Indian Health Care Provider Evaluation of Washington State Managed Care Organizations

FINDINGS AND RECOMMENDATIONS

July 24, 2019

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TABLE OF CONTENTS

ABOUT THE AMERICAN INDIAN HEALTH COMMISSION

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

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

ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

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

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

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

Tribal Centric Health Plan Agreement

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

Indian Health Care Provider Evaluation of Managed Care Organizations

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

potential consequences of MCO practices for AI/AN, tribal communities, and Indian health care providers (IHCP).

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

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

I. Indian Health Care Provider Evaluation of Managed Care Organizations

Purpose

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

Survey Question Design

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

Key Informants

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

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

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

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

Survey Administration

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

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

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

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

Survey Completion

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

Survey Results

Access to Care and Provider Network

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

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

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

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

Care Coordination

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

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

MCO Contracting with Indian Health Care Providers

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

- **All (100%)** of the respondents who stated their IHCP had ended their contract with an MCO stated that "Case management services lacked cultural competency" and "Poor coordination between non-IHCP services and IHCP services" were reasons for ending the contract
- Key informants identified the following reasons for IHCPs choosing not to enter into a contract with MCOs: "Customer service representatives do not fully understand issues specific to the Indian healthcare delivery system and/or benefits and legal protections that apply to American Indians and Alaska Natives", "Don't see a clear benefit to our IHCP from contracting", and "We do not have the capacity to provide Behavioral Health services

to non-Native clients - a contract would require us to provide Behavioral Health services to any individual enrolled in the plan"

MCO Engagement with Indian Health Care Providers

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

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

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

II. Recommended MCO Performance Standards

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

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

III. Recommended MCO Contract Revisions

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

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

The AIHC proposes the following changes to the contract:

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

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

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

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

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

CONCLUSION

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

Based on the 2019 Indian Health Care Provider Evaluation of Managed Care Organizations in Washington, MCOs must improve their performance in providing access to high quality culturally competent health care to American Indians and Alaska Natives (AI/AN) and contracting and engaging with Indian Health Care Providers (IHCPs). MCOs violate their contractual obligations regarding AI/AN protections and IHCP contracting and engagement requirements. Barriers to AI/AN accessing high quality culturally competent care persist, and contracting between MCOs and Tribes continues to lag. MCOs have yet to establish effective service delivery systems for AI/AN and partnerships with IHCPs.

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

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