Indian Health Care Provider Evaluation of Washington State Managed Care Organizations

FINDINGS AND RECOMMENDATIONS

July 24, 2019

Indian Health Care Provider Evaluations of Washington State Managed Care Organizations

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ABOUT THE AMERICAN INDIAN HEALTH COMMISSION

Established in 1994, the American Indian Health Commission (the Commission) seeks to improve the overall health of American Indians and Alaska Natives through advocacy, policy, and programs to advance best practices at the Washington State level. The Commission works on behalf of the 29 federally-recognized Indian Tribes and two Urban Indian Health Programs (UIHPs) in the state. Delegates appointed by resolutions from the Tribes and Urban Indian Health Programs (UIHPs) lead the work of the Commission.

The Commission serves as a forum where a collective Tribal government voice is shaped regarding shared health disparity priorities. Tribes and UIHPs work collaboratively with Washington State health leaders, the Governor's office, and legislature to address these priorities. The Commission's policy work improves access for individual Indian people to state-funded health services, enhances reimbursement mechanisms for Tribal and UIHP health programs to deliver their own culturally-appropriate care, and creates an avenue for Tribes and UIHPs to receive timely and relevant information about state health regulations, policies, funding opportunities, and health-specific topics. The Commission brings together state, Tribal and UIHP partners to collaboratively address health disparity priorities across multiple systems, pooling resources and expertise for improved health outcomes.

ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

In 2018, the Washington State Health Care Authority awarded funding to the American Indian Health Commission for Washington State (the Commission) to provide technical assistance to the Governor's Indian Health Council for the purpose of carrying out the objectives set forth in Section 213(mmm) of Senate Bill 6032. These objectives include overseeing the performance of services coordination organizations or service contracting entities (as defined in RCW 70.320.010) to assess their impact on health care services to American Indians and Alaska Natives and the effectiveness of their relationships with Indian health care providers.

The 2013 Report to the Legislature provided an important overview of the failures of the managed care system in serving American Indian and Alaska Native insureds and in coordinating with the Indian health care delivery system. Over the last several years, Tribes, Indian health care providers (IHCPs), and the American Indian Health Commission for Washington State (the Commission) have identified key areas that require change and improvement which include ensuring the preservation of the Indian health care fee-for-service system and access to care for American Indians/Alaska Natives (AI/AN).

This report and the accompanying documents provide recommended revisions to the Washington State Health Care Authority's (HCA's) contract with managed care organizations. Recommended revisions are based on the Washington Tribal Centric Health Plan Agreement, findings from the AIHC 2019 Indian Health Care Provider Evaluation of Managed Care Organizations in Washington, and recommendations from the Tribal Managed Care Organization Performance Workgroup. The report also includes proposed standards for assessing the performance of services coordination organizations or service contracting entities (as defined in RCW 70.320.010) in providing services to AI/AN and contracting and engaging with IHCPs.

Tribal Centric Health Plan Agreement

The Tribal Centric Health Plan Agreement, signed by the director of the HCA on July 1, 2017, was created in collaboration with the Tribes, IHCPs, the HCA, the Department of Social and Health Services, and the Commission). Pursuant to this agreement, the State agrees to abide by and implement requirements upon managed care organizations (MCOs) specific to the Indian health care system. The Commission has reviewed the provisions of this agreement and incorporated MCO-related requirements into the current HCA contract with MCOs.

Indian Health Care Provider Evaluation of Managed Care Organizations

To inform this report, the Commission engaged key informants from tribally-operated health programs, Indian Health Service (IHS) programs, and urban Indian health programs to complete an assessment of MCOs on June 18, 2019. An online survey platform was used to administer the Indian Health Care Provider Evaluation of Managed Care Organizations. Key informants included individuals who serve as tribal health directors, policy officers, behavioral health directors, and health service managers. These individuals have first-hand experience working with MCOs and knowledge of the Washington managed care system, including (1) MCO engagement and coordination requirements with Tribes and urban Indian health programs (UIHPs); and (2) potential consequences of MCO practices for AI/AN, tribal communities, and Indian health care providers (IHCP).

The survey questions and this report focus on the following contractual obligations of MCOs for providing services to AI/AN, and coordinating and contracting with IHCPs:

1. Access to Care and Provider Network
2. Utilization Management Program and Authorization of Services
3. Care Coordination
4. MCO Contracting with Indian Health Care Providers
5. Engagement with Indian Health Care Providers

I. Indian Health Care Provider Evaluation of Managed Care Organizations

Purpose

The purpose of the Indian Health Care Provider Evaluation of Managed Care Organizations was to document the assessments of individuals who work in Indian healthcare in Washington State on how managed care organizations are performing in providing access for AI/AN to culturally competent medical and behavioral health services and engaging and contracting with Indian health care providers (IHCPs). This included identifying what has worked well, what needs improvement, and potential consequences of MCOs' failure to comply with their contractual obligations.

Survey Question Design

The Commission invited representatives from Tribes and UIHPs to oversee the Project Team's efforts to develop a structured key informant survey tool. An invitation was made to participate in the Workgroup via emails to Tribal Health Directors and Commission Delegates, and by announcement at the May 9, 2019 Commission Delegates Meeting. Participation was voluntary. The Workgroup was comprised of representatives from 5 Tribes and 2 UIHPs. The Workgroup met 4 times to recommend, edit and approve a list of questions designed to assess MCOs' performance, and document what is working well and what improvements are needed in Washington State's managed care system.

Key Informants

Target Population. The target population for key informants to complete the survey was individuals who work in Indian healthcare in Washington and have first-hand experience and knowledge of the managed care system, including an understanding of how well MCOs are performing in:

1. Engagement and contracting with Tribes and urban Indian health programs; and
2. AI/AN access to specialty care and culturally-informed care

These individuals serve as Tribal Health Directors, Policy Officers, Behavioral Health Directors, and Health Services Managers.

Invitation to Participate. In consultation with Health Directors and Commission Delegates, the Commission identified target key informants for each of the Tribes and UIHPs. Targeted individuals were called by telephone and invited to serve as key informants. Those who were not reached immediately by telephone received a voicemail message and an email describing the project. Follow-up communications were conducted via telephone and email. Participation was strictly voluntary. Key informants who completed the survey were provided a gift card. No negative consequences resulted from non-participation.

Survey Administration

An online survey platform was used to administer the Indian Health Care Provider Evaluation of Managed Care Organizations. The Commission hosted a webinar to provide key informants with background and context. The same set of questions was asked for each of the MCOs in

Washington State, with key informants having the ability to skip questions for managed care organizations that do not operate in their Tribe's or UIHP's region. Questions were included for each of the following managed care organizations:

1. Great Rivers Behavioral Health Organization
2. Greater Columbia Behavioral Health Organization
3. King County Behavioral Health Organization
4. North Central Behavioral Health Organization*
5. North Sound Behavioral Health Organization*
6. Optum Pierce Behavioral Health Organization*
7. Salish Behavioral Health Organization
8. Spokane Regional Behavioral Health Organization
9. Thurston-Mason Behavioral Health Organization*
10. Amerigroup
11. Community Health Plan of Washington
12. Coordinated Care
13. Molina Healthcare of Washington
14. UnitedHealthcare

* Of the key informants who chose to participate in the Indian Health Care Provider Evaluation of Managed Care Organizations, none contracted with: North Central Behavioral Health Organization, North Sound Behavioral Health Organization, Optum Pierce Behavioral Health Organization, and Thurston-Mason Behavioral Health Organization. For this reason, there are no responses specific to these entities.

Survey Completion

The Indian Health Care Provider Evaluation of Managed Care Organizations was completed by individuals who work for 11 of the 29 (38%) Tribes in Washington and 2 of the 2 (100%) urban Indian health programs. Some Tribes and UIHPs had two individuals complete the survey, to accurately represent the perspectives of the medical health programs as well as the behavioral health programs.

Survey Results

Access to Care and Provider Network

Survey results indicate that longstanding barriers to access to care persist. These include but are not limited to burdensome prior authorization requirements and lack of access to culturally competent care. Results show that Indian health care providers are having to take actions and expend their own resources to remediate these problems; for example, expending IHCP staff time to expedite delayed prior authorizations, acquiring culturally competent care with

"Prior authorization delays access to care especially for specialty care, imaging and prescription services. Due to incorrect race coding, we have tribal children in foster care that have been assigned to [MCO] in error. This has created a lot of problems with coordinating services for these kids. It took forever to contract with them due to lack of understanding the Federal Torts Claims Act and provider credentialing process."

IHCP Respondent

tribal funds, transporting patients to distant non-IHCP providers, etc. The following statistics highlight these findings:

- 81% of responses indicate that MCOs' prior authorization requirements cause delays for accessing care
- 51% of responses indicate that MCOs fail to provide their patients with access to culturally competent care
- 41% of responses indicate that the informant's Tribe or UIHP has had to cover costs from its own funds for care that was denied or delayed by an MCO as a result of preauthorization

Care Coordination

The HCA-MCO contract has several requirements for care coordination between MCOs and Indian health care providers. results indicate that MCOs must improve significantly on coordinating care with IHCPs. The following statistics highlight these findings:

> "I have been told by [MCO] that we have made the WA Code up. They do not have good communication. I'm fighting with them right now because our claims are being denied stating they are not payable with the managed care plan. I'm on my 3rd representative and still have not resolved the issue and it has been a month."
>
> IHCP Respondent

- Only 41% of responses indicate that MCOs have met with respondents' IHCPs at least once per year; 32% of responses indicate MCOs have never met with respondents' IHCPs
- 45% of responses indicate that MCOs are not coordinating care at all with IHCP providers on outpatient care
- 56% of responses indicate that MCOs are not coordinating care with IHCPs on inpatient discharge planning and discharge activities

MCO Contracting with Indian Health Care Providers

MCOs are required to comply with the Special Terms and Conditions set forth in the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers referenced in section 15.1.1.1 of the HCA-MCO contract. The survey revealed several reasons why IHCPs are choosing to end their contracts with MCOs or not to enter into one at all:

- All (100%) of the respondents who stated their IHCP had ended their contract with an MCO stated that "Case management services lacked cultural competency" and "Poor coordination between non-IHCP services and IHCP services" were reasons for ending the contract

- Key informants identified the following reasons for IHCPs choosing not to enter into a contract with MCOs: "Customer service representatives do not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives", "Don't see a clear benefit to our IHCP from contracting", and "We do not have the capacity to provide Behavioral Health services to non-Native clients - a contract would require us to provide Behavioral Health services to any individual enrolled in the plan"

MCO Engagement with Indian Health Care Providers

MCOs are required to offer contracts to IHCPs and coordinate with IHCPs in the development of the IHCP Coordination and Access Plan. MCO engagement with IHCP providers appears to remain the biggest deficiency in MCO performance with IHCPs as seen by the following findings:

- 44% of responses indicate that MCOs have not provided IHCPs a specific contact for communication and service coordination
- 32% of responses indicate that MCOs have not offered timely and competent assistance when they interacted with them
- 59% of responses indicate that MCOs have a poor understanding of the Indian healthcare delivery system and the benefits and legal protections that apply to AI/AN
- 71% of responses indicate that MCOs have not included IHCPs in the development of coordinating care and services
- 71% of responses indicate that MCOs have not an effective process IHCPs to suggest how the MCO could better serve the needs of the IHCP and the community members

II. Recommended MCO Performance Standards

The Commission has developed managed care organization (MCO) performance standards for contracting and engaging with Indian health care providers (IHCP) and providing access to high quality and culturally appropriate services to American Indians and Alaska Natives (AI/ANs). See Appendix B. These standards were developed based on the results of the Indian Health Care Provider Evaluation of Managed Care Organizations, recommendations from the IHCP Workgroup, a review of the Tribal Centric Health Plan Agreement and the HCA-MCO contract provisions that address AI/AN and IHCPs. The purpose of these standards is to assist MCOs in serving AI/ANs and the Indian health care delivery system in a manner that assures access and complies with state and federal requirements.

The Commission recommends the HCA assesses MCO compliance with performance standards utilizing year-round mechanisms for collecting and managing MCO reporting and internal data related to performance indicators, and an annual evaluation completed by IHCPs. HCA should also report annually to IHCPs on all performance measures for each MCO. Failure by an MCO to

meet one or more of the standards should result in HCA developing and implementing a corrective action plan for the MCO. The corrective action plan should also delineate the time and manner in which each deficiency must be corrected. Failure to complete the corrective action plan within the required number of days should result in sanctions or termination of the contract.

III. Recommended MCO Contract Revisions

Many MCOs and non-IHCP providers fail to comply with existing state and federal requirements regarding the Indian health care delivery system. Understanding and complying with these requirements remains a challenge, in part, because the State managed care contract is over fourhundred pages long and contains AI/AN and IHCP references throughout the contract. The contract provides a summary section of AI/AN protections. However, MCOs and IHCPs may be confused by differing language on the same issue in the summary section when compared to other key sections of the contract, such as "Care Coordination," "Access," and "Enrollment." In addition, these key sections of the contract may not contain all the relevant AI/AN or IHCP provisions.

Given the unique complexity of AI/AN and IHCP protections under federal and state law, these protections should be included in *both* the relevant sections of the contract and within a separate exhibit attached to the contract.

The AIHC proposes the following changes to the contract:

(1) including all AI/AN and IHCP protections within each relevant section of the contract (i.e., access, care coordination, etc.); inserting these in the relevant contract sections will help ensure MCOs do not overlook these protections when complying with access, care coordination, etc. (See Appendix A)

(2) striking the summary AI/AN protections provision; this will reduce the possibility of conflicting language in the contract

(3) attaching an exhibit that contains all AI/AN- and IHCP-relevant contract provisions; the exhibit will assist MCOs in understanding their responsibilities and IHCPs in having clear documentation of the AI/AN and IHCP protections (See Appendix A)

(4) attaching the Indian Health Care Provider Addendum to the contract as an Exhibit

(5) attaching the Performance Standards for Contracting, Engaging, and Providing Access for American Indians/Alaska Natives and Indian Health Care Providers as an Attachment 11 (See Appendix C).

CONCLUSION

It is imperative for Managed Care Organizations (MCOs) to assure access to high quality culturally competent care for AI/AN by establishing effective partnerships with IHCPs. American Indians and Alaska Natives experience the highest rates of health disparities in Washington and have a per capita personal health care expenditure that is over sixty percent lower than the overall United States population. Indian health care providers operate within a complex system of federal and state regulations and are uniquely qualified to address the health care needs of AI/AN. To adequately serve AI/AN and reduce the significant health disparities, MCOs must comply with regulations and contractual obligations, and operate effectively in coordination with the Indian health care system.

Based on the 2019 Indian Health Care Provider Evaluation of Managed Care Organizations in Washington, MCOs must improve their performance in providing access to high quality culturally

competent health care to American Indians and Alaska Natives (AI/AN) and contracting and engaging with Indian Health Care Providers (IHCPs). MCOs violate their contractual obligations regarding AI/AN protections and IHCP contracting and engagement requirements. Barriers to AI/AN accessing high quality culturally competent care persist, and contracting between MCOs and Tribes continues to lag. MCOs have yet to establish effective service delivery systems for AI/AN and partnerships with IHCPs.

The Washington State Health Care Authority (HCA) should develop and implement systems to assure that MCOs clearly understand their obligations and perform as quality service providers to AI/AN and effective partners to IHCPs. MCOs should be provided with clear performance expectations and evaluated on an ongoing basis. The Commission has drafted a core set of performance standards and measures. HCA should implement year-round mechanisms for collecting and managing MCO reports and internal data related to performance indicators. Also, HCA should provide support for an annual IHCP evaluation of all MCOs. HCA should report to Tribes and IHCPs annually on each MCO's performance, and implement corrective actions for every MCO that fails to meet the standards. In addition to monitoring MCO performance, HCA should update and revise the HCA-MCO contracts to clearly include the protections within the Tribal Centric Health Plan Agreement.

To honor the government to government relationship, HCA should hold informational roundtables and consultations with Tribes regarding the proposed contract revisions and performance evaluation systems.

APPENDIX A: MCO AI/AN IHCP Contract Provisions

American Indian Health Commission

EXHIBIT L

American Indian/Alaska Native and Indian Health Care Provider Contract Requirements

This exhibit provides a summary of contract provisions that impact American Indians and Alaska Natives (AI/AN) and Indian health care providers (IHCPs).

1. Definitions

1.1 Access

"Access" as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by the Contractor's successful demonstration and reporting on outcome information for the availability and timeliness elements defined in the Network Adequacy Standards and Availability of Services described in this Contract. (42 C.F.R. § 438.14(b), § 438.68, § 438.206, § 438.320).

1.23 Behavioral Health Agency

"Behavioral Health Agency" means an entity licensed or certified by the Department of Health or the Department of Social and Health Services to provide behavioral health services, including mental health disorders and Substance Use Disorders and that is:

1.23.1 An entity licensed or certified according to Chapter 71.24 RCW or chapter 71.05;

1.23.2 An entity deemed to meet state minimum standards as a result of accreditation by a recognized behavioral health accrediting body recognized and having a current agreement with the department; or

1.23.3 An entity with a tribal attestation through the Washington State Department of Health that it meets state minimum standards for a licensed or certified behavioral health agency. [SOURCE: SB 5432, § 1004(25)(c) amends Washington Substitute House Bill 1388, § 4002(24) and RCW 71.24.024].

1.40 Care Manager (CM)

"Care Manager (CM)" means an individual employed by the Contractor or a contracted organization who provides Care Management services. Care Managers shall be licensed as registered nurses, advanced registered nurse practitioners, practical nurses, psychiatric nurses, psychiatrists, physician assistants, clinical psychologists, mental health counselors, agency affiliated counselors, marriage and family therapists, social workers with a Masters in Social Work (MSW), or shall be social service or healthcare professionals with a Bachelors in Social Work or

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closely related field, Indian Health Service Community Health Representatives (CHR), or certified chemical dependency professionals.

1.59 Community Health Workers (CHW)

"Community Health Workers (CHW)" means individuals who serve as a liaison and advocate between social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs include Community Health Representatives (CHR) in the Indian Health Service funded, Tribally contracted program.

1.137 Indian Health Care Provider

"Indian Health Care Provider (IHCP)" means the Indian Health Service and/or any Tribe, Tribal organization, or Urban Indian Health Program (UIHP) that provides Medicaid-reimbursable services

1.157 Local IHCP Provider

"Local IHCP Provider" means an IHCP Provider with a Facility in the Contractor's Regional Service Area or with a client residing in the Contractor's Regional Service Area.

1.158 Local Tribe

"Local Tribe" means a federally recognized tribe that has all or part of its Contract Health Service Delivery Areas (as established by 42.C.F.R. § 136.22 and is updated from time to time within the Federal Register) within the Contractor's Regional Service Area.

1.176 Mental Health Professional

1.176.7 **[New Section]** A person who is licensed as a mental health counselor, mental, health counselor associate, marriage and family therapist, or marriage and family therapist associate in another state and is an employee of an Indian Health Care Provider. [SOURCE: CMS Model Medicaid CHIP Managed Care Addendum for IHCPs, Section 11 and RCW 71.24.024].

1.183 Network Adequacy

"Network Adequacy" means a network of providers for the Contractor that is sufficient in numbers and types of providers/facilities to ensure that all services are accessible to Enrollees without unreasonable delay. Adequacy is determined by a number of factors including, but not limited to provider/patient ratios, geographic accessibility and travel distance. (42 C.F.R § 438.68, § 438.14(b) and 438.206).

1.226 Provider

"Provider" means

1.226.1 Any individual or entity engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services. (42 C.F.R. § 438.2)~~.~~; or

1.226.2 An induvial engaged in the delivery of services, or ordering or referring for those services and is legally authorized to do so in another State and is an employee of an

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Indian Health Care Provider. [SOURCE: CMS Model Medicaid CHIP Managed Care Addendum for IHCPs, Section 11 and RCW 71.24.024].; or

1.226.3 Any entity engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by tribal attestation through the Washington State Department of Health that it meets state minimum standards for a licensed or certified behavioral health agency. [SOURCE: SB 5432, § 1004(25)(c) amends Washington Substitute House Bill 1388, § 4002(24) and RCW 71.24.024].

3. Health Home Care Coordinator Qualification and Training Requirements The

Contractor shall ensure that:

3.1 Health Home Coordinators must possess one of the following licenses or credentials:

3.1.3. Certified Medical Assistants with an Associate Degree or Indian Health Service (IHS) Certified Community Health Representatives (CHR).

4. Enrollment

4.3 Eligible Client Groups

The HCA shall determine Medicaid eligibility for enrollment under this Contract. The HCA will provide the Contractor a list of Recipient Aid Categories (RACs) that are eligible to enroll in Apple Health – Fully Integrated Managed Care (AH–FIMC) to receive either full scope benefits or Behavioral Health Services Only under BHSO enrollment type. Enrollees in the following eligibility groups shown on Exhibit J, RAC Codes, at the time of enrollment are eligible for enrollment under this Contract.

4.3.9 American Indian/Alaska Native (but see 4.13 regarding no auto-enrollment of AI/AN)

4.13 Restriction on AI/AN Enrollment in Managed Care

Individuals identifying themselves as AI/AN on their application will be exempted from enrollment in managed care services. AI/AN residing within the BHO regions will access care from within the fee-for-service system. [SOURCE: Washington State Tribal Centric Health Plan] Agreement]. The Contractor will make a good faith effort to ensure that AI/AN individuals who are enrolled in the fee-for-service system remain in the fee-for-service system.

5. Payment for Services by Non-Participating Providers and IHCPs

5.20.5 In accordance with the Section 5006(d) of the American Recovery and Reinvestment Act of 2009, the Contractor is required to allow American Indians and Alaska Natives free access to and make payments for any participating and nonparticipating IHCPs for contracted services provided to AI/AN Enrollees at a rate equal to the rate negotiated between the Contractor and the IHCP. If such a rate has not been negotiated, the payment is to be made at a rate that is not less than what would have otherwise been paid to a participating provider who is not an IHCP. [SOURCE: 15.3.3]

5.20.6 For Indian Health Care Providers (IHCPs) that are FQHCs, when the amount the IHCP receives from the Contractor for services to an Indian Enrollee of the Contractor's plan is less than the total amount the IHCP is entitled to receive (including any supplemental payment under Section 1902(bb)(5) of the Social Security Act, the state must make a supplemental payment to the IHCP to make up the difference between the amount the Contractor pays and the amount the IHCP is entitled to receive as an FQHC, whether or not the IHCP has a contract with the Contractor. For IHCPs that are not FQHCs, when the amount the IHCP receives from the Contractor is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, the state must make a supplemental payment to the IHCP to make up the difference between the amount the Contractor pays and the amount the IHCP would have received under FFS or the applicable encounter rate, whether or not the IHCP has a contract with the Contractor. [SOURCE: 15.3.4]

5.20.7 **Right of Recovery**. The Contractor acknowledges that the United States (including the Indian Health Service), each Tribe, and each Tribal Organization has the right to recover

from liable third parties, including the Contractor, notwithstanding network restrictions, pursuant to 25 U.S.C. § 1621e. [SOURCE: Washington State Tribal Centric Health Plan Agreement]

5.20.8 **Prompt Payment to Indian Health Care Providers.** The Contractor agrees to make prompt payment to IHCPs, whether such IHCPs are participating providers or nonparticipating providers. [SOURCE: Washington State Tribal Centric Health Plan Agreement].

6. Access to Care and Provider Network, p. 112

6.1 Network Capacity

6.1.2 On a quarterly basis, no later than the 15th of the month following the last day of the quarter, the Contractor shall provide documentation of its provider network, including critical provider types and all contracted specialty providers. This report shall provide evidence that the Contractor has adequate provider capacity to deliver services that meet the timeliness standards described in Subsection 6.12 to all Enrollees and shall ensure sufficient choice and number of community health centers (FQHCs/RHCs) and/or private providers to allow Enrollees a choice of service systems or clinics. The report shall include information regarding the Contractor's maintenance, monitoring and analysis of the network. The quarterly reports shall include a one page narrative describing the contracting activities in border communities and service areas.

6.1.7 To the extent necessary to comply with the provider network adequacy and distance standards required under this Contract, the Contractor shall offer contracts to providers in bordering states. The Contractor's provider contracts with providers in bordering states must ensure access to necessary care, including inpatient and outpatient services and must coordinate with Oregon and Idaho providers to explore opportunities for reciprocal arrangements that allow Washington, Oregon, and Idaho border residents to access care when care is appropriate, available, and cost-effective.

6.1.8 [New Section] The Contractor will treat every Indian health care provider as an in-network provider, whether participating or not, to ensure timely access to services for Indian enrollees who are eligible to receive services from such providers. [SOURCE: Washington State Tribal Centric Health Plan Agreement].

6.2.5.3 **[New Section]** Pursuant to 25 USC 1621t and 1647a, the Contractor shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, the Contractor shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State. [SOURCE: CMS Model Medicaid CHIP Managed Care Addendum for IHCPs, Section 11 and RCW 71.24.024].

6.2.11 The Contractor shall maintain an online provider directory that meets the requirements listed below and include information about available interpreter services, communication,

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and other language assistance services. Information must be provided for each of the provider types covered under this Contract: physicians, including specialists, hospitals, pharmacies, behavioral health providers, and LTSS providers as appropriate. The

Contractor shall make all information in the online provider directory available on the Contractor's website in a machine readable file and format as specified by the Secretary. The Contractor shall also make copies of all provider information in the online provider directory available to Enrollees in paper form upon request. The online provider directory must meet the following requirements:

6.2.11.14 [New Section] Contractors will provide information from the State's Indian health care provider list to the same extent as any network provider including via their online provider directory and through customer service lines. [SOURCE: Washington State Tribal Centric Health Plan Agreement]

9 SUBCONTRACTS

9.3 Provider Nondiscrimination

9.3.5 [New Section] Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136.

No term or condition of the Contractor's network provider agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The Contractor acknowledges that pursuant to 45 C.F.R. 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the IHCP.

9.7.2.2 **[New Section]** Pursuant to 25 USC 1621t and 1647a, the Contractor shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the State or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, the Contractor shall not require the licensure of a health professional employed by such an entity under the State or local law where the entity is located, if the professional is licensed in another State. [SOURCE: CMS Model Medicaid CHIP Managed Care Addendum for IHCPs, Section 11 and RCW 71.24.024].

10 ENROLLEE RIGHTS AND PROTECTIONS

10.5 Enrollee Choice of PCP/Behavioral Health Provider

10.5.5 ~~In the case of American Indian/Alaska Native (AI/AN) Enrollees, the Enrollee may choose a tribal clinic as his or her PCP, whether or not the tribal clinic is a network provider.~~

10.5.5 If an American Indian/Alaska Native Enrollee indicates to the Contractor that he or she wishes to have an IHCP as his or her PCP, the Contractor must treat the IHCP as an innetwork PCP under this Contract for such Enrollee regardless of whether or not such IHCP has entered into a subcontract with the Contractor. (Formerly 15.3.1).

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11 UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES

11.4 Authorization of Services

11.4.7 **[New Section]** The Contractor will not require prior authorization for any services provided by an Indian health care provider to an American Indian/Alaska Native enrollee by referral from an Indian Health Care Provider. [SOURCE: Washington State Tribal Centric Health Plan Agreement]

11.4.8 [New Section] The Contractor must honor the referral of an out-of-network IHCP who refers an AI/AN Enrollee to a network provider. (42 C.F.R. § 438.14(b)(6)) (formerly 15.3.2) without requiring prior authorization or a referral from a participating network provider for the same or substantially similar service. [SOURCE: Washington State Tribal Centric Health Plan Agreement]

11.4.9 The Contractor will require documentation from IHCPs that is no more burdensome than applicable to non-IHCP providers and/or non-AI/AN enrollees, in order to avoid duplicate visits and delay of treatment. [SOURCE: Washington State Tribal Centric Health Plan Agreement]

14 CARE COORDINATION

14.1 Continuity of Care

The Contractor shall ensure Continuity of Care for Enrollees in an active course of treatment for a chronic or acute physical or behavioral health condition, including children receiving WISe services and TAY who have a current care plan. The Contractor shall ensure medically necessary care for Enrollees is not interrupted and transitions from one setting or level of care to another are promoted for six months after the implementation of this Contract. The Contractor shall honor service authorizations made by other systems such as BHOs, Indian Health Care Providers, FFS and Apple Health Managed Care Organizations (42 C.F.R. § 438.208). After the initial six months of the contract, the continuity of care period shall be no less than ninety (90) days for all new Enrollees.

14.1.1 When changes occur in the Contractor's provider network or service areas, the Contractor shall comply with the notification requirements identified in the Service Area and Provider Network Changes provisions in this Contract.

14.1.2 The Contractor shall make a good faith effort to preserve Enrollee provider relationships, including relationships through transitions.

14.1.3 Where preservation of provider relationships is not possible and reasonable, the Contractor shall assist the Enrollee to transition to a provider who will provide equivalent, uninterrupted care as expeditiously as the Enrollee's physical and behavioral health condition requires.

14.1.4 The Contractor shall allow Enrollees to continue to receive care from non-participating providers with whom an Enrollee has a documented established relationship. The Contractor shall take the following steps:

14.1.4.1 The Contractor must make a good faith effort to subcontract with the established non-participating provider.

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14.1.4.3 If transition is necessary, the Contractor shall facilitate collaboration between the established non-participating provider and the new participating provider to plan a safe, medically appropriate transition in care. If the non-participating provider or the Enrollee will not cooperate with a necessary transition, the

Contractor may transfer the Enrollee's care to a participating provider within ninety (90) calendar days of the Enrollee's enrollment effective date. Pay the non-participating provider indefinitely if it chooses when the non-participating provider accepts payment rates the Contractor has established. Apply utilization management decision-making standards to non-participating providers that are no more stringent than standards for participating providers.

14.10 Coordination Between the Contractor and External Entities

14.10.1 The Contractor shall coordinate with, and refer Enrollees to, health care and social services/programs, including, but not limited to:

14.10.1.18 Tribal entities;

14.12 Children's Long Term Care (CLIP)

14.12.5 The Contractor's Tribal Liaison and the Enrollee's Indian Health Care Provider shall participate in treatment and discharge planning, including continuity of care in the nearest clinically appropriate setting for all AI/AN Enrollees (including BHSO) admitted for voluntary inpatient psychiatric and/or residential substance use disorder services.

14.16 American Indian/Alaska Natives

14.16.1 The Contractor must designate a tribal liaison to work with Indian Health Care Providers (IHCPs).

14.16.2 The Contractor must provide for training of its tribal liaison, conducted by one (1) or more IHCPs and/or the American Indian Health Commission for Washington State and/or the DSHS Indian Policy Advisory Committee, on AI/AN health disparities and needs, the Indian health care delivery system, the government-to-government relationship between the state of Washington and the federally recognized tribes, applicable federal and state laws and regulations, applicable provisions in this Contract, and matters specific to IHCPs.

14.16.3 ~~The Contractor must ensure its employees and agents receive training in cultural humility, including training on how to communicate with AI/AN Enrollees and IHCP staff, and in the history, culture, and services of IHCPs within the RSAs under the Contract. Training shall be obtained in collaboration with the tribes and IHCPs in such RSAs.~~

[New Section] The Contractor will require staff to receive, at least once per calendar year, cultural humility training that is applicable to the respective AI/AN communities they serve. The Contractor will provide written documentation of efforts to coordinate with tribe(s) and urban Indian health programs in the Contractor's service area, AIHC, IPAC, and/or DSHS Office of Indian Policy (OIP) to obtain this training. The Contractor will coordinate with IHCPs on how to provide culturally appropriate evidence-based AI/AN practices, to include assessments and treatments and/or traditional healing services, with a plan for reimbursement for providing the service, when these services are

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covered by the Washington Medicaid State Plan as approved by CMS. [SOURCE: Washington State Tribal Centric Health Plan Agreement].

14.16.4 **Maintenance of the AI/AN IHCP Medical Home.** The Contractor must notify and coordinate care and transitions with any IHCP when the Contractor becomes aware an Enrollee is AI/AN or is receiving care from an IHCP and the Enrollee consents to such notification. To meet this requirement, the Contractor must develop and maintain a process for asking whether an Enrollee is a member of a federally recognized tribe or is receiving care from an IHCP and, if applicable, whether the Enrollee consents to the Contractor notifying such IHCP or federally recognized tribe. The Contractor will provide only the services requested by the IHCP and/or AI/AN enrollee and maintain the IHCP as the AI/AN enrollee's medical home through care coordination with the IHCP including the IHCP's purchased and referred care program (PRC). The Contractor will provide nonIHCP providers with state guidance on the critical role played by IHCPs for the care of AI/AN enrollees. Subject to the AI/AN enrollee's release of information, the Contractor will require non-IHCPs to deliver progress notes, including any referrals made, to the AI/AN enrollee's IHCP medical home. (See 15.3.8) [SOURCE: Washington State Tribal Centric Health Plan Agreement].

14.16.5 With respect to voluntary psychiatric hospitalization authorization, the Contractor shall:

14.6.5.1 Develop and maintain policies and procedures that:

14.16.5.1.1 Explain how IHCP request voluntary psychiatric hospitalization authorizations for Enrollees; and

14.16.5.1.2 Authorize only psychiatrists or doctoral level psychologists of the Contractor to deny such request.

14.16.5.2 Obtain the approval of HCA's tribal liaison for such policies and procedures before they are implemented; and

14.16.5.3 Make available to IHCPs information on how to request voluntary psychiatric hospitalization authorizations for Enrollees, including policies and procedures, and how to submit appeals and expedited appeals.

14.16.6 The Contractor's Tribal Liaison and the Enrollee's Indian Health Care Provider shall participate in treatment and discharge planning, including continuity of care in the nearest clinically appropriate setting for all AI/AN Enrollees (including BHSO) admitted for voluntary inpatient psychiatric and/or residential substance use disorder services.

14.16.7 The following provisions address ongoing barriers for AI/AN when accessing Medicaid services that should be addressed under 42 C.F.R. § 431.55(b)(2)(i).

14.16.7.1 The Contractor will develop protocols with each tribe in the Contractor's service area, for accessing Tribal land to provide crisis services, including coordination of outreach and debriefing of crisis review and outcome with the IHCP mental health provider. The protocols will include agreed upon timeframes and participation for debrief and review, in compliance with HIPAA and 42 C.F.R. Part 2 requirements.

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14.16.7.2 To the extent permitted by law, the Contractor will make its best efforts to require participating psychiatric hospitals and Evaluation & Treatment (E&T) facilities to notify and coordinate AI/AN discharge planning with IHCPs. [SOURCE: Washington State Tribal Centric Health Plan Agreement].

15 SPECIAL PROVISIONS FOR FIMC

15. 1 ~~Special Provisions~~ Requirements for Subcontracts with Indian Health Care Providers (IHCPs)

15.1.1 If, at any time during the term of this Contract, an IHCP submits a written request to the Contractor at the mailing address set forth on the cover page of this Contract indicating such IHCP's intent to enter into a subcontract with the Contractor, the Contractor must negotiate in good faith with the IHCP. The Contractor will offer and negotiate contracts in good faith to all IHCPs, including any tribal care coordination, transportation, or related providers; the Contractor will acknowledge that IHCPs may not be required to contract with any Contractor. To be offered in good faith, a Contractor must offer contract terms comparable to terms that it offers to a similarly-situated non-IHCP provider, except for terms that would not be applicable to an IHCP, such as by virtue of the types of services that an IHCP provides. The Contractor will provide verification of such offers on request for the State to verify compliance with this provision. [SOURCE: Washington State Tribal Centric Health Plan Agreement]

15.1.1.1 Any such subcontract must include the Special Terms and Conditions set forth in the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (the IHCP Addendum) issued by the Centers for Medicare and Medicaid Services (CMS). To the extent that any provision set forth in the subcontract between the Contractor and the IHCP conflicts with the provisions set forth in the IHCP Addendum, the provisions of the IHCP Addendum shall prevail. The addendum must reference the HCA's mechanism in Section 15.2.3 for each IHCP to submit complaints to the HCA regarding unresolved issues, including, but not limited to, crisis coordination between the IHCP and the Contractor, for the HCA to facilitate resolution directly with the Contractor.[SOURCE: Washington State Tribal Centric Health Plan Agreement]

15.1.1.2 Such subcontract may include additional Special Terms and Conditions that are approved by the IHCP and the Contractor. Each party must provide the HCA Tribal Liaison with a complete copy of such additional Special Terms and Conditions, in the format specified by the HCA, and a written statement that both parties have agreed to such additional Special Terms and Conditions.

15.1.2 Any subcontracts with IHCP must be consistent with the laws and regulations that are applicable to the IHCP. The Contractor must work with each IHCP to prevent the Contractor's business operations from placing requirements on the IHCP that are not consistent with applicable law or any of the Special Terms and Conditions in the subcontract between the Contractor and the IHCP.

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15.1.3 The Contractor may seek technical assistance from the HCA Tribal Affairs Office to understand the legal protections applicable to IHCPs and American Indian/Alaska Native Medicaid recipients.

15.1.4 In the event that (a) the Contractor and the IHCP fail to reach an agreement on a subcontract within ninety (90) calendar days from the date of the IHCP's written request (as described in subsection 15.1.1) and (b) the IHCP submits a written request to HCA for a meeting to discuss the subcontract, the Contractor and the IHCP shall meet in person with HCA in Olympia, Washington or at an alternate location agreed upon by the parties involved within thirty (30) calendar days from the date of the IHCP's written consultation request in an effort to resolve differences and come to an agreement.

Executive leadership of the Contractor must attend this meeting in person and be permitted to have legal counsel present.

15.1.5 [New Section] Resolution of Issues. The Contractor will include reference in any contract between the Contractor and the IHCP to the Separate Issue Resolution Mechanism maintained by HCA. [SOURCE: Washington State Tribal Centric Health Plan Agreement]

15.2 IHCP Engagement

15.2.1 No later than April 30 of each year, the Contractor shall submit to the HCA Tribal Affairs Office a report that includes:

15.2.1.1 A description of Pre-Planning Meeting Activity. Prior to the development of any plan with an IHCP that is required by this section, the Contractor will meet with the State and the IHCP to identify and resolve issues related to the Contractor's performance of services under this Agreement. [SOURCE: Washington State Tribal Centric Health Plan Agreement]

15.2.1.2 A plan that describes the outreach activities the Contractor will undertake during the upcoming year to work with IHCPs in developing and implementing various services, financing models, and other activities for the Contractor to:

15.2.1.2.1 Support and enhance the care coordination services provided by IHCPs for Enrollees, both American Indian/Alaska Native and non-American Indian/Alaska Native, including coordination with nonIHCP;

15.2.1.2.2 Improve access for American Indian/Alaska Native Enrollees (including those who do not receive care at IHCPs) to receive trauma-informed care; ~~and~~

15.2.1.2.3 A summary of the progress made during the previous year in building relationships, contractual and otherwise, with IHCPs;

15.2.1.2.4 A summary of action taken to implement any corrective action found by the HCA, including but not limited to, HCA's annual evaluation under 15.2.6.

15.2.1.2.5 Any written proposed changes to the plan submitted by the IHCP; and

15.2.1.2.6 Certification that the Contractor

15.2.1.2.6.1 Submitted a draft plan to the IHCP and provided thirty(30) days for the IHCP to review and make changes to the plan.

15.2.1.2.6.2 Made a good faith effort to incorporate any IHCP changes to the plan that are consistent with the terms of the contract. Any disagreements regarding the plan must be resolved by the HCA.

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15.2.2 No later than the 15th calendar day after the end of each calendar quarter, the Contractor shall submit to the HCA Tribal Affairs Office a report that briefly describes:

15.2.2.1 IHCPs the Contractor has worked with during the previous quarter;

15.2.2.2 IHCPs with whom the Contractor successfully negotiated collaborative or contractual arrangements during the previous quarter; and

15.2.2.3 IHCPs to whom the Contractor will reach out during the coming quarter.

15.2.3 [New Section] Separate Issue Resolution Mechanism. The HCA will maintain a mechanism for each IHCP to submit complaints to the HCA regarding unresolved issues, including, but not limited to, crisis coordination, between the IHCP and an HCA, for the State to facilitate resolution directly with the MCE. [SOURCE: Washington State Tribal Centric Health Plan Agreement].

15.2.4 [New Section] Corrective Action. The Contractor will be subject to corrective action and penalties against the Contractor by the State if the Contractor fails to: (1) Perform any obligation under this Contract; or (2) Ensure that AI/AN enrollees are afforded access to care, rights, and benefits on par with all other Contractor enrollees. [SOURCE: Washington State Tribal Centric Health Plan Agreement].

15.2.5 [New Section] Contractor Tribal Liaison. The Contractor's tribal liaison will facilitate resolution of any issue between the Contractor and an IHCP, including but not limited to billing and provider enrollment/credentialing issues; the Tribal Liaison's function may be an additional duty assigned to existing Contractor's staff. The Contractor will document with the State every such issue identified by the Tribal Liaison. The Contractor will make the Tribal Liaison available for training by tribes and UIHPs in the Contractor's service area, the Indian Policy Advisory Committee (IPAC) of the Department of Social and Health Services (DSHS), and/or the American Indian Health Commission for Washington State (AIHC). [SOURCE: Washington State Tribal Centric Health Plan Agreement].

15.2.6 [New Section] Contractor Indian Health Performance Standards

The Health Care Authority (HCA) has developed Contractor performance standards (Attachment 11) for performance regarding contracting and engaging with Indian health care providers (IHCP) and providing access to high quality and culturally appropriate services to American Indians and Alaska Natives (AI/ANs). The purpose of these standards is to assist the Contractor in serving AI/ANs and the Indian health delivery system in a manner that assures access and complies with state and federal requirements.

HCA will assess Contractor compliance with performance standards utilizing year-round mechanisms for collecting and managing Contractor reporting and internal data related to performance indicators, and an annual IHCP survey. HCA shall report on an annual basis to IHCPs on Contractor performance for all performance measures. Failure by a Contractor meet one or more of the standards will result in HCA developing and implementing a corrective action plan for the Contractor. The corrective action plan shall delineate the time and manner in which each deficiency must be corrected. Failure to complete the corrective action plan within the required number of days may result in sanctions or termination of the contract.

~~15.3 Special Provisions for American Indians and Alaska Natives~~

~~15.3.1 If an American Indian/Alaska Native Enrollee indicates to the Contractor that he or she wishes to have an IHCP as his or her PCP, the Contractor must treat the IHCP as an in-network PCP under this Contract for such Enrollee regardless of whether or not such IHCP has entered into a subcontract with the Contractor.~~ (moved to 10.5.5)

~~15.3.2 The Contractor must honor the referral of an out-of-network IHCP who refers an AI/AN Enrollee to a network provider. (42 C.F.R. § 438.14(b)(6)).~~ (moved to 11.4.8)

~~15.3.3 In accordance with the Section 5006(d) of the American Recovery and Reinvestment Act of 2009, the Contractor is required to allow American Indians and Alaska Natives free access to and make payments for any participating and nonparticipating IHCPs for contracted services provided to AI/AN Enrollees at a rate equal to the rate negotiated between the Contractor and the IHCP. If such a rate has not been negotiated, the payment is to be made at a rate that is not less than what would have otherwise been paid to a participating provider who is not an IHCP.~~ (moved to 5.20.5)

~~15.3.4 For Indian Health Care Providers (IHCPs) that are FQHCs, when the amount the IHCP receives from the Contractor for services to an Indian Enrollee of the Contractor's plan is less than the total amount the IHCP is entitled to receive (including any supplemental payment under Section 1902(bb)(5) of the Social Security Act, the state must make a supplemental payment to the IHCP to make up the difference between the amount the Contractor pays and the amount the IHCP is entitled to receive as an FQHC, whether or not the IHCP has a contract with the Contractor. For IHCPs that are not FQHCs, when the amount the IHCP receives from the Contractor is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, the state must make a supplemental payment to the IHCP to make up the difference between the amount the Contractor pays and the amount the IHCP would have received under FFS or the applicable encounter rate, whether or not the IHCP has a contract with the Contractor.~~ (Moved to 5.20.6)

16 Benefits

16.11 Enrollee Self-Referral

16.11.7 The services to which an Enrollee may self-refer are:

16.11.7.4 All services received by American Indian or Alaska Native Enrollees under the ~~Special P~~ protections for American Indians and Alaska Natives ~~subsection of~~ provided in this Contract.

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APPENDIX B: MCO Performance Standards

American Indian Health Commission

ATTACHMENT 11
MCO Performance Standards for Contracting, Engaging, and Providing Access for American Indian/Alaska Natives and Indian Health Care Providers

The Health Care Authority (HCA) has developed managed care organization (MCO) standards for performance regarding contracting and engaging with Indian health care providers (IHCP) and providing access to high quality and culturally appropriate services to American Indians and Alaska Natives (AI/ANs). The purpose of these standards is to assist MCOs in serving AI/ANs and the Indian health care delivery system in a manner that assures access and complies with state and federal requirements.

HCA will assess MCO compliance with performance standards utilizing year-round mechanisms for collecting and managing MCO reporting and internal data related to performance indicators, and an annual IHCP survey. HCA shall report on an annual basis to IHCPs on MCO performance for all performance measures. Failure by an MCO to meet one or more of the standards will result in HCA developing and implementing a corrective action plan for the MCO. The corrective action plan shall delineate the time and manner in which each deficiency must be corrected. Failure to complete the corrective action plan within the required number of days may result in sanctions or termination of the contract.

Standard 1.1: Enrollment

Restriction on AI/AN Enrollment in Managed Care
Individuals identifying themselves as AI/AN on their application will be exempted from enrollment in managed care services. AI/AN residing in the MCO's service area will access care within the Fee-ForService system. The Contractor will make a good faith effort to ensure that AI/AN individuals who are enrolled in the fee-for-service system remain in the fee-for-service system. (Contract Provision 4.13).

Compliance Measures

The Contractor incorrectly enrolls in managed care plans fewer than 2% of all new AI/AN Medicaid enrollees per quarter

Compliance Indicators

- Number of incorrect AI/AN enrollments in managed care plans reported to HCA by IHCPs and AI/ANs is zero (0) in each quarter

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Standard 1.2: Payment for Services

IHCP Payment Rate

In accordance with the Section 5006(d) of the American Recovery and Reinvestment Act of 2009, the Contractor is required to allow American Indians and Alaska Natives free access to and make payments for any participating and nonparticipating IHCPs for contracted services provided to AI/AN Enrollees at a

rate equal to the rate negotiated between the Contractor and the IHCP. If such a rate has not been negotiated, the payment is to be made at a rate that is not less than what would have otherwise been paid to a participating provider who is not an IHCP. (Contract Provision 5.20.5).

Right of Recovery

The Contractor acknowledges that the United States (including the Indian Health Service), each Tribe, and each Tribal Organization has the right to recover from liable third parties, including the Contractor, notwithstanding network restrictions, pursuant to 25 U.S.C. § 1621e. (Contract Provisions 5.20.7).

Prompt Payment to Indian Health Care Providers

The Contractor agrees to make prompt payment to IHCPs, whether such IHCPs are participating providers or non-participating providers. (Contract Provisions 5.20.8).

Compliance Measures – Payment for Services

The Contractor denies access to no (0%) AI/AN enrollees to participating and nonparticipating Indian health care providers in each quarter

The Contractor makes fewer than 2% incorrect payments to IHCPs, at a rate lower than the negotiated rate or the rate that would have been paid to a non-IHCP provider in each quarter

At least 95% of Contractor payments to IHCPs are paid within 60 days of claims submitted to the Contractor, in each quarter

Compliance Indicators - Payment for Services

- Number of cases of denied access to care from IHCPs reported to HCA by IHCPs and AI/ANs is zero (0) in each quarter
- Number of incorrect payments reported to HCA by IHCPs is zero (0) in each quarter
- Number of late payments reported to HCA by IHCPs is zero (0) in each quarter

Standard 1.3: Access to Care and Provider Network

MCO Reporting on IHCP Provider Network Adequacy and AI/AN Access to Care

On a quarterly basis, no later than the 15th of the month following the last day of the quarter, the Contractor shall provide documentation of its provider network, including critical provider types and all contracted specialty providers. This report shall provide evidence that the Contractor has adequate provider capacity to deliver services that meet the timeliness standards described in Subsection 6.12 to all Enrollees and shall ensure sufficient choice and number of community health centers (FQHCs/RHCs) and/or private providers to allow Enrollees a choice of service systems or clinics. The report shall include

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information regarding the Contractor's maintenance, monitoring and analysis of the network. The quarterly reports shall include a one page narrative describing the contracting activities in border communities and service areas. (Contract Provisions 6.1.2).

MCO Contracts with IHCPs in Bordering States

To the extent necessary to comply with the provider network adequacy and distance standards required under this Contract, the Contractor shall offer contracts to providers in bordering states. The Contractor's provider contracts with providers in bordering states must ensure access to necessary care, including inpatient and outpatient services and must coordinate with Oregon and Idaho providers to explore opportunities for reciprocal arrangements that allow Washington, Oregon, and Idaho border

residents to access care when care is appropriate, available, and cost-effective. (Contract Provisions 6.1.2).

MCO Treatment of IHCP as In-Network

The Contractor will treat every Indian health care provider as an in-network provider, whether participating or not, to ensure timely access to services for Indian enrollees who are eligible to receive services from such providers. (Contract Provision 6.1.8).

MCO Inclusion of IHCP in Provider Directory. Contractors will provide information from the State's Indian health care provider list to the same extent as any network provider including via their online provider directory and through customer service lines. (Contract Provision 6.2.11.14).

Compliance Measures – Access to Care and Provider Network

The Contractor submits network adequacy reports no later than the 15th of the month following the last day of the quarter

The Contractor's quarterly network adequacy reports content demonstrates Contractor meets the regional criteria for network adequacy *(to be determined; e.g., distance, provider to population ratio, appointment lead time, etc.)* for AI/AN enrollees

The Contractor treats every Indian health care provider as an in-network provider

The Contractor includes every Indian health care provider in its online provider directory and customer service information

Compliance Indicators - Access to Care and Provider Network

- Date of submission of Contractor's network adequacy report is no later than the 15th of the month following the last day of the quarter in each quarter
- The Contractor meets network adequacy criteria in each quarter
- Number of cases in which Contractor has not treated IHCPs as in-network providers reported to HCA by IHCPs is zero (0) in each quarter
- Contractor's online provider directory includes every IHCP in Washington

Standard 1.4: Utilization Management Program and Authorization of Services

No Prior Authorization for IHCP Services

The Contractor will not require prior authorization for any services provided by an Indian health care provider to an American Indian/Alaska Native enrollee by referral from an Indian Health Care Provider. (Contract Provision 11.4.7).

IHCP Referrals

The Contractor must honor the referral of an out-of-network IHCP who refers an AI/AN Enrollee to a network provider. (42 C.F.R. § 438.14(b)(6)) (formerly 15.3.2) without requiring prior authorization or a referral from a participating network provider for the same or substantially similar service. (Contract Provision 11.4.8).

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The Contractor will require documentation from IHCPs that is no more burdensome than applicable to non-IHCP providers and/or non-AI/AN enrollees, in order to avoid duplicate visits and delay of treatment. (Contract Provision 11.4.9).

The Contractor will ensure that an AI/AN may self-refer all services under the protections for AI/AN provided in this Contract. (Contract 16.11.7.4).

Compliance Measures – Utilization Management Program and Authorization of Services

The Contractor incorrectly requires prior authorization from fewer than 2% AI/AN enrollees with referrals in each quarter

Description of referral documentation required for IHCPs and non-IHCPs

Compliance Indicators - Utilization Management Program and Authorization of Services

- Number of cases in which Contractor incorrectly requires prior authorization from AI/AN enrollees reported to HCA by IHCPs and AI/ANs is zero (0) in each quarter

Standard 1.5: Care Coordination

MCO Referral to IHCP Health Care and Social Services Programs

The Contractor shall coordinate with, and refer Enrollees to, health care and social services/programs, including, but not limited to Tribal entities (Contract Provision 14.10.1 and 14.1.18).

MCO Coordination with IHCPs in Treatment and Discharge Planning for Children's Long-Term Care The Contractor's Tribal Liaison and the Enrollee's Indian Health Care Provider shall participate in treatment and discharge planning, including continuity of care in the nearest clinically appropriate setting for all AI/AN Enrollees (including BHSO) admitted for voluntary inpatient psychiatric and/or residential substance use disorder services. (Contract Provision 14.12.5).

MCO Tribal Liaison

The Contractor must designate a tribal liaison to work with Indian Health Care Providers (IHCPs). (Contract Provision 14.16.1).

The Contractor must provide for training of its tribal liaison, conducted by one (1) or more IHCPs and/or the American Indian Health Commission for Washington State and/or the DSHS Indian Policy Advisory Committee, on AI/AN health disparities and needs, the Indian health care delivery system, the government-to-government relationship between the state of Washington and the federally recognized tribes, applicable federal and state laws and regulations, applicable provisions in this Contract, and matters specific to IHCPs. (Contract Provisions 14.16.2).

Cultural Humility Training of MCO Employees/Agents

The Contractor will require staff to receive, at least once per calendar year, cultural humility training that is applicable to the respective AI/AN communities they serve. The Contractor will provide written documentation of efforts to coordinate with tribe(s) and urban Indian health programs in the Contractor's service area, AIHC, IPAC, and/or DSHS Office of Indian Policy (OIP) to obtain this training. The Contractor will coordinate with IHCPs on how to provide culturally appropriate evidence-based

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AI/AN practices, to include assessments and treatments and/or traditional healing services, with a plan for reimbursement for providing the service, when these services are covered by the Washington Medicaid State Plan as approved by CMS. (Contract Provision 14.16.3)

Maintenance of the AI/AN IHCP Medical Home.
The Contractor must notify and coordinate care and transitions with any IHCP when the Contractor becomes aware an Enrollee is AI/AN or is receiving care from an IHCP and the Enrollee consents to such notification. To meet this requirement, the Contractor must develop and maintain a process for asking whether an Enrollee is a member of a federally recognized tribe or is receiving care from an IHCP and, if applicable, whether the Enrollee consents to the Contractor notifying such IHCP or federally recognized tribe. The Contractor will provide only the services requested by the IHCP and/or AI/AN enrollee and maintain the IHCP as the AI/AN enrollee's medical home through care coordination with the IHCP including the IHCP's purchased and referred care program (PRC). The Contractor will provide non-IHCP providers with state guidance on the critical role played by IHCPs for the care of AI/AN enrollees. Subject to the AI/AN enrollee's release of information, the Contractor will require non-IHCPs to deliver progress notes, including any referrals made, to the AI/AN enrollee's IHCP medical home. (See 15.3.8) (Contract Provision 14.16.4).

Coordination with IHCP for Voluntary Psychiatric Hospitalization and Residential SUD Services

1. With respect to voluntary psychiatric hospitalization authorization, the Contractor shall (Contract Provision 14.16.5):
    a. Develop and maintain policies and procedures that:
        i. Explain how IHCP request voluntary psychiatric hospitalization authorizations for Enrollees; and (Contract Provision 14.16.5.1.1)
        ii. Authorize only psychiatrists or doctoral level psychologists of the Contractor to deny such request. (Contract Provision 14.16.5.1.2)
    b. Obtain the approval of HCA's tribal liaison for such policies and procedures before they are implemented; and (Contract Provision 14.16.5.2)
    c. Make available to IHCPs information on how to request voluntary psychiatric hospitalization authorizations for Enrollees, including policies and procedures, and how to submit appeals and expedited appeals. (Contract Provision 14.16.5.3)
2. The Contractor's Tribal Liaison and the Enrollee's Indian Health Care Provider shall participate in treatment and discharge planning, including continuity of care in the nearest clinically appropriate setting for all AI/AN Enrollees (including BHSO) admitted for voluntary inpatient psychiatric and/or residential substance use disorder services. (Contract Provision 14.16.6)
3. The following provisions address ongoing barriers for AI/AN when accessing Medicaid services that should be addressed under 42 C.F.R. § 431.55(b)(2)(i). (Contract Provision 14.16.7)
    a. The Contractor will develop protocols with each tribe in the Contractor's service area, for accessing Tribal land to provide crisis services, including coordination of outreach and debriefing of crisis review and outcome with the IHCP mental health provider. The protocols will include agreed upon timeframes and participation for debrief and review,

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in compliance with HIPAA and 42 C.F.R. Part 2 requirements. (Contract Provision 14.16.7.1).

b. To the extent permitted by law, the Contractor will make its best efforts to require participating psychiatric hospitals and Evaluation & Treatment (E&T) facilities to notify and coordinate AI/AN discharge planning with IHCPs. (Contract Provision 14.16.7.2).

Compliance Measures – Care Coordination

- The Contractor refers enrollees to IHCP health care and social services programs, when appropriate
- The Contractor includes the enrollee's IHCP and the Contractor's Tribal Liaison in treatment and discharge planning for all (100%) voluntary inpatient psychiatric and/or residential substance use disorders services in each quarter
- The Contractor staffs the Tribal Liaison function at all times
- Incumbents serving in the Tribal Liaison function more than 1 month complete training conducted by one (1) or more IHCPs and/or the American Indian Health Commission for Washington State and/or the DSHS Indian Policy Advisory Committee, on AI/AN health disparities and needs, the Indian health care delivery system, the government-to-government relationship between the state of Washington and the federally recognized tribes, applicable federal and state laws and regulations, applicable provisions in this Contract, and matters specific to IHCPs at least once
- Contractor employees, including but not limited to: Tribal Liaison, customer service representatives, and care coordination representatives receive cultural humility training no less than once every 12 months
- The Contractor provides a mechanism to track for every enrollee whether they have a IHCP Medical Home
- The Contractor does not reassign enrollees to a non-IHCP Medical Home, unless specifically requested by enrollees through fully informed consent
- The Contractor provides non-IHCP providers with information regarding IHCPs and their key role in care coordination for AI/AN
- The Contractor requires non-IHCP providers to share information and coordinate care with enrollee's IHCP, subject to the enrollee's informed consent and request
- The Contractor obtains HCA approval for policies and procedures regarding voluntary psychiatric hospitalization and substance use disorder residential services
- The Contractor provides their HCA-approved policies and procedures for voluntary psychiatric hospitalization and substance use disorder residential services to IHCPs
- The Contractor develops with the approval of each Tribe in its service area protocols for accessing tribal land to provide crisis services, including coordination of outreach and debriefing of crisis review and outcome with the IHCP

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- The Contractor requires participating psychiatric hospitals and Evaluation & Treatment (E&T) facilities to notify and coordinate AI/AN discharge planning with IHCPs, to the extent permitted by law

Compliance Indicators - Care Coordination

- Contractor provides documentation of number of referrals made to IHCP health care and social services programs in cases in each quarter
- Number of cases in which Contractor has not included the enrollee's IHCP and the Contractor's Tribal Liaison in treatment and discharge planning for voluntary inpatient psychiatric and/or residential substance use disorders services reported by IHCPs or AI/ANs is zero (0) in each quarter
- The Tribal Liaison function is staffed by an incumbent at least 65% of the time in each quarter or by a temporary Acting Tribal Liaison no more than 35% of the time in each quarter
- Contractor provides certificate and date of completion of Tribal Liaison incumbent's training
- Contractor provides certificates and dates of completion for cultural humility training completed by Contractor employees' within the past 12 months
- Contractor manages a mechanism for tracking all (100%) enrollees' IHCP Medical Home
- Contractor includes enrollees' IHCP and the Contractor's Tribal Liaison in treatment and discharge planning for voluntary inpatient psychiatric and/or residential substance use disorders services reported by IHCPs and AI/AN enrollees for all (100%) cases in each quarter
- Contractor reassigns zero (0) enrollees to a non-IHCP Medical Home, without the enrollees specifically requesting reassignment through fully informed consent reported by IHCPs and AI/AN enrollees in each quarter
- The contracts between Contractor and non-IHCP providers includes language regarding IHCPs' key role in care coordination for AI/AN enrollees
- The contracts between Contractor and non-IHCP providers require non-IHCP providers to share information and coordinate care with enrollees' IHCP, subject to the enrollee's informed consent and request
- Contractor provides documentation of when and how they have delivered HCA-approved policies and procedures for voluntary psychiatric hospitalization and substance use disorder residential services to IHCPs
- Protocols are approved by each Tribe in the Contractor's service area for Contractor accessing tribal land to provide crisis services, coordination of outreach and debriefing of crisis review and outcome with the IHCP
- Contracts between Contractor and participating psychiatric hospitals and Evaluation & Treatment (E&T) facilities include language requiring the hospitals and treatment facilities to notify and coordinate AI/AN discharge planning with IHCPs, to the extent permitted by law

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Standard 1.6: Managed Care Organization Contracting with Indian Health Care Provider

MCO Offer to Contract and Negotiation with IHCP

If, at any time during the term of this Contract, an IHCP submits a written request to the Contractor at the mailing address set forth on the cover page of this Contract indicating such IHCP's intent to enter into a subcontract with the Contractor, the Contractor must negotiate in good faith with the IHCP. The Contractor will offer and negotiate contracts in good faith to all IHCPs, including any tribal care coordination, transportation, or related providers; the Contractor will acknowledge that IHCPs may not be required to contract with any Contractor. To be offered in good faith, a Contractor must offer contract terms comparable to terms that it offers to a similarly-situated non-IHCP provider, except for terms that would not be applicable to an IHCP, such as by virtue of the types of services that an IHCP provides. The Contractor will provide verification of such offers on request for the State to verify compliance with this provision. (Contract Provision 15.1.1).

MCO-IHCP Contract Addendum

Any such subcontract must include the Special Terms and Conditions set forth in the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (the IHCP Addendum) issued by the Centers for Medicare and Medicaid Services (CMS). To the extent that any provision set forth in the subcontract between the Contractor and the IHCP conflicts with the provisions set forth in the IHCP Addendum, the provisions of the IHCP Addendum shall prevail. (Contract Provision 15.1.1.1).

The addendum must reference the HCA's mechanism in Section 15.2.3 for each IHCP to submit complaints to the HCA regarding unresolved issues, including, but not limited to, crisis coordination between the IHCP and the Contractor, for the State to facilitate resolution directly with the Contractor. (Contract Provision 15.1.1.1).

MCO-IHCP Contract Consistency with Federal and State IHCP and AI/AN Protections:

Any subcontracts with IHCP must be consistent with the laws and regulations that are applicable to the IHCP. The Contractor must work with each IHCP to prevent the Contractor's business operations from placing requirements on the IHCP that are not consistent with applicable law or any of the Special Terms and Conditions in the subcontract between the Contractor and the IHCP. (Contract Provision 15.1.2).

Resolution of Issues. The Contractor will include reference in any contract between the Contractor and the IHCP to the Separate Issue Resolution Mechanism maintained by the State under Section 4 of this Agreement. (Contract Provision 15.1.5).

Compliance Measures – Managed Care Organization Contracting with Indian Health Care Provider

- The Contractor offers and negotiate contracts in good faith to all IHCPs
- The Contractor includes in all contracts with IHCPs the Special Terms and Conditions set forth in the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (the IHCP Addendum) issued by the Centers for Medicare and Medicaid Services (CMS)

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- The Contractor’s subcontracts with IHCPs are consistent with the laws and regulations that are applicable to the IHCP
- The Contractor’s subcontract with IHCPs include reference to the Separate Issue Resolution Mechanism maintained by the Health Care Authority

Compliance Indicators - Managed Care Organization Contracting with Indian Health Care Provider

- Number of cases in which Contractor has not negotiated contracts in good faith with IHCPs reported by IHCPs in each quarter is zero (0)
- Contracts between Contractor and IHCPs include the Special Terms and Conditions set forth in the Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Addendum for

  Indian Health Care Providers (the IHCP Addendum) issued by the Centers for Medicare and Medicaid Services (CMS)
- Contracts between Contractor and IHCPs include reference to the Separate Issue Resolution Mechanism maintained by the Health Care Authority

Standard 1.7 Engagement with Indian Health Care Provider

MCO IHCP Coordination and Access Plan

No later than April 30 of each year, the Contractor shall submit to the HCA Tribal Affairs Office a report that includes (Contract Provision 15.2.1):

1. A description of Pre-Planning Meeting Activity. Prior to the development of any plan with an IHCP that is required by this section, the Contractor will meet with the State and the IHCP to gather IHCP input for the MCO-IHCP Plan and identify and resolve issues related to the Contractor’s performance of services under this Agreement. (Contract Provisions 15.2.1.1).
2. An MCO-IHCP Coordination and Access Plan that describes the outreach activities the Contractor will undertake during the upcoming year to work with IHCPs in developing and implementing various services, financing models, and other activities for the Contractor to (Contract Provision 15.2.1.1):
    a. Support and enhance the care coordination services provided by IHCPs for Enrollees, both American Indian/Alaska Native and non-American Indian/Alaska Native, including coordination with non-IHCP (Contract Provision 15.2.1.2.1);

    b. Improve access for American Indian/Alaska Native Enrollees (including those who do not receive care at IHCPs) to receive trauma-informed care (Contract Provision 15.2.1.2.2); and

    c. A summary of the progress made during the previous year in building relationships, contractual and otherwise, with IHCPs. (Contract Provision 15.2.1.2.3).

    d. Certification that the Contractor (Contract Provision 15.2.1.2.5)

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i. submitted a draft plan to the IHCP and provided thirty(30) days for the IHCP to review and make changes to the plan.

ii. made a good faith effort to incorporate any IHCP changes to the plan that are consistent with the terms of the contract. Any disagreements regarding the plan must be resolved by the HCA.

MCO Report on IHCP Engagement

No later than the 15th calendar day after the end of each calendar quarter, the Contractor shall submit to the HCA Tribal Affairs Office a report that briefly describes (Contract Provision 15.2.2):

1. IHCPs the Contractor has worked with during the previous quarter (Contract Provision 15.2.2.1);
2. IHCPs with whom the Contractor successfully negotiated collaborative or contractual arrangements during the previous quarter (Contract Provision 15.2.2.2); and

3. IHCPs to whom the Contractor will reach out during the coming quarter (Contract Provision 15.2.2.3).

Contractor Tribal Liaison

The Contractor's tribal liaison will facilitate resolution of any issue between the Contractor and an IHCP, including but not limited to billing and provider enrollment/credentialing issues; the Tribal Liaison's function may be an additional duty assigned to existing Contractor's staff. The Contractor will document with the State every such issue identified by the Tribal Liaison. The Contractor will make the Tribal Liaison available for training by tribes and UIHPs in the Contractor's service area, the Indian Policy Advisory Committee (IPAC) of the Department of Social and Health Services (DSHS), and/or the American Indian Health Commission for Washington State (AIHC). (Contract Provision 15.2.5).

Compliance Measures – Engagement with Indian Health Care Provider

- The Contractor submits IHCP Coordination and Access Plan report to HCA and IHCPs with all required documentation
- The Contractor's Tribal Liaison facilitates resolution of issues and completes the other duties of the Tribal Liaison function to the satisfaction of IHCPs

Compliance Indicators – Engagement with Indian Health Care Provider

- Date of submission of Contractor's IHCP Coordination and Access Plan report is no later than the 15th calendar day after the end of each calendar quarter
- The Contractor's IHCP Coordination and Access Plan report's content demonstrates that the Contractor meets the substantive intent of the coordination and access planning requirements
- Number of cases where the Contractor's Tribal Liaison has failed to facilitate resolution of issues or to perform other duties of the Tribal Liaison function to the satisfaction of IHCPs, reported by IHCPs is fewer than 2 in each quarter

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APPENDIX C: Indian Health Care Provider Evaluation of Managed Care Entities

Indian Healthcare Provider Evaluation of Managed Care Entities in Washington

RESPONDENT INFORMATION

In gratitude for your participation, we will be sending all respondents who fully complete this survey a $20 gift card for Amazon or Starbucks (your choice). For this purpose, to keep track of who participated, and to follow up if we have questions about any of your answers, we are asking for your name and contact information. WE WILL NOT LINK YOUR NAME (IDENTITY) TO YOUR RESPONSES IN ANY REPORT OR ANY OTHER USE OF THE DATA.

1. Contact Information

Name [ ]

Name of Your Tribe or Urban Indian Health Program [ ]

Email Address [ ]

Phone Number [ ]

2. If you fully complete the survey, what gift card would you like to receive?

○ Amazon

○ Starbucks

Indian Healthcare Provider Evaluation of Managed Care Entities in Washington

Behavioral Health Organizations (BHOs)

GREAT RIVERS BHO

PURPOSE. The purpose of this survey is to evaluate the performance of "service coordination organizations or service contracting entities as defined in RCW 70.320.010 in order to address their impacts on services to American Indians and Alaska Natives and relationships with Indian health care providers." See SB 5415(3)(d).

INSTRUCTIONS. Questions that show responses with circles require you to choose one of the answers provided. Questions that show responses with squares allow you to select as many responses as appropriate.

3. Has your IHCP ever had a contract with GREAT RIVERS BHO that your IHCP chose to end ? (Counties served by Great Rivers BHO are Cowlitz, Grays Harbor, Lewis, Pacific, Wahkiakum)

- ○ Yes
- ○ No

4. What issues led your IHCP to end the contract with GREAT RIVERS BHO? (Choose all that apply)

- ☐ It took too long to receive reimbursement payments
- ☐ Reimbursement rates were too low
- ☐ It took too much staff time to have claims fully processed
- ☐ Customer service representatives did not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives
- ☐ Requirements for credentialing/certifying our providers was too burdensome
- ☐ Needed to do data entry twice on claims to receive reimbursement
- ☐ Preauthorization requirements caused too many delays and barriers
- ☐ Case management services lacked cultural competency
- ☐ Poor coordination between non-IHCP services and IHCP services
- ☐ We do not have the capacity to provide Behavioral Health services to non-Native clients - the contract required us to provide Behavioral Health services to any individual enrolled in the plan
- ☐ Other (please specify)

5. Does your IHCP have a current contract with GREAT RIVERS BH

- ◯ Yes
- ◯ No

6. Why does your IHCP NOT have a current contract with GREAT F apply)

- ☐ Don't see a clear benefit to our IHCP from contracting
- ☐ Would impose an unreasonable administrative burden to enter into a contract
- ☐ Would impose an unreasonable administrative burden on an ongoing basis
- ☐ We do not have the capacity to provide Behavioral Health services to non-Native clients - a contract would require us to provide Behavioral Health services to any individual enrolled in the plan
- ☐ Would impose an unreasonable administrative burden to enter into a contract
- ☐ Would impose an unreasonable administrative burden on an ongoing basis
- ☐ Reimbursement rates are too low
- ☐ Would take too long to receive reimbursement payments
- ☐ Would take too much staff time to have claims fully processed
- ☐ Customer service representatives do not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives
- ☐ Requirements for credentialing/certifying our providers is too burdensome
- ☐ Need to do data entry twice on claims to receive reimbursement
- ☐ Preauthorization requirements cause too many delays and barriers
- ☐ Case management services lack cultural competency
- ☐ Poor coordination between non-IHCP services and IHCP services

Other (please specify)

7. Has GREAT RIVERS BHO provided you with a specific contact for communication and service coordination?

- Yes
- No

8. Has your GREAT RIVERS BHO contact offered timely and competent assistance when you have interacted with them?

- Have not had a need to interact with the contact
- Yes
- No

9. Based on your interactions with GREAT RIVERS BHO staff, how would you describe their understanding of the Indian healthcare delivery system and the benefits and legal protections that apply to American Indians and Alaska Natives?

- Poor
- Adequate
- Good

10. How often has GREAT RIVERS BHO met with you or others at your IHCP?

- Never
- Quarterly
- 1 or more times every 6 months
- About once every 1 year
- About once every 2 years
- Less than once every 2 years

11. Has GREAT RIVERS BHO included you or others at your IHCP to develop a plan for coordinating care and services?

- Yes

No

12. Has GREAT RIVERS BHO provided an effective process for your IHCP to suggest how they can better serve the needs of your IHCP and your community members?

Yes

No

13. Compared to other plans, how would you describe the timeliness of GREAT RIVERS BHO's payments?

Very slow

Somewhat slower

About the same

Somewhat faster

Much faster

14. How frequently does GREAT RIVERS BHO require your IHCP to credential/certify your providers?

Once every six months (or less)

Once every year

Once every 18 months or more

15. Approximately, how much of your staff time (provider time and administrative staff time) does GREAT RIVERS BHO's

- [ ] NONE
- [ ] Inpatient SUD treatment
- [ ] Evaluation
- [ ] Other (please specify)
- [ ] Medication management
- [ ] Medication assisted therapy (MAT)

initial (first time) credentialing/certification process require for one provider?

- One hour or less
- 1.5 to 3 hours
- More than 3 hours

16. Approximately, how much of your staff time (provider time and administrative staff time) does GREAT RIVERS BHO's ongoing recredentialing/recertification process require for one provider, each time you have to recredential/recertify?

- One hour or less
- 1.5 to 3 hours
- More than 3 hours

17. Does GREAT RIVERS BHO provide your IHCP's patients/clients with access to culturally competent care?

- Never - not available from this BHO
- Sometimes
- Usually
- Always

18. For what types of services does GREAT RIVERS BHO require prior authorization? (Choose all that apply)

19. To what extent do GREAT RIVERS BHO's prior authorization requirements delay access to care?

- Prior authorization significantly delays access to care
- Prior authorization somewhat delays access to care
- Prior authorization does not delay access to care

20. To what extent do GREAT RIVERS BHO's prior authorization requirements result in NO ACCESS (or denied access) to care?

- Prior authorization often results in NO ACCESS to care
- Prior authorization results in NO ACCESS to care for a reasonable number of cases
- Prior authorization rarely results in NO ACCESS to care

21. Has your tribe or urban Indian health program had to cover costs (paid out of your own funds) for care that was denied or delayed by GREAT RIVERS BHO as a result of preauthorization? ◯ Yes

◯ No

22. Does GREAT RIVERS BHO notify the appropriate tribal authority when they provide crisis services on tribal land?

◯ Does not apply (no tribal land)

◯ Never

◯ Sometimes

◯ Usually

◯ Always

23. Are non-tribal crisis responders and designated crisis responders (DCRs) from GREAT RIVERS BHO debriefing the appropriate providers at your IHCP after they provide crisis services? ◯ Never

◯ Sometimes

◯ Usually

◯ Always

24. Please describe how well non-tribal crisis responders and designated crisis responders (DCRs) from GREAT RIVERS BHO are coordinating care with your providers.

◯ GREAT RIVERS BHO crisis responders and designated crisis responders (DCRs) are not coordinating at all with our providers

◯ GREAT RIVERS BHO crisis responders and designated crisis responders (DCRs) are coordinating poorly with our providers

◯ GREAT RIVERS BHO crisis responders and designated crisis responders (DCRs) are coordinating adequately with our providers

GREAT RIVERS BHO crisis responders and designated crisis responders (DCRs) are coordinating very well with our providers

- Does not apply (no tribal land)
- Usually
- Never
- Always

25. Does GREAT RIVERS BHO consult with your IHCP's behavioral health providers regarding the determination to detain

for involuntary commitment?

Never

Sometimes

Usually

Always

26. Does GREAT RIVERS BHO coordinate with your providers on Involuntary Treatment Act (ITA) mental health and Involuntary Treatment Act (ITA) substance use disorder evaluations on tribal lands - including when non-Designated Crisis Responders (DCRs) conduct ITA evaluations on tribal land?

Sometimes

27. Does GREAT RIVERS BHO coordinate with your providers on Involuntary Treatment Act (ITA) mental health and Involuntary Treatment Act (ITA) substance use disorder evaluations NOT conducted on tribal lands - in particular, during transportation to a site for evaluation or detention?

Never

Sometimes

Usually

Always

28. Does GREAT RIVERS BHO coordinate with your providers on inpatient discharge planning and discharge activities?

Never

Sometimes

Usually

Always

29. Do your IHCP's patients/clients who are insured with a GREAT RIVERS BHO plan have access to providers they have a need for, but would not have access to if they had other insurance coverage? Yes

No

30. Do your IHCP's patients/clients who are insured with a GREAT RIVERS BHO plan have access to services or benefits

- [ ] Acupuncture
- [ ] Housing assistance
- [ ] Employment assistance
- [ ] Non-emergency transportation to care
- [ ] Other (please specify)

that make a significant impact on their health status, but would not have access to if they had other insurance coverage?

◯ Yes

◯ No

31. What services or benefits (that make a significant impact on health status) do your IHCP patients/clients who are insured with a GREAT RIVERS BHO plan have access to because they are insured with GREAT RIVERS BHO. These patients/clients would not have access to these services or benefits if they were not on a GREAT RIVERS BHO plan.

32. Please provide specific examples that demonstrate poor (unsatisfactory) service by GREAT RIVERS BHO to your IHCP and/or your IHCP's patients. (What has not gone well?)

Behavioral Health Organizations (BHOs)

GREATER COLUMBIA BHO

33. Please provide specific examples that demonstrate good (satisfactory) service by GREAT RIVERS BHO to your IHCP and/or your IHCP's patients.

PURPOSE. The purpose of this survey is to evaluate the performance of "service coordination organizations or service contracting entities as defined in RCW 70.320.010 in order to address their impacts on services to American Indians and Alaska Natives and relationships with Indian health care providers." See SB 5415(3)(d).

INSTRUCTIONS. Questions that show responses with circles require you to choose one of the answers provided. Questions that show responses with squares allow you to select as many responses as appropriate.

34. Has your IHCP ever had a contract with GREATER COLUMBIA BHO that your IHCP chose to end? (Counties served are Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman, Yakima)

◯ Yes

◯ No

35. What issues led your IHCP to end the contract with GREATER COLUMBIA BHO? (Choose all that apply)

☐ It took too long to receive reimbursement payments

☐ Reimbursement rates were too low

☐ It took too much staff time to have claims fully processed

☐ Customer service representatives did not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives

☐ Preauthorization requirements caused too many delays and barriers

☐ Requirements for credentialing/certifying our providers was too burdensome

☐ Needed to do data entry twice on claims to receive reimbursement

☐ provide Behavioral Health services to any individual enrolled

☐ Other (please specify)

Case management services lacked cultural competency

Poor coordination between non-IHCP services and IHCP services

We do not have the capacity to provide Behavioral Health

services to non-Native clients - the contract required us to

in the plan

36. Does your IHCP have a current contract with GREATER (

- ◯ Yes
- ◯ No

37. Why does your IHCP NOT have a current contract with (
all that apply)

- ☐ Don't see a clear benefit to our IHCP from contracting
- ☐ Would impose an unreasonable administrative burden to enter into a contract
- ☐ Would impose an unreasonable administrative burden on an ongoing basis
- ☐ We do not have the capacity to provide Behavioral Health services to non-Native clients - a contract would require us to provide Behavioral Health services to any individual enrolled in the plan
- ☐ Would impose an unreasonable administrative burden to enter into a contract
- ☐ Would impose an unreasonable administrative burden on an ongoing basis
- ☐ Reimbursement rates are too low
- ☐ Would take too long to receive reimbursement payments
- ☐ Would take too much staff time to have claims fully processed
- ☐ Customer service representatives do not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives
- ☐ Requirements for credentialing/certifying our providers is too burdensome
- ☐ Need to do data entry twice on claims to receive reimbursement
- ☐ Preauthorization requirements cause too many delays and barriers
- ☐ Case management services lack cultural competency
- ☐ Poor coordination between non-IHCP services and IHCP services

☐ Other (please specify)

38. Has GREATER COLUMBIA BHO provided you with a specific contact for communication and service coordination?

○ Yes

○ No

39. Has your GREATER COLUMBIA BHO contact offered timely and competent assistance when you have interacted with them?

○ Have not had a need to interact with the contact

○ Yes ○

No

40. Based on your interactions with GREATER COLUMBIA BHO staff, how would you describe their understanding of the Indian healthcare delivery system and the benefits and legal protections that apply to American Indians and Alaska Natives?

○ Poor

○ Adequate

○ Good

41. How often has GREATER COLUMBIA BHO met with you or others at your IHCP?

○ Never

○ Quarterly

○ 1 or more times every 6 months

○ About once every 1 year

○ About once every 2 years

○ Less than once every 2 years

42. Has GREATER COLUMBIA BHO included you or others at your IHCP to develop a plan for coordinating care and services?

○ Yes

- ◯ No

43. Has GREATER COLUMBIA BHO provided an effective process for your IHCP to suggest how they can better serve the needs of your IHCP and your community members?

- ◯ Yes
- ◯ No

44. Compared to other plans, how would you describe the timeliness of GREATER COLUMBIA BHO's payments?

- ◯ Very slow
- ◯ Somewhat slower
- ◯ About the same
- ◯ Somewhat faster
- ◯ Much faster

45. How frequently does GREATER COLUMBIA BHO require your IHCP to credential/certify your providers?

- ◯ Once every six months (or less)
- ◯ Once every year
- ◯ Once every 18 months or more

46. Approximately, how much of your staff time (provider time and administrative staff time) does GREATER COLUMBIA BHO's initial (first time) credentialing/certification process require for one provider?

- ◯ One hour or less
- ◯ 1.5 to 3 hours
- ◯ More than 3 hours

47. Approximately, how much of your staff time (provider time and administrative staff time) does GREATER COLUMBIA BHO's ongoing recredentialing/recertification process require for one provider, each time you have to recredential/recertify?

- ◯ One hour or less
- ◯ 1.5 to 3 hours
- ◯ More than 3 hours

48. Does GREATER COLUMBIA BHO provide your IHCP's patients/clients with access to culturally competent care?

- ◯ Never - not available from this BHO
- ◯ Sometimes
- ◯ Usually

Always

49. For what types of services does GREATER COLUMBIA BHO require prior authorization? (Choose all that apply)

- NONE
- Inpatient SUD treatment
- Evaluation
- Other (please specify)
- Medication management
- Medication assisted therapy (MAT)

50. To what extent do GREATER COLUMBIA BHO's prior authorization requirements delay access to care?

- Prior authorization significantly delays access to care
- Prior authorization somewhat delays access to care
- Prior authorization does not delay access to care

51. To what extent do GREATER COLUMBIA BHO's prior authorization requirements result in NO ACCESS (or denied access) to care?

- Prior authorization often results in NO ACCESS to care
- Prior authorization results in NO ACCESS to care for a reasonable number of cases
- Prior authorization rarely results in NO ACCESS to care

52. Has your tribe or urban Indian health program had to cover costs (paid out of your own funds) for care that was denied or delayed by GREATER COLUMBIA BHO as a result of preauthorization?

- Yes
- No

53. Does GREATER COLUMBIA BHO notify the appropriate tribal authority when they provide crisis services on tribal land?

- Does not apply (no tribal land)
- Never
- Sometimes
- Usually
- Always

54. Are non-tribal crisis responders and designated crisis responders (DCRs) from GREATER COLUMBIA BHO debriefing the appropriate providers at your IHCP after they provide crisis services?

- Never
- Sometimes

- Usually
- Always

55. Please describe how well non-tribal crisis responders and designated crisis responders (DCRs) from GREATER COLUMBIA BHO are coordinating care with your providers.

- GREATER COLUMBIA BHO crisis responders and designated crisis responders (DCRs) are not coordinating at all with our providers
- GREATER COLUMBIA BHO crisis responders and designated crisis responders (DCRs) are coordinating poorly with our providers
- GREATER COLUMBIA BHO crisis responders and designated crisis responders (DCRs) are coordinating adequately with our providers
- GREATER COLUMBIA BHO crisis responders and designated crisis responders (DCRs) are coordinating very well with our providers

56. Does GREATER COLUMBIA BHO consult with your IHCP's behavioral health providers regarding the determination to detain for involuntary commitment?

- Never
- Sometimes
- Usually
- Always

57. Does GREATER COLUMBIA BHO coordinate with your providers on Involuntary Treatment Act (ITA) mental health and Involuntary Treatment Act (ITA) substance use disorder evaluations on tribal lands including when non-Designated Crisis Responders (DCRs) conduct ITA evaluations on tribal land?

- Does not apply (no tribal land)
- Never
- Sometimes
- Usually
- Always

58. Does GREATER COLUMBIA BHO coordinate with your providers on Involuntary Treatment Act (ITA) mental health and Involuntary Treatment Act (ITA) substance use disorder evaluations NOT conducted on tribal lands - in particular, during transportation to a site for evaluation or detention?

- Never
- Sometimes
- Usually
- Always

59. Does GREATER COLUMBIA BHO coordinate with your providers on inpatient discharge planning and discharge activities?

- Never
- Sometimes

Usually

Always

60. Do your IHCP's patients/clients who are insured with a GREATER COLUMBIA BHO plan have access to providers they have a need for, but would not have access to if they had other insurance coverage? Yes

No

61. Do your IHCP's patients/clients who are insured with a GREATER COLUMBIA BHO plan have access to services or benefits that make a significant impact on their health status, but would not have access to if they had other insurance coverage?

Yes

No

62. What services or benefits (that make a significant impact on health status) do your IHCP patients/clients who are insured with a GREATER COLUMBIA BHO plan have access to because they are insured with GREATER COLUMBIA BHO. These patients/clients would not have access to these services or benefits if they were not on a GREATER COLUMBIA BHO plan.

- Acupuncture
- Housing assistance
- Employment assistance
- Non-emergency transportation to care
- Other (please specify)

63. Please provide specific examples that demonstrate poor (unsatisfactory) service by GREATER COLUMBIA BHO to your IHCP and/or your IHCP's patients. (What has not gone well?)

64. Please provide specific examples that demonstrate good (satisfactory) service by GREATER COLUMBIA BHO to your IHCP and/or your IHCP's patients.

Indian Healthcare Provider Evaluation of Managed Care Entities in Washington

Behavioral Health Organizations (BHOs)

KING COUNTY BHO

PURPOSE. The purpose of this survey is to evaluate the performance of "service coordination organizations or service contracting entities as defined in RCW 70.320.010 in order to address their impacts on services to American Indians and Alaska Natives and relationships with Indian health care providers." See SB 5415(3)(d).

INSTRUCTIONS. Questions that show responses with circles require you to choose one of the answers provided. Questions that show responses with squares allow you to select as many responses as appropriate.

65. Has your IHCP ever had a contract with KING COUNTY BHO that your IHCP chose to end ? (County served is King County only)

66. What issues led your IHCP to end the contract with KING COUNTY BHO? (Choose all that apply)

It took too long to receive reimbursement payments

Reimbursement rates were too low

It took too much staff time to have claims fully processed

Customer service representatives did not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives

Requirements for credentialing/certifying our providers was
Needed to do data entry twice on claims to receive reimbursement

barriers

Case management services lacked cultural competency

Poor coordination between non-IHCP services and IHCP services

We do not have the capacity to provide Behavioral Health services to non-Native clients - the contract required us to

in the plan

67. Does your IHCP have a current contract with KING COUNTY BI

- ◯ Yes
- ◯ No

68. Why does your IHCP NOT have a current contract with KING C apply)

- ☐ Don't see a clear benefit to our IHCP from contracting
- ☐ Would impose an unreasonable administrative burden to enter into a contract
- ☐ Would impose an unreasonable administrative burden on an ongoing basis
- ☐ We do not have the capacity to provide Behavioral Health services to non-Native clients - a contract would require us to provide Behavioral Health services to any individual enrolled in the plan
- ☐ Would impose an unreasonable administrative burden to enter into a contract
- ☐ Would impose an unreasonable administrative burden on an ongoing basis
- ☐ Reimbursement rates are too low
- ☐ Would take too long to receive reimbursement payments
- ☐ Would take too much staff time to have claims fully processed
- ☐ Customer service representatives do not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives
- ☐ Requirements for credentialing/certifying our providers is too burdensome
- ☐ Need to do data entry twice on claims to receive reimbursement
- ☐ Preauthorization requirements cause too many delays and barriers
- ☐ Case management services lack cultural competency
- Poor coordination between non-IHCP services and IHCP services

☐ Other (please specify)

69. Has KING COUNTY BHO provided you with a specific contact for communication and service coordination?

◯ Yes

◯ No

70. Has your KING COUNTY BHO contact offered timely and competent assistance when you have interacted with them?

◯ Have not had a need to interact with the contact

◯ Yes

◯ No

71. Based on your interactions with KING COUNTY BHO staff, how would you describe their understanding of the Indian healthcare delivery system and the benefits and legal protections that apply to American Indians and Alaska Natives?

◯ Poor

◯ Adequate

◯ Good

72. How often has KING COUNTY BHO met with you or others at your IHCP?

◯ Never

◯ Quarterly

◯ 1 or more times every 6 months

◯ About once every 1 year

◯ About once every 2 years

◯ Less than once every 2 years

73. Has KING COUNTY BHO included you or others at your IHCP to develop a plan for coordinating care and services?

◯ Yes

No

74. Has KING COUNTY BHO provided an effective process for your IHCP to suggest how they can better serve the needs of your IHCP and your community members?

Yes

No

75. Compared to other plans, how would you describe the timeliness of KING COUNTY BHO's payments?

Very slow

Somewhat slower

About the same

Somewhat faster

Much faster

76. How frequently does KING COUNTY BHO require your IHCP to credential/certify your providers?

Once every six months (or less)

Once every year

Once every 18 months or more

77. Approximately, how much of your staff time (provider time and administrative staff time) does KING COUNTY BHO's initial (first time) credentialing/certification process require for one provider?

One hour or less

1.5 to 3 hours

More than 3 hours

78. Approximately, how much of your staff time (provider time and administrative staff time) does KING COUNTY BHO's ongoing recredentialing/recertification process require for one provider, each time you have to recredential/recertify?

One hour or less

1.5 to 3 hours

More than 3 hours

79. Does KING COUNTY BHO provide your IHCP's patients/clients with access to culturally competent care?

Never - not available from this BHO

Sometimes

Usually

Always

80. For what types of services does KING COUNTY BHO require prior authorization? (Choose all that apply)

- [ ] NONE
- [ ] Inpatient SUD treatment
- [ ] Evaluation
- [ ] Other (please specify)
- [ ] Medication management
- [ ] Medication assisted therapy (MAT)

81. To what extent do KING COUNTY BHO's prior authorization requirements delay access to care?

- ○ Prior authorization significantly delays access to care
- ○ Prior authorization somewhat delays access to care
- ○ Prior authorization does not delay access to care

82. To what extent do KING COUNTY BHO's prior authorization requirements result in NO ACCESS (or denied access) to care?

- ○ Prior authorization often results in NO ACCESS to care
- ○ Prior authorization results in NO ACCESS to care for a reasonable number of cases
- ○ Prior authorization rarely results in NO ACCESS to care

83. Has your tribe or urban Indian health program had to cover costs (paid out of your own funds) for care that was denied or delayed by KING COUNTY BHO as a result of preauthorization?

- ○ Yes
- ○ No

84. Does KING COUNTY BHO notify the appropriate tribal authority when they provide crisis services on tribal land?

- ○ Does not apply (no tribal land)
- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

85. Are non-tribal crisis responders and designated crisis responders (DCRs) from KING COUNTY BHO debriefing the appropriate providers at your IHCP after they provide crisis services?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

86. Please describe how well non-tribal crisis responders and designated crisis responders (DCRs) from KING COUNTY BHO are coordinating care with your providers.

- KING COUNTY BHO crisis responders and designated crisis responders (DCRs) are not coordinating at all with our providers
- KING COUNTY BHO crisis responders and designated crisis responders (DCRs) are coordinating poorly with our providers
- KING COUNTY BHO crisis responders and designated crisis responders (DCRs) are coordinating adequately with our providers
- KING COUNTY BHO crisis responders and designated crisis responders (DCRs) are coordinating very well with our providers

87. Does KING COUNTY BHO consult with your IHCP's behavioral health providers regarding the determination to detain for involuntary commitment?

- Never
- Sometimes
- Usually
- Always

88. Does KING COUNTY BHO coordinate with your providers on Involuntary Treatment Act (ITA) mental health and Involuntary Treatment Act (ITA) substance use disorder evaluations on tribal lands - including when non-Designated Crisis Responders (DCRs) conduct ITA evaluations on tribal land?

- Does not apply (no tribal land)
- Never
- Sometimes
- Usually
- Always

89. Does KING COUNTY BHO coordinate with your providers on Involuntary Treatment Act (ITA) mental health and Involuntary Treatment Act (ITA) substance use disorder evaluations NOT conducted on tribal lands - in particular, during transportation to a site for evaluation or detention?

- Never
- Sometimes
- Usually
- Always

90. Does KING COUNTY BHO coordinate with your providers on inpatient discharge planning and discharge activities?

- Never
- Sometimes
- Usually
- Always

91. Do your IHCP's patients/clients who are insured with a KING COUNTY BHO plan have access to providers they have a need for, but would not have access to if they had other insurance coverage? ◯ Yes ◯ No

92. Do your IHCP's patients/clients who are insured with a KING COUNTY BHO plan have access to services or benefits that make a significant impact on their health status, but would not have access to if they had other insurance coverage?

◯ Yes

◯ No

93. What services or benefits (that make a significant impact on health status) do your IHCP patients/clients who are insured with a KING COUNTY BHO plan have access to because they are insured with KING COUNTY BHO. These patients/clients would not have access to these services or benefits if they were not on a KING COUNTY BHO plan.

☐ Acupuncture

☐ Housing assistance

☐ Employment assistance

☐ Non-emergency transportation to care

☐ Other (please specify)

94. Please provide specific examples that demonstrate poor (unsatisfactory) service by KING COUNTY BHO to your IHCP and/or your IHCP's patients. (What has not gone well?)

95. Please provide specific examples that demonstrate good (satisfactory) service by KING COUNTY BHO to your IHCP and/or your IHCP's patients.

Behavioral Health Organizations (BHOs)

NORTH CENTRAL BHO

PURPOSE. The purpose of this survey is to evaluate the performance of "service coordination organizations or service contracting entities as defined in RCW 70.320.010 in order to address their impacts on services to American Indians and Alaska Natives and relationships with Indian health care providers." See SB 5415(3)(d).

INSTRUCTIONS. Questions that show responses with circles require you to choose one of the answers provided. Questions that show responses with squares allow you to select as many responses as appropriate.

96. Has your IHCP ever had a contract with NORTH CENTRAL BHO that your IHCP chose to end? (Counties served are Chelan, Douglas, Grant)

◯ Yes

◯ No

97. What issues led your IHCP to end the contract with NORTH CENTRAL BHO? (Choose all that apply)

It took too long to receive reimbursement payments

Reimbursement rates were too low

It took too much staff time to have claims fully processed

Customer service representatives did not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives

Requirements for credentialing/certifying our providers was
Needed to do data entry twice on claims to receive reimbursement

barriers

Case management services lacked cultural competency

Poor coordination between non-IHCP services and IHCP services

We do not have the capacity to provide Behavioral Health services to non-Native clients - the contract required us to

in the plan

98. Does your IHCP have a current contract with NORTH CE

- ◯ Yes
- ◯ No

99. Why does your IHCP NOT have a current contract with I
all that apply)

- ☐ Don't see a clear benefit to our IHCP from contracting
- ☐ Would impose an unreasonable administrative burden to enter into a contract
- ☐ Would impose an unreasonable administrative burden on an ongoing basis
- ☐ We do not have the capacity to provide Behavioral Health services to non-Native clients - a contract would require us to provide Behavioral Health services to any individual enrolled in the plan
- ☐ Would impose an unreasonable administrative burden to enter into a contract
- ☐ Would impose an unreasonable administrative burden on an ongoing basis
- ☐ Reimbursement rates are too low
- ☐ Would take too long to receive reimbursement payments
- ☐ Would take too much staff time to have claims fully processed
- ☐ Customer service representatives do not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives
- ☐ Requirements for credentialing/certifying our providers is too burdensome
- ☐ Need to do data entry twice on claims to receive reimbursement
- ☐ Preauthorization requirements cause too many delays and barriers
- ☐ Case management services lack cultural competency
- ☐ Poor coordination between non-IHCP services and IHCP services

☐ Other (please specify)

100. Has NORTH CENTRAL BHO provided you with a specific contact for communication and service coordination?

◯ Yes

◯ No

101. Has your NORTH CENTRAL BHO contact offered timely and competent assistance when you have interacted with them?

◯ Have not had a need to interact with the contact

◯ Yes

◯ No

102. Based on your interactions with NORTH CENTRAL BHO staff, how would you describe their understanding of the Indian healthcare delivery system and the benefits and legal protectionsthat apply to American Indians and Alaska Natives?

- Poor
- Adequate
- Good

103. How often has NORTH CENTRAL BHO met with you or others at your IHCP?

- Never
- Quarterly
- 1 or more times every 6 months
- About once every 1 year
- About once every 2 years
- Less than once every 2 years

104. Has NORTH CENTRAL BHO included you or others at your IHCP to develop a plan for coordinating care and services?

- Yes
- No

105. Has NORTH CENTRAL BHO provided an effective process for your IHCP to suggest how they can better serve the needs of your IHCP and your community members?

- Yes
- No

106. Compared to other plans, how would you describe the timeliness of NORTH CENTRAL BHO's payments?

- Very slow
- Somewhat slower
- About the same
- Somewhat faster
- Much faster

107. How frequently does NORTH CENTRAL BHO require your IHCP to credential/certify your providers?

- Once every six months (or less)
- Once every year
- Once every 18 months or more

108. Approximately, how much of your staff time (provider time and administrative staff time) does NORTH CENTRAL BHO's initial (first time) credentialing/certification process require for one provider?

- One hour or less
- 1.5 to 3 hours
- More than 3 hours

109. Approximately, how much of your staff time (provider time and administrative staff time) does NORTH CENTRAL BHO's ongoing recredentialing/recertification process require for one provider, each time you have to recredential/recertify?

- One hour or less
- 1.5 to 3 hours
- More than 3 hours

110. Does NORTH CENTRAL BHO provide your IHCP's patients/clients with access to culturally competent care?

- Never - not available from this BHO
- Sometimes
- Usually
- Always

111. For what types of services does NORTH CENTRAL BHO require prior authorization? (Choose all that apply)

- NONE
- Inpatient SUD treatment
- Evaluation
- Other (please specify)
- Medication management
- Medication assisted therapy (MAT)

112. To what extent do NORTH CENTRAL BHO's prior authorization requirements delay access to care?

- Prior authorization significantly delays access to care
- Prior authorization somewhat delays access to care
- Prior authorization does not delay access to care

113. To what extent do NORTH CENTRAL BHO's prior authorization requirements result in NO ACCESS (or denied access) to care?

◯ Prior authorization often results in NO ACCESS to care

◯ Prior authorization results in NO ACCESS to care for a reasonable number of cases

◯ Prior authorization rarely results in NO ACCESS to care

114. Has your tribe or urban Indian health program had to cover costs (paid out of your own funds) for care that was denied or delayed by NORTH CENTRAL BHO as a result of preauthorization? ◯ Yes

◯ No

115. Does NORTH CENTRAL BHO notify the appropriate tribal authority when they provide crisis services on tribal land?

◯ Does not apply (no tribal land)

◯ Never

◯ Sometimes

◯ Usually

◯ Always

116. Are non-tribal crisis responders and designated crisis responders (DCRs) from NORTH CENTRAL

BHO debriefing the appropriate providers at your IHCP after they provide crisis services?

- Never
- Sometimes
- Usually
- Always

117. Please describe how well non-tribal crisis responders and designated crisis responders (DCRs) from NORTH CENTRAL BHO are coordinating care with your providers.

- NORTH CENTRAL BHO crisis responders and designated crisis responders (DCRs) are not coordinating at all with our providers
- NORTH CENTRAL BHO crisis responders and designated crisis responders (DCRs) are coordinating poorly with our providers
- NORTH CENTRAL BHO crisis responders and designated crisis responders (DCRs) are coordinating adequately with our providers
- NORTH CENTRAL BHO crisis responders and designated crisis responders (DCRs) are coordinating very well with our providers

118. Does NORTH CENTRAL BHO consult with your IHCP's behavioral health providers regarding the determination to detain for involuntary commitment?

- Never
- Sometimes
- Usually
- Always

119. Does NORTH CENTRAL BHO coordinate with your providers on Involuntary Treatment Act (ITA) mental health and Involuntary Treatment Act (ITA) substance use disorder evaluations on tribal lands including when non-Designated Crisis Responders (DCRs) conduct ITA evaluations on tribal land?

- Does not apply (no tribal land)
- Never
- Sometimes
- Usually
- Always

120. Does NORTH CENTRAL BHO coordinate with your providers on Involuntary Treatment Act (ITA) mental health and Involuntary Treatment Act (ITA) substance use disorder evaluations NOT conducted on tribal lands - in particular, during transportation to a site for evaluation or detention? ◯ Never

◯ Sometimes

◯ Usually

◯ Always

121. Does NORTH CENTRAL BHO coordinate with your providers on inpatient discharge planning and discharge activities?

◯ Never

◯ Sometimes

◯ Usually

◯ Always

122. Do your IHCP's patients/clients who are insured with a NORTH CENTRAL BHO plan have access to providers they have a need for, but would not have access to if they had other insurance coverage? ◯ Yes ◯ No

123. Do your IHCP's patients/clients who are insured with a NORTH CENTRAL BHO plan have access to services or benefits that make a significant impact on their health status, but would not have access to if they had other insurance coverage?

- Yes
- No

124. What services or benefits (that make a significant impact on health status) do your IHCP patients/clients who are insured with a NORTH CENTRAL BHO plan have access to because they are insured with NORTH CENTRAL BHO. These patients/clients would not have access to these services or benefits if they were not on a NORTH CENTRAL BHO plan.

- [ ] Acupuncture
- [ ] Housing assistance
- [ ] Employment assistance
- [ ] Non-emergency transportation to care
- [ ] Other (please specify)

125. Please provide specific examples that demonstrate poor (unsatisfactory) service by NORTH CENTRAL BHO to your IHCP and/or your IHCP's patients. (What has not gone well?)

Behavioral Health Organizations (BHOs)

NORTH SOUND BHO

126. Please provide specific examples that demonstrate good (satisfactory) service by NORTH CENTRAL BHO to your IHCP and/or your IHCP's patients.

PURPOSE. The purpose of this survey is to evaluate the performance of "service coordination organizations or service contracting entities as defined in RCW 70.320.010 in order to address their impacts on services to American Indians and Alaska Natives and relationships with Indian health care providers." See SB 5415(3)(d).

INSTRUCTIONS. Questions that show responses with circles require you to choose one of the answers provided. Questions that show responses with squares allow you to select as many responses as appropriate.

127. Has your IHCP ever had a contract with NORTH SOUND BHO that your IHCP chose to end? (Counties served are Island, San Juan, Skagit, Snohomish, Whatcom)

- ○ Yes
- ○ No

128. What issues led your IHCP to end the contract with NORTH SOUND BHO? (Choose all that apply)

- ☐ It took too long to receive reimbursement payments
- ☐ Reimbursement rates were too low
- ☐ It took too much staff time to have claims fully processed
- ☐ Customer service representatives did not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives
- ☐ Requirements for credentialing/certifying our providers was too burdensome
- ☐ Needed to do data entry twice on claims to receive reimbursement
- ☐ Preauthorization requirements caused too many delays and barriers
- ☐ Case management services lacked cultural competency
- ☐ Poor coordination between non-IHCP services and IHCP services
- ☐ We do not have the capacity to provide Behavioral Health services to non-Native clients - the contract required us to provide Behavioral Health services to any individual enrolled in the plan
- ☐ Other (please specify)

129. Does your IHCP have a current contract with NORTH SC

- ◯ Yes
- ◯ No

130. Why does your IHCP NOT have a current contract with I
all that apply)

- ☐ Don't see a clear benefit to our IHCP from contracting
- ☐ Would impose an unreasonable administrative burden to enter into a contract
- ☐ Would impose an unreasonable administrative burden on an ongoing basis
- ☐ We do not have the capacity to provide Behavioral Health services to non-Native clients - a contract would require us to provide Behavioral Health services to any individual enrolled in the plan
- ☐ Would impose an unreasonable administrative burden to enter into a contract
- ☐ Would impose an unreasonable administrative burden on an ongoing basis
- ☐ Reimbursement rates are too low
- ☐ Would take too long to receive reimbursement payments
- ☐ Would take too much staff time to have claims fully processed
- ☐ Customer service representatives do not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives
- ☐ Requirements for credentialing/certifying our providers is too burdensome
- ☐ Need to do data entry twice on claims to receive reimbursement
- ☐ Preauthorization requirements cause too many delays and barriers
- ☐ Case management services lack cultural competency
- Poor coordination between non-IHCP services and IHCP services

☐ Other (please specify)

131. Has NORTH SOUND BHO provided you with a specific contact for communication and service coordination?

◯ Yes

◯ No

132. Has your NORTH SOUND BHO contact offered timely and competent assistance when you have interacted with them?

◯ Have not had a need to interact with the contact

◯ Yes ◯ No

133. Based on your interactions with NORTH SOUND BHO staff, how would you describe their understanding of the Indian healthcare delivery system and the benefits and legal protections that apply to American Indians and Alaska Natives?

◯ Poor

◯ Adequate

◯ Good

134. How often has NORTH SOUND BHO met with you or others at your IHCP?

◯ Never

◯ Quarterly

◯ 1 or more times every 6 months

◯ About once every 1 year

◯ About once every 2 years

◯ Less than once every 2 years

135. Has NORTH SOUND BHO included you or others at your IHCP to develop a plan for coordinating care and services?

◯ Yes

◯ No

136. Has NORTH SOUND BHO provided an effective process for your IHCP to suggest how they can better serve the needs of your IHCP and your community members?

- Yes
- No

137. Compared to other plans, how would you describe the timeliness of NORTH SOUND BHO's payments?

- Very slow
- Somewhat slower
- About the same
- Somewhat faster
- Much faster

138. How frequently does NORTH SOUND BHO require your IHCP to credential/certify your providers?

- Once every six months (or less)
- Once every year
- Once every 18 months or more

139. Approximately, how much of your staff time (provider time and administrative staff time) does NORTH SOUND BHO's initial (first time) credentialing/certification process require for one provider?

- One hour or less
- 1.5 to 3 hours
- More than 3 hours

140. Approximately, how much of your staff time (provider time and administrative staff time) does NORTH SOUND BHO's ongoing recredentialing/recertification process require for one provider, each time you have to recredential/recertify?

- One hour or less
- 1.5 to 3 hours
- More than 3 hours

141. Does NORTH SOUND BHO provide your IHCP's patients/clients with access to culturally competent care?

- Never - not available from this BHO
- Sometimes
- Usually
- Always

142. For what types of services does NORTH SOUND BHO require prior authorization? (Choose all that apply)

- [ ] NONE
- [ ] Inpatient SUD treatment
- [ ] Evaluation
- [ ] Other (please specify)
- [ ] Medication management
- [ ] Medication assisted therapy (MAT)

143. To what extent do NORTH SOUND BHO's prior authorization requirements delay access to care?

- Prior authorization significantly delays access to care
- Prior authorization somewhat delays access to care
- Prior authorization does not delay access to care

144. To what extent do NORTH SOUND BHO's prior authorization requirements result in NO ACCESS (or denied access) to care?

- Prior authorization often results in NO ACCESS to care
- Prior authorization results in NO ACCESS to care for a reasonable number of cases
- Prior authorization rarely results in NO ACCESS to care

145. Has your tribe or urban Indian health program had to cover costs (paid out of your own funds) for care that was denied or delayed by NORTH SOUND BHO as a result of preauthorization?

- Yes
- No

146. Does NORTH SOUND BHO notify the appropriate tribal authority when they provide crisis services on tribal land?

- Does not apply (no tribal land)
- Never
- Sometimes
- Usually
- Always

147. Are non-tribal crisis responders and designated crisis responders (DCRs) from NORTH SOUND BHO

debriefing the appropriate providers at your IHCP after they provide crisis services? ◯ Never

◯ Sometimes

◯ Usually

◯ Always

148. Please describe how well non-tribal crisis responders and designated crisis responders (DCRs) from NORTH SOUND BHO are coordinating care with your providers.

◯ NORTH SOUND BHO crisis responders and designated crisis responders (DCRs) are not coordinating at all with our providers

◯ NORTH SOUND BHO crisis responders and designated crisis responders (DCRs) are coordinating poorly with our providers

◯ NORTH SOUND BHO crisis responders and designated crisis responders (DCRs) are coordinating adequately with our providers

◯ NORTH SOUND BHO crisis responders and designated crisis responders (DCRs) are coordinating very well with our providers

149. Does NORTH SOUND BHO consult with your IHCP's behavioral health providers regarding the determination to detain for involuntary commitment?

◯ Never

◯ Sometimes

◯ Usually

◯ Always

150. Does NORTH SOUND BHO coordinate with your providers on Involuntary Treatment Act (ITA) mental health and Involuntary Treatment Act (ITA) substance use disorder evaluations on tribal lands - including when non-Designated Crisis Responders (DCRs) conduct ITA evaluations on tribal land?

◯ Does not apply (no tribal land)

◯ Never

◯ Sometimes

◯ Usually

◯ Always

151. Does NORTH SOUND BHO coordinate with your providers on Involuntary Treatment Act (ITA) mental health and Involuntary Treatment Act (ITA) substance use disorder evaluations NOT conducted on tribal lands - in particular, during transportation to a site for evaluation or detention?

- ◯ Never
- ◯ Sometimes
- ◯ Usually
- ◯ Always

152. Does NORTH SOUND BHO coordinate with your providers on inpatient discharge planning and discharge activities?

- ◯ Never
- ◯ Sometimes
- ◯ Usually
- ◯ Always

153. Do your IHCP's patients/clients who are insured with a NORTH SOUND BHO plan have access to providers they have a need for, but would not have access to if they had other insurance coverage? ◯ Yes ◯ No

154. Do your IHCP's patients/clients who are insured with a NORTH SOUND BHO plan have access to services or benefits that make a significant impact on their health status, but would not have access to if they had other insurance coverage?

- Yes
- No

155. What services or benefits (that make a significant impact on health status) do your IHCP patients/clients who are insured with a NORTH SOUND BHO plan have access to because they are insured with NORTH SOUND BHO. These patients/clients would not have access to these services or benefits if they were not on a NORTH SOUND BHO plan.

- Acupuncture
- Housing assistance
- Employment assistance
- Non-emergency transportation to care
- Other (please specify)

156. Please provide specific examples that demonstrate poor (unsatisfactory) service by NORTH SOUND BHO to your IHCP and/or your IHCP's patients. (What has not gone well?)

157. Please provide specific examples that demonstrate good (satisfactory) service by NORTH SOUND BHO to your IHCP and/or your IHCP's patients.

PURPOSE. The purpose of this survey is to evaluate the performance of "service coordination organizations or service contracting entities as defined in RCW 70.320.010 in order to address their impacts on services to American Indians and Alaska Natives and relationships with Indian health care providers." See SB 5415(3)(d).

INSTRUCTIONS. Questions that show responses with circles require you to choose one of the answers provided. Questions that show responses with squares allow you to select as many responses as appropriate.

158. Has your IHCP ever had a contract with OPTUM PIERCE BHO that your IHCP chose to end? (County served is Pierce)

- ○ Yes
- ○ No

159. What issues led your IHCP to end the contract with OPTUM PIERCE BHO? (Choose all that apply)

- ☐ It took too long to receive reimbursement payments
- ☐ Reimbursement rates were too low
- ☐ It took too much staff time to have claims fully processed
- ☐ Customer service representatives did not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives
- ☐ Requirements for credentialing/certifying our providers was too burdensome
- ☐ Needed to do data entry twice on claims to receive reimbursement
- ☐ Preauthorization requirements caused too many delays and barriers
- ☐ Case management services lacked cultural competency
- ☐ Poor coordination between non-IHCP services and IHCP services
- ☐ We do not have the capacity to provide Behavioral Health services to non-Native clients - the contract required us to provide Behavioral Health services to any individual enrolled in the plan
- ☐ Other (please specify)

160. Does your IHCP have a current contract with OPTUM PI

- ◯ Yes
- ◯ No

161. Why does your IHCP NOT have a current contract with (
all that apply)

- ☐ Don't see a clear benefit to our IHCP from contracting
- ☐ Would impose an unreasonable administrative burden to enter into a contract
- ☐ Would impose an unreasonable administrative burden on an ongoing basis
- ☐ We do not have the capacity to provide Behavioral Health services to non-Native clients - a contract would require us to provide Behavioral Health services to any individual enrolled in the plan
- ☐ Would impose an unreasonable administrative burden to enter into a contract
- ☐ Would impose an unreasonable administrative burden on an ongoing basis
- ☐ Reimbursement rates are too low
- ☐ Would take too long to receive reimbursement payments
- ☐ Would take too much staff time to have claims fully processed
- ☐ Customer service representatives do not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives
- ☐ Requirements for credentialing/certifying our providers is too burdensome
- ☐ Need to do data entry twice on claims to receive reimbursement
- ☐ Preauthorization requirements cause too many delays and barriers
- ☐ Case management services lack cultural competency
- Poor coordination between non-IHCP services and IHCP services

☐ Other (please specify)

162. Has OPTUM PIERCE BHO provided you with a specific contact for communication and service coordination?

◯ Yes

◯ No

163. Has your OPTUM PIERCE BHO contact offered timely and competent assistance when you have interacted with them?

◯ Have not had a need to interact with the contact

◯ Yes

◯ No

164. Based on your interactions with OPTUM PIERCE BHO staff, how would you describe their understanding of the Indian healthcare delivery system and the benefits and legal protections that apply to American Indians and Alaska Natives?

◯ Poor

◯ Adequate

◯ Good

165. How often has OPTUM PIERCE BHO met with you or others at your IHCP?

◯ Never

◯ Quarterly

◯ 1 or more times every 6 months

◯ About once every 1 year

◯ About once every 2 years

◯ Less than once every 2 years

166. Has OPTUM PIERCE BHO included you or others at your IHCP to develop a plan for coordinating care and services?

◯ Yes

◯ No

167. Has OPTUM PIERCE BHO provided an effective process for your IHCP to suggest how they can better serve the needs of your IHCP and your community members?

- Yes
- No

168. Compared to other plans, how would you describe the timeliness of OPTUM PIERCE BHO's payments?

- Very slow
- Somewhat slower
- About the same
- Somewhat faster
- Much faster

169. How frequently does OPTUM PIERCE BHO require your IHCP to credential/certify your providers?

- Once every six months (or less)
- Once every year
- Once every 18 months or more

170. Approximately, how much of your staff time (provider time and administrative staff time) does OPTUM PIERCE BHO's initial (first time) credentialing/certification process require for one provider?

- One hour or less
- 1.5 to 3 hours
- More than 3 hours

171. Approximately, how much of your staff time (provider time and administrative staff time) does OPTUM PIERCE BHO's ongoing recredentialing/recertification process require for one provider, each time you have to recredential/recertify?

- One hour or less
- 1.5 to 3 hours
- More than 3 hours

172. Does OPTUM PIERCE BHO provide your IHCP's patients/clients with access to culturally competent care?

- Never - not available from this BHO
- Sometimes
- Usually
- Always

173. For what types of services does OPTUM PIERCE BHO require prior authorization? (Choose all that apply)

- NONE
- Medication management
- Inpatient SUD treatment
- Medication assisted therapy (MAT)
- Evaluation
- Other (please specify)

174. To what extent do OPTUM PIERCE BHO's prior authorization requirements delay access to care?

- Prior authorization significantly delays access to care
- Prior authorization somewhat delays access to care
- Prior authorization does not delay access to care

175. To what extent do OPTUM PIERCE BHO's prior authorization requirements result in NO ACCESS (or denied access) to care?

- Prior authorization often results in NO ACCESS to care
- Prior authorization results in NO ACCESS to care for a reasonable number of cases
- Prior authorization rarely results in NO ACCESS to care

176. Has your tribe or urban Indian health program had to cover costs (paid out of your own funds) for care that was denied or delayed by OPTUM PIERCE BHO as a result of preauthorization?

- Yes
- No

177. Does OPTUM PIERCE BHO notify the appropriate tribal authority when they provide crisis services on tribal land?

- Does not apply (no tribal land)
- Never
- Sometimes
- Usually
- Always

178. Are non-tribal crisis responders and designated crisis responders (DCRs) from OPTUM PIERCE BHO debriefing the appropriate providers at your IHCP after they provide crisis services?

- Never
- Sometimes
- Usually
- Always

179. Please describe how well non-tribal crisis responders and designated crisis responders (DCRs) from OPTUM PIERCE BHO are coordinating care with your providers.

- OPTUM PIERCE BHO crisis responders and designated crisis responders (DCRs) are not coordinating at all with our providers
- OPTUM PIERCE BHO crisis responders and designated crisis responders (DCRs) are coordinating poorly with our providers
- OPTUM PIERCE BHO crisis responders and designated crisis responders (DCRs) are coordinating adequately with our providers
- OPTUM PIERCE BHO crisis responders and designated crisis responders (DCRs) are coordinating very well with our providers

180. Does OPTUM PIERCE BHO consult with your IHCP's behavioral health providers regarding the determination to detain for involuntary commitment?

- Never

Sometimes

Usually

Always

181. Does OPTUM PIERCE BHO coordinate with your providers on Involuntary Treatment Act (ITA) mental health and Involuntary Treatment Act (ITA) substance use disorder evaluations on tribal lands - including when non-Designated Crisis Responders (DCRs) conduct ITA evaluations on tribal land?

Does not apply (no tribal land)

Never

Sometimes

Usually

Always

182. Does OPTUM PIERCE BHO coordinate with your providers on Involuntary Treatment Act (ITA) mental health and Involuntary Treatment Act (ITA) substance use disorder evaluations NOT conducted on tribal lands - in particular, during transportation to a site for evaluation or detention?

Never

Sometimes

Usually

Always

183. Does OPTUM PIERCE BHO coordinate with your providers on inpatient discharge planning and discharge activities?

Never

Sometimes

Usually

Always

184. Do your IHCP's patients/clients who are insured with a OPTUM PIERCE BHO plan have access to providers they have a need for, but would not have access to if they had other insurance coverage?

Yes

No

185. Do your IHCP's patients/clients who are insured with a OPTUM PIERCE BHO plan have access to services or benefits that make a significant impact on their health status, but would not have access to if they had other insurance coverage?

◯ Yes

◯ No

186. What services or benefits (that make a significant impact on health status) do your IHCP patients/clients who are insured with a OPTUM PIERCE BHO plan have access to because they are insured with OPTUM PIERCE BHO. These patients/clients would not have access to these services or benefits if they were not on a OPTUM PIERCE BHO plan.

☐ Acupuncture

☐ Housing assistance

☐ Employment assistance

☐ Non-emergency transportation to care

☐ Other (please specify)

187. Please provide specific examples that demonstrate poor (unsatisfactory) service by OPTUM PIERCE BHO to your IHCP and/or your IHCP's patients. (What has not gone well?)

188. Please provide specific examples that demonstrate good (satisfactory) service by OPTUM PIERCE BHO to your IHCP and/or your IHCP's patients.

Indian Healthcare Provider Evaluation of Managed Care Entities in Washington

Behavioral Health Organizations (BHOs)

SALISH BHO

PURPOSE. The purpose of this survey is to evaluate the performance of "service coordination organizations or service contracting entities as defined in RCW 70.320.010 in order to address their impacts on services to American Indians and Alaska Natives and relationships with Indian health care providers." See SB 5415(3)(d).

INSTRUCTIONS. Questions that show responses with circles require you to choose one of the answers provided. Questions that show responses with squares allow you to select as many responses as appropriate.

189. Has your IHCP ever had a contract with SALISH BHO that your IHCP chose to end ? (Counties served are Clallam, Jefferson, Kitsap)

◯ Yes

◯ No

190. What issues led your IHCP to end the contract with SALISH BHO? (Choose all that apply)

It took too long to receive reimbursement payments

Reimbursement rates were too low

It took too much staff time to have claims fully processed

Customer service representatives did not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives

Requirements for credentialing/certifying our providers was
Needed to do data entry twice on claims to receive reimbursement

barriers

Case management services lacked cultural competency

Poor coordination between non-IHCP services and IHCP services

We do not have the capacity to provide Behavioral Health services to non-Native clients - the contract required us to

in the plan

191. Does your IHCP have a current contract with SALISH BHO?

- ◯ Yes
- ◯ No

192. Why does your IHCP NOT have a current contract with SALIS apply)

- ☐ Don't see a clear benefit to our IHCP from contracting
- ☐ Would impose an unreasonable administrative burden to enter into a contract
- ☐ Would impose an unreasonable administrative burden on an ongoing basis
- ☐ We do not have the capacity to provide Behavioral Health services to non-Native clients - a contract would require us to provide Behavioral Health services to any individual enrolled in the plan
- ☐ Would impose an unreasonable administrative burden to enter into a contract
- ☐ Would impose an unreasonable administrative burden on an ongoing basis
- ☐ Reimbursement rates are too low
- ☐ Would take too long to receive reimbursement payments
- ☐ Would take too much staff time to have claims fully processed
- ☐ Customer service representatives do not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives
- ☐ Requirements for credentialing/certifying our providers is too burdensome
- ☐ Need to do data entry twice on claims to receive reimbursement
- ☐ Preauthorization requirements cause too many delays and barriers
- ☐ Case management services lack cultural competency
- ☐ Poor coordination between non-IHCP services and IHCP services

☐ Other (please specify)

193. Has SALISH BHO provided you with a specific contact for communication and service coordination?

○ Yes

○ No

194. Has your SALISH BHO contact offered timely and competent assistance when you have interacted with them?

○ Have not had a need to interact with the contact

○ Yes

○ No

195. Based on your interactions with SALISH BHO staff, how would you describe theirunderstanding of the Indian healthcare delivery system and the benefits and legal protections that apply to American Indians and Alaska Natives?

○ Poor

○ Adequate

○ Good

196. How often has SALISH BHO met with you or others at your IHCP?

○ Never

○ Quarterly

○ 1 or more times every 6 months

○ About once every 1 year

○ About once every 2 years

○ Less than once every 2 years

197. Has SALISH BHO included you or others at your IHCP to develop a plan for coordinating care and services?

○ Yes

○ No

198. Has SALISH BHO provided an effective process for your IHCP to suggest how they can better serve the needs of your IHCP and your community members?

Yes

No

199. Compared to other plans, how would you describe the timeliness of SALISH BHO's payments?

Very slow

Somewhat slower

About the same

Somewhat faster

Much faster

200. How frequently does SALISH BHO require your IHCP to credential/certify your providers?

Once every six months (or less)

Once every year

Once every 18 months or more

201. Approximately, how much of your staff time (provider time and administrative staff time) does SALISH BHO's initial (first time) credentialing/certification process require for one provider?

One hour or less

1.5 to 3 hours

More than 3 hours

202. Approximately, how much of your staff time (provider time and administrative staff time) does SALISH BHO's ongoing recredentialing/recertification process require for one provider, each time you have to recredential/recertify?

One hour or less

1.5 to 3 hours

More than 3 hours

203. Does SALISH BHO provide your IHCP's patients/clients with access to culturally competent care?

Never - not available from this BHO

Sometimes

Usually

Always

204. For what types of services does SALISH BHO require prior authorization? (Choose all that apply)

- [ ] NONE
- [ ] Inpatient SUD treatment
- [ ] Evaluation
- [ ] Other (please specify)
- [ ] Medication management
- [ ] Medication assisted therapy (MAT)

205. To what extent do SALISH BHO's prior authorization requirements delay access to care?

- ○ Prior authorization significantly delays access to care
- ○ Prior authorization somewhat delays access to care
- ○ Prior authorization does not delay access to care

206. To what extent do SALISH BHO's prior authorization requirements result in NO ACCESS (or denied access) to care?

- ○ Prior authorization often results in NO ACCESS to care
- ○ Prior authorization results in NO ACCESS to care for a reasonable number of cases
- ○ Prior authorization rarely results in NO ACCESS to care

207. Has your tribe or urban Indian health program had to cover costs (paid out of your own funds) for care that was denied or delayed by SALISH BHO as a result of preauthorization?

- ○ Yes
- ○ No

208. Does SALISH BHO notify the appropriate tribal authority when they provide crisis services on tribal land?

- ○ Does not apply (no tribal land)
- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

209. Are non-tribal crisis responders and designated crisis responders (DCRs) from SALISH BHO debriefing the appropriate providers at your IHCP after they provide crisis services?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

210. Please describe how well non-tribal crisis responders and designated crisis responders (DCRs) from SALISH BHO are coordinating care with your providers.

- ○ SALISH BHO crisis responders and designated crisis responders (DCRs) are not coordinating at all with our providers

- SALISH BHO crisis responders and designated crisis responders (DCRs) are coordinating poorly with our providers
- SALISH BHO crisis responders and designated crisis responders (DCRs) are coordinating adequately with our providers
- SALISH BHO crisis responders and designated crisis responders (DCRs) are coordinating very well with our providers

211. Does SALISH BHO consult with your IHCP's behavioral health providers regarding the determination to detain for involuntary commitment?

- Never
- Sometimes
- Usually
- Always

212. Does SALISH BHO coordinate with your providers on Involuntary Treatment Act (ITA) mental health and Involuntary Treatment Act (ITA) substance use disorder evaluations on tribal lands - including when non-Designated Crisis Responders (DCRs) conduct ITA evaluations on tribal land?

- Does not apply (no tribal land)
- Never
- Sometimes
- Usually
- Always

213. Does SALISH BHO coordinate with your providers on Involuntary Treatment Act (ITA) mental health and Involuntary Treatment Act (ITA) substance use disorder evaluations NOT conducted on tribal lands - in particular, during transportation to a site for evaluation or detention?

- Never
- Sometimes
- Usually
- Always

214. Does SALISH BHO coordinate with your providers on inpatient discharge planning and discharge activities?

- Never
- Sometimes
- Usually
- Always

215. Do your IHCP's patients/clients who are insured with a SALISH BHO plan have access toproviders they have a need for, but would not have access to if they had other insurance coverage?

- Yes

○ No

216. Do your IHCP's patients/clients who are insured with a SALISH BHO plan have access toservices or benefits that make a significant impact on their health status, but would not have access to if they had other insurance coverage?

○ Yes

○ No

217. What services or benefits (that make a significant impact on health status) do your IHCP patients/clients who are insured with a SALISH BHO plan have access to because they are insured with SALISH BHO. These patients/clients would not have access to these services or benefits if they were not on a SALISH BHO plan.

☐ Acupuncture

☐ Housing assistance

☐ Employment assistance

☐ Non-emergency transportation to care

☐ Other (please specify)

218. Please provide specific examples that demonstrate poor (unsatisfactory) service by SALISH BHO to your IHCP and/or your IHCP's patients. (What has not gone well?)

219. Please provide specific examples that demonstrate good (satisfactory) service by SALISH BHO to your IHCP and/or your IHCP's patients.

PU... ...rpose of this survey is to evaluate the performance of "service coordination organizations or

Indian Healthcare Provider Evaluation of Managed Care Entities in Washington

Behavioral Health Organizations (BHOs)

SPOKANE COUNTY REGIONAL BHO

220. Has your IHCP ever had a contract with SPOKANE COUNTY REGIONAL BHO that your IHCP chose

- ◯ Yes
- ◯ No

221. What issues led your IHCP to end the contract with SPOKANE COUNTY REGIONAL BHO? (Choose all that apply)

- ☐
- ☐
- ☐ Preauthorization requirements caused too many delays and
- ☐
- ☐
- ☐
- ☐
- ☐ too burdensome
- ☐ provide Behavioral Health services to any individual enrolled
- ☐ Other (please specify)

service contracting entities as defined in RCW 70.320.010 in order to address their impacts on services to American Indians and Alaska Natives and relationships with Indian health care providers." See SB 5415(3)(d).

INSTRUCTIONS. Questions that show responses with circles require you to choose one of the answers provided. Questions that show responses with squares allow you to select as many responses as appropriate.

to end? (Counties served are Adams, Ferry, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens)

It took too long to receive reimbursement payments

Reimbursement rates were too low

It took too much staff time to have claims fully processed

Customer service representatives did not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives

Requirements for credentialing/certifying our providers was
Needed to do data entry twice on claims to receive reimbursement

barriers

Case management services lacked cultural competency

Poor coordination between non-IHCP services and IHCP services

We do not have the capacity to provide Behavioral Health services to non-Native clients - the contract required us to

in the plan

222. Does your IHCP have a current ANE COUNTY REGIONAL BHO?

- [ ] Yes
- [ ] No

223. Why does your IHCP NOT have a current contract with SPOK REGIONAL BHO?

(Choose all that apply)

- [ ] Don't see a clear benefit to our IHCP from contracting
- [ ] Would impose an unreasonable administrative burden to enter into a contract
- [ ] Would impose an unreasonable administrative burden on an ongoing basis
- [ ] We do not have the capacity to provide Behavioral Health services to non-Native clients - a contract would require us to provide Behavioral Health services to any individual enrolled in the plan
- [ ] Would impose an unreasonable administrative burden to enter into a contract
- [ ] Would impose an unreasonable administrative burden on an ongoing basis
- [ ] Reimbursement rates are too low
- [ ] Would take too long to receive reimbursement payments
- [ ] Would take too much staff time to have claims fully processed
- [ ] Customer service representatives do not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives
- [ ] Requirements for credentialing/certifying our providers is too burdensome
- [ ] Need to do data entry twice on claims to receive reimbursement
- [ ] Preauthorization requirements cause too many delays and barriers
- [ ] Case management services lack cultural competency
- [ ] Poor coordination between non-IHCP services and IHCP services
- [ ]

Other (please specify)

224. Has SPOKANE COUNTY REGIONAL BHO provided you with a specific contact for communication and service coordination?

- Yes
- No

225. Has your SPOKANE COUNTY REGIONAL BHO contact offered timely and competent assistance when you have interacted with them?

- Have not had a need to interact with the contact
- Yes
- No

226. Based on your interactions with SPOKANE COUNTY REGIONAL BHO staff, how would you describe their understanding of the Indian healthcare delivery system and the benefits and legal protections that apply to American Indians and Alaska Natives?

- Poor
- Adequate
- Good

227. How often has SPOKANE COUNTY REGIONAL BHO met with you or others at your IHCP?

- Never
- Quarterly
- 1 or more times every 6 months
- About once every 1 year
- About once every 2 years
- Less than once every 2 years

228. Has SPOKANE COUNTY REGIONAL BHO included you or others at your IHCP to develop a plan for coordinating care and services?

- Yes

No

229. Has SPOKANE COUNTY REGIONAL BHO provided an effective process for your IHCP to suggest how they can better serve the needs of your IHCP and your community members? Yes

No

230. Compared to other plans, how would you describe the timeliness of SPOKANE COUNTY REGIONAL BHO's payments?

Very slow

Somewhat slower

About the same

Somewhat faster

Much faster

231. How frequently does SPOKANE COUNTY REGIONAL BHO require your IHCP to credential/certify your providers?

Once every six months (or less)

Once every year

Once every 18 months or more

232. Approximately, how much of your staff time (provider time and administrative staff time) does SPOKANE COUNTY REGIONAL BHO's initial (first time) credentialing/certification process require for one provider?

One hour or less

1.5 to 3 hours

More than 3 hours

233. Approximately, how much of your staff time (provider time and administrative staff time) does SPOKANE COUNTY REGIONAL BHO's ongoing recredentialing/recertification process require for one provider, each time you have to recredential/recertify?

One hour or less

1.5 to 3 hours

More than 3 hours

234. Does SPOKANE COUNTY REGIONAL BHO provide your IHCP's patients/clients with access to culturally competent care?

Never - not available from this BHO

Sometimes

Usually

Always

235. For what types of services does SPOKANE COUNTY REGIONAL BHO require prior authorization? (Choose all that apply)

- NONE
- Inpatient SUD treatment
- Evaluation
- Other (please specify)
- Medication management
- Medication assisted therapy (MAT)

236. To what extent do SPOKANE COUNTY REGIONAL BHO's prior authorization requirements delay access to care?

- Prior authorization significantly delays access to care
- Prior authorization somewhat delays access to care
- Prior authorization does not delay access to care

237. To what extent do SPOKANE COUNTY REGIONAL BHO's prior authorization requirements result in NO ACCESS (or denied access) to care?

- Prior authorization often results in NO ACCESS to care
- Prior authorization results in NO ACCESS to care for a reasonable number of cases
- Prior authorization rarely results in NO ACCESS to care

238. Has your tribe or urban Indian health program had to cover costs (paid out of your own funds) for care that was denied or delayed by SPOKANE COUNTY REGIONAL BHO as a result of preauthorization?

- Yes
- No

239. Does SPOKANE COUNTY REGIONAL BHO notify the appropriate tribal authority when they provide crisis services on tribal land?

- Does not apply (no tribal land)
- Never
- Sometimes
- Usually
- Always

240. Are non-tribal crisis responders and designated crisis responders (DCRs) from SPOKANE COUNTY REGIONAL BHO debriefing the appropriate providers at your IHCP after they provide crisis services?

- Never

Sometimes

Usually

Always

241. Please describe how well non-tribal crisis responders and designated crisis responders (DCRs) from SPOKANE COUNTY REGIONAL BHO are coordinating care with your providers.

SPOKANE COUNTY REGIONAL BHO crisis responders and designated crisis responders (DCRs) are not coordinating at all with our providers

SPOKANE COUNTY REGIONAL BHO crisis responders and designated crisis responders (DCRs) are coordinating poorly with our providers

SPOKANE COUNTY REGIONAL BHO crisis responders and designated crisis responders (DCRs) are coordinating adequately with our providers

SPOKANE COUNTY REGIONAL BHO crisis responders and designated crisis responders (DCRs) are coordinating very well with our providers

242. Does SPOKANE COUNTY REGIONAL BHO consult with your IHCP's behavioral health providers regarding the determination to detain for involuntary commitment?

Never

Sometimes

Usually

Always

243. Does SPOKANE COUNTY REGIONAL BHO coordinate with your providers on Involuntary Treatment Act (ITA) mental health and Involuntary Treatment Act (ITA) substance use disorder evaluations on tribal lands - including when non-Designated Crisis Responders (DCRs) conduct ITA evaluations on tribal land?

Does not apply (no tribal land)

Never

Sometimes

Usually

Always

244. Does SPOKANE COUNTY REGIONAL BHO coordinate with your providers on Involuntary Treatment Act (ITA) mental health and Involuntary Treatment Act (ITA) substance use disorder evaluations NOT conducted on tribal lands - in particular, during transportation to a site for evaluation or detention?

Never

Sometimes

Usually

Always

245. Does SPOKANE COUNTY REGIONAL BHO coordinate with your providers on inpatient discharge planning and discharge activities?

- ◯ Never
- ◯ Sometimes
- ◯ Usually
- ◯ Always

246. Do your IHCP's patients/clients who are insured with a SPOKANE COUNTY REGIONAL BHO plan have access to providers they have a need for, but would not have access to if they had other insurance coverage?

- ◯ Yes
- ◯ No

247. Do your IHCP's patients/clients who are insured with a SPOKANE COUNTY REGIONAL BHO plan have access to services or benefits that make a significant impact on their health status, but would not have access to if they had other insurance coverage?

- ◯ Yes
- ◯ No

248. What services or benefits (that make a significant impact on health status) do your IHCP patients/clients who are insured with a SPOKANE COUNTY REGIONAL BHO plan have access to because they are insured with SPOKANE COUNTY REGIONAL BHO. These patients/clients would not have access to these services or benefits if they were not on a SPOKANE COUNTY REGIONAL BHO plan.

- ☐ Acupuncture
- ☐ Housing assistance
- ☐ Employment assistance
- ☐ Non-emergency transportation to care
- ☐ Other (please specify)

249. Please provide specific examples that demonstrate poor (unsatisfactory) service by SPOKANE COUNTY REGIONAL BHO to your IHCP and/or your IHCP's patients. (What has not gone well?)

250. Please provide specific examples that demonstrate good (satisfactory) service by SPOKANE COUNTY REGIONAL BHO to your IHCP and/or your IHCP's patients.

Behavioral Health Organizations (BHOs)

THURSTON-MASON BHO

PURPOSE. The purpose of this survey is to evaluate the performance of "service coordination organizations or service contracting entities as defined in RCW 70.320.010 in order to address their impacts on services to American Indians and Alaska Natives and relationships with Indian health care providers." See SB 5415(3)(d).

INSTRUCTIONS. Questions that show responses with circles require you to choose one of the answers provided. Questions that show responses with squares allow you to select as many responses as appropriate.

251. Has your IHCP ever had a contract with THURSTON-MASON BHO that your IHCP chose to end? (Counties served are Mason, Thurston)

- ◯ Yes
- ◯ No

252. What issues led your IHCP to end the contract with THURSTON-MASON BHO? (Choose all that apply)

- ☐ It took too long to receive reimbursement payments
- ☐ Reimbursement rates were too low
- ☐ It took too much staff time to have claims fully processed
- ☐ Customer service representatives did not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives
- ☐ Requirements for credentialing/certifying our providers was too burdensome
- ☐ Needed to do data entry twice on claims to receive reimbursement
- ☐ Preauthorization requirements caused too many delays and barriers
- ☐ Case management services lacked cultural competency
- ☐ Poor coordination between non-IHCP services and IHCP services
- ☐ We do not have the capacity to provide Behavioral Health services to non-Native clients - the contract required us to provide Behavioral Health services to any individual enrolled in the plan
- ☐ Other (please specify)

253. Does your IHCP have a current contract with THURSTON

○ Yes

○ No

254. Why does your IHCP NOT have a current contract with
that apply)

- [ ] Don't see a clear benefit to our IHCP from contracting
- [ ] Would impose an unreasonable administrative burden to enter into a contract
- [ ] Would impose an unreasonable administrative burden on an ongoing basis
- [ ] We do not have the capacity to provide Behavioral Health services to non-Native clients - a contract would require us to provide Behavioral Health services to any individual enrolled in the plan
- [ ] Would impose an unreasonable administrative burden to enter into a contract
- [ ] Would impose an unreasonable administrative burden on an ongoing basis
- [ ] Reimbursement rates are too low
- [ ] Would take too long to receive reimbursement payments
- [ ] Would take too much staff time to have claims fully processed
- [ ] Customer service representatives do not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives
- [ ] Requirements for credentialing/certifying our providers is too burdensome
- [ ] Need to do data entry twice on claims to receive reimbursement
- [ ] Preauthorization requirements cause too many delays and barriers
- [ ] Case management services lack cultural competency
- [ ] Poor coordination between non-IHCP services and IHCP services

☐ Other (please specify)

255. Has THURSTON-MASON BHO provided you with a specific contact for communication and service coordination?

◯ Yes

◯ No

256. Has your THURSTON-MASON BHO contact offered timely and competent assistance when you have interacted with them?

◯ Have not had a need to interact with the contact

◯ Yes ◯
No

◯ Never

◯ Quarterly

◯ 1 or more times every 6 months

◯ About once every 1 year

◯ About once every 2 years

◯ Less than once every 2 years

Very slow

Somewhat slower

Somewhat faster

Much faster

257. Based on your interactions with THURSTON-MASON BHO staff, how would you describe their understanding of the

Indian healthcare delivery system and the benefits and legal protections that apply to American Indians and Alaska Natives?

◯ Poor

◯ Adequate

◯ Good

258. How often has THURSTON-MASON BHO met with you or others at your IHCP?

259. Has THURSTON-MASON BHO included you or others at your IHCP to develop a plan for coordinating care and services?

◯ Yes

◯ No

260. Has THURSTON-MASON BHO provided an effective process for your IHCP to suggest how they can better serve the needs of your IHCP and your community members?

◯ Yes

◯ No

261. Compared to other plans, how would you describe the timeliness of THURSTON-MASON BHO's payments?

◯ About the same

262. How frequently does THURSTON-MASON require your IHCP to credential/certify your providers?

◯ Once every six months (or less)

◯ Once every year

◯ Once every 18 months or more

263. Approximately, how much of your staff time (provider time and administrative staff time) does

- [ ] NONE
- [ ] Inpatient SUD treatment
- [ ] Evaluation
- [ ] Other (please specify)
- [ ] Medication management
- [ ] Medication assisted therapy (MAT)

THURSTON-MASON BHO's initial (first time) credentialing/certification process require for one provider?

- One hour or less
- 1.5 to 3 hours
- More than 3 hours

264. Approximately, how much of your staff time (provider time and administrative staff time) does THURSTON-MASON BHO's ongoing recredentialing/recertification process require for one provider, each time you have to recredential/recertify?

- One hour or less
- 1.5 to 3 hours
- More than 3 hours

265. Does THURSTON-MASON BHO provide your IHCP's patients/clients with access to culturally competent care?

- Never - not available from this BHO
- Sometimes
- Usually
- Always

266. For what types of services does THURSTON-MASON BHO require prior authorization? (Choose all that apply)

267. To what extent do THURSTON-MASON BHO's prior authorization requirements delay access to care?

- Prior authorization significantly delays access to care
- Prior authorization somewhat delays access to care
- Prior authorization does not delay access to care

268. To what extent do THURSTON-MASON BHO's prior authorization requirements result in NO ACCESS (or denied access) to care?

- Prior authorization often results in NO ACCESS to care
- Prior authorization results in NO ACCESS to care for a reasonable number of cases
- Prior authorization rarely results in NO ACCESS to care

269. Has your tribe or urban Indian health program had to cover costs (paid out of your own funds) for care that was denied or delayed by THURSTON-MASON BHO as a result of preauthorization?

- Yes
- No

270. Does THURSTON-MASON BHO notify the appropriate tribal authority when they provide crisis services on tribal land?

- Does not apply (no tribal land)
- Never
- Sometimes
- Usually
- Always

271. Are non-tribal crisis responders and designated crisis responders (DCRs) from THURSTON-MASON BHO debriefing the appropriate providers at your IHCP after they provide crisis services?

- Never
- Sometimes
- Usually
- Always

272. Please describe how well non-tribal crisis responders and designated crisis responders (DCRs) from THURSTON-MASON BHO are coordinating care with your providers.

- THURSTON-MASON BHO crisis responders and designated crisis responders (DCRs) are not coordinating at all with our providers

○ THURSTON-MASON BHO crisis responders and designated crisis responders (DCRs) are coordinating poorly with our providers

◯ THURSTON-MASON BHO crisis responders and designated crisis responders (DCRs) are coordinating adequately with our providers

◯ THURSTON-MASON BHO crisis responders and designated crisis responders (DCRs) are coordinating very well with our providers

◯ Does not apply (no tribal land)

◯ Never

◯ Usually

◯ Always

273. Does THURSTON-MASON BHO consult with your IHCP's behavioral health providers regarding the determination to

detain for involuntary commitment?

- Never
- Sometimes
- Usually
- Always

274. Does THURSTON-MASON BHO coordinate with your providers on Involuntary Treatment Act (ITA) mental health and Involuntary Treatment Act (ITA) substance use disorder evaluations on tribal lands including when non-Designated Crisis Responders (DCRs) conduct ITA evaluations on tribal land?

- Sometimes

275. Does THURSTON-MASON BHO coordinate with your providers on Involuntary Treatment Act (ITA) mental health and Involuntary Treatment Act (ITA) substance use disorder evaluations NOT conducted on tribal lands - in particular, during transportation to a site for evaluation or detention?

- Never
- Sometimes
- Usually
- Always

276. Does THURSTON-MASON BHO coordinate with your providers on inpatient discharge planning and discharge activities?

- Never
- Sometimes
- Usually
- Always

277. Do your IHCP's patients/clients who are insured with a THURSTON-MASON BHO plan have access to providers they have a need for, but would not have access to if they had other insurance coverage?

- Yes
- No

278. Do your IHCP's patients/clients who are insured with a THURSTON-MASON BHO plan have access to services or

- [ ] Acupuncture
- [ ] Housing assistance
- [ ] Employment assistance
- [ ] Non-emergency transportation to care
- [ ] Other (please specify)

benefits that make a significant impact on their health status, but would not have access to if they had other insurance coverage?

- ◯ Yes
- ◯ No

279. What services or benefits (that make a significant impact on health status) do your IHCP patients/clients who are insured with a THURSTON-MASON BHO plan have access to because they are insured with THURSTON-MASON BHO. These patients/clients would not have access to these services or benefits if they were not on a THURSTON-MASON BHO plan.

280. Please provide specific examples that demonstrate poor (unsatisfactory) service by THURSTON-MASON BHO to your IHCP and/or your IHCP's patients. (What has not gone well?)

281. Please provide specific examples that demonstrate good (satisfactory) service by THURSTONMASON BHO to your IHCP and/or your IHCP's patients.

PU... ...pose of this survey is to evaluate the performance of "service coordination organizations or service

Indian Healthcare Provider Evaluation of Managed Care Entities in Washington

Managed Care Organizations (MCOs) - AMERIGROUP

appropriate.

- Yes
- No

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ] Preauthorization requirements caused too many delays and
- [ ]
- [ ]
- [ ] Requirements for credentialing/certifying our providers was too burdensome
- [ ] Other (please specify)

- Yes
- No

contracting entities as defined in RCW 70.320.010 in order to address their impacts on services to American Indians and Alaska Natives and relationships with Indian health care providers." See SB 5415(3)(d).

INSTRUCTIONS. Questions that show responses with circles require to choose one of the answers provided. Questions that show responses with squares allow you to select as many responses as 282. Has your IHCP ever had a contract with AMERIGROUP that your IHCP chose to end?

283. What issues led your IHCP to end the contract with AMERIGROUP? (Choose all that apply)

It took too long to receive reimbursement payments

Needed to do data entry twice on claims to receive reimbursement

Reimbursement rates were too low

It took too much staff time to have claims fully processed

barriers

Customer service representatives did not fully understand the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives

Case management services lacked cultural competency issues specific to

Poor coordination between non-IHCP services and IHCP services

284. Does your IHCP have a current contract with AMERIGROUP?

285. Why not? (Choose all that apply)

- [ ]
- [ ]
- [ ]
- [ ]
- [ ] Would impose an unreasonable administrative burden to enter into a contract
- [ ] Would impose an unreasonable administrative burden on an ongoing basis
- [ ] Reimbursement rates are too low
- [ ] Would take too long to receive reimbursement payments
- [ ] Other (please specify)
- [ ]
- [ ]
- [ ] Requirements for credentialing/certifying our providers is too
- [ ] Need to do data entry twice on claims to receive
- [ ] Preauthorization requirements cause too many delays and barriers
- [ ] Case management services lack cultural competency
- [ ] Poor coordination between non-IHCP services and IHCP services

Don't see a clear benefit to our IHCP from contracting

Would impose an unreasonable administrative burden to enter into a contract

Would impose an unreasonable administrative burden on an ongoing basis

We do not have the capacity to provide Behavioral Health services to non-Native clients - a contract would require us to provide Behavioral Health services to any individual enrolled in the plan

Would take too much staff time to have claims fully processed

Customer service representatives do not fully understand issues

specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives

burdensome

reimbursement

286. Has AMERIGROUP provided you with a specific contact for communication and service coordination?

◯ Yes

◯ No

287. Has your AMERIGROUP contact offered timely and competent assistance when you have interacted with them?

◯ Have not had a need to interact with the contact

◯ Yes

◯ No

288. Based on your interactions with AMERIGROUP's staff, how would you describe their understanding of the Indian healthcare delivery system and the benefits and legal protections that apply to American Indians and Alaska Natives?

◯ Poor

◯ Adequate ◯

Good

289. How often has AMERIGROUP met with you or others at your IHCP?

- Never
- 1 or more times every 6 months
- About once every 1 year
- About once every 2 years
- Less than once every 2 years

290. How often has AMERIGROUP met with you or others at your IHCP?

- Never
- Quarterly
- 1 or more times every 6 months
- About once every 1 year
- About once every 2 years
- Less than once every 2 years

291. Has AMERIGROUP included you or others at your IHCP to develop a plan for coordinating care and services?

- Yes
- No

292. Has AMERIGROUP provided an effective process for your IHCP to suggest how they can better serve the needs of your IHCP and your community members?

- Yes
- No

293. Compared to other plans, how would you describe the timeliness of AMERIGROUP's payments?

- Very slow
- Somewhat slower
- About the same
- Somewhat faster
- Much faster

294. How frequently does AMERIGROUP require your IHCP to credential/certify your provider?

- Once every six months (or less)
- Once every year
- Once every 18 months or more

295. Approximately, how much of your staff time (provider time and administrative staff time) does the initial (first time) credentialing/certification process require for one provider?

- One hour or less
- 1.5 to 3 hours
- More than 3 hours

296. Approximately, how much of your staff time (provider time and administrative staff time) does the ongoing recredentialing/recertification process require for one provider, each time you have to recredential/recertify?

- One hour or less

1.5 to 3 hours

More than 3 hours

297. Does AMERIGROUP provide your IHCP's patients/clients with access to culturally competent care?

Never - not available from this MCO

Sometimes

Usually

Always

298. For what types of services does AMERIGROUP require prior authorization?

- [ ] Imaging
- [ ] Specialty care provider visits
- [ ] Non-emergency surgery
- [ ] Prescriptions
- [ ] Physical therapy
- [ ] Rehabilitative care
- [ ] Home Health care
- [ ] Chiropractic
- [ ] Durable medical equipment
- [ ] NONE
- [ ] Other (please specify)

299. To what extent do AMERIGROUP's prior authorization requirements delay access to care?

Prior authorization significantly delays access to care

Prior authorization somewhat delays access to care

Prior authorization does not delay access to care

300. To what extent do AMERIGROUP's prior authorization requirements result in NO ACCESS to care?

Prior authorization often results in NO ACCESS to care

Prior authorization results in NO ACCESS to care for a reasonable number of cases

Prior authorization rarely results in NO ACCESS to care

301. Has your tribe or urban Indian health program had to cover costs (paid out of your own funds) for care that was denied or delayed by AMERIGROUP as a result of preauthorization?

Yes

No

302. Please describe how well AMERIGROUP coordinates care with your providers on OUTPATIENT CARE.

- AMERIGROUP is not coordinating care at all with our providers on outpatient care
- AMERIGROUP is coordinating care poorly with our providers on outpatient care
- AMERIGROUP is coordinating care adequately with our providers on outpatient care
- AMERIGROUP is coordinating care very well with our providers on outpatient care

303. Does AMERIGROUP coordinate with your providers on inpatient discharge planning and discharge activities?

- AMERIGROUP is not coordinating at all on inpatient discharge planning and discharge activities
- AMERIGROUP is coordinating poorly on inpatient discharge planning and discharge activities
- AMERIGROUP is coordinating adequately on inpatient discharge planning and discharge activities
- AMERIGROUP is coordinating very well on inpatient discharge planning and discharge activities

304. Do your IHCP's patients/clients who are insured with an AMERIGROUP plan have access toproviders they have a need for, but would not have access to if they had other insurance coverage?

- Yes
- No

305. Do your IHCP's patients/clients who are insured with an AMERIGROUP plan have access toservices or benefits that make a significant impact on their health status, but would not have access to if they had other insurance coverage?

- Yes
- No

306. What services or benefits (that make a significant impact on health status) do your IHCP patients/clients who are insured with an AMERIGROUP plan have access to because they are insured with AMERIGROUP. These patients/clients would not have access to these services or benefits if they were not on an AMERIGROUP plan.

- Vision exams
- Eyeglasses
- Hearing aids
- Traditional healing
- Acupuncture
- Massage
- Gym membership
- Cell phones
- Breast pumps
- Non-emergency transportation to care
- Other (please specify)

307. Please provide specific examples that demonstrate poor (unsatisfactory) service by AMERIGROUP to your IHCP and/or your IHCP's patients. (What has not gone well?)

308. Please provide specific examples that demonstrate good (satisfactory) service by AMERIGROUP to your IHCP and/or your IHCP's patients. (What has gone well?)

PU[illegible] pose of this survey is to evaluate the performance of "service coordination organizations or service

Indian Healthcare Provider Evaluation of Managed Care Entities in Washington

Managed Care Organizations (MCOs) - COMMUNITY HEALTH PLAN OF WASHINGTON

appropriate.

IHCP chose to end?

- Yes
- No

310. What issues led your IHCP to end the contract with COMMUNITY HEALTH PLAN OF WASHINGTON?

- [ ]
- [ ] Reimbursement rates were too low
- [ ]
- [ ] issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians
- [ ] Requirements for credentialing/certifying our providers was
- [ ] Other (please specify)

contracting entities as defined in RCW 70.320.010 in order to address their impacts on services to American Indians and Alaska Natives and relationships with Indian health care providers." See SB 5415(3)(d).

INSTRUCTIONS. Questions that show responses with circles require to choose one of the answers provided. Questions that show responses with squares allow you to select as many responses as

309. Has your IHCP ever had a contract with COMMUNITY HEALTH PLAN OF WASHINGTON that your

It took too long to receive reimbursement payments

It took too much staff time to have claims fully processed

Customer service representatives did not fully understand

and Alaska Natives

too burdensome

311. What issues ract with COMMUNITY HEALTH PLAN OF WASHINGTON?

(Choose all that apply)

- ☐ It took too long to receive reimbursement payments
- ☐ Reimbursement rates were too low
- ☐ It took too much staff time to have claims fully processed
- ☐ Customer service representatives did not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives
- ☐ Requirements for credentialing/certifying our providers was too burdensome
- ☐ Needed to do data entry twice on claims to receive reimbursement
- ☐ Preauthorization requirements caused too many delays and barriers
- ☐ Case management services lacked cultural competency
- ☐ Poor coordination between non-IHCP services and IHCP services
- We do not have the capacity to provide Behavioral Health services to non-Native clients - the contract required us to provide Behavioral Health services to any individual enrolled in the plan

- [ ] Other (please specify)

312. Does your IHCP have a current contract with COMMUNITY HEALTH PLAN OF WASHINGTON?

- ( ) Yes
- ( ) No

313. Why not? (Choose all that apply)

- [ ] Would impose an unreasonable administrative burden to enter into a contract
- [ ] Would impose an unreasonable administrative burden on an ongoing basis
- [ ] Reimbursement rates are too low
- [ ] Would take too long to receive reimbursement payments
- [ ] Would take too much staff time to have claims fully processed
- [ ] Customer service representatives do not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives
- [ ] Requirements for credentialing/certifying our providers is too burdensome
- [ ] Need to do data entry twice on claims to receive reimbursement
- [ ] Preauthorization requirements cause too many delays and barriers
- [ ] Case management services lack cultural competency
- [ ] Poor coordination between non-IHCP services and IHCP services
- [ ] Other (please specify)

Don't see a clear benefit to our IHCP from contracting

Would impose an unreasonable administrative burden to enter into a contract

Would impose an unreasonable administrative burden on an ongoing basis

We do not have the capacity to provide Behavioral Health services to non-Native clients - a contract would require us to provide Behavioral Health services to any individual enrolled in the plan

314. Has COMMUNITY HEALTH PLAN OF WASHINGTON provided you with a specific contact for communication and service coordination?

- Yes
- No

315. Has your COMMUNITY HEALTH PLAN OF WASHINGTON contact offered timely and competent assistance when you have interacted with them?

- Have not had a need to interact with the contact
- Yes
- No

316. Based on your interactions with COMMUNITY HEALTH PLAN OF WASHINGTON's staff, how would you describe their understanding of the Indian healthcare delivery system and the benefits and legal protections that apply to American Indians and Alaska Natives?

- Poor
- Adequate
- Good

317. How often has COMMUNITY HEALTH PLAN OF WASHINGTON met with you or others at your IHCP?

- Never
- 1 or more times every 6 months
- About once every 1 year
- About once every 2 years
- Less than once every 2 years

318. How often has COMMUNITY HEALTH PLAN OF WASHINGTON met with you or others at your IHCP?

- Never
- Quarterly
- 1 or more times every 6 months
- About once every 1 year
- About once every 2 years
- Less than once every 2 years

319. Has COMMUNITY HEALTH PLAN OF WASHINGTON included you or others at your IHCP to develop a plan for coordinating care and services?

- Yes
- No

320. Has COMMUNITY HEALTH PLAN OF WASHINGTON provided an effective process for your IHCP to suggest how they can better serve the needs of your IHCP and your community members?

- Yes
- No

321. Compared to other plans, how would you describe the timeliness of COMMUNITY HEALTH PLAN OF WASHINGTON's payments?

- Very slow
- Somewhat slower
- About the same
- Somewhat faster
- Much faster

322. How frequently does COMMUNITY HEALTH PLAN OF WASHINGTON require your IHCP to credential/certify your provider?

- Once every six months (or less)

- Once every year
- Once every 18 months or more

323. Approximately, how much of your staff time (provider time and administrative staff time) does the initial (first time) credentialing/certification process require for one provider?

- One hour or less
- 1.5 to 3 hours
- More than 3 hours

324. Approximately, how much of your staff time (provider time and administrative staff time) does the ongoing recredentialing/recertification process require for one provider, each time you have to recredential/recertify?

- One hour or less
- 1.5 to 3 hours
- More than 3 hours

325. Does COMMUNITY HEALTH PLAN OF WASHINGTON provide your IHCP's patients/clients with access to culturally competent care?

- Never - not available from this MCO
- Sometimes
- Usually
- Always

326. For what types of services does COMMUNITY HEALTH PLAN OF WASHINGTON require prior authorization?

- Imaging
- Specialty care provider visits
- Non-emergency surgery
- Prescriptions
- Physical therapy
- Other (please specify)
- Rehabilitative care
- Home Health care
- Chiropractic
- Durable medical equipment
- NONE

327. To what extent do COMMUNITY HEALTH PLAN OF WASHINGTON's prior authorization requirements delay access to care?

- Prior authorization significantly delays access to care
- Prior authorization somewhat delays access to care
- Prior authorization does not delay access to care

328. To what extent do COMMUNITY HEALTH PLAN OF WASHINGTON's prior authorization requirements result in NO ACCESS to care?

- Prior authorization often results in NO ACCESS to care
- Prior authorization results in NO ACCESS to care for a reasonable number of cases
- Prior authorization rarely results in NO ACCESS to care

329. Has your tribe or urban Indian health program had to cover costs (paid out of your own funds) for care that was denied or delayed by COMMUNITY HEALTH PLAN OF WASHINGTON as a result of preauthorization?

- Yes
- No

330. Please describe how well COMMUNITY HEALTH PLAN OF WASHINGTON coordinates care with your providers on OUTPATIENT CARE.

◯ COMMUNITY HEALTH PLAN OF WASHINGTON is not coordinating care at all with our providers on outpatient care

◯ COMMUNITY HEALTH PLAN OF WASHINGTON is coordinating care poorly with our providers on outpatient care

◯ COMMUNITY HEALTH PLAN OF WASHINGTON is coordinating care adequately with our providers on outpatient care

◯ COMMUNITY HEALTH PLAN OF WASHINGTON is coordinating care very well with our providers on outpatient care

331. Does COMMUNITY HEALTH PLAN OF WASHINGTON coordinate with your providers on inpatient discharge planning and discharge activities?

◯ COMMUNITY HEALTH PLAN OF WASHINGTON is not coordinating at all on inpatient discharge planning and discharge activities

◯ COMMUNITY HEALTH PLAN OF WASHINGTON is coordinating poorly on inpatient discharge planning and discharge activities

◯ COMMUNITY HEALTH PLAN OF WASHINGTON is coordinating adequately on inpatient discharge planning and discharge activities

◯ COMMUNITY HEALTH PLAN OF WASHINGTON is coordinating very well on inpatient discharge planning and discharge activities

332. Do your IHCP's patients/clients who are insured with a COMMUNITY HEALTH PLAN OF WASHINGTON plan have access to providers they have a need for, but would not have access to if they had other insurance coverage?

◯ Yes

◯ No

333. Do your IHCP's patients/clients who are insured with a COMMUNITY HEALTH PLAN OF WASHINGTON plan have access to services or benefits that make a significant impact on their health status, but would not have access to if they had other insurance coverage? ◯ Yes

◯ No

334. What services or benefits (that make a significant impact on health status) do your IHCP patients/clients who are insured with a COMMUNITY HEALTH PLAN OF WASHINGTON plan have access to because they are insured with COMMUNITY HEALTH PLAN OF WASHINGTON. These patients/clients would not have access to these services or benefits if they were not on a COMMUNITY HEALTH PLAN OF WASHINGTON plan.

- [ ] Vision exams
- [ ] Massage
- [ ] Eyeglasses
- [ ] Gym membership
- [ ] Hearing aids
- [ ] Cell phones
- [ ] Traditional healing
- [ ] Breast pumps
- [ ] Acupuncture
- [ ] Non-emergency transportation to care
- [ ] Other (please specify)

335. Please provide specific examples that demonstrate poor (unsatisfactory) service by COMMUNITY HEALTH PLAN OF WASHINGTON to your IHCP and/or your IHCP's patients. (What has not gone well?)

336. Please provide specific examples that demonstrate good (satisfactory) service by COMMUNITY HEALTH PLAN OF WASHINGTON to your IHCP and/or your IHCP's patients. (What has gone well?)

PU[illegible] [illegible]pose of this survey is to evaluate the performance of "service coordination organizations or service

Indian Healthcare Provider Evaluation of Managed Care Entities in Washington

Managed Care Organizations (MCOs) - COORDINATED CARE OF WASHINGTON

appropriate.

chose to end?

- Yes
- No

(Choose all that apply)

- [ ]
- [ ]
- [ ]
- [ ]
- [ ]
- [ ] Preauthorization requirements caused too many delays and
- [ ]
- [ ]
- [ ] Requirements for credentialing/certifying our providers was too burdensome
- [ ] Other (please specify)

- Yes
- No

contracting entities as defined in RCW 70.320.010 in order to address their impacts on services to American Indians and Alaska Natives and relationships with Indian health care providers." See SB 5415(3)(d).

INSTRUCTIONS. Questions that show responses with circles require to choose one of the answers provided. Questions that show responses with squares allow you to select as many responses as 337. Has your IHCP ever had a contract with COORDINATED CARE OF WASHINGTON that your IHCP

338. What issues led your IHCP to end the contract with COORDINATED CARE OF WASHINGTON?

It took too long to receive reimbursement payments

Reimbursement rates were too low

It took too much staff time to have claims fully processed

Customer service representatives did not fully understand to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians

Natives services

Needed to do data entry twice on claims to receive reimbursement

barriers

Case management services lacked cultural competency issues specific

Poor coordination between non-IHCP services and IHCP and Alaska

339. Does your IHCP have a current contract with COORDINATED CARE OF WASHINGTON?

340. Why not? (Choose all that apply)

- [ ] Requirements for credentialing/certifying our providers is too
- [ ] Need to do data entry twice on claims to receive
- [ ] Would impose an unreasonable administrative burden to enter into a contract
- [ ] Would impose an unreasonable administrative burden on an ongoing basis
- [ ] Reimbursement rates are too low
- [ ] Would take too long to receive reimbursement payments
- [ ] Other (please specify)
- [ ] Preauthorization requirements cause too many delays and barriers
- [ ] Case management services lack cultural competency
- [ ] Poor coordination between non-IHCP services and IHCP services

Don't see a clear benefit to our IHCP from contracting

Would impose an unreasonable administrative burden to enter into a contract

Would impose an unreasonable administrative burden on an ongoing basis

We do not have the capacity to provide Behavioral Health services to non-Native clients - a contract would require us to provide Behavioral Health services to any individual enrolled in the plan

Would take too much staff time to have claims fully processed

Customer service representatives do not fully understand issues

specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives	burdensome
	reimbursement

341. Has COORDINATED CARE OF WASHINGTON provided you with a specific contact for communication and service coordination?

- Yes
- No

342. Has your COORDINATED CARE OF WASHINGTON contact offered timely and competent assistance when you have interacted with them?

- Have not had a need to interact with the contact
- Yes
- No

343. Based on your interactions with COORDINATED CARE OF WASHINGTON's staff, how would you describe their understanding of the Indian healthcare delivery system and the benefits and legal protections that apply to American Indians and Alaska Natives?

- Poor
- Adequate
- Good

344. How often has COORDINATED CARE OF WAS INGTON met with you or others at your IHCP?

- Never
- 1 or more times every 6 months
- About once every 1 year
- About once every 2 years
- Less than once every 2 years

345. How often has COORDINATED CARE OF WAS INGTON met with you or others at your IHCP?

- Never
- Quarterly
- 1 or more times every 6 months
- About once every 1 year
- About once every 2 years
- Less than once every 2 years

346. Has COORDINATED CARE OF WASHINGTON included you or others at your IHCP to develop a plan for coordinating care and services?

- Yes
- No

347. Has COORDINATED CARE OF WASHINGTON provided an effective process for your IHCP to suggest how they can better serve the needs of your IHCP and your community members?

- Yes
- No

348. Compared to other plans, how would you describe the timeliness of COORDINATED CARE OF WASHINGTON's payments?

- Very slow
- Somewhat slower
- About the same
- Somewhat faster
- Much faster

349. How frequently does COORDINATED CARE OF WASHINGTON require your IHCP to credential/certify your provider?

- Once every six months (or less)
- Once every year
- Once every 18 months or more

350. Approximately, how much of your staff time (provider time and administrative staff time) does the initial (first time) credentialing/certification process require for one provider?

- One hour or less
- 1.5 to 3 hours
- More than 3 hours

351. Approximately, how much of your staff time (provider time and administrative staff time) does the ongoing recredentialing/recertification process require for one provider, each time you have to recredential/recertify?

- One hour or less

1.5 to 3 hours

More than 3 hours

352. Does COORDINATED CARE OF WASHINGTON provide your IHCP's patients/clients with access to culturally competent care?

Never - not available from this MCO

Sometimes

Usually

Always

353. For what types of services does COORDINATED CARE OF WASHINGTON require prior authorization?

- Imaging
- Specialty care provider visits
- Non-emergency surgery
- Prescriptions
- Physical therapy
- Other (please specify)
- Rehabilitative care
- Home Health care
- Chiropractic
- Durable medical equipment
- NONE

354. To what extent do COORDINATED CARE OF WASHINGTON's prior authorization requirements delay access to care?

Prior authorization significantly delays access to care

Prior authorization somewhat delays access to care

Prior authorization does not delay access to care

355. To what extent do COORDINATED CARE OF WASHINGTON's prior authorization requirements result in NO ACCESS to care?

Prior authorization often results in NO ACCESS to care

Prior authorization results in NO ACCESS to care for a reasonable number of cases

Prior authorization rarely results in NO ACCESS to care

356. Has your tribe or urban Indian health program had to cover costs (paid out of your own funds) for care that was denied or delayed by COORDINATED CARE OF WASHINGTON as a result of preauthorization? Yes

No

357. Please describe how well COORDINATED CARE OF WASHINGTON coordinates care with your providers on OUTPATIENT CARE.

- ◯ COORDINATED CARE OF WASHINGTON is not coordinating care at all with our providers on outpatient care
- ◯ COORDINATED CARE OF WASHINGTON is coordinating care poorly with our providers on outpatient care
- ◯ COORDINATED CARE OF WASHINGTON is coordinating care adequately with our providers on outpatient care
- ◯ COORDINATED CARE OF WASHINGTON is coordinating care very well with our providers on outpatient care

358. Does COORDINATED CARE OF WASHINGTON coordinate with your providers on inpatient discharge planning and discharge activities?

- ◯ COORDINATED CARE OF WASHINGTON is not coordinating at all on inpatient discharge planning and discharge activities
- ◯ COORDINATED CARE OF WASHINGTON is coordinating poorly on inpatient discharge planning and discharge activities
- ◯ COORDINATED CARE OF WASHINGTON is coordinating adequately on inpatient discharge planning and discharge activities
- ◯ COORDINATED CARE OF WASHINGTON is coordinating very well on inpatient discharge planning and discharge activities

359. Do your IHCP's patients/clients who are insured with a COORDINATED CARE OF WASHINGTON plan have access to providers they have a need for, but would not have access to if they had other insurance coverage?

- ◯ Yes
- ◯ No

360. Do your IHCP's patients/clients who are insured with an COORDINATED CARE OF WASHINGTON plan have access to services or benefits that make a significant impact on their health status, but would not have access to if they had other insurance coverage?

- ◯ Yes
- ◯ No

361. What services or benefits (that make a significant impact on health status) do your IHCP patients/clients who are insured with a COORDINATED CARE OF WASHINGTON plan have access to because they are insured with COORDINATED CARE OF WASHINGTON. These patients/clients would not have access to these services or benefits if they were not on a COORDINATED CARE OF WASHINGTON plan.

- [ ] Vision exams
- [ ] Eyeglasses
- [ ] Hearing aids
- [ ] Traditional healing
- [ ] Acupuncture
- [ ] Massage
- [ ] Gym membership
- [ ] Cell phones
- [ ] Breast pumps
- [ ] Non-emergency transportation to care
- [ ] Other (please specify)

362. Please provide specific examples that demonstrate poor (unsatisfactory) service by COORDINATED CARE OF WASHINGTON to your IHCP and/or your IHCP's patients. (What has not gone well?)

363. Please provide specific examples that demonstrate good (satisfactory) service by COORDINATED CARE OF WASHINGTON to your IHCP and/or your IHCP's patients. (What has gone well?)

PU[illegible] pose of this survey is to evaluate the performance of "service coordination organizations or service

Indian Healthcare Provider Evaluation of Managed Care Entities in Washington

Managed Care Organizations (MCOs) - MOLINA HEALTHCARE OF WASHINGTON

appropriate.

chose to end?

- ◯ Yes
- ◯ No

(Choose all that apply)

- ☐
- ☐
- ☐
- ☐
- ☐
- ☐ Preauthorization requirements caused too many delays and
- ☐
- ☐
- ☐ Requirements for credentialing/certifying our providers was too burdensome
- ☐ Other (please specify)

- ◯ Yes
- ◯ No

contracting entities as defined in RCW 70.320.010 in order to address their impacts on services to American Indians and Alaska Natives and relationships with Indian health care providers." See SB 5415(3)(d).

INSTRUCTIONS. Questions that show responses with circles require to choose one of the answers provided. Questions that show responses with squares allow you to select as many responses as 364. Has your IHCP ever had a contract with MOLINA HEALTHCARE OF WASHINGTON that your IHCP

365. What issues led your IHCP to end the contract with MOLINA HEALTHCARE OF WASHINGTON?

It took too long to receive reimbursement payments

Needed to do data entry twice on claims to receive reimbursement

Reimbursement rates were too low

It took too much staff time to have claims fully processed

barriers

Customer service representatives did not fully understand specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives

Case management services lacked cultural competency issues

Poor coordination between non-IHCP services and IHCP services

366. Does your IHCP have a current contract with MOLINA HEALTHCARE OF WASHINGTON?

367. Why not? (Choose all that apply)

- [ ]
- [ ]
- [ ]
- [ ]
- [ ] Would impose an unreasonable administrative burden to enter into a contract
- [ ] Would impose an unreasonable administrative burden on an ongoing basis
- [ ] Reimbursement rates are too low
- [ ] Would take too long to receive reimbursement payments
- [ ] Other (please specify)
- [ ]
- [ ]
- [ ] Requirements for credentialing/certifying our providers is too
- [ ] Need to do data entry twice on claims to receive
- [ ] Preauthorization requirements cause too many delays and barriers
- [ ] Case management services lack cultural competency
- [ ] Poor coordination between non-IHCP services and IHCP services

Don't see a clear benefit to our IHCP from contracting

Would impose an unreasonable administrative burden to enter into a contract

Would impose an unreasonable administrative burden on an ongoing basis

We do not have the capacity to provide Behavioral Health services to non-Native clients - a contract would require us to provide Behavioral Health services to any individual enrolled in the plan

Would take too much staff time to have claims fully processed

Customer service representatives do not fully understand issues

specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives	burdensome reimbursement

368. Has MOLINA HEALTHCARE OF WASHINGTON provided you with a specific contact for communication and service coordination?

- Yes
- No

369. Has your MOLINA HEALTHCARE OF WASHINGTON contact offered timely and competent assistance when you have interacted with them?

- Have not had a need to interact with the contact
- Yes
- No

370. Based on your interactions with MOLINA HEALTHCARE OF WASHINGTON's staff, how would you describe their understanding of the Indian healthcare delivery system and the benefits and legal protections that apply to American Indians and Alaska Natives?

- Poor
- Adequate
- Good

371. How often has MOLINA HEALTHCARE OF WASHINGTON met with you or others at your IHCP?

- Never
- 1 or more times every 6 months
- About once every 1 year
- About once every 2 years
- Less than once every 2 years

372. How often has MOLINA HEALTHCARE OF WASHINGTON met with you or others at your IHCP?

- Never
- Quarterly
- 1 or more times every 6 months
- About once every 1 year
- About once every 2 years
- Less than once every 2 years

373. Has MOLINA HEALTHCARE OF WASHINGTON included you or others at your IHCP to develop a plan for coordinating care and services?

- Yes
- No

374. Has MOLINA HEALTHCARE OF WASHINGTON provided an effective process for your IHCP to suggest how they can better serve the needs of your IHCP and your community members?

- Yes
- No

375. Compared to other plans, how would you describe the timeliness of MOLINA HEALTHCARE OF WASHINGTON's payments?

- Very slow
- Somewhat slower
- About the same
- Somewhat faster
- Much faster

376. How frequently does MOLINA HEALTHCARE OF WASHINGTON require your IHCP to credential/certify your provider?

- Once every six months (or less)
- Once every year
- Once every 18 months or more

377. Approximately, how much of your staff time (provider time and administrative staff time) does the initial (first time) credentialing/certification process require for one provider?

- One hour or less
- 1.5 to 3 hours
- More than 3 hours

378. Approximately, how much of your staff time (provider time and administrative staff time) does the ongoing recredentialing/recertification process require for one provider, each time you have to recredential/recertify?

- One hour or less

1.5 to 3 hours

More than 3 hours

379. Does MOLINA HEALTHCARE OF WASHINGTON provide your IHCP's patients/clients with access to culturally competent care?

Never - not available from this MCO

Sometimes

Usually

Always

380. For what types of services does MOLINA HEALTHCARE OF WASHINGTON require prior authorization?

- [ ] Imaging
- [ ] Specialty care provider visits
- [ ] Non-emergency surgery
- [ ] Prescriptions
- [ ] Physical therapy
- [ ] Rehabilitative care
- [ ] Home Health care
- [ ] Chiropractic
- [ ] Durable medical equipment
- [ ] NONE
- [ ] Other (please specify)

381. To what extent do MOLINA HEALTHCARE OF WASHINGTON's prior authorization requirements delay access to care?

Prior authorization significantly delays access to care

Prior authorization somewhat delays access to care

Prior authorization does not delay access to care

382. To what extent do MOLINA HEALTHCARE OF WASHINGTON's prior authorization requirements result in NO ACCESS to care?

Prior authorization often results in NO ACCESS to care

Prior authorization results in NO ACCESS to care for a reasonable number of cases

Prior authorization rarely results in NO ACCESS to care

383. Has your tribe or urban Indian health program had to cover costs (paid out of your own funds) for care that was denied or delayed by MOLINA HEALTHCARE OF WASHINGTON as a result of preauthorization? Yes

No

384. Please describe how well MOLINA HEALTHCARE OF WASHINGTON coordinates care with your providers on OUTPATIENT CARE.

- MOLINA HEALTHCARE OF WASHINGTON is not coordinating care at all with our providers on outpatient care
- MOLINA HEALTHCARE OF WASHINGTON is coordinating care poorly with our providers on outpatient care
- MOLINA HEALTHCARE OF WASHINGTON is coordinating care adequately with our providers on outpatient care
- MOLINA HEALTHCARE OF WASHINGTON is coordinating care very well with our providers on outpatient care

385. Does MOLINA HEALTHCARE OF WASHINGTON coordinate with your providers on inpatient discharge planning and discharge activities?

- MOLINA HEALTHCARE OF WASHINGTON is not coordinating at all on inpatient discharge planning and discharge activities
- MOLINA HEALTHCARE OF WASHINGTON is coordinating poorly on inpatient discharge planning and discharge activities
- MOLINA HEALTHCARE OF WASHINGTON is coordinating adequately on inpatient discharge planning and discharge activities
- MOLINA HEALTHCARE OF WASHINGTON is coordinating very well on inpatient discharge planning and discharge activities

386. Do your IHCP's patients/clients who are insured with a MOLINA HEALTHCARE OF WASHINGTON plan have access to providers they have a need for, but would not have access to if they had other insurance coverage?

- Yes
- No

387. Do your IHCP's patients/clients who are insured with a MOLINA HEALTHCARE OF WASHINGTON plan have access to services or benefits that make a significant impact on their health status, but would not have access to if they had other insurance coverage?

- Yes
- No

388. What services or benefits (that make a significant impact on health status) do your IHCP patients/clients who are insured with a MOLINA HEALTHCARE OF WASHINGTON plan have access to because they are insured with MOLINA HEALTHCARE OF WASHINGTON. These patients/clients would not have access to these services or benefits if they were not on a MOLINA HEALTHCARE OF WASHINGTON plan.

- [ ] Vision exams
- [ ] Massage
- [ ] Eyeglasses
- [ ] Gym membership
- [ ] Hearing aids
- [ ] Cell phones
- [ ] Traditional healing
- [ ] Breast pumps
- [ ] Acupuncture
- [ ] Non-emergency transportation to care
- [ ] Other (please specify)

389. Please provide specific examples that demonstrate poor (unsatisfactory) service by MOLINA HEALTHCARE OF WASHINGTON to your IHCP and/or your IHCP's patients. (What has not gone well?)

390. Please provide specific examples that demonstrate good (satisfactory) service by MOLINA HEALTHCARE OF WASHINGTON to your IHCP and/or your IHCP's patients. (What has gone well?)

PU[illegible] pose of this survey is to evaluate the performance of "service coordination organizations or service

Indian Healthcare Provider Evaluation of Managed Care Entities in Washington

Managed Care Organizations (MCOs) - UNITED HEALTHCARE COMMUNITY PLAN

appropriate.

391. Has your IHCP ever had a contract with UNITED HEALTHCARE COMMUNITY PLAN that your IHCP chose to end?

- ◯ Yes
- ◯ No

(Choose all that apply)

- ☐
- ☐
- ☐
- ☐
- ☐
- ☐ Preauthorization requirements caused too many delays and
- ☐
- ☐
- ☐ Requirements for credentialing/certifying our providers was too burdensome
- ☐ Other (please specify)

- ◯ Yes
- ◯ No

contracting entities as defined in RCW 70.320.010 in order to address their impacts on services to American Indians and Alaska Natives and relationships with Indian health care providers." See SB 5415(3)(d).

INSTRUCTIONS. Questions that show responses with circles require to choose one of the answers provided. Questions that show responses with squares allow you to select as many responses as

392. What issues led your IHCP to end the contract with UNITED HEALTHCARE COMMUNITY PLAN?

It took too long to receive reimbursement payments

Needed to do data entry twice on claims to receive reimbursement

Reimbursement rates were too low

It took too much staff time to have claims fully processed

barriers

Customer service representatives did not fully understand specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives

Case management services lacked cultural competency issues

Poor coordination between non-IHCP services and IHCP services

393. Does your IHCP have a current contract with UNITED HEALTHCARE COMMUNITY PLAN?

394. Why not? (Choose all that apply)

- [ ] Requirements for credentialing/certifying our providers is too
- [ ] Need to do data entry twice on claims to receive
- [ ] Would impose an unreasonable administrative burden to enter into a contract
- [ ] Would impose an unreasonable administrative burden on an ongoing basis
- [ ] Reimbursement rates are too low
- [ ] Would take too long to receive reimbursement payments
- [ ] Other (please specify)
- [ ] Preauthorization requirements cause too many delays and barriers
- [ ] Case management services lack cultural competency
- [ ] Poor coordination between non-IHCP services and IHCP services

Don't see a clear benefit to our IHCP from contracting

Would impose an unreasonable administrative burden to enter into a contract

Would impose an unreasonable administrative burden on an ongoing basis

We do not have the capacity to provide Behavioral Health services to non-Native clients - a contract would require us to provide Behavioral Health services to any individual enrolled in the plan

Would take too much staff time to have claims fully processed

Customer service representatives do not fully understand issues

specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives

burdensome

reimbursement

395. Has UNITED HEALTHCARE COMMUNITY PLAN provided you with a specific contact for communication and service coordination?

- Yes
- No

396. Has your UNITED HEALTHCARE COMMUNITY PLAN contact offered timely and competent assistance when you have interacted with them?

- Have not had a need to interact with the contact
- Yes
- No

397. Based on your interactions with UNITED HEALTHCARE COMMUNITY PLAN's staff, how would you describe their understanding of the Indian healthcare delivery system and the benefits and legal protections that apply to American Indians and Alaska Natives?

- Poor
- Adequate
- Good

398. How often has UNITED HEALTHCARE COMMUNITY PLAN met with you or others at your IHCP?

- Never
- 1 or more times every 6 months
- About once every 1 year
- About once every 2 years
- Less than once every 2 years

399. How often has UNITED HEALTHCARE COMMUNITY PLAN met with you or others at your IHCP?

- Never
- Quarterly
- 1 or more times every 6 months
- About once every 1 year
- About once every 2 years
- Less than once every 2 years

400. Has UNITED HEALTHCARE COMMUNITY PLAN included you or others at your IHCP to develop a plan for coordinating care and services?

◯ Yes

◯ No

401. Has UNITED HEALTHCARE COMMUNITY PLAN provided an effective process for your IHCP to suggest how they can better serve the needs of your IHCP and your community members? ◯ Yes

◯ No

402. Compared to other plans, how would you describe the timeliness of UNITED HEALTHCARE COMMUNITY PLAN's payments?

◯ Very slow

◯ Somewhat slower

◯ About the same

◯ Somewhat faster

◯ Much faster

403. How frequently does UNITED HEALTHCARE COMMUNITY PLAN require your IHCP to credential/certify your provider?

◯ Once every six months (or less)

◯ Once every year

◯ Once every 18 months or more

404. Approximately, how much of your staff time (provider time and administrative staff time) does the initial (first time) credentialing/certification process require for one provider?

◯ One hour or less

◯ 1.5 to 3 hours

◯ More than 3 hours

405. Approximately, how much of your staff time (provider time and administrative staff time) does the ongoing recredentialing/recertification process require for one provider, each time you have to recredential/recertify?

◯ One hour or less

1.5 to 3 hours

More than 3 hours

406. Does UNITED HEALTHCARE COMMUNITY PLAN provide your IHCP's patients/clients with access to culturally competent care?

Never - not available from this MCO

Sometimes

Usually

Always

407. For what types of services does UNITED HEALTHCARE COMMUNITY PLAN require prior authorization?

- Imaging
- Specialty care provider visits
- Non-emergency surgery
- Prescriptions
- Physical therapy
- Other (please specify)
- Rehabilitative care
- Home Health care
- Chiropractic
- Durable medical equipment
- NONE

408. To what extent do UNITED HEALTHCARE COMMUNITY PLAN's prior authorization requirements delay access to care?

Prior authorization significantly delays access to care

Prior authorization somewhat delays access to care

Prior authorization does not delay access to care

409. To what extent do UNITED HEALTHCARE COMMUNITY PLAN's prior authorization requirements result in NO ACCESS to care?

Prior authorization often results in NO ACCESS to care

Prior authorization results in NO ACCESS to care for a reasonable number of cases

Prior authorization rarely results in NO ACCESS to care

410. Has your tribe or urban Indian health program had to cover costs (paid out of your own funds) for care that was denied or delayed by UNITED HEALTHCARE COMMUNITY PLAN as a result of preauthorization? Yes

No

411. Please describe how well UNITED HEALTHCARE COMMUNITY PLAN coordinates care with your providers on OUTPATIENT CARE.

◯ UNITED HEALTHCARE COMMUNITY PLAN is not coordinating care at all with our providers on outpatient care

◯ UNITED HEALTHCARE COMMUNITY PLAN is coordinating care poorly with our providers on outpatient care

◯ UNITED HEALTHCARE COMMUNITY PLAN is coordinating care adequately with our providers on outpatient care

◯ UNITED HEALTHCARE COMMUNITY PLAN is coordinating care very well with our providers on outpatient care

412. Does UNITED HEALTHCARE COMMUNITY PLAN coordinate with your providers on inpatient discharge planning and discharge activities?

◯ UNITED HEALTHCARE COMMUNITY PLAN is not coordinating at all on inpatient discharge planning and discharge activities

◯ UNITED HEALTHCARE COMMUNITY PLAN is coordinating poorly on inpatient discharge planning and discharge activities

◯ UNITED HEALTHCARE COMMUNITY PLAN is coordinating adequately on inpatient discharge planning and discharge activities

◯ UNITED HEALTHCARE COMMUNITY PLAN is coordinating very well on inpatient discharge planning and discharge activities

413. Do your IHCP's patients/clients who are insured with a UNITED HEALTHCARE COMMUNITY PLAN plan have access to providers they have a need for, but would not have access to if they had other insurance coverage?

◯ Yes

◯ No

414. Do your IHCP's patients/clients who are insured with a UNITED HEALTHCARE COMMUNITY PLAN plan have access to services or benefits that make a significant impact on their health status, but would not have access to if they had other insurance coverage?

◯ Yes

◯ No

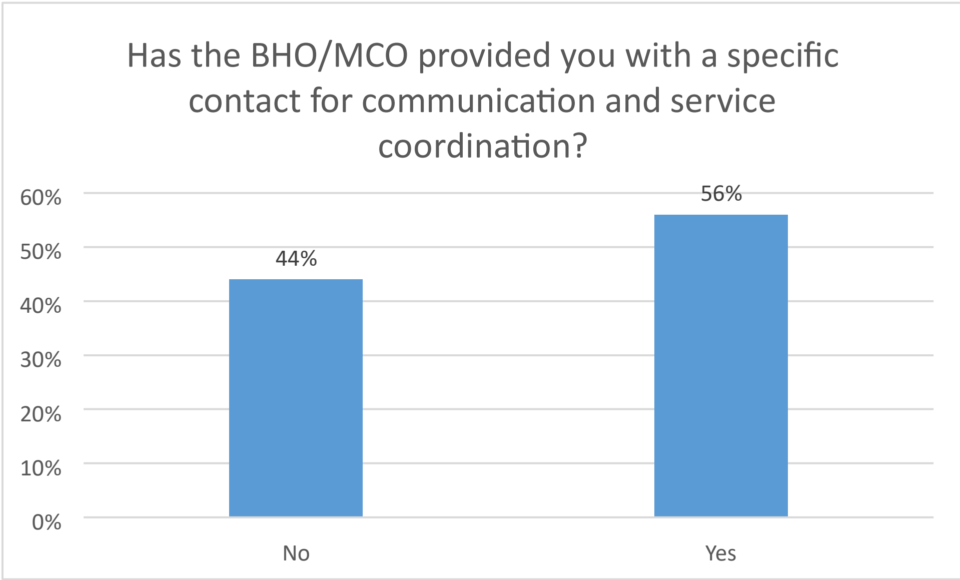
415. What services or benefits (that make a significant impact on health status) do your IHCP patients/clients who are insured with a UNITED HEALTHCARE COMMUNITY PLAN plan have access to because they are insured with UNITED HEALTHCARE COMMUNITY PLAN. These patients/clients would not have access to these services or benefits if they were not on a UNITED HEALTHCARE COMMUNITY PLAN plan.

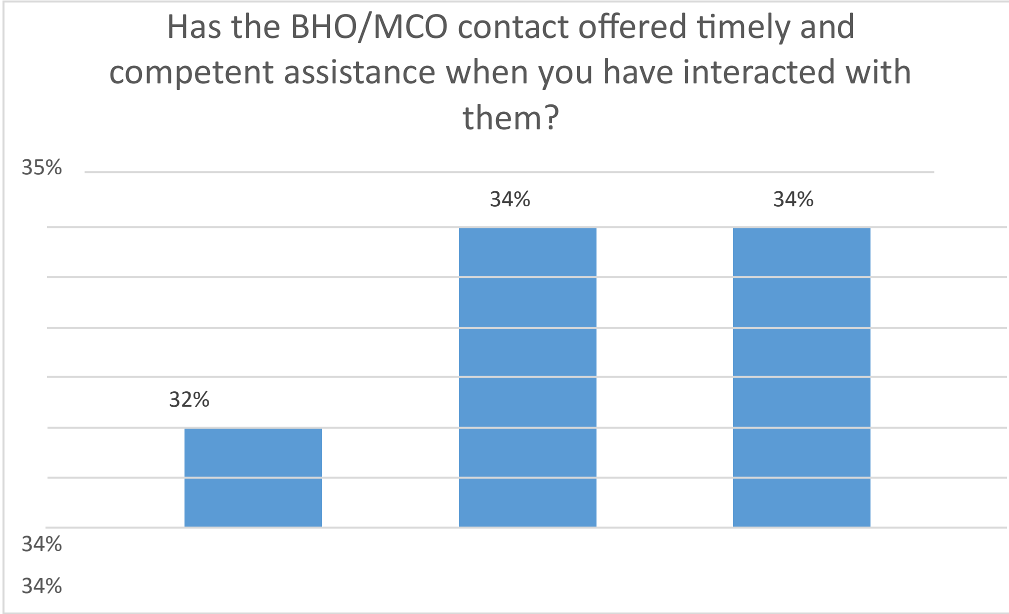
- [ ] Vision exams
- [ ] Eyeglasses
- [ ] Hearing aids
- [ ] Traditional healing
- [ ] Acupuncture
- [ ] Massage
- [ ] Gym membership
- [ ] Cell phones
- [ ] Breast pumps
- [ ] Non-emergency transportation to care
- [ ] Other (please specify)

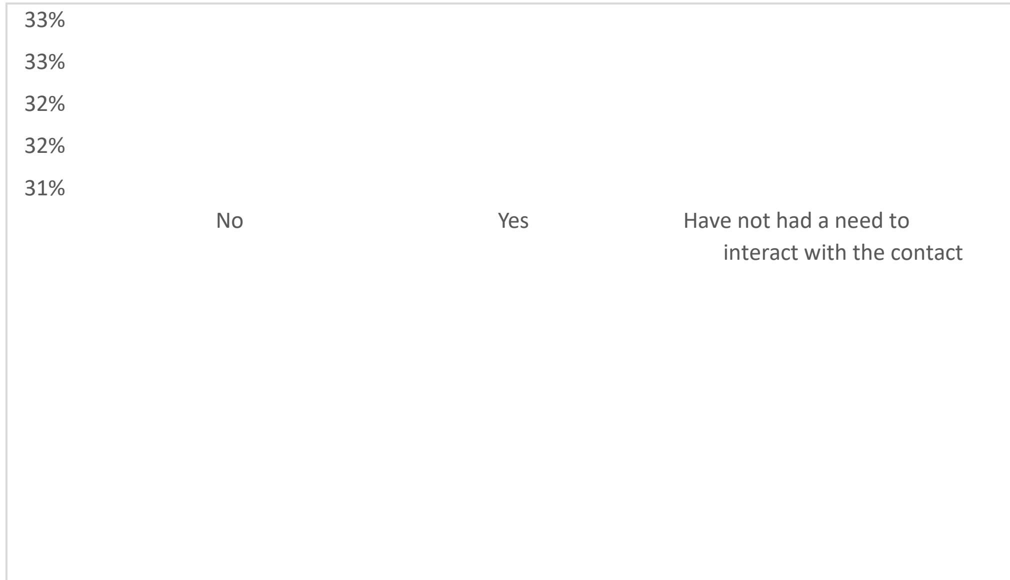
416. Please provide specific examples that demonstrate poor (unsatisfactory) service by UNITED HEALTHCARE COMMUNITY PLAN to your IHCP and/or your IHCP's patients. (What has not gone well?)

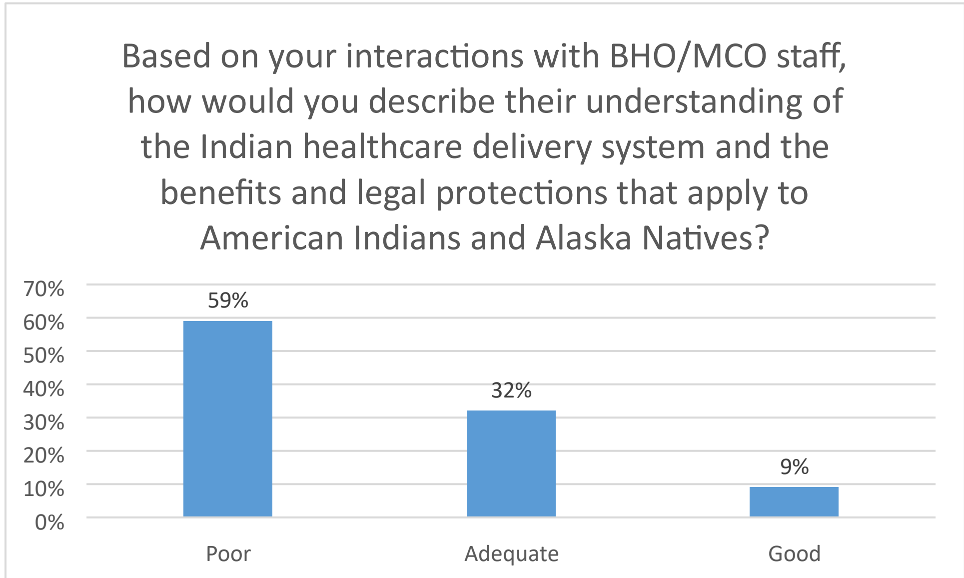
417. Please provide specific examples that demonstrate good (satisfactory) service by UNITED HEALTHCARE COMMUNITY PLAN to your IHCP and/or your IHCP's patients. (What has gone well?)

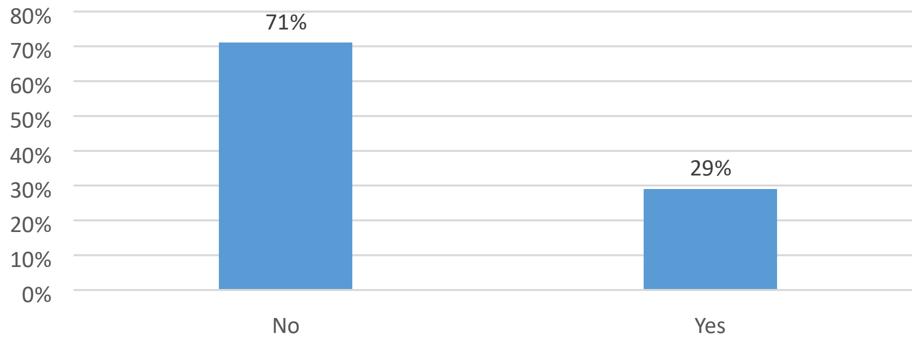
APPENDIX D: RESULTS - Indian Health Care Provider Evaluation of Managed Care Entities


Has the BHO/MCO provided you with a specific contact for communication and service coordination?
60%
50%
40%
30%
20%
10%
0%
44%
56%
No
Yes

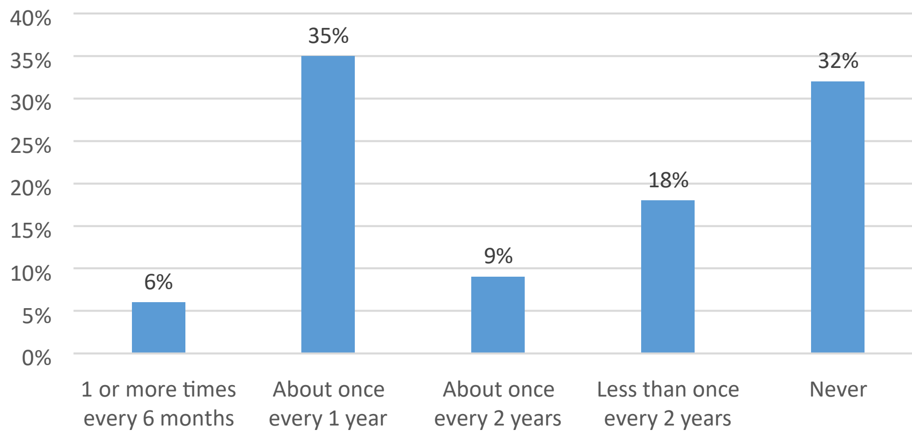

Has the BHO/MCO contact offered timely and competent assistance when you have interacted with them?
35%
34%
34%
32%
34%
34%


33%
33%
32%
32%
31%
No
Yes
Have not had a need to interact with the contact

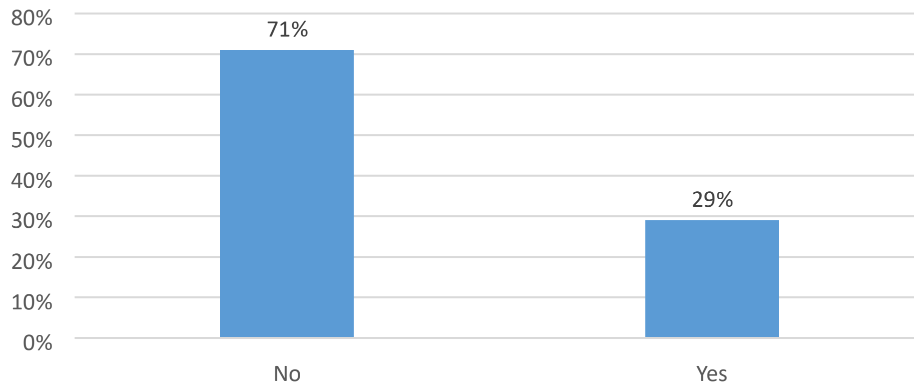

Based on your interactions with BHO/MCO staff, how would you describe their understanding of the Indian healthcare delivery system and the benefits and legal protections that apply to American Indians and Alaska Natives?
70%
60%
50%
40%
30%
20%
10%
0%
59%
32%
9%
Poor
Adequate
Good

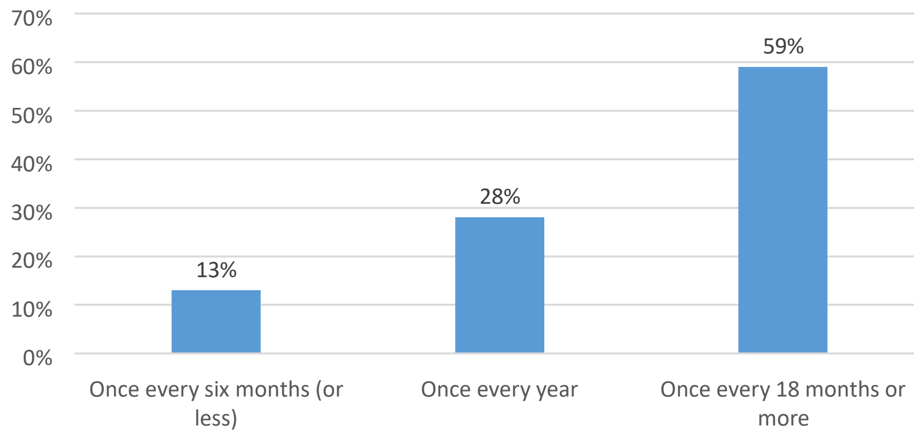


Has your BHO/MCO provided an effective process for your IHCP to suggest how they can better serve the needs of your IHCP and your community members?
80%
70%
60%
50%
40%
30%
20%
10%
0%
71%
29%
No
Yes

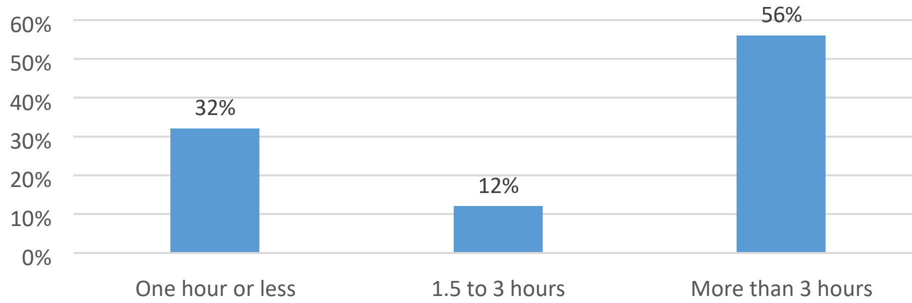


How often has the BHO/MCO contact met with you or others at your IHCP?
40%
35%
30%
25%
20%
15%
10%
5%
0%
6%
35%
9%
18%
32%
1 or more times every 6 months
About once every 1 year
About once every 2 years
Less than once every 2 years
Never

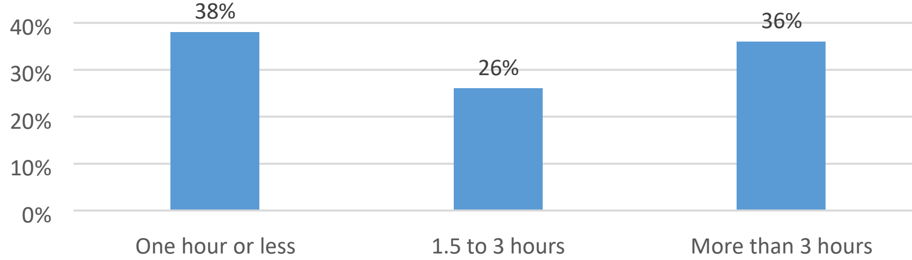

Has the BHO/MCO included you or others at your IHCP to develop a plan for coordinating care and services?
80%
70%
60%
50%
40%
30%
20%
10%
0%
71%
29%
No
Yes

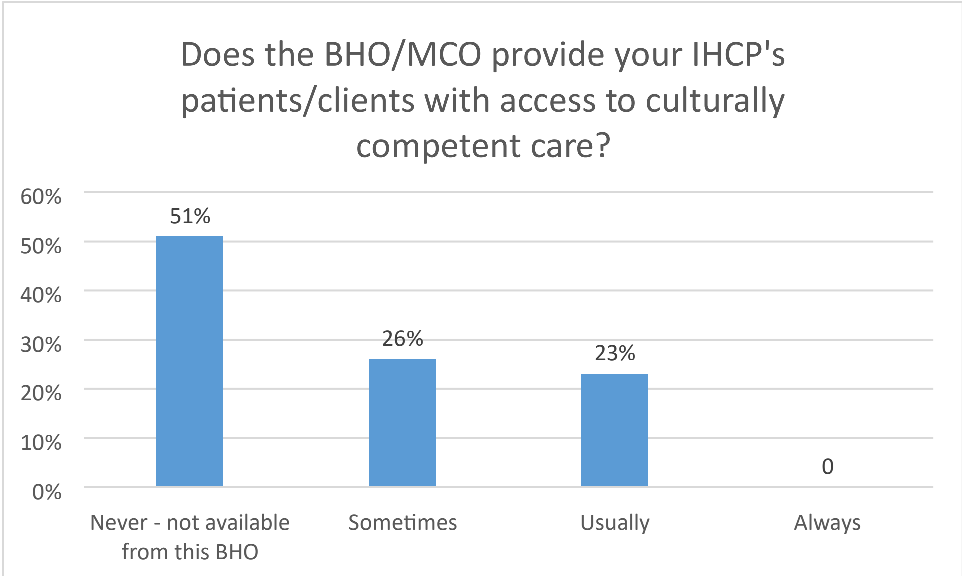

How frequently does the BHO/MCO require your IHCP to credential/certify your providers?
70%
60%
50%
40%
30%
20%
10%
0%
13%
28%
59%
Once every six months (or less)
Once every year
Once every 18 months or more

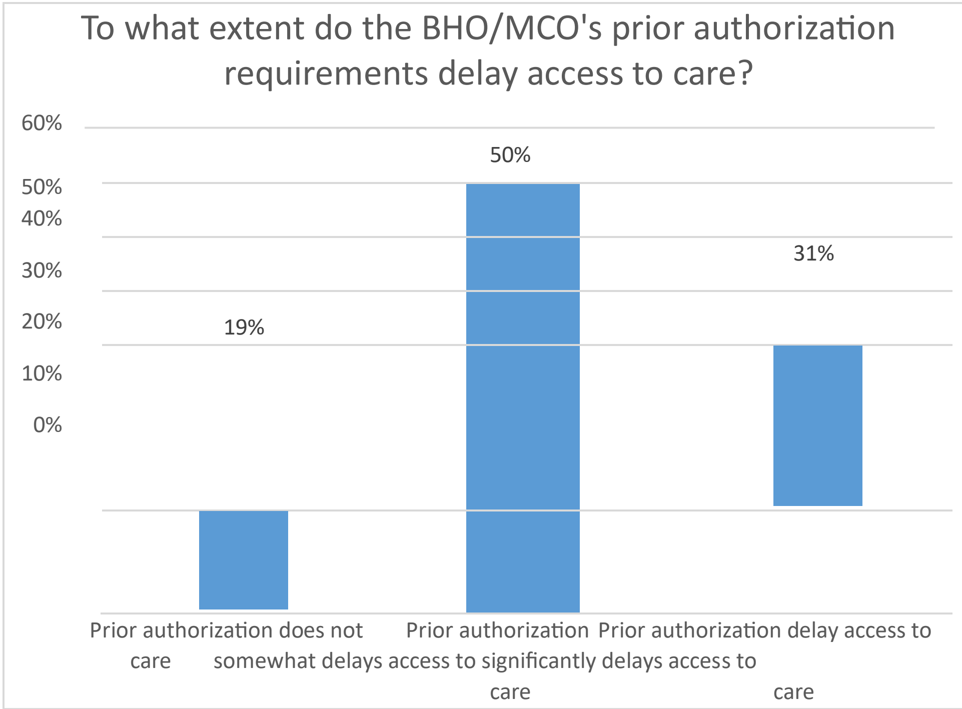
Approximately, how much of your staff time (provider time and administrative staff time) does the BHO/MCO's initial (first time) credentialing/certification process require for one provider?

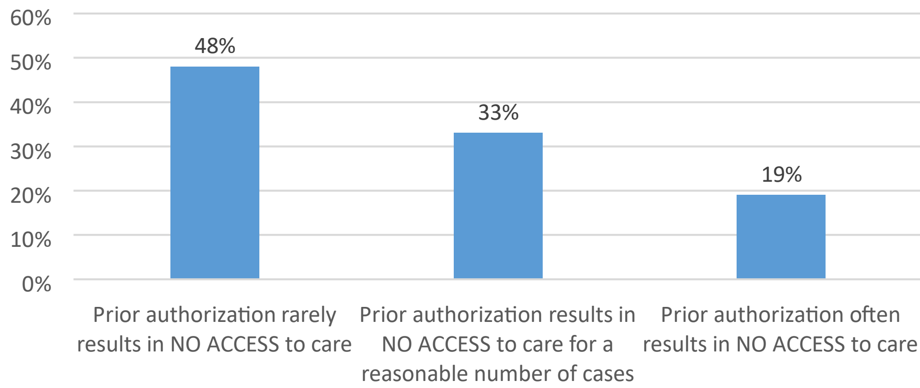


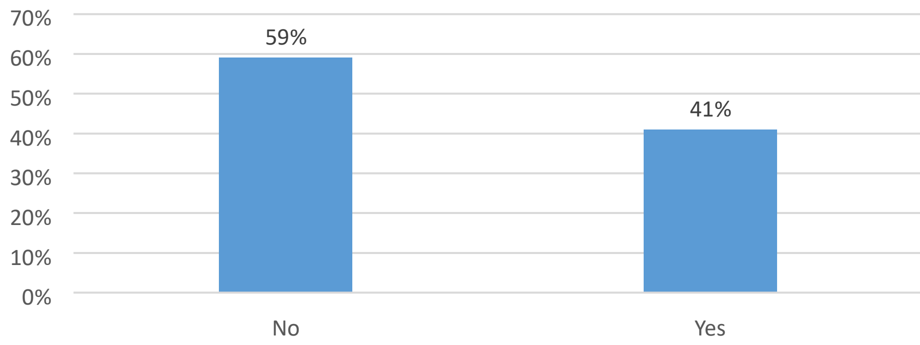
Approximately, how much of your staff time (provider time and administrative staff time) does the BHO/MCO's ongoing recredentialing/recertification process require for one provider, each time you have to recredential/recertify?

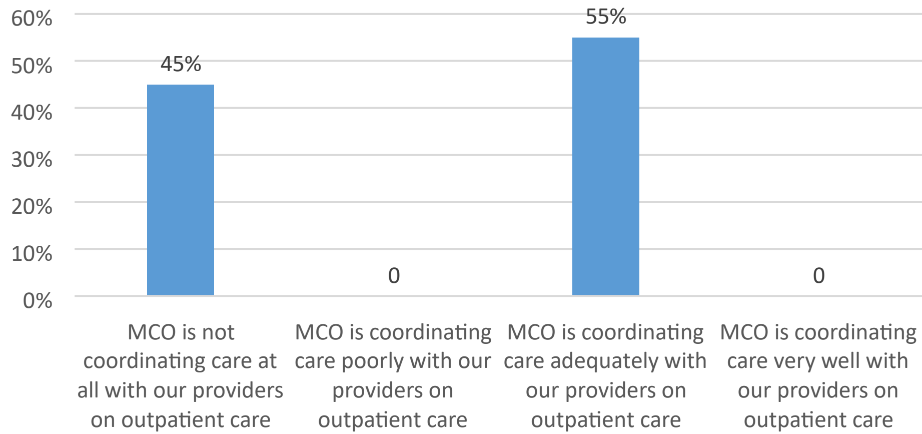



Does the BHO/MCO provide your IHCP's patients/clients with access to culturally competent care?
60%
50%
40%
30%
20%
10%
0%
51%
26%
23%
0
Never - not available from this BHO
Sometimes
Usually
Always

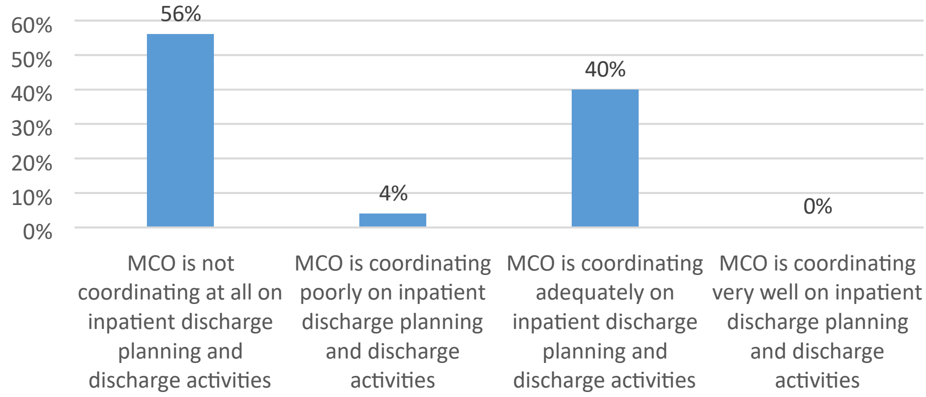

To what extent do the BHO/MCO's prior authorization requirements delay access to care?
60%
50%
40%
30%
20%
10%
0%
19%
50%
31%
Prior authorization does not delay access to care
Prior authorization somewhat delays access to care
Prior authorization significantly delays access to care


To what extent do the BHO/MCO's prior authorization requirements result in NO ACCESS (or denied access) to care?
60%
50%
40%
30%
20%
10%
0%
48%
33%
19%
Prior authorization rarely results in NO ACCESS to care
Prior authorization results in NO ACCESS to care for a reasonable number of cases
Prior authorization often results in NO ACCESS to care


Has your tribe or urban Indian health program had to cover costs (paid out of your own funds) for care that was denied or delayed by the BHO/MCO as a result of preauthorization?
70%
60%
50%
40%
30%
20%
10%
0%
59%
41%
No
Yes

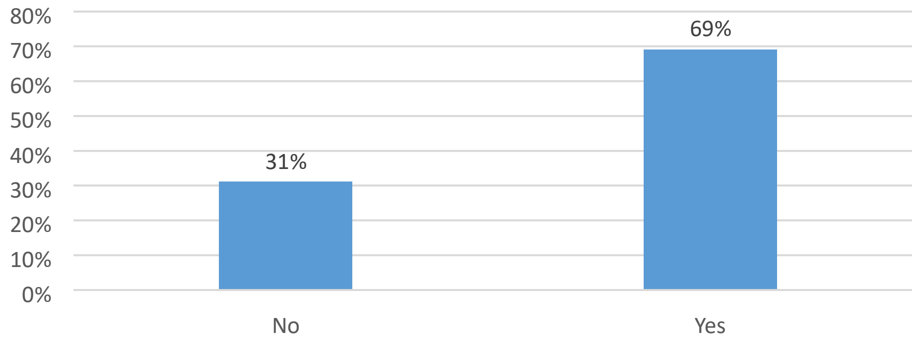


Please describe how well the MCO coordinates care with your providers on OUTPATIENT CARE.
60%
50%
40%
30%
20%
10%
0%
45%
0
55%
0
MCO is not coordinating care at all with our providers on outpatient care
MCO is coordinating care poorly with our providers on outpatient care
MCO is coordinating care adequately with our providers on outpatient care
MCO is coordinating care very well with our providers on outpatient care



Does the MCO coordinate with your providers on inpatient discharge planning and discharge activities?
60%
50%
40%
30%
20%
10%
0%
56%
4%
40%
0%
MCO is not coordinating at all on inpatient discharge planning and discharge activities
MCO is coordinating poorly on inpatient discharge planning and discharge activities
MCO is coordinating adequately on inpatient discharge planning and discharge activities
MCO is coordinating very well on inpatient discharge planning and discharge activities

Do your IHCP's patients/clients who are insured with a MCO plan have access to providers they have a need for, but would not have access to if they had other insurance coverage?



Do your IHCP's patients/clients who are insured with a MCO plan have access to services or benefits that make a significant impact on their health status, but would not have access to if they had other insurance coverage?