Washington State Tribal Centric Health Plan Agreement

Effective Date: July 1, 2017

The Tribes and Indian Health Care Providers (IHCPs) in Washington have raised various issues of concern with the State of Washington's Medicaid program. Through numerous consultations and meetings over the course of the past five years, the State has worked to understand these concerns.

Based on this understanding, the State, the Tribes, and the IHCPs have developed this Washington State Tribal Centric Health Plan Agreement (the Agreement). The State agrees to abide by, and to implement, the following terms in this Agreement:

1. Definitions

   a. **American Indian/Alaska Native (AI/AN)**[1] or **Indian** means any individual defined at 25 U.S.C. § 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual:

      i. Is a member of an Indian Tribe (defined below);

      ii. Is an Urban Indian (defined below);

      iii. Is considered by the Secretary of the Interior to be an Indian for any purpose; or

      iv. Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian (as defined in 25 U.S.C. § 1603(3)), Eskimo, Aleut, or other Alaska Native.

   b. **Fee-for-Service (FFS)** means the Washington Medicaid State Plan's fee-for-service payment methodology.

   c. **Indian Health Care Provider (IHCP)** means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Health Program (otherwise known as an ITU) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).[2]

   d. **Indian Tribe** or **Tribe** means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. § 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.[3]

   e. **Managed Care Entity (MCE), as defined by the State,** means Behavioral Health Organizations (as established by chapter 71.24 RCW) which are PIHPs and Managed Care Organizations.

   f. **Managed Care Organization (MCO)** has the meaning set forth in 42 U.S.C. § 438.2 and in WAC 182-526-0010.

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[1] Final managed care rule at 42 C.F.R. § 438.14(a), effective July 2017.

[2] Final managed care rule at 42 C.F.R. § 438.14(a), effective July 2017.

[3] 25 U.S.C. § 1603(14).

g. **MCE-State Agreement** means any agreement between the State and an MCE for the implementation of coverage under this waiver.

h. **Prepaid Inpatient Health Plan (PIHP)** has the meaning set forth in 42 U.S.C. § 438.2.

i. **Tribal Organization** means the recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities; provided, that in any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian tribe, the approval of each such Indian tribe shall be a prerequisite to the letting or making of such contract or grant.[4]

j. **Urban Indian** means any individual who resides in an urban center and meets one or more of the four criteria:[5]

   i. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

   ii. Is an Eskimo or Aleut or other Alaska Native;

   iii. Is considered by the Secretary of the Interior to be an Indian for any purpose; or

   iv. Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

k. **Urban Indian Health Program (UIHP)** means an Urban Indian Organization, as defined by 25 U.S.C. § 1603(29), that is operating a facility delivering health care. In Washington State, there are two UIHPs: the Seattle Indian Health Board and the NATIVE Project of Spokane.

2. **MCE-State Agreement.** The following provisions will be added to every MCE-State Agreement:[6]

   a. **MCE Network Adequacy.** In accordance with the rating period compliance requirements in the Federal Register, Vol. 81, No. 88, May 6, 2016, the MCE will treat every IHCP 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.[7] MCEs will provide information from the

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[4] 25 U.S.C. § 1603(26).

[5] 25 U.S.C. § 1603(28).

[6] *See* 42 C.F.R. § 438.14(b). The Managed Care Rule requires that "All contracts between a State and a MCO, PIHP, PAHP, and PCCM entity, to the extent that the PCCM entity has a provider network, which enroll Indians" must contain certain requirements within this section.

[7] 42 C.F.R. § 438.14(b)(1). *See also* The American Recovery and Reinvestment Act of 2009 (ARRA), § 5006(d) codified at 42 U.S.C. § 1396 (h)(2)(A)(i); See also CMS Dear Tribal Leader Letter, January 22, 2010. Note that the federal language requires "sufficient" providers as opposed to all providers. However, CMS also provides that "States would have the flexibility to specify in the managed care contract that the managed care plans must offer a provider agreement to all IHCPs in the serves area...." HHS Medicaid Manage Care Rule; Final Rule, 81 Fed. Reg. 88, 27746 (May 16, 2016). (codified at 42 C.F.R. § Parts 431, 433, 438, et. al.). In addition, the network access

State IHCP list to the same extent as any network provider including via their websites and through their customer service lines.

b. **Access to IHCP.** The MCE will ensure that AI/AN enrollees may:

   i. Obtain covered services from any IHCP, regardless of whether the IHCP participates in the network of the MCE; and

   ii. Choose an IHCP as his or her primary care provider if he or she is eligible to receive primary care services from that IHCP and that IHCP is participating as a network provider.[8]

c. **Model Indian Health Care Provider Contract Addendum.** The MCE will apply an IHCP contract addendum to every contract between the MCE and an IHCP. This addendum will include:

   i. All terms in the state's model IHCP contract addendum, which will be substantially similar to the CMS Model Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers, as may be amended by CMS from time to time;[9]

   ii. Reference to the Separate Issue Resolution Mechanism maintained by the State under Section 4 of this Agreement; and

   iii. Additional terms that are approved by the IHCP and the MCE.

d. **Offering and Negotiating Contracts with IHCPs.** The MCE will offer and negotiate contracts in good faith to all IHCPs, including any tribal care coordination, transportation, or related providers;[10] the MCE will acknowledge that IHCPs may not be required to contract with any MCE.[11] To be offered in good faith, an MCE 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 MCE will provide verification of such offers on request for the State to verify compliance with this provision.[12] In the event that an MCE and an IHCP fail to reach an agreement within 90 days from the start of negotiations and the IHCP submits a written request to the State for a consultation with the MCE, the State will facilitate an in-person meeting of the MCE and the IHCP in Olympia within 30 days from the date of the IHCP's request in an effort to resolve differences and facilitate an agreement.[13]

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regulations in WAC 284-170-200, while not binding for Medicaid managed care entities, do provide guidance here. WAC 284-170-200(9) requires that all AI/AN must be able to access any IHCP at no greater cost than if the IHCP were in-network. Requiring that all IHCPs be treated as in-network will alleviate administrative burden upon IHCPs as well as timely access issues for AI/AN.

[8] *See* Final managed care rule at 42 C.F.R. § 438.14(b)(3-4), effective July 2017.

[9] http://www.nihb.org/tribalhealthreform/wp-content/uploads/2015/07/NIHB-Comment-on-CMS-2390-P.pdf. Note: there may be a more current version of the TTAG Indian Managed Care Addendum.

[10] *See* NM 1115 demonstration STCs.

[11] *See* NM 1115 demonstration STCs.

[12] CMS has yet to provide a definition of "good faith" contracting with IHCPs in the Medicaid realm. However, CMS has provided definition of "good faith" in their "2017 Letter to Issuers in the Federally-facilitated Marketplaces."

[13] Section 18.1.4 of the form of Apple Health – Fully Integrated Managed Care Contract between the State and the Managed Care Organizations.

e. **MCE Payments to IHCPs.** The MCE will pay every IHCP for covered services provided to AI/AN enrollees who are eligible to receive services from that IHCP as follows:

i. **IHCPs Not Enrolled in Medicaid as a FQHC.** When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether or not it participates in the network of the MCE, the MCE will pay the IHCP the full applicable IHS encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under FFS (such amount, the "Applicable IHCP Rate"; provided that, when the amount an IHCP receives from the MCE is less than the full Applicable IHCP Rate, the State will make a supplemental payment to the IHCP to make up the difference between the amount the MCE pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

ii. **IHCPs Enrolled in Medicaid as a FQHC.** When an IHCP is enrolled in Medicaid as a FQHC and is a participating provider of the MCE, the MCE will pay the IHCP at a rate negotiated between the MCE and the IHCP or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment that the MCE would make for the services to a participating provider which is a FQHC but not an IHCP.[14]

iii. **Right of Recovery**. The MCE 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 MCE, notwithstanding network restrictions, pursuant to 25 U.S.C. § 1621e.[15]

iv. **Prompt Payment to Indian Health Care Providers.** Any contract between HCA and/or DSHS and an MCE under this waiver must require that as a condition of receiving payment under such contract, the MCE agrees to make prompt payment to IHCPs, whether such IHCPs are participating providers or non-participating providers.[16]

f. **Corrective Action.** The MCE will be subject to corrective action and penalties against the MCE by the State if the MCE fails to:

i. Perform any obligation under the MCE-State Agreement, or

ii. Ensure that AI/AN enrollees are afforded access to care, rights, and benefits on par with all other MCE enrollees.

g. **MCE Tribal Liaison**. The MCE will designate a Tribal Liaison to facilitate resolution of any issue between the MCE 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 MCE staff.[17] The MCE will document with the State every such issue identified by the Tribal Liaison. The MCE will make the Tribal Liaison available for training by tribes and UIHPs in the MCE's service area, the Indian Policy Advisory Committee (IPAC) of the Department of Social

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[14] 42 C.F.R. §§ 438.14(b)(2) and 438.14(c)(1).

[15] NM and IN 1115 demonstration STCs.

[16] *See* ARRA § 5006(d) codified at 42 U.S.C. § 1396 (h)(2)(B); 42 C.F.R. § 438.14 (b)(2)(iii).

[17] NM and IN demonstration STCs.

and Health Services (DSHS), and/or the American Indian Health Commission for Washington State (AIHC).[18]

h. **Resolution of Issues.** The MCE will include reference in any contract between the MCE and the IHCP to the Separate Issue Resolution Mechanism maintained by the State under Section 4 of this Agreement. Prior to the development of any plan with an IHCP that is required by the MCE-State Agreement, the MCE will meet with the State and the IHCP to identify and resolve issues related to the MCE's performance of services under the MCE-State Agreement.

i. **No Prior Authorization for IHCP Services.** The MCE will not require prior authorization for any services provided by an IHCP to an AI/AN enrollee by referral from an IHCP.[19]

j. **IHCP Referrals.** The MCE will accept referrals by an IHCP, regardless of whether the IHCP participates in the network of the MCE, for an AI/AN enrollee to receive services from a network provider without requiring prior authorization or a referral from a participating network provider for the same or substantially similar service.[20] The MCE 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.

k. **Maintenance of the AI/AN IHCP Medical Home.** The MCE 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 MCE 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 MCE will require non-IHCPs to deliver progress notes, including any referrals made, to the AI/AN enrollee's IHCP medical home.

l. **Cultural Humility.** The MCE 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 MCE will provide written documentation of efforts to coordinate with tribe(s) and urban Indian health programs in the MCE's service area, AIHC, IPAC, and/or DSHS Office of Indian Policy (OIP) to obtain this training. The MCE 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 covered by the Washington Medicaid State Plan as approved by CMS.

m. **Crisis Coordination**. 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).

   i. The MCE will develop protocols with each tribe in the MCE'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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[18] Currently Molina and AmeriGroup have tribal liaisons or are in the process of doing so.

[19] *See* 42 C.F.R. § 438.14(b)(4) and (6), effective July 2017.

[20] *See* 42 C.F.R. § 438.14(b)(4) and (6), effective July 2017.

ii. To the extent permitted by law, the MCE 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.

3. **State Maintenance of an IHCP List.** The State shall maintain a list of all IHCPs within the State of Washington as well as IHCPs within border states. The State shall provide the list to all MCEs and practice transformation hub contractors. All MCEs and contractors will be trained in the Indian health delivery system.

4. **Separate Issue Resolution Mechanism**. The State will maintain a mechanism for each IHCP to submit complaints to the State regarding unresolved issues, including, but not limited to, crisis coordination, between the IHCP and an MCE, for the State to facilitate resolution directly with the MCE.

5. **State IHCP Reimbursement**. The State agrees to comply with the following provisions when reimbursing IHCPs:

   a. **MCO Payment of Encounter Rates; Supplemental Payments by State.** No later than July 1, 2018 (subject to change technical difficulties), MCOs must pay directly to the IHCP the applicable encounter rate published annually in the Federal Register by the Indian Health Service or the rate specified in the Medicaid state plan. For any IHCP that does not have a published encounter rate, the MCO must pay the amount the IHCP would receive if the services were provided under the State plan's fee-for-service payment methodology. If the amount paid by any MCO to an IHCP is less than the rate that applies to the provision of such services by the IHCP under the Medicaid state plan, the State will provide for payment to the IHCP, whether the IHCP is a participating or nonparticipating provider, of the difference between such applicable rate and the amount paid by the PIHP or MCO to the IHCP for such services. (See 42 U.S.C. § 1396u-2(h) and 42 C.F.R. § 438.14(b)(2)(iii).)

   b. **IHS Encounter Rate – Categories.** Until such time as the State Plan provides more specific guidance regarding the number of encounter rate payment that will be made during a day, the State will continue to allow the following: for any single 24-hour period ending at midnight, the IHS outpatient encounter rate is paid for up to one of each of the following four categories of encounters: medical, dental, mental health, and substance use disorder services.

6. **Historical Trauma/Intergenerational Trauma/Trauma Informed Care.** The State, in consultation with tribes and urban Indian health programs, will provide written and verbal technical assistance to support the incorporation of cultural awareness and development of strategies to address historical trauma/intergenerational trauma in treatment planning for services covered by Medicaid.

7. **Training and Technical Assistance.** The State will provide training and technical assistance to IHCPs in outreach and Medicaid program enrollment, billing, service alignment, documentation and licensing.

8. **AI/AN Mandatory Managed Care Enrollment Exemption and Maintenance/Establishment of FFS System**

   a. **Prior to July 2017**

      i. **BHO Substance Use Disorder Services (SUD) "Carve Out."** Individuals identifying themselves as AI/AN on their application will be exempted from enrollment in BHO for SUD services. AI/AN residing within the BHO regions will access care from within the Fee-For-Service system. The State will provide an Opt-In option no later than July 2017.

ii. **Notice of Opportunity to Opt-Out of Mental Health Managed Care and MCOs.** The State will provide notice to AI/AN Medicaid enrollees explaining that AI/ANs may opt-out of MCE coverage and receive Medicaid FFS coverage with access to covered benefits at an IHCP.[21]

b. **After July 2017.**

i. **No Auto-Assignment in Managed Care Entities (BHO/MCO or any other managed care entities).** Individuals identifying themselves as AI/AN on their application will be exempted from this waiver/enrollment in managed care unless they opt-in to participate.[22] FFS will be maintained for both behavioral and physical health services for AI/AN.

ii. **Notice of Opportunity to Opt-In of All Managed Care Entities.** The State will provide notice to AI/AN Medicaid enrollees explaining that AI/ANs may opt-in to a managed care plan.[23]

9. **Data Reporting.**

a. To the extent that such reporting does not risk exposure of personal information, the State will, in consultation with tribes and conferral with IHCPs, prepare reports on IHCPs and the AI/AN population using data on AI/AN enrollment and the HEDIS measures that the MCEs are required to report to the State.[24]

b. Reports to CMS.

i. The state will submit a report to CMS detailing its implementation and coordination of efforts with the tribes on managing the care of Indians under this waiver in a format to be agreed upon by the state and the tribes and IHCPs in the state. The reporting is required to occur no less than annually with reports submitted to CMS by April 1 for every calendar year. The reports must include at a minimum:

A. Description of concerns raised by the tribes and IHCPs and the state's efforts to address each concern.
B. Managed care entities' compliance with section 1932(h) of the Social Security Act and 42 C.F.R. § 438.14.
C. Information on IHCPs and the Indian population using data on Indian enrollment and the behavioral health performance measures that the MCEs are required by contract to report to the State. Such reporting must not risk exposure of personal information,
D. The effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program as required. See 42 C.F.R. § 431.55(b)(2)(ii). Such analysis should include the impacts that the expansion of managed care will have upon the fee-for-service system.

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[21] *See* IN 1115 demonstration STCs.

[22] *See* AL 1115 demonstration STCs: "Individuals identifying themselves as AI/AN on their application will be excluded from this demonstration unless they opt-in to participate."

[23] *See* IN 1115 demonstration STCs.

[24] https://www.nd.gov/dhs/services/medicalserv/medicaid/docs/1915b-waiver.pdf

ii. The state will submit a draft report to the tribes and IHCPs and allow tribes and IHCPs the opportunity to provide recommendations at least 60 days prior to submission of the final report to CMS.

10. **State Consultation & Engagement Requirements**

a. The State will apply one consultation policy to all Medicaid matters, including state plan amendments, waivers, and program-related contracts. Under this consultation policy, IHCPs and tribes will be provided the opportunity and resources to be fully informed of 1915(b) Waiver and SPA implementation and their impacts on the Indian health care delivery system and Tribal and urban Indian communities. The State will give IHCPs sufficient information in order to determine how these changes will impact their individual health care delivery systems. The state will consult with the tribes and seek advice regarding any Medicaid managed care contracts between the state and a PIHP or MCO.

b. In meeting its requirement to consult and coordinate with the twenty-nine tribes and two urban Indian health programs, the State will seek technical expertise from the tribes, the urban Indian health programs, the DSHS Indian Advisory Policy Committee, and the American Indian Health Commission for Washington State to inform State planning and analysis.

c. The State will consult with the tribes and seek advice regarding MCE-State Agreements and in particular, the section(s) that address IHCPs and/or AI/AN enrollees and which operationalize the waiver.

d. The state will solicit advice and guidance from a tribal technical advisory board on at least a quarterly basis to ensure that Indians receive quality care and access to services. The Tribes will appoint representatives to serve as members on this advisory board. Meetings with a tribal technical advisory board shall not be a substitute for formal government-to-government Tribal consultation.

11. **Other AI/AN & IHCP Protections**

a. **Tribal Centric Health System.** Pursuant to RCW 43.20A.897, the State "shall enter into agreements with the tribes and urban Indian health programs and modify behavioral health organization contracts as necessary to develop a tribal-centric health system that better serves the needs of the Tribes." In doing so, the State will provide a specific timeline for completing recommendations provided in the 2013 Tribal Centric Health Report to the Legislature under RCW 43.20A.897.

b. **Consulting Psychiatrists for Medication Consultation.** Within available funds, the State will contract with adult and child consulting psychiatrists to provide medication consultation services to IHCPs and develop and promote a system for IHCP mental health providers to obtain specialty psychiatric consultations with child psychiatrists, psychiatrists certified in addictionology and geriatric psychiatry.

12. **Legislative Efforts.** The State will work with the tribes on the following issues:

a. **100% FMAP Savings.** Develop a methodology to calculate and report savings realized from the care coordination plans under the 100% FMAP received by IHS facilities to tribally operated facilities contracting or compacting with the IHS under the Indian Self-Determination and Education Assistance Act (P.L. 93-638).

b. **Tribal Court ITA Orders.** Necessary statutory changes that will allow Tribal Courts to make ITA (involuntarily place an individual to a psychiatric facility for inpatient care) committals on Tribal lands based on a Tribal provider's referral and assessment.

c. **Report Funding.** Funding for reports on the following issues:
   i. Efficacy of inpatient Mental Health and Evaluate & Treat Services for AI/AN
   ii. Best Practices/cultural protective practices
   iii. Support for feasibility of Tribal In-Patient Facilities
   iv. Comparison of Tribal and non-tribal SUD
   v. How to improve patient care

d. **MCE and County Relationship with Tribes**. Definition of the relationship between MCEs and counties, on the one hand, and tribal governments on the other, when funding for health care activities is funneled through a local government, a council of local governments, or non-governmental entities such as Accountable Communities of Health or MCEs.

This Agreement is effective as of July 1, 2017, even if any signatures are made after that date. This Agreement will be reviewed and evaluated annually at the request of the parties as agreed upon in the Washington Health Care Authority Consultation Policy.

Lou McDermott
Acting Director, Health Care Authority

10/10/17
Date

Cheryl Strange
Secretary, Department of Social and Health Services

10/10/17
Date

Authorized Representative
Confederated Tribes of the Chehalis Reservation

Date

Authorized Representative
Confederated Tribes of the Colville Reservation

Date

Authorized Representative
Cowlitz Indian Tribe

10/11/17
Date

Authorized Representative
Hoh Indian Tribe

Date

Authorized Representative
Jamestown S'Klallam Tribe

10/10/2017
Date

Authorized Representative
Kalispel Tribe of Indians

Date