STATE OF WASHINGTON

October 14, 2013

Mary Greene, Grants Management Officer
Centers for Medicare and Medicaid Services
Office of Acquisition and Grants Management
7500 Security Boulevard, M/S B3-30-03
Baltimore, MD 21244

Dear Ms. Greene:

SUBJECT: Washington State Money Follows the Person (MFP) Tribal Initiative: 2013

Washington State is pleased to have the opportunity to develop infrastructure in Tribal Lands that support American Indians/Native Americans receiving care in institutional settings to move to community settings through the Money Follows the Person Tribal Initiative. The Department of Social and Health Services (DSHS) will serve as the designated single state entity to apply for and administer the initiative on behalf of the Washington State Tribes and Tribal Organizations, the Health Care Authority (HCA) and DSHS. DSHS is the current Money Follows the Person awardee/representative. The HCA is designated as the single Washington State Medicaid Agency.

Washington State, in alliance with the Indian Policy Advisory Committee (IPAC) and the American Indian Health Commission (AIHC), are seeking funding to complete phase one of the initiative. IPAC and AIHC are the two recognized committees representing the Federally Recognized Tribes and Recognized Indian Organizations that provide services to Native Americans primarily in urban settings. We formally request a direct supplement of $300,000 to our Money Follows the Person program to create:

1. A concept paper outlining the state-tribal partnerships;
2. A commitment agreement between Washington State and the Tribes/Tribal Organizations to pursue the MFP initiative; and
3. A description of relevant tribal characteristics in Washington State, including a tribal needs assessment and population details. The assessment will be used for planning purposes.

Inclusive in the assessment will be specific population details for each of the 29 Federally Recognized Tribes, identification of service gaps that required movement to institutions and of "promising" long-term care practices and delivery methods that have been successful in tribal services.

The principal contact person for this initiative is Traci Adair, Resource Support and Development Unit Manager at 206-341-7653 or traci.adair@dshs.wa.gov.

Sincerely,

MaryAnne Lindeblad, Medicaid Director
Health Care Authority

Kevin W. Quigley, Secretary
Department of Social and Health Services

Project Abstract:

For the first time, with the passage of the Affordable Care Act and its conjoined American Indian Health Improvement Act, long term services and supports (LTSS) can be developed and supported through Indian Health Service resources. This establishes an opportunity for tribes to plan and develop community-based services which meet the needs of their people in culturally appropriate ways.

Indian Country will experience the Baby Boomer Age Wave in the same way as in the non-Indian community and the need for services will increase dramatically. Collaborating with Tribes, Urban Indian Organizations, and allied long term care organizations, Washington State will seek to identify pertinent tribal characteristics through surveys, assessments and broad input to determine respective roles for Medicaid administrative functions. This process will ensure that native services will be of high quality and ready to accept tribal members discharged from skilled nursing facilities and other institutional settings.

The Washington Health Care Authority, the State Medicaid Agency, and the Department of Social and Health Services (DSHS), the designated single state entity with delegated Medicaid authority for long term services and supports will work with the DSHS Office of Indian Policy, the Washington American Indian Health Commission, the 29 federally recognized tribes and the recognized urban Indian organizations to create:

1) A concept paper outlining the state-tribal partnerships;
2) A commitment agreement between Washington State and Tribes/Tribal Organizations to pursue the MFP initiative; and
3) A description of relevant tribal characteristics in Washington State, including a tribal needs assessment and population details.

Washington State is requesting a direct supplement of $300,000 to our Money Follows the Person program for the anticipated November 19, 2013 – April 19, 2014 planning phase.

It is anticipated that more than 193,378 Native Americans/Alaskan natives may benefit from the outcomes of this initiative. In 2010, DSHS data documented 22,362 persons receiving servings in nursing facilities. Eight hundred and fifty (850) or 3.8% of those persons were identified as AI/AN. Documentation of AI/AN is often unreliable and it is anticipated that a larger number of tribal members reside in nursing facilities than documented.

Washington State Money Follows the Person Tribal Initiative: 2013

Project Narrative: For the first time, with the passage of the Affordable Care Act and its conjoined American Indian Health Improvement Act, long term services and supports (LTSS) can be developed and supported through Indian Health Service resources. This provides an opportunity for Washington State, Tribes, Urban Indian Organizations and allied long term care organizations to utilize existing strong partnerships as a base to plan and develop community-based services which meet the needs of Tribal people in culturally appropriate ways. The partners will seek to identify pertinent tribal characteristics through surveys, assessments and broad input to determine respective roles for Medicaid administrative functions at the tribal level. This process will ensure that native services will be of high quality and ready to accept tribal members discharged from skilled nursing facilities and other institutional settings. Key partners and existing formal relationships that support cooperative relationships for the continued improvement of services and service delivery for tribal members will provide a strong base. **State/Tribal Partners and Partnerships**: The **Primary Partners**[1] will include the Indian Policy Advisory Committee (IPAC), the Washington American Indian Health Commission (AIHC), the Department of Social and Health Services (DSHS), Aging and Long Term Support Administration (ALTSA) and the Health Care Authority (HCA). This partnership will provide leadership throughout the Initiative.

The **Indian Policy Advisory Committee**[2] is the oldest tribal advisory committee in the state, established in 1977. The IPAC is an advisory body to the Secretary of the Department of Social and Health Services, the largest state agency in Washington State. Membership is the 29

[1] For additional information on the Primary Partners refer to Appendix A
[2] http://www.dshs.wa.gov/oip/ipac.shtml

Washington State Money Follows the Person Tribal Initiative: 2013

ALTSA Phase One Budget Narrative/Justification: 11/19/2013 – 04/19/2014

Object Class Category	MFP Tribal Initiative Funds	Justification
		Existing MFP staff and other state personnel will provide staff support. MFP: 25 hr/mo; OIP: 8 hr/mo; HCA as needed. No personnel will be charged to this grant.
a. Personnel	$0	**Personnel Total:**
		Project Support Staff - 31% of Salary
		Existing MFP staff and other state personnel will provide staff support. MFP: 25 hr/mo; OIP: 8 hr/mo; HCA as needed. No personnel will be charged to this grant.
b. Fringe Benefits	$0	**Fringe Benefit Total:**
		State Government Travel
		Local Travel 5433 miles X $.565 per mile OR dedicated state car
		Airfare (assumes car travel to allow for visits to multiple tribal locations)
		Hotel, 30 nights at average rate of $93.00 including tax /night *2 staff, 15 nights each
		Per Diem, 60 days times average of $55.50, *2 staff 30 days each
		Travel beyond above estimates will be charged to current MFP
c. Travel	$9,652	**Travel Total**
d. Equipment	$0	**Equipment Total:**
		Supplies provided by ADS/ALTSA
e. Supplies	$0	**Supplies Total**
		Federal:
		American Indian Health Commission

Appendix A: MFP Tribal Initiative Partners

The Washington Money follows the Person Rebalancing Demonstration Grant: Tribal Initiative will be based upon an expansion of formal relationships with key partners to focus on planning and developing community based services that will support the return of tribal members to their communities of choice with the necessary supports. Primary Partners within the initiative will be the Indian Policy Advisory Committee, The Washington American Indian Health Commission, the Department of Social and Health Services (DSHS), Aging and Long Term Support Administration (ALTSA) and the Health Care Authority (HCA). This partnership will provide leadership to the Initiative.

The **Indian Policy Advisory Committee**[1] (IPAC), established in 1977, is the oldest tribal advisory committee. The IPAC is an advisory body to the Secretary of the Department of Social and Health Services (DSHS), the largest state agency in Washington. Membership includes the 29 Federally Recognized Tribes in Washington as well as 6 Recognized American Indian Organizations. The IPAC was created to guide implementation of the Centennial Accord and the American Indian Administrative Policy 7.01. Its role is to assist the collective needs of the Tribal governments and other American Indian organizations to assure quality and comprehensive service delivery to all American Indians and Alaska Natives in Washington State.

The **Office of Indian Policy**[2] (OIP), DSHS will continue to provide administrative support and technical assistance to the grant through monthly IPAC subcommittee meetings. The Office of Indian Policy's role, in conjunction with the DSHS administration, the Secretary's Indian Policy

[1] Indian Policy Advisory Committee; http://www.dshs.wa.gov/oip/ipac.shtml
[2] DSHS Office of Indian Policy; http://www.dshs.wa.gov/oip/

Advisory Committee, Tribal governments and Indian organizations is to support quality and comprehensive program service delivery to Indian people.

The American Indian Health Commission[3] (AIHC) for Washington State is a tribally-driven non-profit organization. Its mission is to improve health outcomes for American Indians and Alaska Natives (AI/AN) through a health policy focus at the state level. AIHC, created in 1994, works on behalf of the 29 federally-recognized Indian Tribes, Urban Indian Health Organizations and other Indian organizations. The Commission serves as an effective forum for achieving unity and guiding the collective needs of tribal governments and urban Indian health programs in providing high-quality, comprehensive health care to AI/ANs in Washington. The ultimate goal is to promote increased tribal-state collaboration to improve the health status of American Indians and Alaska Natives by influencing state and tribal health policy and resource allocation. Key activities include: • Identifying health policy issues and advocating strategies to address Tribal concerns; • Coordinating policy analysis; • Soliciting and collecting information from the state for Tribal review and response; • Disseminating information to Tribal health programs and leaders; and • Promoting the government-to government relationship between tribes and state health agencies.

The Department of Social and Health Services (DSHS), through a memorandum of agreement with the **Health Care Authority** (HCA), has delegated Medicaid authority to administer long-term services and supports for Medicaid recipients. Both State agencies will participate in the initiative with DSHS/ALTSA as the designated MFP lead.

[3] The American Indian Health Commission-WA; http://www.aihc-wa.com/

The **Health Care Authority** (HCA), as the lead Medicaid agency, will participate to ensure that Medicaid policy, potential waivers and/or State Plan Amendment requests are within federal rules. It is anticipated that HCA will become more active in phases two through four.

Additionally, Washington has a **Governor's Office of Indian Affairs** (GOIA). The office serves to advise the Governor on tribal issues and act as a liaison between the state and Tribes and tribal organizations. It promotes the government to government principles outlined in the 1989 Centennial Accord. Since 1997 the plan (and its subsequent updates) has served as a framework for Tribes, Urban Indian Health Organizations, the Commission, and Washington State to address a shared goal of improving the health status of American Indian/Alaska Native people (AI/AN). Although not an active partner in this initiative, the GOIA will be informed of activities and provided updates as the demonstration moves from phase one through four.

Appendix B: State Medicaid Agency Structure

On July 1, 2011 the Washington state legislature created the Health Care Authority (HCA) and designated it the **single state Medicaid agency** for the administration of Medicaid Services. Formerly, the Department of Social and Health Services (DSHS) was the designated agency. This designation is provided through RCW 74.09.530.

The designation as the single state Medicaid agency is a formal recognition by the federal Centers for Medicare and Medicaid Services and state government of the Health Care Authority's leadership and direction of all health care proposals under Title XIX and XXI of the federal social security act and Washington Law. The Medicaid/CHIP financing available under Title XIX and XXI crosses both organizations so clear processes and understanding are fundamental to maintaining the "single state designation" responsibilities and to administer services and implement new processes and/or changes that will affect consumers and providers. HCA and DSHS have completed a thorough review of areas that might be impacted by the creation of the Health Care Authority. HCA and DSHS have agreed to work cooperatively and in collaboration in all relevant areas as partners towards the effective and efficient operation of the Medicaid program, Children's Health Insurance program and state-funded health care programs. These processes have been formalized through a HCA/DSHS Cooperative Agreement[4] , finalized on November 1, 2012.

Governance is shared between DSHS/Aging and Disability Services (ADS) and the HCA. The two agencies have a history of collaboration to develop new strategies to improve health care,

[4] http://dshs.wa.gov/pdf/HCA_DSHS_CooperativeAgreement_November2012.pdf

services and supports and their associated costs. The HCA is the Medicaid agency responsible for purchasing Medicaid medical services. As the single state Medicaid Agency, the Health Care Authority has delegated to DSHS the responsibility to administer certain identified Medicaid programs and acknowledges that DSHS is, at times, also a direct service provider. ADS is responsible for purchasing, program and service development for mental health, chemical dependency, long term services and supports and services to individuals with developmental disabilities.

The Department of Social and Health Services (DSHS) will serve as the designated single state entity to apply for and administer the initiative on behalf of the HCA and DSHS. DSHS is the current Money Follows the Person awardee/representative.

Oversight of the MFP Tribal Initiative will be a joint effort through DSHS/HCA and Tribal representation. The collaborative joint governance will form a strong partnership that draws from a diversity of strengths and expertise in the community and shares a commitment to develop new, innovative ways to improve service delivery for tribes. Authorizing and decision making staff will ensure critical information is acted upon quickly. High level oversight will ensure strategies and directions are carried out systematically and effectively.

Washington is well positioned to implement an initiative to explore and plan Medicaid activities with Tribes and oversee contracts, activities and associated funding. HCA and DSHS have extensive experience in implementing large system change projects that require collaboration with tribes, providers, stakeholders, community groups, advocates and state and local government entities. Both agencies are experienced in health promotion, consumer

engagement, program development and evidence-based methods to improve participation. Washington has a demonstrated commitment to use data to compliment decision making. The goal and objectives established by Washington State Tribes through IPAC and AIHC form the basis for the Money Follows the Person Demonstration project.

Project leadership will bridge administrative boundaries to ensure appropriate subject matter experts are consulted for joint administration of MFP-AI/AN. The project will be informed by a broad range of tribal input and through a hands-on, face to face assessment process with active involvement of each individual tribe. Within DSHS, the Aging and Long Term Support Administration, Home and Community Services Division will have lead responsibility for administration, monitoring and contracting the AI/AN initiative within the existing MFP program. Washington has operated the MFP program since 2007. In that time, over 3170 persons have returned to their communities of choice after an institutional placement.

Key State Staff: MaryAnne Lindeblad, HCA Medicaid Director and Kevin Quigley, Secretary of DSHS are the executive level sponsors of MFP-AI/AN. Day to day sponsorship will be delegated to Bill Moss, Assistant Secretary, Aging and Long Term Support Administration (ALTSA). DSHS Program Manager Elizabeth Prince will manage the overall MFP program and Traci Adair, Resource Support and Development Unit Manager will provide direct project management for Phase 1. Ms. Adair in collaboration with tribal identified leads will provide planning, implementation, contract development/administration and completion of phase 1 activities and deliverables.

Appendix C: Washington/Tribal Agreements

The **Centennial Accord**[5]**,** first enacted in 1989, memorializes the mutual goals of improved relationships between sovereign governments through a framework for government-to-government relationships and implementation procedures to assure execution of the relationship. Sovereignty recognition is paramount for both parties to govern and represent their respective governments. The ACCORD has been initiated by the signatory tribes and state governor but it also recognizes that Washington is governed in part by independent state officials. As a result, inclusion and participation of chief representatives of state government participate in the government to government relationship. This relationship respects the sovereign status of the parties, enhances and improves communication between them, and facilitates the resolution of issues. The ACCORD's ultimate purpose is to improve the services delivered to people by the parties. Annually the parties develop joint strategies and specific agreements to outline tasks, overcome obstacles and achieve specific goals.

The **Indian Nation Consolidated Tribal Social and Health Services Plan**[6] is a required component of the Indian Nation – Department of Social and Health Services Contract Consolidation Project. The project is specific to the government-to-government relationship between Tribes and DSHS. It supports Indian self-determination by decreasing DSHS requirements regarding the design and delivery of social and health services programs. Services

[5] http://www.dshs.wa.gov/oip/centaccord.shtml
[6] http://www.dshs.wa.gov/oip/contractconsol.shtml

and programs are better tailored to the needs of populations to be served. The project has been modeled after Public Law 102-477 [7]and contains many of the same requirements. The plan describes how Tribes will provide culturally relevant services while meeting applicable statutory and regulatory requirements and potential needs for waivers. The project seeks to reduce administrative and staff burdens by consolidating multiple agreements without reducing funding but merging required reports, audits and documentation.

The **Intergovernmental agreement for social and health services between a tribe and DSHS**[8] supports Tribal Consolidated Services Plans to recognize government to government relationships. It honors a tribes' right to design and operate culturally relevant and appropriate programs for their population and increase quality and efficiency of state and tribal benefits and services to native peoples and other persons served by the tribes. The agreement also simplifies contracting processes to allow increased direct services, support tribal dedication of funding resources to actual needs and to simplify reporting programs to improve the health of Indians. An example is the American Indian Health Care delivery Plan[9], a collaborative effort between the Washington Department of Health, the Washington American Indian Health Commission and the Tribes.

[7] Public Law 102-477. http://www.doleta.gov/dinap/cfml/477page.cfm
[8] http://www.dshs.wa.gov/oip/contractconsol.shtml
[9] American Indian Health Care Delivery Plan 2010-2013. http://www.aihc-wa.com/wp-content/uploads/2011/09/American-Indian-Health-Care-Delivery-Plan-2010-20134.pdf

Appendix D: Preliminary Tribal Populations: Washington State

For the first time, with the passage of the Affordable Care Act and its conjoined American Indian Health Improvement Act, long term services and supports (LTSS) can be developed and supported through Indian Health Service resources. This establishes an opportunity for tribes to plan and develop community-based services which meet the needs of their people in culturally appropriate ways. Indian Country will experience the Baby Boomer Age Wave in the same way as in the non-Indian community and the need for services will increase dramatically. Collaborating with Tribes, Urban Indian Organizations, and allied long term care organizations, Washington State will seek to identify pertinent tribal characteristics through surveys, assessments and broad input to determine respective roles for Medicaid administrative functions. This process will ensure that native services will be of high quality and ready to accept tribal members discharged from skilled nursing facilities and other institutional settings.

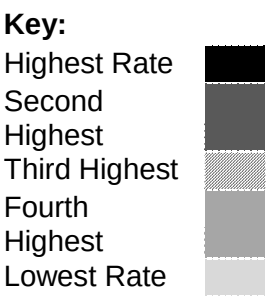
The ultimate goal of this project is to improve the ability of Tribes to deliver long-term care, home and community services for vulnerable Tribal members in their communities with a focus on those who are receiving care in facilities. Improving and maintaining the health of Tribal elders and other tribal members with chronic conditions and disabilities is a priority for Washington State Tribes, yet comprehensive long-term care or home and community services are not fully in place. Tribes lack both technical and financial resources to develop the comprehensive delivery systems that can meet the complex medical, physical and cultural needs of elder and disabled members as well as those needing long-term services and supports

at home or in their communities. Access to primary, specialty and acute care are critical to the overall health. The continuity of care must include home and community based services.

Population—State Data

The AI/AN population in Washington is diverse, geographically dispersed, and economically disadvantaged. AI/ANs are more likely to live in poverty than any other racial or ethnic group in Washington. They also experience disproportionately high mortality and morbidity burden compared to the general population. Recent Washington State Department of Health statistics (from BRFSS and other community data sets) establish that AI/ANs have the highest rates of most diseases and chronic conditions, self-reported poor mental health, heart disease, diabetes, binge drinking, drug abuse, traumatic brain injury, motor vehicle accidents, and disability when compared with other ethnic groups in our state. The table below shows graphically the health and well-being disparities in Washington state Indian communities. These health disparities indicate a population at high risk of need for support with activities of daily living. Developing services to support them is imperative.

Health and Well-being Indicator	Ethnic Group				
	White	Black	Asian	Hispanic	AI/AN
Income below $20,000/year					
Self-reported poor or fair health					
Death rate					
Disability rate					
Obesity rate					
Self-reported poor mental health					
Binge Drinking					
Drug Abuse					
Heart Disease					
Stroke					
Diabetes					
Traumatic Brain Injury					



Existing data is unreliable in terms of providing consistent information about the population of AI/AN individual in skilled nursing facility or other Medicaid funded long-term settings. The graph below provides an overview from 2010 of the settings and population percentages by settings of AI/NA individuals served by the state's long-term services and supports structure. More detailed tribal needs-assessment and tribal population details will be completed as an element of Phase 1 and contribute to the overall program design.

DSHS Client Services Data for All Ages by Race, July 2009-June 2010 shows

Washington State	**DSHS Clients Served**	**American Indian/ Alaskan Native**
Aging and Adult Services Total	**72,413**	**4.4%**
Adult Family Homes	6,739	3.3%
Adult Residential Care	2,786	3.2%
Assisted Living	6,379	2.4%
Comprehensive Assessment	48,280	4.7%
In-Home Services	38,360	5.4%
Managed Care	228	4.0%
Nursing Facilities	22,362	3.8%
Additional Services	6,957	4.1%
Medical Assistance Total	**1,414,352**	**5.3%**

Washington has a diverse set of long-term services and supports provided by tribes or tribal organizations. The Colville Confederated Tribes has the only skilled nursing facility owned and operated by a Washington State Tribal Government. It is a 44 bed facility in the North central Washington state. The Lummi Nation and Spokane Tribe of Indians both provide home and community based home care agency services. Those services are subject to State regulations that do not always support the needs and the realities of service delivery of the tribes.

Current Service Utilization: All individuals eligible for Medicaid funded LTSS in Washington receive the CARE assessment which includes demographic information. The report from July 2009- June 2010 indicates there were 4,522 AI/AN individual's receiving services primarily from non-tribal providers. Nearly 1,000 people were living in skilled nursing facilities. Many of these individuals could be transitioned to tribally operated community based services if the tribal services were ready to receive them. The transition to culturally appropriate care would certainly enhance quality of life and result in a savings of $26 million in state funding for these services. Indian Country will experience the Baby Boomer Age Wave in the same way as in the non-Indian community and the need for services will increase dramatically.

Two Area Agencies on Aging in Washington State are tribal based. The Colville Indian and Yakama Nation Area Agency on Aging serves tribal members and community members within the interior boundaries of the Colville Confederated Tribes primarily in Okanagan and Ferry, and the Yakima and Klickitat counties.

Appendix E:

Preliminary Letter of commitment between Washington State and Tribes:

March 2013

STATE OF WASHINGTON

March 12, 2013

CMS MFP Tribal Project Officer
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, Maryland 21244-1850
Attn: Anita Yuskauskas
Email: anita.yuskauskas@cms.hhs.gov

Ms. Yuskauskas;

SUBJECT: 2013 Money Follows the Person (MFP) Tribal Initiative: Washington State

Washington is pleased to enter into a preliminary agreement with the Indian Policy Advisory Committee (IPAC) and American Indian Health Commission (AIHC). In Washington State these are the two committees that represent the Federally Recognized Tribes and Recognized American Indian Organizations providing services to Native Americans, primarily in our urban settings.

The Department of Social and Health Services (DSHS) will serve as the designated single state entity to apply for and administer the agreement on behalf of the Health Care Authority (HCA) and DSHS. DSHS is the current Money Follows the Person awardee/representative. The HCA is designated as the single Washington State entity accountable for the Medicaid State Plan.

In compliance with DSHS Consultation Protocols, a formal consultation on this MFP grant submission was held on March 5, 2013. In advance of the consultation there were two roundtable discussions on February 12th and 26th. During these sessions the Tribes and DSHS worked in collaboration on the enclosed Phase One proposal of the 2013 MFP Tribal Initiative. The HCA has more recently been engaged in conversations and will participate further as the grant work proceeds.

Our commitment for Phase One is to collaborate on three elements over the first six to nine months of the anticipated award. These include a statewide tribal needs assessment, a state-tribal concept paper, and a formalized commitment to pursue all phases of the MFP initiative.

If you have further questions on our submission please contact Traci Adair at 360-725-2455 or traci.adair@dshs.wa.gov or Liz Mueller at 360- 681-4628 or lmueller@jamestowntribe.org.

Respectfully,

Kevin W. Quigley
Secretary
Department of Social and Health Services

Liz Mueller
Chair
Indian Policy Advisory Committee

MaryAnne Lindeblad
Medicaid Director
Health Care Authority

Marilyn Scott
Chair
American Indian Health Commission

Appendix F: Federally Recognized Tribes in Washington State:

There are 29 federally recognized tribes in Washington State.

- Colville Confederated Tribes
- Confederated Tribes of the Chehalis Reservation
- Confederated Tribes of the Yakama Indian Reservation
- Cowlitz Tribe
- Hoh Tribe
- Jamestown S'Klallam Indian Tribe
- Kalispel Tribe
- Lower Elwha Klallam Tribe
- Lummi Nation
- Makah Tribe
- Muckleshoot Tribe
- Nisqually Tribe
- Nooksack Tribe
- Port Gamble S'Klallam Tribe
- Puyallup Tribe
- Quileute Tribe
- Quinault Nation
- Samish Nation
- Sauk-Suiattle Tribe
- Shoalwater Bay Tribe
- Skokomish Tribe
- Snoqualmie Tribe
- Spokane Tribe
- Squaxin Island Tribe
- Stillaguamish Tribe
- Suquamish Tribe
- Swinomish Tribe
- Tulalip Tribe
- Upper Skagit Tribe

		The AIHC will, through consultant services, develop a statewide assessment to be utilized by all 29 tribes. The survey will include relevant tribal characteristics and population details. The consultant will orient tribes to the assessment, meet with tribes to provide technical assistance, modeling and other supports as needed. The consultant will analyze the results and provide DSHS, OIP, IPAC and AIHC leadership with a draft and final report. Contractual amount = $150,000.
		Office of Indian Policy
		Individual Tribal[1] disbursements (29) to support culturally appropriate outreach and survey/assessment at the tribal level. Average of $3,700 per tribe*29=$107,300.
f. Contractual	$257,300	**Contractual Total**
		Printing of final report and dissemination to tribes:
		Final report: colored graphics, logos and photos. Dissemination to Tribal entities, 35 copies printed, 1 mailed to each of the 29 Federally Recognized tribes; 6 mailed to Tribal organizations. Cost= 150 page report @$.22 pp for 35 color pages; .04 for 115 standard pages and .15 pp binding to print with postage @$3.50/each.
		Statewide working session:
		82 guest room nights @ $124/nights (50 Tribal members living outside 50 mile radius, 12 for members from Recognized American Indian Organizations, and 20 for third night lodging for those who live 250 miles from meeting)
		Rental of Tribally owned facility for 2-day event: $18,000 (including banquet facility, break-out rooms, refreshments)
		A.V. equipment rental: $2,550, based on past experience with statewide work session planning
		Meeting Materials: $1,750
h. Other	$33,048	**Other Total**
I. Total Direct Charges (6a- 6h)	**$300,000**	
j. Ind. Charges	0	
k. TOTALS	**$300,000**	

[1] For a listing of the federally recognized tribes see Appendix F

Federally Recognized Tribes in Washington State as well as 6 Recognized American Indian Organizations. The **Office of Indian Policy**[3] (OIP), DSHS will continue to provide administrative support and technical assistance to the grant. This will be done through the monthly IPAC subcommittee meetings. The **Washington State American Indian Health Commission**[4] was created in 1994 by federally recognized tribes, urban Indian health organizations, and other Indian organizations to improve the health of AI/AN people through collaboration on health policies and programs that will help decrease disparities, which are contained within the American Indian Health Care Delivery Plan. The **Department of Social and Health Services**, through a memorandum of agreement with the **Health Care Authority**[5], administers long-term services and supports for Medicaid recipients. Both State agencies will participate in the initiative with DSHS/ALTSA as the designated MFP lead.

A number of formal agreements[6] currently exist between Washington and the Federally Recognized Tribes and/or Recognized American Indian Organizations. Additional supports for a strong working relationship include formal consultation policies for both DSHS and HCA, (Administrative Policy #7.01 (DSHS) and Administrative Policy #1-15 (HCA)).

Through decades of planning, trial, and continuous quality improvement, Washington State's LTSS system is of high quality and reasonable cost. It is likely that the lessons learned in Washington's development of home and community-based services will provide an excellent foundation and starting point for the development of services in tribal communities.

[3] http://www.dshs.wa.gov/oip/
[4] http://www.aihc-wa.com/
[5] For additional information on Washington's State Medicaid Agency Structure refer to Appendix B
[6] For additional information on Washington/Tribal Agreements refer to Appendix C and http://www.dshs.wa.gov/oip/contractconsol.shtml

Relevant tribal characteristics in the state: The AI/AN population in Washington is diverse, geographically dispersed, and economically disadvantaged. AI/ANs are more likely to live in poverty than any other racial or ethnic group in Washington. They also experience disproportionately high mortality and morbidity burden compared to the general population. Recent Washington State Department of Health statistics (from BRFSS and other community data sets) establish that AI/ANs have the highest rates of most diseases and chronic conditions, self-reported poor mental health, heart disease, diabetes, binge drinking, drug abuse, traumatic brain injury, motor vehicle accidents, and disability when compared with other ethnic groups in our state. These health disparities[7] indicate a population at high risk and need for support with activities of daily living. Developing services to support them is imperative.

Activities to develop State-Tribal Partnership Commitment Agreement

Based on the solid groundwork of the existing partnerships, agreements, and the March 2013 preliminary letter of commitment[8], the primary partners will:

- Expand and improve the government-to-government relationship between DSHS Aging and Long Term Services Administration (ALTSA), HCA, Department of Health (DOH) and Tribes/Tribal Organizations to develop appropriate policies and delivery systems for providing home and community based services to Tribal elders and adults with disabilities.
- Identify areas on which to partner with sister agencies to address any barriers associated with licensure and/or payment processes for long-term services and supports.

[7] For additional information on Washington Tribal Characteristics refer to Appendix D.
[8] Preliminary Agreement Letter is available in Appendix E

- Create and finalize a concept paper, proposing the pathways Tribes/Tribal Organizations and Washington will work together on the Money Follows the Person Tribal Initiative and
- Enter into a signed commitment agreement, based upon the March 2013 preliminary letter of commitment to expand the capacity of Medicaid LTSS in tribal areas, enhance the leadership roles of tribes in the design and operations of these programs, and rebalance the LTSS system by transitioning eligible and interested tribal members to their communities of choice.

Activities to assess relevant tribal characteristics in the state: A priority in establishing the need for services in Indian Country is the need for **tribal assessment**. The National Resource Center on Native American Aging (NRCNAA) has been asked to consider adding some Washington-specific questions to their survey tool, 'Identifying Our Needs: A Survey of Elders IV' to use for this purpose. Using this survey process will accomplish two goals, one tribal data will be available for each Washington tribe to compare their information with those of the US All-tribes data and secondly, it will provide opportunity for the NRCNAA to determine questions for other tribes seeking to establish LTSS. Additional direct input from Tribes will be sought to gather specific population details and identify when and why decisions have been made to seek services in an institutional environment. DSHS/ALTSA will contract with the American Indian Health Commission to provide face-to-face needs assessment for the tribes of Washington to draft the Concept paper." Specific activities to assess relevant tribal characteristics in the state will include:

- Collect and analyze data, population projections of vulnerable AI/AN adults to enable planning for long-term service and support (LTSS) needs.
- Identify existing “promising” LTSS practices and service delivery methods provided in Tribal communities.
- Identify challenges and barriers in providing local Tribal LTSS.
- Educate Tribal programs on all LTSS funding resources available and develop a matrix for local tribal planning purposes.
- Implement strategies to address regulatory and policy barriers for Tribes to provide and be reimbursed for state-funded LTSS in their own communities, including State licensing/certification challenges and coordination issues with Area Agencies on Aging.
- Identify LTSS ‘train-the-trainer’ opportunities, such as Statewide Health Insurance Benefits Advisors (SHIBA) for Tribes to build internal expertise for assisting elders with their needs.

The combined data collection of tribal characteristics, evaluation of promising practices, and continued exploration of government to government relations will result in a concept paper to enter into Phases Two through Four and a signed commitment letter between Washington and the Federally Recognized Tribes to expand the capacity of Medicaid LTSS in tribal areas, enhance the leadership roles of tribes in the design and operations of these programs, and rebalance the LTSS system by transitioning eligible and interested tribal members to their communities of choice.