WASHINGTON INDIAN HEALTH CARE IMPROVEMENT ACT

An Act relating to Indian health care in Washington state; amending RCW XXX; adding a chapter to XXXX.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. Sec. 1. The legislature declares it is the policy of this State, in fulfillment of the State’s unique relationships and shared respect between sovereign governments to:

1. Ensure the State of Washington and tribes work in a government-to-government relationship to ensure quality health care for all tribal members;

2. Require that all actions under this chapter shall be carried out with active and meaningful consultation with tribes and conference with urban Indian health programs, to implement this chapter and the national policy of Indian self-determination.

3. Ensure the highest possible status for American Indians and Alaska Natives by providing resources necessary to effect that policy;

4. Raise the health status of American Indians and Alaska Natives to at least the levels set forth in the goals contained within the Healthy People 2020 initiative or successor objectives;

5. Ensure maximum American Indian and Alaska Native participation in the direction of health care services so as to render the persons administering such services themselves more responsive to the needs and desires of American Indian and Alaskan Native individuals and communities;

6. Ensure savings realized by the state of Washington when medicaid eligible American Indians and Alaska Natives receive services through an Indian health care provider are reinvested back into the Indian healthcare delivery system within the state.

Definitions

Sec. 1. NEW SECTION/AMENDED TBD RCW ____ are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

1. “American Indian/Alaska Native” or “Indian” means any individual defined as 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 is (a) a member of an Indian Tribe as
defined in subsection 4; (b) an Urban Indian as defined in subsection 7; (c) considered by the
Secretary of the Interior to be an Indian for any purpose or (d) 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.

(2) “American Indian Health Program,” means the state medicaid fee-for-service system
for American Indians and Alaska Natives.

(3) “Community health aide” means a health care worker certified by an Indian
Community Health Aide Program of the Indian Health Service or an Indian tribe or Tribal
organization that is consistent with the requirements of under 25 U.S.C. § 1616(a) and (b) who
can perform a wide range of duties within the worker’s scope of certified practice in health
programs of an Indian tribe or tribal organization.²

(4) “Fee-for-service” means the state’s medicaid plan fee-for-service payment
methodology.

(5) “Indian health care provider” means a health care program operated by the Indian
Health Service or by an Indian tribe, tribal organization, or urban Indian health program as those
terms are defined in Section 4 of the Indian Health Care Improvement Act. (25 U.S.C. § 1603).³

(6) “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.⁴

(7) “Managed care organization” means Behavioral Health Organizations (as established
by chapter 71.24 RCW) and Managed Care Organizations (as defined in WAC 182-526-0010 and

(8) “Qualifying entity” means a facility governing body or its designated entity with
tribal acknowledgment to endorse traditional healers and the services they perform.

(9) “Traditional healing practices” means a system of culturally appropriate healing
methods developed and practiced by generations of tribal healers who apply methods for
physical, mental and emotional healing. The array of practices provided by traditional healers
shall be in accordance with an individual tribe’s established and accepted traditional healing practices as identified by the qualifying entity.  

(10) “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.  

(11) “Urban Indian” means any individual who resides in an urban center and is (a) a member of a tribe terminated since 1940 and those tribes 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; or (b) an Eskimo or Aleut or other Alaska Native; or (c) considered by the Secretary of the Interior to be an Indian for any purpose; or (d) 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.  

(12) “Urban Indian health program” 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 urban Indian health programs: the Seattle Indian Health Board and the NATIVE Project of Spokane.  

Consultation and Engagement Requirements  

Sec. 2. NEW SECTION/AMENDED TBD  

(1) The state will apply one tribal consultation policy and Urban Indian Health Program confer to all medicaid matters, including medicaid state plan amendments, waivers, and program-related contracts. Under this consultation policy, tribes and Indian health care providers will be provided the opportunity and resources to be fully informed of all waiver and medicaid state plan amendment implementation and their impacts on the Indian health care delivery system and tribal and urban Indian communities. The state will give Indian health care providers 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 Indian Health Care Providers and seek advice regarding any medicaid managed care contracts between the state and a managed care organization.

(2) State agencies will engage and consult with tribes and urban Indian health in the design and implementation of health transformation initiatives to assure coordination between Indian and non-Indian health systems, and will include approaches that will be effective in addressing the needs of American Indian and Alaska Native people.

(3) The state will establish the Interagency Indian Advisory Committee. The purpose of the Governor’s Indian Health Advisory Committee is to (a) assist in the identification of any policy or action proposed by the Office of the Insurance Commissioner, the Washington Health Benefit Exchange, the Health Care Authority, the Department of Social and Health Services, the Department of Youth and Family Services, and the Department of Health that directly affects Indian tribes or American Indian and Alaska Native residents of Washington State; (b) seek advice on a regular, ongoing basis from tribes and Indian health care providers; (c) facilitate training for agency leadership, staff and legislators on the Indian health system and tribal sovereignty; and (d) ensure that agency plans and initiatives include tribally-driven processes and culturally appropriate strategies that are effective in tribal and urban Indian settings.

(a) The Governor’s Indian Health Advisory Committee shall be facilitated by the American Indian Health Commission for Washington State in coordination with the Office of the Insurance Commissioner, the Washington Health Benefit Exchange, the Health Care Authority, the Department of Social and Health Services, the Department of Youth and Family Services, and the Department of Health.

(b) The Governor’s Indian Health Advisory Committee shall consist of the following representatives:

(i) The state agencies shall be represented by their tribal liaisons and other subject-matter relevant managers and staff;
(ii) Each tribe shall be represented by an individual designated by tribal council, either the tribe’s American Indian Health Commission for Washington State delegate or an individual specifically designated for this role, or his or her designee;
(iii) Each Indian Health Service Area office and service unit shall be represented by the chief operating officer or his or her designee;
(iv) Each urban Indian health program shall be represented by the chief operating officer, the urban Indian health program’s American Indian Health Commission for Washington State delegate, or his or her designee;

(v) The American Indian Health Commission for Washington State shall be represented by the executive director or his or her designee;

(vi) Northwest Portland Area Indian Health Board shall be represented by the executive director or his or her designee;

(vii) Washington State House and Senate Committees on Health and Human Services;

and

(viii) Representatives from the Governor’s Office.

(c) The state agency representatives listed in this section will participate in Governor’s Indian Health Advisory Committee meetings at least once per quarter. Notice regarding these meetings will be emailed to the individuals in Section 2(ii)-(vi), and the state agencies will post details of these meetings on their websites.

(d) The state agencies’ portion of the agenda of Governor’s Indian Health Advisory Committee meetings will be agreed upon at least three (3) days before the meetings by the agencies and the American Indian Health Commission for Washington State and/or the Northwest Portland Area Indian Health Board. The agenda will include a brief summary of the policies, programs, and agreements being planned for implementation by the state agencies.

(e) The Governor’s Indian Health Advisory Committee meetings may include the participation of experts and decision-makers who will explain issues and listen to the concerns raised by the committee. The committee members will provide advice and recommendations on whether agency policies or actions directly affect Indian tribes or American Indians/Alaska Natives.

(f) The Governor’s Indian Health Advisory Committee meetings, recommendations, and other forms of collaboration contribute to the consultation process but are not a substitute for the requirement for state agencies to conduct consultation as required under this policy.

(4) Service coordination or service contracting entities as defined in RCW 70.320.010; Accountable Communities of Health as defined in XXXXX; and local health jurisdictions as defined in RCW 70.05.010(1) shall: (a) provide one seat on the entities’ governing board for each of the tribes and urban Indian health programs within their region. The tribal representative

Commented [A1]: This section is intended to amend the following RCWs.

RCW 71.24.025 (39) "Tribal authority," for the purposes of this section and RCW 71.24.300 only, means: The federally recognized Indian tribes and the major Indian organizations recognized by the secretary insofar as these organizations do not have a financial relationship with any behavioral health organization that would present a conflict of interest.

RCW 71.24.300
(1) Upon the request of a tribal authority or authorities within a behavioral health organization the joint operating agreement or the county authority shall allow for the inclusion of the tribal authority to be represented as a party to the behavioral health organization.

(2) The roles and responsibilities of the county and tribal authorities shall be determined by the terms of that agreement including a determination of membership on the governing board and advisory committees, the number of tribal representatives to be party to the agreement, and the provisions of law and shall assure the provision of culturally competent services to the tribes served.

(4) If a behavioral health organization is a private entity, the department shall allow for the inclusion of the tribal authority to be represented as a party to the behavioral health organization.

(5) The roles and responsibilities of the private entity and the tribal authorities shall be determined by the department, through negotiation with the tribal authority.
and the tribe and the urban Indian health program representative and the urban Indian health program will be exempt from bearing financial risk; (b) appoint a tribal liaison within the organization; and (c) establish mutually-agreed upon written engagement and communication protocols with the tribes and urban Indian health programs within their regions or jurisdictions.

**Indian Health Improvement Reinvestment Account**

**Sec. 3. NEW SECTION/AMENDED TBD**

(1) The Indian health improvement reinvestment account is created in the state treasury. Moneys in the account may be spent only after appropriation. Moneys in the account may be expended solely for improving outcomes related to the following: (a) reducing Indian health disparities; and (b) increasing access to quality health care for American Indians and Alaska Natives in the state.

(2) Revenues to the Indian health improvement reinvestment account consist of: (a) all savings to the state general fund resulting from the 100% federal medical assistance percentage for services provided at Indian Health Services facilities or tribally operated facilities contracting or compacting with the Indian Health Services under the Indian Self-Determination and Education Assistance Act (P.L. 93-638); (b) care coordination plans under the 100% federal medical assistance percentage for services received through Indian Health Services facilities or tribally operated facilities contracting or compacting with the Indian Health Services under the Indian Self-Determination and Education Assistance Act (P.L. 93-638); (c) 12% of all state annual funding allocated to behavioral health organizations and behavioral health service organizations; and (e) any other public or private funds appropriated to or deposited in the account.

(3) The state will develop a data reporting system to determine the actuarial amounts for 100% federal medical assistance percentage for services provided at Indian Health Services facilities or tribally operated facilities contracting or compacting with the Indian Health Services under the Indian Self-Determination and Education Assistance Act (P.L. 93-638).

(4) The state will provide funds through the Indian Health Improvement Reinvestment Account to the following programs and activities:

(a) Indian health care provider operated evaluation and treatment centers;
(b) contracted services with a third-party administrator to provide, arrange, and make payment for services for American Indian and Alaska Natives through the state medicaid fee-for-service system;

(c) medicaid fee-for-service rate enhancement for providers who provide services to American Indians and Alaska Natives;

(d) contracted services with child and adult psychiatrists, psychiatrists certified in addictionology and geriatric psychiatry. These services will include medication consultation services to Indian health care providers;

(e) contracted and direct services provided by designated mental health providers, designated chemical dependency specialists, and designated crisis responders that are designated by a tribe or Indian health care provider to perform services to the Indian health care provider’s patient population;

(f) licensing, training, and certification of tribal designated mental health providers, tribal designated crisis responders, and tribal designated chemical dependency specialists;

(g) alternative and complementary medicine approaches, including traditional healing services provided to American Indian and Alaska Native patients;

(h) development of an Indian community health aide program for the state consistent with 25 U.S.C. § 1616l;

(i) community health aide programs and services consistent with 25 U.S.C. § 1616l and which include community health aides, behavioral health aides, dental health aides; and other types of aides for which certifications standards are established and enforced by an Indian Health Services or tribal Community Health Aide Program Certification Board;

(j) health information technology capability within tribes and urban Indian health programs to assure the technological capacity to (i) produce sound evidence for best Indian health care provider practices; (ii) effectively coordinate care between Indian health care providers and non-Indian health care providers; (iii) provide interoperability with state claims and reportable data (immunizations, reportable conditions, etc.) systems; and (iv) support patient-centered medical home models, including sufficient resources to purchase and implement (hardware, software, training, staffing) certified electronic health record systems for Indian health care providers;

(k) Care coordination administrative duties reimbursement;
(1) other health care services and public health services that contribute to reducing Indian health disparities; and increasing access to quality health care for American Indians and Alaska Natives in the state; and

(5) The state shall not subject any funds covered under this title to any responsibility or burden without prior approval from the tribal, Indian Health Service, and urban Indian health program representatives of the Governor’s Indian Health Advisory Committee.

**Indian Health Care Provider Traditional Health Practices**

**Sec. 4. NEW SECTION/AMENDED TBD**

(1) Traditional healing practices are offered as part of an integrated service delivery system among Indian health care providers to support care coordination and improved health outcomes.

(2) Each Indian health care provider shall adopt policies and procedures and determine the array of covered traditional healing services they may offer. The covered traditional services, limitations, exclusions and insurance liability shall be described by each facility seeking to participate in this program upon the approval of the Centers for Medicare and Medicaid.

(3) The training and qualifications of traditional healing providers may vary widely depending on the Tribe and/or community served. For this reason, a facility governing body may serve as the Qualifying Entity or designate another Qualifying Entity from the Tribe(s) served to endorse qualified Traditional Healing Providers.

(4) Traditional healing services that meet the above criteria shall be reimbursed at the applicable encounter rate published annually in the Federal Register by the Indian Health Service. If such reimbursement rate is not available, then such services shall be reimbursed the fee-for-service reimbursement rate to be based on traditional healing services provided to an individual patient. Billing for reimbursement will be done using a state designated code for traditional services. If neither the encounter rate nor the fee-for-service rate is available, then reimbursement will be based on a member benefit allowance that would be provided as an added value benefit to eligible American Indians and Alaska Natives through the state medicaid system. The purpose of the reimbursement is to cover costs of providing such services for the benefit of the patient.

**Indian Health Care Provider Crisis Coordination and Commitment**
Sec. 5. NEW SECTION/AMENDED TBD

(1) The courts of this state shall give full faith and credit as provided for in the United States Constitution to the public acts, records, and judicial proceedings of any Indian tribe or band in any proceeding, including, but not limited to, involuntary commitment proceedings, brought pursuant to this chapter to the same extent that full faith and credit is given to the public acts, records, and judicial proceedings of any other state.

(2) An involuntary commitment order of a Washington tribal court filed with the clerk of the superior court shall be recognized and is enforceable by any court of record in this state. A patient committed to a mental health treatment facility under this section is subject to the jurisdiction of the state.9

(3) Decisions regarding discharge or release of a patient committed pursuant to this section shall be made by the facility providing involuntary treatment. Ten days before discharge or release, the mental health treatment facility shall notify the tribal court that issued the involuntary commitment order of the facility's intention to discharge or release a patient. Any necessary outpatient follow-up and transportation for the patient to the jurisdiction of the tribal court, within the time set forth in the notice, shall be provided for in an intergovernmental agreement between the tribe and the state.

(4) A mental health treatment facility must treat a tribal court order of involuntary commitment on the same basis as a superior court order for involuntary commitment. A mental health facility must admit a patient for involuntary treatment on the same basis as any other patient committed by a superior court pending the filing of a tribal court's involuntary commitment order with the clerk of the superior court pursuant to this section. The mental health treatment facility must discharge the patient if the tribal court order is not filed with the clerk of the superior court by the close of business on the next day that the court is open after the admission of the patient unless that day is a tribal holiday in which case the tribal court order must be filed with the clerk of the superior court by the close of business on the following day. If the patient is discharged pursuant to this subsection, the patient shall be transported to the jurisdiction of the tribal court in the same manner provided in subsection (3) of this section.

(5) The state shall ensure that Indian health care providers have bed allocations at state contracted mental health facilities proportionate to the American Indian and Alaska Native percentage of the medicaid population.

Commented [A2]: This is the same language as found in RCW 13.38.100
(6) Amend RCW 71.34.020(5) and RCW 71.05.020 (11) as follows: (1) "Designated mental health professional" means a mental health professional designated by one or more tribes or counties to perform the functions of a designated mental health professional described in this chapter.

(7) Amend RCW 71.05.020 (9) "Designated chemical dependency specialist" means a person designated by a tribe or by the county alcoholism and other drug addiction program coordinator designated under *RCW 70.96A.310 to perform the commitment duties described in chapters 70.96A and 70.96B RCW.

(8) Amend RCW 70.96A.020 (9) "Designated chemical dependency specialist" or "specialist" means a person designated by a tribe or by the behavioral health organization, or the county substance use disorder treatment program coordinator designated by the behavioral health organization to perform the commitment duties described in RCW 70.96A.140 and qualified to do so by meeting standards adopted by the department.

(9) Amend RCW 71.05.020 (10) "Designated crisis responder" means a mental health professional appointed by a tribe, the county or the behavioral health organization to perform the duties specified in this chapter.

(10) Managed care organizations will accept assessments and evaluations from Indian health care providers completed by a physician, a designated mental health professional, or designated chemical dependency specialist for purposes of treatment determinations including, but not limited to, whether to commit a person to inpatient treatment.

**Indian Health Care Provider Reimbursement**

Sec. 6. NEW SECTION/AMENDED TBD

(1) The state will reimburse Indian health care providers 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 services provided to non-American Indian and non-Alaska Native patients including services provided to clinical family members of American Indians and Alaska Natives.

(2) The state will reimburse Indian health care providers the fee-for-service encounter rate for dental services provided to non-Indian medicaid patients.
(3) The state will, subject to federal restrictions, reimburse Indian health care providers for any single 24-hour period ending at midnight, the Indian Health Services outpatient encounter rate for up to one of each of the following four categories of encounters: medical, dental, mental health, and substance use disorder services.

(4) The state will provide funding for community health aide program development and operation and reimbursement for the services of community health aides certified under an Indian Health Service or tribal Community Health Aide Program in a manner consistent with reimbursement of other Indian health providers, that is no less than the reimbursement levels of non-Indian midlevel providers who are eligible to receive funding or be reimbursed under state medicaid waivers and/or similar state programs. The state will not require additional licensure and/or certification of such community health aides who are certified under an Indian Health Service or tribal Community Health Aide Program.

American Indian Health Program

Sec. 7. NEW SECTION/AMENDED TBD

(1) American Indians and Alaska Natives shall be enrolled in the American Indian Health Program which is the state medicaid fee-for-service system. American Indians and Alaska Natives will be eligible to select an Indian health care provider or a fee-for-service provider as their behavioral health care provider and/or their physical health provider. American Indians and Alaska Natives will not be auto-assigned into medicaid managed care.

(2) The State will provide notice to American Indian and Alaska Native medicaid enrollees explaining that American Indians and Alaska Natives may choose to opt-in to a managed care plan.

(3) The American Indian Health Program will contract with a third-party administrator to provide, arrange, and make payment for services for American Indians and Alaska Natives through the state medicaid fee-for-service system.

(4) The American Indian Health Program will contract with a third-party administrator to:

   (a) recruit from existing tribes’ Purchased and Referred Care program networks;
   
   (b) process claims, including, medicaid, medicare, catastrophic health emergency fund, and purchased and referred care at medicare-like rates);
(c) provide or contract with Indian health care providers to provide coordination of benefits for American Indian and Alaska Native clients and repricing of purchased and referred care services;

(d) contract with Indian health care providers to provide services where possible

(e) prepare report to Indian health care providers and to the state on various measures agreed upon with Indian health care providers;

(f) provide assistance with American Indian and Alaska Native and non-American Indian and Alaska Native client eligibility to receive care at different Indian health care providers;

(g) maintain updated knowledge of Indian health care provider eligibility requirements;

(h) maintain an updated list from the Northwest Tribal Registry from the Northwest Portland Area Indian Health Board;

(i) if client is not on Northwest Tribal Registry, validate client according to Indian Health Services requirements;

(j) assign clients to Indian health care provider patient centered medical homes;

(k) provide training for providers and staff on how to deliver culturally appropriate services;

(l) support bringing specialist services to Indian health care providers rather than sending patients to specialists; and

(m) monitor timeliness of access to care for referrals to non-Indian health care providers.

(5) The third-party administrator for the American Indian Health Program must meet state-established network adequacy requirements.

(6) The state will establish fee-for-service fee schedule rates that are competitive to the rates paid by managed care organizations to non-Indian health care providers.

(7) The state will allocate savings achieved by value-based payments to raise the fee-for-service fee schedule rates.

Managed Care Organization Requirements

**Sec. 9. NEW SECTION/AMENDED TBD**
(1) Managed care organizations must pay directly to Indian health care providers 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 Indian health care provider that does not have a published encounter rate, the managed care organizations must pay the amount the Indian health care provider would receive if the services were provided under the state plan’s fee-for-service payment methodology.

(2) Managed care organizations must treat every Indian health care provider as an in-network provider, whether participating or not, to ensure timely access to services for Indian enrollees eligible to receive services from such providers. Managed care organizations will include all Indian health care providers on any in-network provider lists via their websites and through their customer service lines. The state will provide managed care organizations with an updated Indian health care provider list.

(3) Managed care organizations shall ensure that American Indian and Alaska Native enrollees may (a) obtain covered services from any Indian health care provider, regardless of whether the Indian health care provider participates in the network of the managed care organization; and (b) choose an Indian health care provider as his or her primary care provider if he or she is eligible to receive primary care services from that Indian health care provider and that Indian health care provider is participating as a network provider.

(4) Managed care organizations will include an Indian health care provider contract addendum to every contract between the managed care organization and an Indian health care provider. This addendum will include the following: (a) the Model Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers, as may be amended by the Centers for Medicaid and Medicare from time to time; (b) reference to the separate issue resolution mechanism maintained by the State under subsection 15 of this section; and (c) additional terms that are approved by the Indian health care provider and the managed care organization.

(5) Each managed care organization will offer and negotiate contracts in good faith to all Indian health care providers, including any tribal care coordination, transportation, or related providers. Indian health care providers are not required to contract with a managed care organization. To be offered in good faith, a managed care organization must offer contract terms comparable to terms that it offers to a similarly-situated non-Indian health care provider,
except for terms that would not be applicable to an Indian health care provider, such as by virtue of the type of services that an Indian health care provider provides. The managed care organization will provide verification of such offers on request for the state to verify compliance with this provision. In the event that an managed care organization and an Indian health care provider fail to reach an agreement within ninety (90) days from the start of negotiations and the Indian health care provider submits a written request to the state for a consultation with the managed care organization, the state will facilitate an in-person meeting with the managed care organization and the Indian health care provider in Olympia within thirty (30) days from the date of the Indian health care providers’ request in an effort to resolve differences and facilitate an agreement.

(6) Managed care organizations will pay every Indian health care provider for covered services provided to American Indian and Alaska Native enrollees who are eligible to receive services from that Indian health care provider as follows:

(a) When an Indian health care provider is not enrolled in medicaid as a federally qualified health center, regardless of whether or not it participates in the network of the managed care organization, the managed care organization will pay the Indian health care provider the full applicable Indian Health Services 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 medicaid fee-for-service (such amount, the “applicable Indian health care provider rate”) provided that, when the amount an Indian health care provider receives from the managed care organization is less than the full applicable Indian health care provider rate, the state will make a supplemental payment to the Indian health care provider to make up the difference between the amount the managed care organization pays and the amount the Indian health care provider would have received under medicaid fee-for-service or the applicable encounter rate.

(b) When an Indian health care provider is enrolled in medicaid as a federally qualified health center and is a participating provider of the managed care organization, the managed care organization will pay the Indian health care provider at a rate negotiated between the managed care organization and the Indian health care provider or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment that the managed care organization would
make for the services to a participating provider which is a Federally Qualified Health Center but not an Indian health care provider.  

(c) 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 managed care organization, notwithstanding network restrictions, pursuant to 25 U.S.C. § 1621e.  

(d) Any contract between the Health Care Authority, and/or the Department of Social and Health Services and a managed care organization must require that as a condition of receiving payment under such contract, the managed care organizations agree to make prompt payment to Indian health care providers, whether such Indian health care providers are participating providers or non-participating providers.  

(7) A managed care organization shall not require prior authorization for any services provided by an Indian health care provider to an American Indian or Alaska Native enrollee by referral from an Indian health care provider.  

(8) A managed care organization will accept referrals by an Indian health care provider, regardless of whether the Indian health care provider participates in the network of the managed care organization, for an American Indian and Alaska Native 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. A managed care organization shall not require documentation from an Indian health care provider that is more burdensome than documentation required from non-Indian health care providers and/or non-American Indian or Alaska Native enrollees.  

(9) Managed care organizations must provide only the services requested by the Indian health care provider and/or the American Indian or Alaska Native enrollee and maintain the Indian health care provider as the American Indian or Alaska Native enrollee’s medical home through care coordination with the Indian Health Care Provider including the Indian health care provider’s purchased and referred care program. The managed care organization will provide non-Indian health care providers with state written guidance on the critical role played by Indian health care providers for the care of American Indian and Alaska Native enrollees. Subject to the American Indian and Alaska Native enrollee’s release of information, the managed care organization will require non-Indian health care providers to deliver progress notes, including
any referrals made, to the American Indian or Alaska Native enrollee’s Indian health care provider medical home.

(10) Managed care organizations will require staff to receive, at least once per calendar year, Indian health care delivery system and cultural humility training that is applicable to the respective American Indian and Alaska Native communities they serve. Each Managed care organization will provide written documentation of efforts to obtain this training from tribe(s) and urban Indian health programs in the managed care organization’s service area, the American Indian Health Commission for Washington State, the Indian Policy Advisory Committee, or the Department of Social and Health Services Office of Indian Policy. Each managed care organization will coordinate with Indian health care providers in their service area on how to provide culturally appropriate evidence-based American Indian and Alaska Native 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 medicaid state plan as approved by the Centers for Medicare and Medicaid Services.

(11) Each managed care organization will develop protocols with each tribe in the managed care organization’s service area for accessing tribal land to provide crisis services, including coordination of outreach and debriefing of crisis review and outcome with the Indian health care provider. The protocols will include agreed upon timeframes and participation for debrief and review, in compliance with Health Insurance Portability and Accountability Act and 42 C.F.R. Part 2 requirements.

(12) To the extent permitted by law, managed care organizations will make reasonable efforts to require participating psychiatric hospitals and evaluation and treatment facilities to notify and coordinate discharge planning with Indian health care providers for Indian Health Service eligible American Indian and Alaska Native clients.

(13) The state will develop a separate rating system for American Indian and Alaska Native enrollees for purposes of the value-based purchasing methodologies implemented by managed care organizations. The separate rating system will take into account the health care disparities of American Indians and Alaska Natives in the state. The separate rating system will also take into account the payment disparities in health spending the Indian Health Service eligible population experiences as opposed to the non-hispanic, Caucasian population to achieve spending parity.
(14) Each managed care organization must designate a tribal liaison to facilitate resolution of any issue between a managed care organization and an Indian health care provider, including but not limited to billing and provider enrollment/credentialing. The tribal liaison’s function may be an additional duty assigned to existing managed care organization staff. The managed care organization will document with the state every such issue presented by an Indian health care provider or identified by the tribal liaison. The managed care organization will make the tribal liaison available for training by tribes and urban Indian health programs in the managed care organization’s service area, the Indian Policy Advisory Committee of the Department of Social and Health Services, or the American Indian Health Commission for Washington State.

(15) The state will establish a resolution process for each Indian health care provider to submit complaints to the state regarding unresolved issues, including, but not limited to, crisis coordination between the Indian health care providers and a managed care organization. The state will facilitate resolution directly with the managed care organization. The managed care organization will include reference in any contract between the managed care organization and the Indian health care provider to the resolution process maintained by the state. Prior to the development of any plan with an Indian health care provider that is required by the state agreement with the managed care organization, the managed care organization will meet with the state and the Indian health care provider to identify and resolve issues related to the managed care organization’s performance of services under its agreement with the state.

(16) A managed care organization will be subject to corrective action and penalties against the managed care organization by the state if the managed care organization fails to (i) perform any obligation under the managed care organization state agreement or the requirements within this section; or (ii) ensure that American Indian and Alaska Natives are afforded access to care, rights, and benefits on par with all other managed care organization enrollees.

(17) To the extent that such reporting does not risk exposure of personal information, the state will, in consultation with tribes and conferral with Indian health care providers, prepare reports on Indian health care providers and the American Indian and Alaska Native population using data on American Indian and Alaska Native enrollment and the Healthcare Effectiveness
Data and Information Set measures that the managed care organizations are required to report to the state.  

(18) The state will submit a report to all Indian health care providers in the state detailing its implementation and coordination of efforts with the tribes on managing the care of American Indians and Alaska Natives in a format to be agreed upon by the state and the tribes and Indian health care providers in the state. The reporting is required to occur no less than annually. The reports must include at a minimum:

(a) Description of concerns raised by the tribes and Indian health care providers 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 Indian health care providers and the Indian population using data on Indian enrollment and the behavioral health performance measures that the managed care organizations 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. Such analysis shall include the impacts that the expansion of managed care will have upon the fee-for-service system.

(e) The state will allow tribes and Indian health care providers the opportunity to provide recommendations at least 60 days prior to finalizing each report.

(19) The State will consult with the tribes and seek advice regarding the state Agreements with managed care organizations and, in particular, the tribal relationship section(s) that address Indian health care providers and/or American Indian and Alaska Native enrollees and which operationalizes the waiver.

(20) The state will solicit advice and guidance from the Governor’s Indian Health Advisory Committee on at least a quarterly basis to ensure that American Indians and Alaska Natives receive access to quality care in a timely manner. Meetings with the Interagency Indian
Health Advisory Committee shall not be a substitute for formal government-to-government tribal consultation.

**Historical Trauma Informed Care**

**Sec. 10. NEW SECTION/AMENDED TBD**

(1) The state, in consultation with tribes and urban Indian health programs, will develop a plan to ensure written and verbal technical assistance to support the incorporation of cultural awareness and development of strategies to address historical trauma and intergenerational trauma in treatment planning for services covered by Medicaid and other services provided by the state.

(2) The state will require all designated mental health providers, designated chemical dependency specialists, and designated crisis responders, receive training in historical trauma/intergenerational trauma and that historical trauma/intergenerational trauma are addressed in treatment planning for services covered by medicaid.

**Tribal Public Health Services**

**Sec. 11. NEW SECTION/AMENDED TBD**

(1) The Secretary of the Department of Health will include tribes in the development of a public health system that acknowledges tribal authority and responsibility for their community.

(2) The tribes and Indian health care providers, in partnership with the Department of Health, will facilitate a tribally-driven process to define (a) how the Department of Health funding and delivery framework may apply to Indian public health programs; and (b) how tribes, Indian public health programs, the Department of Health, and local health jurisdictions can work together to serve all people in Washington.

(3) The Department of Health will work with tribes and Indian health care providers to establish a tribally-driven track within the state’s practice transformation hub, to assure an appropriate level of expertise on Indian health and the capacity to properly assist Indian health care providers.

(4) The Department of Health will work with tribes and Indian health care providers to ensure that state resources for improving population health include tribally-determined practices
and resources that support tribal concepts of health using the Pulling Together for Wellness case study as a resource to better understand tribally-determined and driven approaches.

(5) The Department of Health will work with Tribal Epidemiology Centers to create a system of epidemiological analysis that meets the needs of the state’s tribal population.

2 “Indian Health Service Plans to Expand Community Health Aide Program.”
6 See Arizona § 12-136.
7 See Arizona Section 1115 Waiver Process, American Indian Initiatives.
8 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.”
10 See NM 1115 demonstration STC.
11 See IN 1115 demonstration STCs.
12 See NM 1115 demonstration STCs.
16 See NM 1115 demonstration STCs.
17 See NM 1115 demonstration STCs.
18 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.”
19 Section 18.1.4 of the form of Apple Health – Fully Integrated Managed Care Contract between the State and the Managed Care Organizations.
21 42 C.F.R. §§ 438.14(b)(2) and 438.14(c)(1).
22 NM and IN 1115 demonstration STCs.
23 See 42 C.F.R. § 438.14(b)(4) and (6), effective July 2017.
24 See 42 C.F.R. § 438.14(b)(4) and (6), effective July 2017.
25 NM and IN demonstration STCs.
26 Currently Molina and AmeriGroup have tribal liaisons or are in the process of doing so.