Indian Health Care Provider Evaluation of Washington State Managed Care Organizations: Findings and Recommendations

# APPENDIX A: MCO AI/AN IHCP Contract Provisions

**EXHIBIT L**
**American Indian/Alaska Native and Indian Health Care Provider Contract Requirements**

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

## 1. Definitions

### 1.1 Access

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

### 1.23 Behavioral Health Agency

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

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

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

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

### 1.40 Care Manager (CM)

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

### 1.59 Community Health Workers (CHW)

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

**1.137 Indian Health Care Provider**

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

**1.157 Local IHCP Provider**

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

**1.158 Local Tribe**

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

**1.176 Mental Health Professional**

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

**1.183 Network Adequacy**

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

**1.226 Provider**

"Provider" means

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

1.226.2 An induvial engaged in the delivery of services, or ordering or referring for those services and is legally authorized to do so in another State and is an employee of an Indian Health Care Provider. [SOURCE: CMS Model Medicaid CHIP Managed Care Addendum for IHCPs, Section 11 and RCW 71.24.024]~~.~~; or

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

**3. Health Home Care Coordinator Qualification and Training Requirements**

The Contractor shall ensure that:

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

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

## 4. Enrollment

### 4.3 Eligible Client Groups

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

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

### 4.13 Restriction on AI/AN Enrollment in Managed Care

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

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

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

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

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

pursuant to 25 U.S.C. § 1621e. [SOURCE: Washington State Tribal Centric Health Plan Agreement]

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

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

### 6.1 Network Capacity

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

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

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

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

6.2.11 The Contractor shall maintain an online provider directory that meets the requirements listed below and include information about available interpreter services, communication, and other language assistance services. Information must be provided for each of the provider types covered under this Contract: physicians, including specialists, hospitals, pharmacies, behavioral health providers, and LTSS providers as appropriate. The

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

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

## 9 SUBCONTRACTS

9.3 Provider Nondiscrimination

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

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

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

## 10 ENROLLEE RIGHTS AND PROTECTIONS

### 10.5 Enrollee Choice of PCP/Behavioral Health Provider

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

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

## 11 UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES

### 11.4 Authorization of Services

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

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

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

## 14 CARE COORDINATION

### 14.1 Continuity of Care

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

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

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

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

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

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

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

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

**14.10 Coordination Between the Contractor and External Entities**

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

14.10.1.18 Tribal entities;

**14.12 Children's Long Term Care (CLIP)**

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

**14.16 American Indian/Alaska Natives**

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

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

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

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

14.16.4 **Maintenance of the AI/AN IHCP Medical Home.** The Contractor must notify and coordinate care and transitions with any IHCP when the Contractor becomes aware an Enrollee is AI/AN or is receiving care from an IHCP and the Enrollee consents to such

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

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

14.6.5.1 Develop and maintain policies and procedures that:

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

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

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

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

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

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

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

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

## 15 SPECIAL PROVISIONS FOR FIMC

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

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

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

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

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

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

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

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

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

**15.2 IHCP Engagement**

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

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

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

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

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

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

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

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

15.2.1.2.6 Certification that the Contractor

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

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

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

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

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

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

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

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

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

**15.2.6 [New Section] Contractor Indian Health Performance Standards**

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

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

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

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

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

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

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

## 16 Benefits

### 16.11 Enrollee Self-Referral

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

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