NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Colville Tribe
Coos, Suislaw & Lower Umpqua Tribe
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
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Hoh Tribe
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Portland, OR 97201
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SENT VIA TELEFAX: (503) 378-6827

August 17, 2012

Bruce Goldberg, M.D.
Medicaid Director/Oregon Health Authority
500 Summer Street, N.E.
Salem, OR 97301-1097

Dear Dr. Goldberg:

As you may be aware, the Oregon Health Authority (OHA) and Washington Health Care Authority (HCA) have joined in an effort with Oregon and Washington Tribes to obtain approval from CMS for an 1115 Demonstration Waiver, or State Plan Amendment, that will allow for certain optional services no longer covered in the Medicaid program to be provided by IHS and Tribally-operated programs and to be reimbursed by their respective States.

A Tribal Workgroup comprised of Tribal health directors from Washington and Oregon Tribes has been appointed to begin this work. The Workgroup convened its first meeting on September 15, 2012. The outcome from our meeting is that we anticipate our recommendations will build on the Arizona model for payments to cover "uncompensated care costs" associated with Medicaid reductions.[1] This model was recently approved by the Centers for Medicare & Medicaid Services (CMS) in the State of Arizona. These payments are intended to support the viability of IHS and Tribal facilities, who are essential community providers of health care for the American Indian and Alaska Native (AI/AN) population.

The Workgroup identified the following action items as necessary to move our work forward, and we respectfully request your assistance to do the following:

1. Send a letter of intent to CMS indicating the State's intent to move forward on this matter and the need to obtain technical assistance and guidance from CMS personnel on the Arizona model.
2. Direct your Medicaid staff to conduct a claims analysis of services provided by IHS, Tribal and urban Indian health providers for the AI/AN and non-Tribal population.
3. Appoint appropriate State Medicaid personnel to work with and provide technical assistance to our Tribal Workgroup charged with developing recommendations to move this process forward.

Respectfully, we request that the letter to CMS be sent as soon as possible so that we can obtain their guidance on how we should proceed using the Arizona model. We are

[1] Please Attached: "Arizona Section 1115 Waiver: Uncompensated Care Payments to Indian Health Service Providers and 638 Facilities".

hopeful our request for data can be completed in time for us to conduct any analysis in time for our next scheduled meeting set for Monday, September 17, 2012. We also recommend that the personnel you appoint will attend our next meeting.

Please let us know if you have any questions concerning the requested items in our letter. If you have questions, please follow up directly with Mr. Jim Roberts, Policy Analyst, at (503) 416-3276 or jroberts@npaihb.org.

Thank you for your attention to this very important matter!

Sincerely,

Joe Finkbonner, RPh, MHA
Executive Director

cc: Helena Kesch, Tribal Program Manager
Donald Ross, Manager, OHA Policy Planning Section

Attachment: "Arizona Section 1115 Waiver: Uncompensated Care Payments to Indian Health Service Providers and 638 Facilities"

Arizona Section 1115 Waiver
Uncompensated Care Payments to Indian Health Services and 638 Facilities

Background: How the Waiver Request Came Into Being

The Great Recession had a severe impact on state budgets across the country. Arizona was among the states most severely impacted. The State lost 300,000 jobs, which resulted in unemployment reaching near 10%. As a consequence, Medicaid enrollment increased by approximately 30%. With State revenues down 34%, there were fewer dollars available to cover the State's share of AHCCCS program costs. These revenue losses also meant fewer dollars available to cover the costs of K-12 education and universities, child protective services, corrections and other basic state public health and safety programs impacting all Arizonans. Meanwhile, the AHCCCS program went from being 18% of the State's budget in 2007 to nearly 30% of the General Fund in 2011.

To address the budget crisis, the State began a process of implementing reductions across all state government. The AHCCCS program alone has been reduced by nearly $2.5 billion in total funds (state and federal) since the start of the Recession. The State also raised taxes by $1 billion. This tax increase prevented additional reductions to education and to the Medicaid program.

Reductions to the AHCCCS program have included decreases in provider and health plan rates, elimination or limitation of benefits, administrative reductions, increased member cost sharing, enrollment freezes for KidsCare and childless adults, and the phase out of the spend down program. Benefit reductions were applied to all adults on the AHCCCS program. Those reductions that had the most significant impact on the American Indian Health Program were the elimination of podiatrists as a provider type as well as elimination of well exams for adults.

After consultation with tribal stakeholders, the State concluded it was in the best interest of the American Indian Health Program to submit a waiver that allows the State to exempt Indian Health Services (IHS) and 638 facilities from the benefits and eligibility restrictions imposed upon the broader AHCCCS program. Because Medicaid covered services provided by IHS and 638 facilities are funded with 100% federal dollars, the application of the reductions to these facilities yielded the State no savings. However, without the exemption, the impact these facilities would experience would certainly be significant. When considering the federal funding stream and existing health disparities among the American Indian/Alaska Native (AI/AN) population served by IHS and 638 facilities, the State agreed to press ahead with the waiver request in partnership with Arizona's 22 tribes.

The Progression of Arizona's Waiver Request

This waiver concept first was submitted to the Centers for Medicare and Medicaid Services (CMS) in June 2010 as Arizona began preparing for a series of benefits reductions that were scheduled to begin October 1, 2010. Later in the summer of 2010 and as part of a broader 1115 amendment, Arizona asked CMS to include language exempting IHS and 638 facilities from the benefits reductions. That request remained unresolved and was later expanded to include an exemption to the enrollment freeze for childless adults receiving services at IHS and 638 facilities as additional reductions were made to the AHCCCS program.

Tribal leaders provided great leadership in advancing the waiver request and in addressing questions from CMS and its federal partners. IHS and 638 facilities have fulfilled numerous requests for data and additional information. CMS officials have remained committed to furthering the dialogue, including hosting tribal leaders and the AHCCCS Director, Tom Betlach, in a tribal consultation held in Washington, DC on December 14, 2011. Throughout the process, the AHCCCS Administration continued to maintain an open dialogue with and obtain guidance and direction from its tribal stakeholders. At the consultation on December 14, 2011, the State assured CMS that it would pay the non-federal share for individuals who are not AI/AN.

Following these discussions, CMS sent the State a letter of agreement in principle on February 17, 2012. This letter committed CMS to approving this waiver amendment to ensure the financial viability of tribal providers by addressing the uncompensated care costs experienced by IHS and 638 facilities as a result of the AHCCCS reductions, subject to resolution of operational details. CMS noted in its letter that the State's commitment to paying the state share of costs provided to non-AI/AN populations was central to CMS' ability to approve the waiver amendment.

The Proposal: Supplemental Payments to IHS and 638 facilities

As indicated in the February 17 agreement in principle letter to Director Betlach, CMS is prepared to provide the State authority to receive Federal financial participation for specified types of care furnished by IHS and tribal 638 facilities to Medicaid-eligible individuals and other individuals with family income at or below 100 percent of the Federal poverty level (FPL). The objective of this proposal is to ensure the continued viability of the IHS and 638 facilities.

To accomplish this, CMS and the State have discussed a supplemental payment structure that supports tribal providers, is simple to administer, and can be operationalized rapidly. Two potential options have been identified for structuring a payment that will be made to the facilities providing services that are no longer covered under the Arizona Medicaid State plan, as well as providing care to individuals (childless adults) who are no longer eligible for the Medicaid program. CMS and the State are open to other ideas or modifications to these proposed options, as long as they meet the basic Federal principles.

Option 1 – Encounter Based Approach

Option 1 requires the IHS and 638 facilities to report to AHCCCS on a regular basis the number of adults under 100% FPL to whom the facilities provided services and how many units of services were provided to that individual.

- Facilities will track the services provided to individuals who are not Medicaid eligible, but have income under 100 percent of the Federal Poverty Level (FPL). This could be accomplished through a simple tracking mechanism such as a spreadsheet, and will also require the facilities to conduct a high level income check.
- Facilities will also track the services provided to Medicaid individuals that are no longer paid for by AHCCCS, using the same tracking tool.
- The tracking document will be sent to AHCCCS on a monthly or quarterly basis for payment, and should include the following elements:
    - Service provided;
    - Service rate; and
    - Whether service provided was to a native or non-native.
- AHCCCS would then pay the facilities, using the all-inclusive rate, the amount of uncompensated care as reported by the facilities in their tracking documents.

Option 2 – Historical Data Approach

Option 2 involves the AHCCCS Administration developing a methodology for capturing the total amount of uncompensated care costs borne by IHS and 638 facilities that can be attributed to the childless adult enrollment freeze and benefit reductions. The State would do the tracking and make payments. There would be no reporting on the part of the facility.

- AHCCCS will pay facilities, on a monthly basis, a prospective "lump sum" payment that is calculated from historical costs associated with care provided to native childless adults as well as costs associated with the benefits that were removed from the Medicaid State plan.
- The "lump sum" payment would also include costs associated with providing care to non-natives (for which AHCCCS will pay the State share).
- The "lump sum" payment will be distributed prospectively from the date that the amendment is approved based on the percentage of claims the facilities submitted to AHCCCS from October 2010 through September 2011 for services provided to AI/AN childless adults.

Calculation for Cost of Services to Persons Ineligible for AHCCCS	
FY 2011 Total Paid	90,000,000
Average monthly membership	23,000
per member per month (pmpm)	326
Monthly Payment Calculation – Ineligible Individuals	
May - Decrease in Native American Childless Adult coverage since Freeze	7,000
May Eligibility Payment (PMPM * 7,000)	2,282,609
Monthly Payment Calculation – Services	
Adult Per Member Per Month Service Funding	5.00
Total Number of AI/AN Adults Enrolled with AHCCCS	60,000
May Services Payment	300,000
Total May Payment to I.H.S and 638 Facilities (Eligibility + Services)	2,582,609
Facility A - Allocation - 1%	25,826.09
Facility B - Allocation - 5%	129,130.43

Calculation for Cost of Services to Persons Ineligible for AHCCCS

		Timeframe:
FY 2011 Total Paid	90,000,000	
Average monthly membership	23,000	
per member per month (pmpm)	326	
Monthly Payment Calculation – Ineligible Individuals		
May - Decrease in Native American Childless Adult coverage since Freeze	7,000	
May Eligibility Payment (PMPM * 7,000)	2,282,609	
Monthly Payment Calculation – Services		
Adult Per Member Per Month Service Funding	5.00	Proxy of what is being lost per the services eliminated.. Well Exams, Podiatry, etc.
Total Number of AI/AN Adults Enrolled with AHCCCS	60,000	
May Services Payment	300,000	
Total May Payment to I.H.S and 638 Facilities (Eligibility + Services)	2,582,609	
Facility A - Allocation - 1%	25,826.09	
Facility B - Allocation - 5%	129,130.43	

Issues:

Choice of Option 1 or 2

New Childless Adults entering the system
Newly Dropped Childless Adults
Inflation adjustment to the PMPM payment
Confirmation of the 7,000 figure
$5.00 PMPM Service Funding
Increase CHS Utilization
Periodic Review

Option One Issues/Concerns	Option Two Issues/Concerns	Hybrid Option Three	Overall
Requiring verification of income – Pay stub. What about other examples? - Self attestation of income. - MSP for example – simply ask the question. - Random sampling for verification purposes. - What would be sufficient if CMS performed an audit. Request AHCCCS to bring to Thursday's meeting a statement authorizing that an Attestation of income is sufficient, including a definition of "high level". What data will AHCCCS require for those that are included on the list/spreadsheet that each facility would generate.	Need to **build in an opportunity to verify** what IHS/Tribes have lost due to the elimination of services and elimination of the Childless Adult population. **The verification #s would result in retroactive adjustment back to April 1 when the original payment period has been identified.**	Hybrid will be the cleanup of Option 1 or Option 2. Includes lump sum payment per month Completely transparent track-able data Allow for Monthly Verification	20 month bridge
Requesting verification will be a challenge as these individuals will not be enrolled in Medicaid bringing them access to other benefits outside of receiving IHS benefits.	Takes into range individuals lost during a timeframe after the benefit reduction. IHS verifies 11,000 not 7,000 have fallen off the Childless Adult. We don't know how many AIAN have fallen off the other plans/managed care plans.		Both options 1 & 2 are faulty
It will be difficult to create another tracking system for this purpose and will not be cost effective for IHS – in this short period	$5 - March 1, 2012 What methodology was used by AHCCCS to arrive at $5.00?		Provide an option to each facility authorizing them to elect Option 1 or Option 2 or Hybrid

of time and to keep in place for less than 2 years.	There is disagreement with this rate as it doesn't cover AIANs who have fallen off other plans. And over 90,000 AIAN adults verified as being in the plan for the state of AZ. AZ option paper states 60,000. The $5 payment needs to reflect payment to those who remain enrolled in Medicaid but do not have access to these Medicaid Services in a facility of the IHS due to the reduction in Medicaid benefits for the Medicaid population. There are members enrolled in the American Indian Program but are not accepted by other Medical providers.		Option
Request discussion related to a qualified population segment who are eligible but never enrolled due to the lack of providing verification or completing the enrollment process.	Build in timeframes where IHS/Tribes can work with state to verify.		
	Suggest an escalator (average increase of those dropping off) of those who will fall under the Uncompensated care category		
	The $90M does not include bills that have not been submitted to date as some facilities are behind in billing and coding.		

2011 I.H.S./638 Supplemental Payments Waiver
Performance Measures

Introduction

Section 1115 Waivers are "demonstrations". They test a particular hypothesis to show that the waiver from the federal Medicaid regulations supports the Medicaid program. Part of supporting a demonstration under an 1115 waiver is providing CMS with performance measures. Below are the hypotheses that the State is testing and some measures that AHCCCS is considering for discussion.

- *Uncompensated care payments to I.H.S. and 638 facilities will increase capacity to provide care and services resulting in AHCCCS members receiving routine care and recommended evidence based care and services for chronic conditions*
- *Implementing uncompensated care payments to I.H.S. and 638 facilities will allow staffing levels to be maintained or increased.*

1115 Waiver Special Terms and Conditions (STC) re payments to IHS and 638 facilities

Intro paragraph:

In addition, the Demonstration will provide for payments to IHS and tribal 638 facilities to address the fiscal burden of uncompensated care for services provided in or by such facilities to individuals with income up to 100 percent of the FPL. This authority will enable the State to evaluate how this approach impacts the financial viability of IHS and 638 facilities and ensures the continued availability of a robust health care delivery network for current and future Medicaid beneficiaries.

STC 26 Payments to IHS and 638 Facilities.

The State is authorized under the expenditure authorities of this Demonstration to make payments to IHS and tribal 638 facilities that take in to account their uncompensated costs in furnishing specified types of care furnished by IHS and tribal 638 facilities to Medicaid-eligible individuals and other individuals with family income at or below 100 percent of the FPL.

Facilities will have the option to elect one of two approved methodologies, as further outlined in Attachment K, to calculate and receive payment for their uncompensated care costs. The facilities will notify AHCCCS of their selection by April 30, 2012, and will have the option to switch their methodology election only once. If a facility elects to switch the methodology by which their uncompensated care payment is calculated, the facility must notify the State by December 15, 2012. The new methodology will be utilized to calculate the facility's uncompensated care payment effective January 1, 2013.

STC 28e) Evaluation re Uncompensated Care Payments to IHS and 638 Facilities.
Arizona must conduct an independent evaluation of the uncompensated care payments provided to IHS and 638 facilities as described in paragraph 26 and Attachment K. The evaluation must test the following specific hypotheses related to the uncompensated care payments:

i. What is the affect on service utilization as a result of the uncompensated care payments broken down by type of service as well as the population served?

ii. Are the affected facilities able to maintain and/or increase their current staffing levels?
Methods by which the State can evaluate these hypotheses include evaluating staffing levels as well as the relative utilization of, and access to, services provided to adults pre-uncompensated care payment period to services with those of the post-uncompensated care payment period. Measures could include examining selected evidence-based measures indicating management of chronic conditions (such as diabetes and asthma).

Measure	Facility Response	Additional Comments
1. Total budget for your facility (so the payment can be compared to the total budget)		
2. Share of total funds in your facility that are Medicaid (ie what is the payor mix)		
3. Staffing reductions each IHS/638 facility was going to have to make if they did not receive the payments.		
4. Breakdown of staffing at each IHS/638 facility before and after payment -- by provider type. (We can select a group of provider types: e.g., PCP, NP, Dental, podiatrist)		
5. Benefit reductions each IHS/638 facility would have made but for the payments		
6. Utilization trends of non-AI and AI before and after the payments.		

7. Utilization trends per accounting under Option 1.		
8. Hours of availability at each IHS/638 facility pre-payments and post		
9. Availability of services by service type at each IHS/638 facility (e.g. dental, pharmacy, podiatry) - Pre the payments and post the payments		
10. How does the continued receipt of Medicaid income support your ability to maintain Accreditation? (there is a requirement that IHS has to use third-party resources (Medicaid) for Accreditation/Certification purposes)		
11. What other actions would you have taken had Medicaid income been reduced as anticipated prior to the CMS Waiver approval?		
Government Performance and Results Act (GPRA) Quality Measures		
12. Access to Care pre- and post-payment: GPRA access to care measure		
13. Oral health care for children ages 0 to21 years of age: General Access Sealants Topical Fluoride *Baseline measurement period* CYE 2011, October 1, 2010 through September 30, 2011 *Remeasurement period* CYE 2016, October 1, 2015 through September 30, 2016		
14. Diabetes and Asthma: Percent of members diagnosed with asthma with a primary diagnosis of diabetes on at least one office visit claim:		

Percent of members diagnosed with asthma with a primary diagnosis of diabetes on at least one emergency room visit claim: *GPRA diabetes Performance Measure Results:* Blood Sugar Assessed Diabetes Prevalence Ideal Blood Pressure Control Ideal Blood Sugar Control LDL Cholesterol Assessed Nephropathy Assessed Poor Blood Sugar Control Retinopathy *Baseline measurement period:* CYE 2011, October 1, 2010 through September 30, 2011 *Remeasurement period* CYE 2016, October 1, 2015 through September 30, 2016		

Resolution No.: 12-01-03
"Support for Optional Medicaid Benefits to be Provided Through the I/T/U"

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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WHEREAS, the Northwest Portland Area Indian Health Board (hereinafter "NPAIHB" or the "Board") was established in 1972 to assist Tribal governments to improve the health status and quality of life of Indian people; and

WHEREAS, the Northwest Portland Area Indian Health Board is a "tribal organization" as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638 seq. et al) that represents forty-three federally recognized tribes in the states of Idaho, Oregon, and Washington; and

WHEREAS, in accordance with the definitions of the Indian Self-Determination and Education Assistance Act at 25 USCS § 450b, a tribal organization is recognized as a governing body of any Indian tribe and includes any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; and

WHEREAS, the Northwest Portland Area Indian Health Board is dedicated to assisting and promoting the health needs and concerns of Indian people; and

WHEREAS, the primary goal of the NPAIHB is to improve the health and quality of life of its member Tribes; and

WHEREAS, Idaho, Oregon and Washington tribes have all requested that State Medicaid programs pursue a 1115 Medicaid Waiver amendment to mitigate benefit reductions in State Medicaid programs that only serve to perpetuate health disparities and have a harmful effect on services to American Indian people; and

WHEREAS, tribes have requested that the states explore options to exempt American Indian and Alaska Natives from benefit reductions and/or explore opportunities to be able to provide optional services that have already been reduced in the Medicaid program; and

WHEREAS, the States have the option to expand Medicaid benefits that would be delivered through Indian Health Service (IHS), Tribal (T), or urban Indian health programs (U) collectively referred to as "I/T/U"; and

WHEREAS, the American Indian Health Commission (AIHC) and NPAIHB have sent letters to State Medicaid Directors recommending that Oregon and Washington move forward with an 1115 Medicaid Waiver amendment to restore benefit reductions and to allow optional services to be provided through the I/T/U; and

WHEREAS, Washington State's Medicaid Program, the Center for Medicare & Medicaid Services (CMS) and the Board have met by conference call to discuss the feasibility of Washington State to pursue such a waiver and for which CMS provided technical issues that would need to be addressed in Washington's request; and

WHEREAS, NPAIHB developed a discussion draft on the policy issues raised by CMS that include: facility based exemption for services, facility capacity, benefit design, FMAP issues, alternatives for State match and surge/capacity issues; and

WHEREAS, the discussion draft has been vetted with Northwest Tribes in the States of Idaho, Oregon, and Washington and there is consensus amongst all Tribes to move the proposals presented in the discussion draft forward to CMS as a waiver request in each of the respective states.

NOW THEREFORE BE IT RESOLVED, that the NPAIHB formally approves the recommendations presented in the discussion draft to allow optional services to be provided by the I/T/U in State Medicaid programs.

BE IT FURTHER RESOLVED, that Northwest Tribes support the collaboration of Oregon and Washington State Medicaid programs to move a joint waiver proposal forward to CMS as soon as possible.

CERTIFICATION

NO. 12-01-03

The foregoing resolution was duly adopted at the regular session of the Northwest Portland Area Indian Health Board. A quorum being established; 26 for, 0 against, 0 abstain on ~~October 20~~, 2011.

Andrew C. Joseph Jr.
Chairman

10.20.11
Date

Brenda Wilson
Secretary

2012 Mid-Year Convention
Lincoln City, Oregon

RESOLUTION #12 – 27

"SUPPORT FOR OPTIONAL MEDICAID BENEFITS TO BE DELIVERED THROUGH THE IHS, TRIBAL AND URBAN INDIAN HEALTH SYSTEM"

PREAMBLE

We the members of Affiliated Tribes of Northwest Indians of the United States, invoking the divine blessing of the Creator upon our efforts and purposes, in order to preserve for ourselves and our descendants rights secured under Indian Treaties, Executive Orders, and benefits to which we are entitled under the laws and constitution of the United States and several states, to enlighten the public toward a better understanding of the Indian people, to preserve Indian cultural values, and otherwise to promote the welfare of the Indian people, do hereby establish and submit the following resolution:

WHEREAS, Affiliated Tribes of Northwest Indians (ATNI) are representatives of and advocates for national, regional, and specific tribal concerns; and

WHEREAS, ATNI is a regional organization comprised of American Indians/Alaska Natives and tribes in the states of Washington, Idaho, Oregon, Montana, Nevada, Northern California, and Alaska; and

WHEREAS, the health, safety, welfare, education, economic and employment opportunity, and preservation of cultural and natural resources are primary goals and objectives of the ATNI; and

WHEREAS, the State of Arizona has recently received approval for a 1115 Demonstration Waiver from the Centers for Medicare & Medicaid Services to provide expanded Medicaid benefits to be delivered through the Indian Health Service (IHS), Tribally-operated and urban Indian health programs that will be very beneficial to addressing the health disparities of American Indian people; and

WHEREAS, Idaho, Oregon and Washington tribes have all requested that State Medicaid programs pursue a 1115 Medicaid Waiver amendment to mitigate benefit reductions in State Medicaid programs that only serve to perpetuate health disparities and have a harmful effect on services to American Indian people; and

WHEREAS, tribes have requested that the states explore options to exempt American Indian and Alaska Natives from benefit reductions and/or explore opportunities to be able to provide optional services that have already been reduced in the Medicaid program; and

WHEREAS, the States have the option to expand Medicaid benefits that would be delivered through Indian Health Service (IHS), Tribal (T), or urban Indian health programs (U) collectively referred to as "I/T/U"; and

WHEREAS, the American Indian Health Commission (AIHC) and the Northwest Portland Area Indian Health Board (NPAIHB) have sent letters to State Medicaid Directors recommending that Oregon and Washington move forward with an 1115 Medicaid Waiver amendment to restore benefit reductions and to allow optional services to be provided through the I/T/U; and

WHEREAS, Washington State's Medicaid Program, the Center for Medicare & Medicaid Services (CMS) and the Board have met by conference call to discuss the feasibility of Washington State to pursue such a waiver and for which CMS provided technical issues that would need to be addressed in Washington's request; and

WHEREAS, NPAIHB developed a discussion draft on the policy issues raised by CMS that include: facility based exemption for services, facility capacity, benefit design, Federal Medical Assistance percentages (FMAP) issues, alternatives for State match and surge/capacity issues; and

WHEREAS, the discussion draft has been vetted with Northwest Tribes in the States of Idaho, Oregon, and Washington and there is consensus amongst all Tribes to move the proposals presented in the discussion draft forward to CMS as a waiver request in each of the respective states; now

THEREFORE BE IT RESOLVED, that ATNI formally approves the recommendations presented in the discussion draft to allow optional services to be provided by the Indian Health Service, Tribal, or urban Indian health programs in State Medicaid programs; and

BE IT FURTHER RESOLVED, that ATNI supports the collaboration of Oregon and Washington State Medicaid programs to move a joint waiver proposal forward to CMS and to do so immediately.

CERTIFICATION

The foregoing resolution was adopted at the 2012 Mid-Year Convention of the Affiliated Tribes of Northwest Indians, held at Chinook Winds Casino Resort, Lincoln City, Oregon, on May 21 – 24, 2012, with a quorum present.

Fawn Sharp, President

Norma Jean Louie, Secretary