STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

June 29, 2015

Andy Joseph, Jr., NPAIHB Chair
Colville Tribal Council Member
2121 SW Broadway, Suite 300
Portland, OR 97201

Dear Mr. Joseph:

SUBJECT: Healthier Washington Reform Efforts

Thank you for your correspondence of April 25, 2015, with the enclosed "White Paper on Tribal Recommendations for Healthier Washington Initiative" that was prepared by the Northwest Portland Area Indian Health Board (NPAIHB)/American Indian Health Commission (AIHC) Healthier Washington Policy Workgroup. We acknowledge the impact that integration of Medicaid health care purchasing and reform of Medicaid provider payments will have on the Indian Health Service, Tribal 638 health programs, and urban Indian health programs (I/T/Us). In your white paper, you asked for the State's Global Medicaid Transformation Waiver application to include special terms and conditions to address the concerns outlined in the paper in an effective manner.

We understand that a Global Medicaid Transformation Waiver Tribal workgroup, with members of the AIHC Policy Committee and members of the Health Care Authority's (HCA's) policy division met on June 11 and June 25, and is scheduled to meet on July 17. We look forward to working through that workgroup to identify specific ways in which to address concerns of I/T/Us and American Indians/Alaska Natives (AI/ANs).

In response to your letter and in support of the Global Medicaid Transformation Waiver Tribal Workgroup, we offer the following dual-agency Medicaid policy commitments and plans:

Federal Medicaid AI/AN Protections
HCA and the Department of Social and Health Services (DSHS) remain committed to the special Medicaid protections in federal law for AI/ANs and I/T/Us, including the protections set forth in:

- 42 U.S.C. §§ 1396o(j), 1396o-1(b)(3), and 1396u-2(h).
- 25 U.S.C. § 1621e(a).

Nothing in the Global Medicaid Transformation Waiver or in any Medicaid State Plan or other State waiver will seek to waive or otherwise circumvent those legal protections.

1. **Requirements to Contract with I/T/Us**
   - **DSHS** - In its 2015 contracts with the Regional Support Networks (RSNs), DSHS included requirements for the RSNs to submit a plan – co-signed by the appropriate Tribal representative for each affected Tribe – for providing crisis, involuntary treatment act evaluation, voluntary patient authorization, and discharge planning services on Tribal lands within the RSN's network within six months of implementation. DSHS will continue this requirement with the Behavioral Health Organizations (BHOs), with potential improvements to the enforcement process.

   - **HCA** - For its 2016 contracts with Apple Health Managed Care Organizations (MCOs), HCA intends to include requirements for the MCOs to (a) negotiate contracts with I/T/Us in good faith within 90 days of an I/T/U request for a contract and (b) participate in an executive-level meeting with the I/T/U and HCA within 30 days after the 90 day deadline in order to resolve outstanding issues. In addition, for its 2016 contracts with MCOs for the fully integrated managed care Regional Service Area (RSA) of Clark and Skamania counties, HCA intends to include the I/T/Us in the list of essential behavioral health providers. Any I/T/Us contracted with an MCO have primary care provider (PCP) status and, therefore, referral privileges within that MCO's specialty provider network for MCO-enrolled clients.

2. **Indian Addendum for Apple Health Managed Care Contracts and BHO Contracts with I/T/Us**
   For its 2016 contracts with MCOs and the Behavioral Health Administrative Services Organization (BH-ASO) in the fully integrated managed care RSA and with BHOs in the other RSAs in Washington, HCA and DSHS intend to require that subcontracts with I/T/Us include an addendum that references all of the legal provisions applicable to AI/AN Medicaid-enrollees and I/T/Us (Apple Health Indian Addendum). HCA and DSHS will work with the I/T/Us to develop this Apple Health Indian Addendum, based on the Indian Addendum prepared for Qualified Health Plans by the AIHC. HCA and DSHS will request a Tribal consultation on the Apple Health Indian Addendum during the latter half of 2015.

3. **Specialty Care Medical Providers**
   Unfortunately, we have a statewide challenge of insufficient numbers of specialty care providers to meet demand in parts of the state and for some specialties. At the May 8 meeting of MCOs and I/T/Us, the MCOs shared some of the challenges they are facing in particular regions and with particular specialties. The MCOs also shared that they sometimes have ways of gaining access to specialty providers that may not be available to I/T/Us or providers and offered this assistance for any I/T/U clients who are enrolled with that particular MCO.

4. **Network Adequacy and Timely Access to Care**
   HCA has begun reviewing the network adequacy and timely access to care rules, particularly in light of the Centers for Medicare and Medicaid Services (CMS) proposed rules regarding Medicaid managed care that were released on June 1, 2015. For any specific cases where an I/T/U believes that an MCO-enrollee is not getting timely access to care, we ask that the I/T/U communicate such concerns with that MCO's I/T/U single point of contact and with HCA's managed care program via email at hcamcprograms@hca.wa.gov.

5. **Assignment to Medicaid Managed Care**
   Medicaid enrollees who indicate that they are AI/AN are not automatically assigned to an MCO. We understand that the process for indicating AI/AN status for Medicaid purposes in Healthplanfinder has been problematic. We are exploring ways to make this process easier and less prone to error.

6. **IHS Encounter Rate**
   Neither DSHS nor HCA has any intention of seeking a change to the Indian Health Service (IHS) encounter rate under the 1996 Memorandum of Agreement between IHS and the Health Care Financing Authority (now CMS). HCA is exploring ways to facilitate MCO payment of the full IHS encounter rate in order to reduce the administrative burden on Tribes for submitting Medicaid claims for AI/AN MCO-enrollees.

7. **Tribal Centric Behavioral Health**
   We are committed to the recommendations in the November 30, 2013 report to the Legislature on Tribal Centric Behavioral Health under 2SSB 5732 (Tribal Centric Behavioral Health Report). DSHS and HCA are currently working together on the implementation of fully integrated managed care (including contracting with a BH-ASO in the RSA of Clark and Skamania counties and on the implementation of the BHOs) in the remainder of the state. Both HCA and DSHS intend to ask the MCOs, BH-ASO, and BHOs to respond to questions, and incorporate these responses into their plans, addressing the recommendations from the Tribal Centric Behavioral Health Report.

8. **Services for Mental Health Prevention and Co-Occurring Disorders**
   We believe that the Global Medicaid Transformation Waiver will offer flexibility to expand the types of services and providers that can receive financial support to address underlying health care delivery challenges. HCA has requested a Tribal consultation on this waiver for August 12, 2015 from 10:30 a.m. to 3:00 p.m. In addition, HCA is meeting with a Tribal workgroup to discuss potential strategies for the waiver. We look forward to working with the I/T/Us to identify strategies for supporting mental health prevention services and services for clients with co-occurring disorders.

While the reforms that are taking place in the larger state health system are likely to be challenging, we do believe that they will help achieve better care, better health outcomes, and lower costs in the long-term. We look forward to working with the NPAIHB, the AIHC, and the I/T/Us to minimize any disruption and to ensure that improved AI/AN health outcomes and better coordination with I/T/Us are part of the Healthier Washington initiative.

If you wish to discuss any of the policies or plans described above or to discuss any other matter, please do not hesitate to contact any of us.

Sincerely,

Dorothy F. Teeter, MHA
Director
Health Care Authority

MaryAnne Lindeblad, BSN, MPH
Medicaid Director
Health Care Authority

Jane Beyer
Assistant Secretary, BHSIA
Department of Social and Health Services

cc: Nathan Johnson, Chief Policy Officer, PPP, HCA
Chris Imhoff, Director, DBHR, BHSIA, DSHS
Jessie Dean, Administrator, Tribal Affairs and Analysis, PPP, HCA
Stephen Kutz, Chair, AIHC

NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Burns-Paiute Tribe
Chehalis Tribe
Coeur d' Alene Tribe
Confederated Tribes of Colville
Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians
Confederated Tribes of Grand Ronde
Confederated Tribes of Siletz
Confederated Tribes of Umatilla
Confederated Tribes of Warm Springs
Coquille Tribe
Cow Creek Tribe
Cowlitz Tribe
Hoh Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe
Klamath Tribe
Kootenai Tribe
Lower Elwha Klallam Tribe
Lummi Tribe
Makah Tribe
Muckleshoot Tribe
Nez Perce Tribe
Nisqually Tribe
Nooksack Tribe
NW Band of Shoshone Tribe
Port Gamble S'Klallam Tribe
Puyallup Tribe
Quileute Tribe
Quinault Tribe
Samish Indian Nation
Sauk-Suiattle Tribe
Shoalwater Bay Tribe
Shoshone-Bannock Tribe
Skokomish Tribe
Snoqualmie Tribe
Spokane Tribe
Squaxin Island Tribe
Stillaguamish Tribe
Suquamish Tribe
Swinomish Tribe
Tulalip Tribe
Upper Skagit Tribe
Yakama Nation

2121 SW Broadway
Suite 300
Portland, OR 97201
(503) 228-4185
(503) 228-8182 FAX
www.npaihb.org

SENT VIA EMAIL: dorothy.teeter@hca.wa.gov;
maryanne.lindeblad@hca.wa.gov;
beyerjd@dshs.wa.gov

April 25, 2015

Dorothy Teeter, Director
WA Health Care Authority
626 8th Avenue, S.E.
P.O. Box 45502
Olympia, WA 98504-5502

MaryAnne Lindeblad, Medicaid Director
WA Health Care Authority
626 8th Avenue, S.E.
P.O. Box 45502
Olympia, WA 98504-5502

Jane Beyer, Assistant Secretary
Dept. of Social & Health Services
Behavioral Health & Service Integration
P.O. Box 45502
Olympia, WA 98504-5502

Dear Health Cabinet Members:

As you are aware, the Northwest Portland Area Indian Health Board is a tribal organization established under the Indian Self-Determination and Education Assistance Act (ISDEAA, P.L. 93-638) to represent health care issues of forty-three Tribes in Idaho, Oregon and Washington. On behalf of our member Washington Tribes, we are writing to you about the Healthier Washington reform efforts described in the State's Dear Tribal Leader letter issued on February 13, 2015.

The Health Care Authority (HCA) also conducted a Tribal Roundtable on March 16, 2015 and a Tribal Consultation session on April 17, 2015. The purpose of the Roundtable and Tribal consultation was for the State to share information about the Healthier Washington initiatives that constitute Washington's health reform efforts and to discuss the State's plan to submit a Section 1115 demonstration waiver to the Centers for Medicare & Medicaid Services (CMS) to obtain federal flexibility and authority to implement that the health system transformations within the Healthier Washington initiatives. The meetings also provided Washington Tribes the opportunity to share their concerns related to the reform efforts underway.

Following these meetings, NPAIHB and the American Indian Health Commission of Washington convened a policy workgroup of elected Tribal leaders, Tribal health directors, and Indian policy experts to review the State's reform efforts and to develop recommendations for a policy framework for how the State can best develop its Medicaid waiver to meet the needs of American Indian and Alaska Natives (AI/AN) enrolled in the Medicaid program and the Indian health system that provides their care. This policy framework is transmitted to you in the attached "White Paper on Tribal

Recommendations for Healthier Washington Initiative" and includes information around the following areas:

- AI/AN protections in the Medicaid program such as cost sharing protections and auto-assignment to Managed Care plans;
- Contracting issues with Managed Care plans, developing a contracting dispute resolution process, ensuring AI/AN access to specialty care, that I/T/U providers are treated as Primary Care Providers, and Medicaid access to care standards;
- Prescribe how payments will be reconciled in the event of disputed payments with a guarantee of an access to care standard that has the option for direct reimbursement for I/T/U whenever these standards cannot be met;
- Require that the HCA is Single State Medicaid agency for administering the managed care arrangements with the I/T/U. Require appropriate state legislation and regulation to support sole agency requirement, and;
- Include the Tribal-centric mental health recommendations in the waiver.

As the Joint NPAIHB/AIHC Workgroup conducted its work to develop the recommendations included in our White Paper, most Tribal health directors concurred that AI/ANs continue to find it difficult to access Indian health care providers in managed care settings, gain access to specialty care services managed by the managed care system, and Indian health care providers routinely have difficulties being reimbursed by managed care entities and the Medicaid program. We hope that you will agree that adopting the recommendations included in the White Paper will help resolve these long-standing issues.

Thank you for the opportunity to provide our comment and recommendations on the Healthier Washington initiatives to reform the State's health system. If you should have any questions concerning the recommendations included in the White Paper, please contact Jim Roberts, NPAIHB Policy Analyst, at (503) 347-7664 or by email at jroberts@npaihb.org.

Sincerely,

Andrew C. Joseph Jr.

Andy Joseph, Jr., NPAIHB Chair
Colville Tribal Council Member

cc: Nathan Johnson, Chief Policy Officer, PPP, HCA
Chris Imhoff, Director, DBHR, DSHS
Jessie Dean, Administrator, Tribal Affairs and Analysis, PPP, HCA
Stephen Kutz, Chair, AIHC
Washington Tribal Chairs & Health Directors
NPAIHB & AIHC Delegates

Attachment: "White Paper on Tribal Recommendations for Healthier Washington Initiative"

A White Paper on Tribal Recommendations for Healthier Washington Initiative
Prepared by NPAIHB/AIHC Healthier Washington Policy Workgroup[1]

April 25, 2015

Introduction

Washington State has embarked on a set of health reforms that are the collaborative result of changes requested by Governor Inslee, supported and directed by the Washington Legislature, and build upon the Washington State Health Care Innovation Plan (SHCIP). The "Healthier Washington" initiative seeks to accomplish policy reforms around four specific components that include: (1) integration of Medicaid purchasing for mental health, substance abuse, and physical (medical) health services; (2) reform provider payments using the Health Care Authority (HCA) through Medicaid and the Public Employee Benefits Board; (3) support providers to use more evidence-based and promising practices, and; (4) develop Accountable Communities of Health (ACH) to align and coordinate health activities and outcomes.

The Indian Health Service (IHS) Tribes and Urban Indian health organizations (I/T/U)[2] appreciate the HCA and DOH awareness of the impacts any reform change around these four components will have on American Indian and Alaska Native (AI/AN) access to health care and reimbursement for health services to health programs managed by the (I/T/U). The policy changes around integration of Medicaid purchasing for mental health, substance abuse, and medical services and reforming provider payments will likely have the greatest impact on Indian health programs. Integration of the Tribal-centric mental health recommendations must also be included in this reform process.

The State plans to submit a Section 1115 demonstration waiver to the Centers for Medicare & Medicaid Services (CMS) to obtain federal flexibility and authority to support the implementation of the health system transformation developed under the Healthier Washington initiative. Tribes respectfully request that the State's proposal to CMS address the concerns outlined in this paper in an effective manner. Specifically, Tribes request that the State and CMS ensure that these issues are adequately addressed in the 1115 Demonstration Waiver's special terms and conditions otherwise they will not be implemented as intended and recommended by Tribes.

Recommendations:

1. Do not approve any arrangements that do not explicitly state how Medicaid AI/AN special protections are, in fact, protected.

---

[1] The Northwest Portland Area Indian Health Board and American Indian Health Commission Healthier Washington Policy Workgroup has been organized to track critical policy issues to reform Washington State's Medicaid system and to make recommendations to the State on how to integrate the Indian health system as the state develops its 1115 demonstration waiver to implement the changes.

[2] I/T/U is often used collectively to refer to programs administered by the federal Indian Health Service ("I"), to tribal health programs operated under the Indian Self-Determination and Education Assistance Act ("T"), and to urban Indian health programs operated under the Indian Health Care Improvement Act ("U").

2. Include in the Medicaid Waiver Special Terms and Conditions (STCs) how the AI/AN special protections are considered in managed care with explicit requirement to contract with I/T/U providers with the use of an Indian addendum.
3. Include the dispute resolution or alternative mediation process that will be used to develop contracts with I/T/U in the Waiver.
4. Develop an explicit requirement that I/T/U providers are Primary Care Providers with the right to refer in the managed care provider system.
5. Prescribe how payments will be reconciled in the event of disputed payments with a guarantee of an access to care standard that has the option for direct reimbursement for I/T/U whenever these standards cannot be met. That is a referral to a non-network provider/specialist will be compensated if referral is required due to failure to meet access to care standard.
6. Require that the HCA is the sole state agency for administering the managed care arrangements with the I/T/U. Require appropriate state legislation and regulation to support sole agency requirement.

Background

Indian health programs, with 66,000 Indian Health Service "active users" serve about 22,000 AI/ANs who are enrolled in Washington's Apple Health Medicaid program. 18,000 are seen in tribally operated or Indian health service operated programs and the balance (3,500) in the State's two Urban Indian Health Programs. The total number of AIANs enrolled in Medicaid is unknown, but 36,000 to 45,000 is a reasonable estimate.

Medicaid expansion has resulted in increased enrollment and increased revenue for patients served by the State's Indian health programs. A recent review of 2014 paid Medicaid claims for the state's 25 largest health programs found an increase of $14,451,345, a 38% increase, for these programs' American Indian and Alaska Native Patients.

The $52.2 million in total 2014 payments to Indian health programs for their AIAN patients is clearly a significant source of revenue, but what is not known is how much was paid for these same patients' specialty and hospital care. The total is likely as large or larger than the payments to the 25 health programs for services provided. This likely means a total $100 million or more in Medicaid payments for the AIAN patients of Washington's Indian health programs. This is just 1% of Washington State's total payments for Medicaid. More to the point however, is the fact that Medicaid enrollment ranges from 15% to 62% of the IHS active users of the state's tribes with an average of 26% (of active users) enrolled in Medicaid. To state the obvious, what is not a large amount of money for the state is a very large percentage of funding for most of the state's Indian health programs. This is why the Healthier Washington policy proposals currently being discussed are so important to Tribes.

The plan for a Healthier Washington began over two years ago with hundreds of people from the public and private sectors sharing ideas on how the health system might be transformed to produce better health, better care and lower cost. The SHCIP was developed from that work and now drives the work of a number of state agencies, county and local governments. Many others from health care organizations (non-profit and for-profit), individual providers, insurance plans, and other health care stakeholders are involved in the Healthier Washington initiative. This work is also supported by State legislation that was signed by Governor Jay Inslee on April 4, 2014.

House Bill 2572 includes a number of requirements related to "accountable collaboratives for health," developing standard statewide measures of health performance, developing common procurement methods for state-purchased health care, best practices, and payer and delivery system organization. With respect to the items described above the most important issue for Indian health programs is the requirement for the HCA and the Department of Social and Health Services (DSHS) to restructure Medicaid procurement of health care services and contracts with managed care systems to better support the integration of physical health, mental health, and substance use treatment.

Senate Bill 6312 authorizes the integration of Medicaid Managed Care behavioral health services by 2020. The bill authorizes DSHS and the HCA to establish regional service areas and contract requirements for the purchase of behavioral health services through the regional service areas for Medicaid and non-Medicaid clients and factors to consider in the purchasing process. SB 6312 established two pathways to fully-integrated purchasing of Medicaid Managed Care services by 2020: (1) a track for fully integrated purchasing beginning in 2016 (Early Adopter track) and (2) a track for integrated purchasing of mental health and chemical dependency treatment through Behavioral Health Organizations (BHO track). The most important issue for Tribes with respect to SB 6312 is how the Tribal-centric mental health system will be integrated into this new system.

Medicaid Reform & the Indian Health System

As Washington State develops its health system reforms it is important to stress at least two overarching policy areas important to Tribal governments and Indian health system and it is very important to be mindful as the State develops its policy proposals to change the health delivery system. First and foremost is there is a special relationship between the United States and Indian Tribes that creates a federal trust responsibility toward Indian people regarding health care. It is important to underscore that even more unique is that the Medicaid definition of AI/AN expands coverage and rights to AI/ANs beyond those who are enrolled in a federally recognized tribe (non/dis-enrolled, descendants, members of terminated, state recognized, and those organized Indian groups). Secondly, the existence of this truly unique obligation supplies the legal justification and moral foundation for specific state and federal health policy making for AI/ANs—with the objectives of enhancing their access to health care and overcoming the chronic health status disparities of this segment of the American population.

It is beyond question that the obligation to carry out the federal trust responsibility to Indians applies to the federal government and in instances the States carry out federal programs like the Medicaid and CHIP programs. Furthermore, with regard to health care for AI/ANs, federal law assigns comprehensive duties to the federal government—who in turn may require the States to carry out—in order to achieve the goals and objectives established by Congress for Indian health (e.g. Medicaid). The trust responsibility, and laws enacted pursuant thereto, provides ample authority for the federal and State governments carrying out Medicaid, CHIP, and Affordable Care Act programs take pro-active efforts to achieve the Indian health objectives Congress has articulated.

The IHS-funded system for providing health services to AI/ANs is one-of-a kind; it is unlike any other mainstream health delivery system. In fact, the Congress and the federal government created and designed the system in use today for the specific purpose of serving Indian people in the communities in which they live. Because of this there are a complex set of federal statutes and regulations that govern the Indian health system and its participation in Medicaid and CHIP programs administered by the

States. It is important to recognize and underscore this very important legal framework as Washington works to reform its health care delivery system.

Special protections for AIANs

In 2009, Congress enacted a set of important new Medicaid protections for AI/ANs in Section 5006 of the American Recovery and Reinvestment Act (ARRA) of 2009. These protections should also be added to the Washington State's managed care integration for mental health, substance use treatment, and physical health services. While these protections are important, however, they are not a substitute for protecting AI/ANs from managed care in the first place. The ARRA 5006 protections provide, in relevant part:

- That no enrollment fee, premium, or similar charge and no deduction, copayment, cost sharing or similar charge may be imposed on AI/ANs with regard to services received through the Indian health system or through contract health services, and payment to an Indian health provider may not be reduced by the amount of any enrollment fee, premium, or similar charge and no deduction, copayment, cost sharing or similar charge that would otherwise be due. 42 U.S.C. §§ 1396o(j), 1396o-1(b)(3)(A)(vii) and (b)(3)(B)(x);

- AI/AN Medicaid managed enrollees may choose an Indian health care provider as their primary health care provider. 42 U.S.C. § 1396u-2(h)(1);

- Indian health providers have a right to be promptly paid by managed care entities whether they are participating providers or not. 42 U.S.C. § 1396u-2(h)(2);

- The State plan must provide for a wraparound supplemental payment to be made to Indian health providers (whether participating or not) to bring the payment amount made by the managed care entity up to the rate that applies for the provision of such services by the Indian health provider (usually the encounter rate). 42 U.S.C. § 1396u-2(h)(2)(C)(ii).

- Additionally, the Indian Health Care Improvement Act provides that the I/T/U with a right to recover the reasonable charges billed whether they are a network provider or not. This federal requirement must apply when the I/T/U provides services when a referral is required by the Managed Care Organization. The statute requires that managed care plans must pay claims to the I/T/U according to IHCIA Section 206. IHCIA §206(a) and (i) (25 U.S.C. §1621e(a).

These Indian managed care protections, along with IHCIA §206(a), were enacted to ensure that AI/ANs that elect to participate in managed care can continue to use their Indian health provider and that the Indian health providers will be paid. They were designed to supplement, not replace, Section 1932(a)(2)(C). They were not designed to be, nor could they be, a solution for all of the problems that are posed by mandating managed care participation in the first place. However, these protections remain important for AI/ANs and Indian health providers, as many managed care systems provide AI/ANs the option to enroll in managed care. The I/T/U welcomes and supports the incorporation of these provisions into the State's Medicaid Waiver and draft contract proposal with managed care plans.

Tribal Consultation and the Medicaid Program

The I/T/U wants to recognize the work and commitment the HCA and DSHS have done and shown in accordance with the Washington Centennial Accord, Medicaid statutes and regulations, the American Recovery and Reinvestment Act[3] (ARRA) and CMS regulations, at 42 CFR 431.408(b). It is critical that the HCA and DSHS continue to consult with the I/T/U in the development of policy proposals to reform the State's health care system. Past experience demonstrates that unless Tribal leaders, Indian health programs and policy experts are consulted and involved in the development health system reforms, they will not effectively integrate with the Indian health system.

Indian Health Programs are Accountable Communities of Health

Accountable Communities of Health (also referred to as Accountable Care Organizations (ACO) or Coordinated Care Organizations (CCO) in other states) are relatively new to most, but not in the Indian health system. Since 1954 the IHS has operated an integrated and community-based health model. The Indian health system is an integrated health care delivery system that combines medical primary care, behavioral health, and public health programs. The system also includes a workforce development program, health facilities maintenance and construction, and community sanitation and construction programs. This is an example of an integrated model and could serve as a sample model for Washington State and the rest of the United States.

The Indian health system also operates on a fixed ('global') budget that is appropriated annually by the Congress. Tribal health budgets are also fixed global budgets that come via annual funding agreements with IHS. Health services are managed through a prioritized list of health services managed by Purchased and Referred Care (PRC) program. Accountable Communities of Health (ACH) service geography is similar to Tribal Contract Health Service Delivery Areas (CHSDA) that defines a Tribe's health care delivery regions. Similar, the urban programs have been operating in ad hoc systems creating networks with the CHSDAs, county, region and state systems to provide care for the urban AI/AN community that is highly mobile and low income.

Health priorities and quality outcomes are often defined by tribal and urban Indian health boards comprised of representatives from the health system, elected tribal and community leadership, and tribal community health consumers. ACH health quality measures and outcomes are comparable to IHS quality measures and reporting processes that are in place for Government Performance Results Act (GPRA) and Performance Assessment Rating Tool (PART). Indian health providers have utilized these reporting requirements for years. Annual financial audits and accreditation also enhance financial solvency, accountability, and quality outcomes. Thus, the objectives of ACHs are not new to the Indian health system. ACHs are delivery systems that Tribes will embrace if they effectively integrate their Indian health care system.

Discussion on Tribal Recommendations:

Washington Tribes welcome this opportunity to submit formal comments and recommendations on the policy proposals to reform Washington Medicaid health care delivery system. Much of the discussion around reforming the health system have centered on various facets of Medicaid managed care and integration of service modalities (medical, mental health, chemical dependency, etc.).

[3] American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, 123 Stat. 115 (Feb. 17, 2009).

It is fair to say that Washington's Medicaid managed care system initially had little to no familiarity with the Indian health system. This has resulted in the Medicaid managed care system disregarding the rights of AI/ANs and Indian health providers under the Medicaid statute, the Indian Health Care Improvement Act, and other federal laws. AI/ANs continue to find it difficult to access Indian health care providers in managed care settings, gain access to specialist care services managed by the managed care system, and Indian health care providers continue to have difficulties being reimbursed by the Medicaid program from managed care entities.

These issues and others pose serious barriers for AI/ANs in accessing the Medicaid program and must be addressed in Washington's health reform process. The following is a brief summary of some of the difficulties AI/ANs and Indian health systems routinely encounter when having to access the Medicaid program in a managed care environment.

1. Managed Care Issues that must be addressed by the HCA, DSHS, and DOH

- In the most extreme cases managed care systems require Indian health providers have contracts in place in order for their AI/AN members to have access to specialty services provided by their network providers. This often results in AI/AN having no access to specialty care services managed by managed care entities.
- Beneficiaries get auto-assigned to particular plans and particular providers in a manner inconsistent with the right of tribal Medicaid enrollees to choose an Indian health care provider as their primary health care provider in 42 U.S.C. § 1396u-2(h)(1). The administrative burden associated with correcting these issues is extremely timely and expensive costing CMS, the HCA and DSHS, and I/T/U valuable resources and ultimately affect the quality and timely care that a patient receives.
- They often impose Medicaid premium and cost-sharing exemptions in a manner inconsistent with AI/AN premium and cost-sharing exemptions at 42 U.S.C. §§ 1396o(j), 1396o-1(b)(3)(A)(vii) and (b)(3)(B)(x).
- They often fail to pay Indian health care providers for the provision of covered services in a manner inconsistent with 42 U.S.C. § 1396u-2(h)(2);
- When they do pay, they pay at rates inconsistent with the OMB encounter rate for Indian health facilities, requiring the Tribe to ask the State to make a wraparound payment under 42 U.S.C. § 1396u-2(h)(2)(C)(ii).
- They employ non-negotiable network provider agreements that require Indian health facilities to waive their federal rights under the Indian Health Care Improvement Act and other laws. Managed care entities often impose licensing and provider certification requirements on Indian health providers, which is inconsistent with their rights under the Indian Health Care Improvement Act. This often restricts timely—or in some instances, complete—access and payments; and
- They impose coordination of care and prior authorization requirements that are inconsistent with how Indian health providers already coordinate care - both within their own systems and with outside providers through contract health (purchased/referred) care services. In the case of prior authorization, in most instances, CMS is paying for the same service twice which is extremely inefficient and costs taxpayers since the Indian health provider is reimbursed for the service and then the patient may be required to see a managed care network provider to which

the state pays for another service. Ultimately, this costs the patient timely access to care and their health condition may have worsened, yet costing CMS more money;

- They are operated by private healthcare providers who have little or no familiarity with the Indian health system or incentive to adapt their profit models to account for the unique attributes and federal protections of the Indian health system.

2. AI/ANs Exemption from Managed Care Auto-enrollment

The I/T/U want to recognize the work and commitment of the HCA and DSHS in ensuring inclusion of the already existing legal protections around this issue. The I/T/U recommends that this requirement continue to be included in future Medicaid Waivers.

3. Access to Care Standards

Medicaid requires each State to ensure that all services covered under the State plan are available and accessible to all enrollees and that managed care entities include a sufficient network of appropriate providers that is sufficient to provide adequate access to all services covered under the managed care plan contracts that take into consideration a variety of factors that include: characteristics of health care needs, cultural competencies, geographic location of providers and enrollees, among other requirements. If the managed care organization is unable to provide necessary services or access to providers, covered under the contract, to a particular enrollee, than they are required to adequately and timely cover these services out of network for the enrollee. While the application of these requirements are generally covered in the HCA's contracts with managed care plans, the enforcement mechanisms related to evaluating network adequacy and access to specialty care for AI/AN enrollees is not. The State must ensure that the Managed Care Organization includes all I/T/U providers in their geographic area. There are very strict federal eligibility regulations that govern the Indian health system and often including one I/T/U provider may not provide coverage for AI/AN people if there are several Tribes located in that geographic area.[4]

4. Require Managed Care Entities to Offer Contracts to Indian health providers and use a I/T/U Addendum similar to that used in Medicare Part D and by ACA Qualified Health Plans

The I/T/U continues to have difficulty entering into contracts with Medicaid managed care entities. Often managed care entities claim they only have to adhere to the requirements of their contract and if these requirements are not clear or strong enough than the likelihood of a contract materializing with an Indian health provider is limited. This is a problem when an AI/AN enrollee who has opted-out of being enrolled in a managed care plan seeks specialty care and the specialist is enrolled with a managed care organization that requires prior authorization. The AI/AN enrollee is locked out of specialty care because their provider of choice (Indian health provider) has not been able to contract with the managed care plan and is therefore not able to engage in the authorization process. Most often because, the managed care plans offer template contracts Indian health providers are not able to enter into because they are not consistent with federal statutes or regulations that govern the Indian health system.

[4] 42 C.F.R. Part 136. IHCIA §813 (25 U.S.C. §1680c)

In order to address barriers related to Indian health providers contracting with managed care plans the HCA, DOH, and DSHS must require managed care plans to contract with all Indian health providers who request such a contract. Building on the success achieved in the Medicare Part D program, and the contracting process with Insurance Exchanges, the State should also require that a Medicaid I/T/U contracting addendum be developed and used by the managed care plans. A draft of this addendum has already been developed by Washington Tribes and transmitted to the HCA with a recommendation that it be used immediately. The Medicaid I/T/U contracting addendum will assist managed care plans to meet the "availability of services" standard required in the Medicaid program.

Specifically, to implement this recommendation these requirements should be included in the 1115 demonstration special terms and conditions (STCs). The I/T/U supports the incorporation of these provisions into the State's draft contract proposal with managed care plans.

5. Tribal-centric Mental Health System

Since the inception of the Regional Support Networks (RSNs), Tribal governments have expressed concerns about the ability of the Washington State RSN system to provide adequate access to services and culturally appropriate mental health care for AI/ANs. To address these ongoing concerns, in 2009 the HCA, Assistant Secretary Doug Porter, acknowledged these issues and committed to work with Tribes to develop a Tribal-centric mental health system in which Tribal issues and solutions would be incorporated into the State's 1915(b) mental health services waiver. This work has been ongoing for over six years and the recommendations from this process have yet to be adopted into the State's 1915(b) waiver.

1. The State and new Regional Service Areas must develop a process to accept referrals from Tribal providers for specialized mental health services;
2. The State and new Regional Service Areas must develop a process of reciprocity to honor involuntary commitments from Tribal courts with appropriate jurisdiction;
3. The State, new Regional Service Areas and Tribes need to develop a coordinated discharge planning process for those clients leaving specialty and inpatient mental health services so that their aftercare can be coordinated by the I/T/U system.

In order to address these long-standing issues, it is recommended that the HCA adopt the Tribal-centric mental health system recommendations into the State's 1115 global waiver. The RSN system has not proved to be effective, accessible, or culturally competent for use by AI/AN patients nor has there been effective participation with tribal providers. This issue must be avoided as the State integrates physical, mental health, and substance use regional system.

The new integrated system must also develop an intensive effort to address cultural competency issues and problems by deeming tribally certified professionals and facilities as eligible to be reimbursed for Medicaid and State funded services. This will increase the culturally competent mental health service providers and AI/AN access to services, since tribal programs excel in the focus on the patient/client as a whole person who must be able to interact with multiple entities in their communities.

The State, in consultation with tribal governments should develop a reimbursement system that is direct and responsive to meet the needs of AI/AN patients and clients. This includes, but should not be limited to increasing the contracting opportunities to increase mental health services between the new Regional Service Areas and Tribes. Under the next request for the 1915 waiver, additional innovative mechanisms could be offered to CMS (i.e. block grants, FFS) to reduce administrative costs from multiple levels of administrative pass through.

There must be reimbursement for all tribal behavioral health services to maintain the economy of scale for basic services. Because of lack of parity of reimbursable services, current programs are over-burdened and consequently do not have the ability to cost-shift expenses to maintain basic mental health programs and services.

The State Medicaid plan needs to be changed to include more mental health reimbursable services for prevention and co-occurring disorders. Without a change in reimbursement for mental health service the health status of AI/ANs will continue to decline resulting in additional cost or worse, mortality and certainly morbidities that could be prevented. A reimbursement mechanism that is not administratively burdensome, allows most of reimbursement/funds to be applied to direct services must be developed to reduce the burden and impact of mental health issues before it overwhelms our communities.

Conclusion

We understand that the State plans to submit a Section 1115 demonstration waiver to the Centers for Medicare and Medicaid Services to obtain federal flexibility and authority to support and implement the health system transformation developed under the Healthier Washington initiative. We respectfully request that the State continue the consultation process with tribes in developing the proposal to CMS in order to address and find workable solutions to the concerns outlined in this paper:

- AI/ANs continue to find it difficult to access Indian health care providers in managed care settings, gain access to specialty care services managed by the managed care system, and Indian health care providers continue to have difficulties being reimbursed by the Medicaid program from managed care entities.
- Require Managed Care Entities to Offer Contracts to Indian health providers and use a I/T/U Addendum similar to that used in Medicare Part D and by ACA Qualified Health Plans
- Washington State reforms related to Provider Payment Reform; Global budgets; Value-based purchasing; and Incentive Payments must implement the ARRA 5006 Indian Managed Care Protections
- Tribal-centric Mental Health System

The Section 5006 protections do not require managed care entities to make changes to or adapt their network provider agreements so that they are consistent with the manner in which Indian health systems operate. For example, many of those provider agreements will require a participating provider to obtain malpractice insurance, license its providers in the state, receive payment at a discounted rate, and comply with managed care requirements. Such requirements are impossible to meet for an Indian health care provider governed by the IHCIA and other federal law. In addition, while an Indian health provider does not have to enter into such an agreement in order to be paid, the right to be paid under ARRA is not self-enforcing. Many managed care entities routinely refuse to pay. As a practical matter,

this system simply does not work, and otherwise reimbursable care provided at Indian health care facilities from individuals enrolled in managed care goes unreimbursed by Medicaid.

There are new managed care regulations under consideration by CMS, which are intended to make improvements to managed care systems and to ensure sufficiency of providers. However, network adequacy requirements of the type implemented in the new Affordable Care Act Exchange regulations fall far short of ensuring Indian health care providers can participate in these federal programs. A recent OIG study of managed care systems across the country concluded that its findings "raise serious questions about the abilities of plans, States, and CMS to ensure that access-to-care standards are met." Access To Care: Provider Availability In Medicaid Managed Care, HHS-OIG, December 2014 OEI-02-13-00670. Yet that report did not even examine access to providers in the Indian health system.

###