be good for consultation for background. BIPA is latest development – tweaked way Medicaid FQHCs are paid. She believes that tribes can show that their costs are over CMS rate. SIHB gets Medicaid FQHC rate pretty close to encounter rate and they are big. Different states do this differently – Oregon has 100% of honest and allowable costs and WA has a capitated rate of 30% for overhead. Most tribes have an indirect of 30% not counting health administration, so the WA rate cuts tribes off at the knees. While rates have to be uniform for all FQHCs in the state, capitation is not required.

Marilyn asked Shulamit to provide contact information. Shulamit said that she would be happy to advise tribes free of charge but that she would need to be hired to do the actual legwork. She can be reached at [Shulamit@decktor.com](mailto:Shulamit@decktor.com) or 206-722-2855.

Rod asked when AIHC should bring the capitated rate discussion forward. Shulamit said that this issue should be discussed now, as should follow-up on Medicaid Administrative Match. All MAM contracts terminate at the end of the year, plus six new tribes have applied for MAM contracts, which means that tribes shouldn't wait until July or August.

Becky said that AIHC and NPAIHB sent a letter to MAA requesting a meeting on MAM issues several months ago and that the issue had been put off by MAA pending the hiring of Gayleen Davis' replacement. Because that person has not yet been hired, we should request a meeting with Roger Gantz immediately. Deb Sosa, MAA Indian Program Manager, agreed that a meeting was needed and requested that another AIHC-NPAIHB letter be sent.

### **Medical Assistance Administration Update**

Deb Sosa provided an update on a number of pending MAA issues.

She shared a copy of the WA response to CMS' request for more information on the Section 1115 waiver request to exempt AI/ANs from Medicaid premiums (*Handout 4*). Hobbs, Straus, Dean & Walker provided trust responsibility information for the document. She said that the state has let CMS know that it intends to press on with the exemption unless it hears otherwise. No premium statements will go out to AI/ANs who are identified under the race code. Other statements will have a line that indicates that, if a person is AI/AN, premiums don't apply.

Jim Reports said that the Health Board requested that the civil rights issue be included at part of last week's HHS consultation in DC and that the Office of Civil Rights said that they wouldn't send a representative to the meeting at the last minute.

Deb said that she also has been working on MAA's 7.01 plan. She said that, because MAA doesn't have a regional structure for input, she wants to request that AIHC work with MAA to provide input and would like to start a dialogue about how that can happen. Deb will provide a copy of the draft 7.01 plan to AIHC

for distribution to tribes. Becky clarified that AIHC could help to coordinate input and technical comments but that the consultation needs to occur with tribes at the government-to-government level.

Marilyn said that Region 3 has a regional tribal coordinating council and that a representative from MAA has been attending the meetings. The region develops its 7.01 plan at these meetings, but they are the only region that has this kind of structure. She said that MAA input should be coordinated with the Mental Health Division and SASA. She is not sure whether AIHC will be the appropriate mechanism because of the way that some tribes do business. She said that AIHC is starting to plan the Tribal Leader Health Summit and that could be a way to start a joint AIHC-IPAC effort on the 7.01 process.

Sheryl Fryberg said that AIHC should also develop a plan for government-to-government training for DSHS employees. Becky said that AIHC could work with the Governor's Office on Indian Affairs on education and outreach and with agencies to institutional government-to-government training as part of the 7.01 plans.

Deb said that MAA has been trying to issue clarification policies and to collaborate more with other Medicaid agencies within DSHS and DOH. CMS has been coming down on states to make sure that no extra federal dollars are going to them, and MAA has a legacy of not having written policies.

She also mentioned the Take Charge Program for family planning and General Assistance Unemployed program to see whether any tribes are interested in learning more about these programs. Puyallup has been interested in the Take Charge Program and Lower Elwha provides GAU funds. Deb doesn't have data on tribal use of GAU.

Tom Ashley requested that Becky e-mail delegates the IPAC minutes in which Rick Arnold stated that MAA had a one facility, one rate policy and that tribes should bill for non-Natives at the encounter rate.

Cecile Greenway said that MAA is the lead agency for Title XIX funding under the state Medicaid Plan, so MAA should set all Title XIX policy. Rod Smith said that AIHC should write a model Title XIX policy for Secretary Braddock, and Sheryl Fryberg agreed. Cecile said the policy should re-state the state plan.

Avreayl Jacobsen, tribal liaison for the Mental Health Division, said that the Division does policy work but can't make policy for something in the MAA budget. She is questioning who is responsible for making policy and said that is why higher level consultation is needed. Cecile said that Lower Elwha does a lot of federal plans and the lead agency is responsible for policy no matter who gets funding.

Shulamit Decktor said that tribes run a risk if they talk about mental health and chemical dependency as linked because DSHS views them separately. She said that the Mental Health Division has a good deal for tribes under the exiting contract language, which was developed over a two-year process. The contract language specifically states that tribes can't bill Medicaid for non-Natives.

### **Traumatic Brain Injury Toolkit**

Rosemary Biggins, DSHS Aging and Disabilities and Services Administration, gave a presentation on a recent federal HRSA grant to Washington State to focus on community-based support and infrastructure for traumatic brain injuries (*Handout 5*).

She said that the state will be developing an educational toolkit and that she would like to ask tribes to consider participating in its development and distribution. Currently, the Yakama Nation Administration on Aging has committed to distribution.

Cecile Greenway asked if other states have developed AI/AN-specific information. Rosemary said that she hasn't found any but that Montana, which recently received a grant, has been doing AI/AN-specific work.

Marilyn Scott asked if the state has a tribal representative on the traumatic brain injury advisory board. Rosemary said that there hasn't been consistent AI/AN representation and that anyone who is interested in participating should contact her.

### **Health Workforce Diversity Network**

Kim Moore, State Board of Health Workforce Diversity Network staff, provided an overview of the network, which was formed based on recommendations and findings of SBOH. Its mission is to improve diversity in the health workforce because doing so will improve health status in minority populations. Members include hospitals, clinics, health associations, public health, and educational institutions. Joe Finkbonner has served as a member. There are three main workgroups – enumeration (data), funding (for diversity efforts), and health careers pathways.

The pathway workgroup has developed a survey designed to identify successful models at elementary/secondary and higher education levels. The survey will show what populations are targeted and where there are gaps. She asked for input on how to disseminate the survey, which is online, and how it could be improved. Survey respondents will have access to raw data, but the final report won't have sensitive information like sources of funding.

Becky Johnston asked how the survey differs from the public health workforce survey and about the timeline for dissemination. Kim said that the survey doesn't identify the current capacity and that the survey will go out in the next few weeks.

Marianne Seifert, the SBOH tribal liaison, said that Becky did a presentation at the March SBOH meeting on AI/AN workforce issues and the tribal leader position paper. She said that the SBOH wants to promote and demystify best practices.

Rod Smith recommended that the SBOH link its efforts with the Commission Corps and other public health service efforts so that young people know about career options. Becky recommended that Kim contact the Portland Area Office to share information.

### **Uniform Benefits Workgroup Update**

Becky Johnston provided an update on the uniform benefits workgroup. She said that the draft report is being finalized by the workgroup and that it will be sent to all AIHC delegates after the workgroup's June 4 conference call. It will be considered at the July AIHC meeting and then sent to tribal leadership for review and comment prior to the Tribal Leader Health Summit.

Shulamit Decktor recommended that the workgroup look at Oregon's case management program for suggestions.

Marilyn Scott state that there was a discussion early in the workgroup process about the need to preserve the local tribal choice about the types of services that are provided at the local level. She said that we need to make sure that this local tribal authority is protected. She said that the work was harder than originally anticipated and that the workgroup has identified a number of programs and services that aren't being accessed by tribes. She is looking forward to the results of the workgroup and said that this topic will be a major part of the November Health Summit.

Rod Smith said that the report will be an influencing factor for MAA and the state for years to come, so it will be important for tribes to read it and comment on it. Jim Roberts said that other IHS Areas also have expressed interest in the workgroup efforts.

### **NPAIHB Update**

Jim Roberts provided an update on several pending issues, including the HHS Region X Consultation Report, the U.S. Commission on Civil Rights "Quiet Crisis" follow-up report, appropriations, and the Indian Health Care Improvement Act (*Handouts 6A – D*).

With respect to facilities, Jim said that the California and Bemidji Areas have sent letters that are similar to Portland's letter. The FAAB is ready to roll out its recommendations for consultation in mid-June – July. Rod Smith will work with NPAIHB to develop model responses for tribes.

For the NPAIHB emergency preparedness funding allocation, Joe Finkbonner sent surveys to WA tribes with a very tight timeline because of contract issues with the EpiCenter and U-WA. The letter was dated May 3 and the deadline was May 14. Marilyn Scott said that the state was trying to encumber its funds before the end of the fiscal year. Becky Johnston said that she would follow up with the state regarding whether funds could be carried over.

### **Next Meeting**

The next AIHC meeting was set for Friday, July 9, from 10:00 – 3:00 at the Seattle Indian Health Board.

### **Adjournment**

The meeting adjourned at 3:00 p.m.