Statewide Tribal Health Care Delivery Issues Log by Authority—Working Copy as of 4/22/2016

#	Issue Description/Analysis	Next Steps—Authority Over the Issue	Timeframe/Target Date
	Legislation Required to Address		
1	Enable Medicaid to pay for treatment at ITUs of clinical family members for all Medicaid-covered services	HCA/BHA will research this request. This request requires legislative and Governor support.	To be addressed in Monthly Tribal Meeting (MTM).
2	Give tribes the funds that were given to BHOs for AI/ANs.	BHA is willing to have this conversation with the HCA-BHA MTM workgroup. DSHS does not have the statutory authority to move dollars from BHOs to anyone else. This would require legislative and Governor support.	Legislative cycle
3	Define and clarify role and scope of governing boards. Require BHOs to include Tribal representatives in their decision and policy making boards. • BHO boards are excluding Tribes and instead inviting Tribes to have a representative on the BHO advisory committee; this is not government-to-government relations. • AIHC has asked that the contract language be consistent with RCW 71.24.300 (1-3). • Tribes have requested one seat per tribe on the BHO governing boards • BHOs have said their existing funding is not sufficient for them to give full faith and credit to Tribal court orders. *AIHC Recommendation, TCBH Workgroup* ADD case mgmt pmts to ITUs for non-AI/ANs? (AIHC Nov recommendations)	With the advice of legal counsel, BHA has interpreted the legislation to prevent it from requiring BHOs to have tribal representation on their governing boards. Tribes may want to seek legislation to clarify the Legislature's intent. BHO funding is sufficient to provide medically necessary behavioral health treatment services. This item should be explored and discussed through MTM.	DSHS will present topic at June MTM.

4	Interest in a Tribal BHO.	BHA is committed to having this conversation; this conversation could start at the HCA-BHA MTM workgroup meetings, but will require DSHS/HCA and tribal leadership involvement as well. Any discussion should keep in mind full integration in 2020. A Tribal BHO would require legislative and Governor support. Consider different models: • Tribal MCO • Tribal BHO • Tribal ASO Possibility of BHO or ASO as interim step to larger integrated ITU model in Medicaid?	Legislative cycle
5	DSHS/HCA should contract with adult and child consulting psychiatrists to provide medication consultation services to Tribal and urban Indian health programs (State funded). *State Response: For children, the state funds the Partnership Access Line (PAL); for more information, see http://www.palforkids.org/. PAL is a telephone based child mental health consultation system for primary care providers funded by the Washington State legislature. PAL employs child psychiatrists and social workers affiliated with Seattle Children's Hospital to deliver its consultation services.*	For adults (and for children – if UW contract ended), this request requires legislative and Governor funding support. Timeframe to be discussed at MTM.	TBD
6	DSHS and HCA should establish an ongoing project with Tribes and urban Indian health programs to develop and reimburse for AI/AN culturally appropriate evidence-based practices (EBPs) and promising practices (State funded).	Developing AI/AN EBPs – To develop AI/AN EBPs, funding will require legislative and Governor support.	TBD

7	Obtain necessary statutory and/or regulatory changes that will allow Tribal Courts to make ITA commitments for Tribal members.	Currently, RCW 71.05 states that commitments required from Superior Court. Would require statutory change to include jurisdiction of a tribal court. In addition, ITA hearings must be held where the facility is (where the client is being treated), not where the client was detained. This would require legislative and Governor support. Timing and prioritizing to be discussed at MTM. Deadline: July 31 for steps to be taken (DSHS working with AGO) (Note: In Arizona, tribal court makes decision with state court reviewing the decision)(Consider researching Alaska – BHA is looking for other state models)	Legislative cycle
8	DSHS should seek **state funds to pay Tribal programs for chemical dependency services provided to non-AI/ANs** (State funded; Medicaid funded with Medicaid expansion).	This would require legislative and Governor funding support.	Legislative cycle
9	State will work with ITUs to **analyze complications for ITU behavioral health programs and AI/AN health care needs** due to (1) the integration of SUD services with mental health managed care (BHOs), and (2) the coordination of the BHO system with physical health care. *State Response: State Plan and covered services for Medicaid enrollees are not changing. IHS and Tribal facilities will continue to bill HCA directly for MH/SUD services and will continue to receive the IHS encounter rate.*	BHA will review legislative authority to require BHOs to coordinate care with physical health care providers for AI/ANs. Concerns: • Continuity of care with different authorities/payers • How is the state capturing data and ensuring that data on culturally relevant services are being captured?	TBD

10	Obtain **state funding to conduct a feasibility study for one or more E&T facilities to service AI/AN people needing inpatient psychiatric care** (State funded). *State Response: Original state funding is no longer available.* CHANGE TO: Obtain **state funding to support construction and implementation one or more Tribal Evaluation & Treatment facilities to service AI/AN people needing inpatient psychiatric care?**	This would require legislative and Governor support. BHA will look at 2017-19 budget. Tribes might also consider going to the Legislature for funding of construction of a tribal E&T facility as an investment for future savings due to the transfer of inpatient mental health expenses from the state budget to the federal budget due to the AI/AN 100% FMAP.	Legislative cycle
CMS Authority Required to Address			
11	**Need to reinvest savings** from Medicaid Transformation Waiver to prevent federal and state recoupment of savings and to support non-project/community reinvestment.	HCA: Work with CMS to ensure that savings can be reinvested to sustain transformations.	
SAMHSA Authority Required to Address			
12	Inconsistent confidentiality rules for HIPAA and SUD services	1. HCA/BHA are reviewing the changes proposed for 42 CFR Part 2 (https://www.federalregister.gov/articles/2016/02/09/2016-01841/confidentiality-of-substance-use-disorder-patient-records). 2. Changes to this rule require federal (SAMHSA) action.	
DSHS-BHA Capacity to Address			

13	DBHR use 2SSB 5732 appropriations to contract or employ a dedicated FTE to assist with implementation of the report's recommendations (State and Medicaid funded).	This funding for this ended. IPAC and AIHC agreed to re-purpose the funds to pay for Suicide Prevention Conference.	Completed. Funds expended and returned.
14	DBHR dedicated FTE to provide technical assistance to Tribes and monitor Tribal relations in BHO contracts (State funded).	Loni Greninger hired on July 1, 2015.	Completed.
15	Continue to allow Tribal and urban Indian health program mental health services to clinical family members of Tribal members (Medicaid funded).	State Response: The rules are staying the same for clinical family members – Medicaid will continue to pay for mental health treatment of non-AI/AN family members of AI/ANs by IHS and Tribal facilities.	Completed.
16	Tribes want to make sure BHOs follow Gov. to Gov.	BHA is requiring BHOs to develop and implement a tribal coordination implementation plan under Section 15.2 of the BHSC. The plan must include service delivery goals/outcomes, activities to implement service delivery, expected outcomes of the service delivery goals, lead staff from the BHO and ITU, and a progress report throughout the year. This is very similar to the 7.01 Plan. BHA will work with ITUs on this.	In BHO Contracts. DBHR will monitor. If need for clarifying language, July 2016 is the next opportunity to amend the contract.
17	BHOs not reaching out to Tribes/RAIOs for governing boards, advisory boards, crisis coordination plans, or information on how to access services	The BHSC requires BHOs to reach out to Tribes for all aspects listed. BHA will continue to follow up with the BHOs to assist and monitor. DBHR Tribal Liaison can attend meetings between BHOs and ITUs to assist in coordination and ITU access to medically necessary care. DBHR also plans to work with HCA-BHA MTM workgroup on training curricula for Ombuds trainings.	In BHO Contracts. DBHR will monitor. If need for clarifying language, July 2016 is the next opportunity to amend the contract.
18	Require each BHO to identify BHO staff member as Tribal liaison.	This is required in the BHSC and PIHP contracts.	In current contract. Scott McCarty is waiting on three BHOs to send in the contact information.

19	Develop protocols, in conjunction with each tribe in their catchment area, for accessing tribal land to provide crisis and ITA services. These protocols would include coordinating the outreach and debriefing the crisis/ITA review outcome with the I/T/U mental health provider within twenty four hours.	This is required in the BHSC and PIHP contracts.	In BHO Contracts. DBHR will monitor. If need for clarifying language, July 2016 is the next opportunity to amend the contract.
20	Tribes being asked to waive sovereign immunity or partial immunity in BHO contracts.	Tribes do not have to contract with a BHO. If a tribe would like to contract with a BHO, BHA expects BHOs to not require Tribes to waive sovereign immunity. The BHOs are required to sign the BHO Indian Addendum when they contract with Tribes.	BHA sent a communication to the BHOs to remind them that Tribes do not have to contract. American Indian Addendum required in BHO contracts; bring to MTM. Explicit instructions re: Medicaid coverage for Tribal members to be in July amendment.
21	Remedial action for BHOs, including reduction of funding to BHOs.	BHA can place a BHO on a corrective action plan if the BHO does not meet its contractual obligations.	In BHO Contracts.
22	**Require BHOs to provide timely and equitable access to crisis services for AI/AN.** This would include BHOs to contract with Tribal and urban Indian health programs that are willing and able to provide crisis services. • BHOs to develop protocols, in conjunction with each Tribe with CHSDA in BHO's RSA, for accessing Tribal land and providing crisis and ITA commitment services (including protocols for coordinating outreach and debriefing the crisis/ITA review outcome with the ITU mental health provider within 24 hours) *AIHC Recommendation, TCBH Workgroup*	BHO contract requires that each BHO develop and implement a BHO-Tribal Crisis Coordination Plan, which includes: 1. How non-tribal DMHP can access tribal land 2. How to coordinate services between the BHO contracted facility and ITU 3. How BHO will respond to tribal ITAs and SUD ITAs BHA: Look at HCA's language on MCO requirement to contract with IHS; check on BHO contracting requirement with FQHC (UIHOs). Already in BHO contracts: related to crisis coordination plans	

23	Request to change the DSHS 7.01 policy to include RAIOs (Urbans). [Consider clarification of request]	This will need to go through IPAC, and other approval processes. Update: IPAC Executive Committee will consider IHS Confer Policy with urbans to see if it should be added to the DSHS 7.01 Policy.	Sunset review date of the 7.01 policy is March 31, 2019
24	Care coordination; BHOs and subcontractors should notify tribes to coordinate client discharge planning and care coordination.	In BHO contracts under crisis planning and discharge requirement – BHOs need to push these into sub-contracts For providers to coordinate discharge planning with other providers, they need to obtain a release of information.	BHA will add this to the HCA-BHA MTM workgroup to discuss this request further.
25	Require BHOs to submit to mandatory mediation in the event that tribes and the BHO disagree in regard to (1) an individual's assessment for the provision of crisis services; or (2) the tribal and BHO plan for coordination of crisis services.	DBHR's Tribal Liaison is available to respond to concerns regarding access and timeliness of service. For Medicaid services, access standards are identified in the PIHP contract. Each BHO must follow the federal regulations for managing the grievance process. This includes timeliness of notice of actions, denials, notification of rights, appeals process and access to the Ombuds office in each BHO. DBHR will work with the participants in the MTM to develop a training for the BHO Ombuds so that they can appropriately respond to requests for advocacy from AI/AN. DBHR will also request that the Ombuds Office for each BHO notify the DBHR Tribal Liaison, with the approval from of the Tribal member, whenever there is an advocacy issue involving AI/AN individuals.	July 2016 (training for Ombuds)

26	MCOs and BHOs will be required to contract with all I/T/Us and use the Indian Addendum.	DBHR does not have the authority to require BHO/PIHPs to contract with Tribes or other provider types. DBHR does have the authority to require that BHOs meet network adequacy requirement and have a sufficient array of providers and that the BHO has policies and procedures for purchasing out of network services when a medically necessary specialty services is requested. If a BHO and Tribe/UIHO do enter into a contract, the BHO must use the Indian Addendum. BHA to consider good faith negotiation requirement and to review BHO contract language in sections addressing culturally appropriate providers and choice of providers	
27	Require BHO-contracted and DBHR-credentialed licensed psychiatric care hospitals, including state psychiatric hospitals, and Evaluation & Treatment (E&T) facilities to notify and coordinate AI/AN discharge planning with the Tribes and urban Indian health programs.	For providers to coordinate discharge planning with other providers, they need to obtain a release of information. BHA will add this to the HCA-BHA MTM workgroup to discuss this request further. BHOs need to take care individuals if ITU cannot (e.g., AI/AN who is not eligible to receive care from IHS or Tribal clinic)	
28	Require that BHOs and their provider networks who provide Medicaid encounters to AI/AN consumers meet minimal cultural competency standards to be established through a joint AIHC/OIP/Washington Behavioral Health Council and departmental Workgroup. *AIHC Recommendation, From Consultation 3/9/16*	BHA and HCA will to participate in this workgroup. Consider collaboration between BHO and local tribes/UIHOs for cultural competency training curricula and delivery for all CMHA providers. We should include care coordination/discharge planning in this training. Next Step: Develop guidelines for CMHAs, including those contracted with BHOs.	~~Timeframe to be established at March MTM meeting.~~Discuss next steps.

29	Require BHOs to accept, full faith and credit, tribal MH and SUD assessments. *From Consultation 3/9/16, TCBH Workgroup*	For an individual to receive Medicaid Behavioral Health Services through a BHO, the BHO must determine that there is *current* medical necessity for the requested service. In making this determination the clinician conducting the assessment should use all other information available, this would include assessments conducted by other behavioral health providers. At a minimum, the BHO has to verify that at the point in time services are requested medical necessity for the treatment is present. The certified agency must assure that assessments used meet the all licensure requirements. Tribes are attested or licensed, so their assessments should be viewed equally with non-Tribal provider assessments. This will be further discussed at the HCA-DBHR Monthly Tribal Meeting.	TBA
30	Information required by BHOs from subcontractors for authorization or extension of a residential treatment stay (e.g., progress notes). *From Consultation 3/9/16*	CMS requires BHOs to comply with Medicaid requirements including determining that there is medical necessity for services provided. As risk-bearing entities, BHOs develop their own procedures for managing provider compliance with these requirements. BHA is looking into the possibility of forming a workgroup to standardize the procedures BHOs use for authorizations and extensions – with carve out, BHA is focused on gaining FFS access. Still need standardized process.	TBD
31	Require BHOs to contract with Tribal DMHPs to serve AI/AN people on Tribal Land (if Tribal DMHPs are available and willing to contract with the BHO). *AIHC Recommendation, TCBH Workgroup*	This is currently not required in the BHO contract. BHA will research whether DSHS has the authority to require this in the BHO contacts. ~~DBHR will report findings at the July 2016, Monthly Tribal Meeting.~~BHA has drafted contract provision to be include in July amendment to BHO contract.	7/16

32	DSHS should assist Tribal programs to train and have DMHPs who can detain AI/AN for ITA commitments (State funded).	1. BHA is currently working on a tribal DMHP project with the Chehalis Tribe. This tribal DMHP will be funded by the BHO, and serve four different tribes within the BHO service area. Other BHOs and tribes could implement a similar agreement if they choose. BHA would be happy to provide technical assistance. i. Tribe would need to provide the MHP to be certified as a DMHP by the BHO. ii. Tribal attestation vs. state licensing. Look up MHP WAC. iii. BHO would need to designate the MHP. iv. BHO and tribe would clarify who pays for the DMHP. v. DMHP would have authority to detain under state court. Tribe would need to consider this. For more information, please contact David Reed. BHA will check with Jessica Shook on upcoming DMHP training opportunities provided by DBHR.	BH-TCBH*
33	Data that BHOs can require of subcontractors for authorization or extension (e.g., progress notes). *From Consultation 3/9/16*	CMS requires BHOs to comply with Medicaid requirements including medical necessity for services provided. As risk bearing entities, BHOs develop their own procedures for managing provider compliance with these requirements. BHA is looking into the possibility of forming a workgroup to standardize the procedures BHOs use for authorizations and extensions. (Consolidate with comment #30 above)	
34	Need to ensure that the payment methodology for Medicaid Transformation Waiver Initiative 3 (foundational community supports) services is compatible with ITUs	BHA: Work with ITUs on this.	TBD

35	Need to ensure AI/AN and ITU exception to the integration into MCO and BHO rates of the cost of the benefit and delivery of foundational community supports under Medicaid Transformation Waiver Initiative 3	BHA: Work with ITUs on this.	TBD
	HCA Capacity to Address		
36	**No auto-assignment** for AI/ANs into managed care.	HCA policy is not to auto-assign AI/ANs into MCO plans. For ICW and foster care, need better communication between tribe and foster parents – tribe has custody. [TRIBAL SUB-GROUP ENDED HERE – PICK UP AT MTM]	Completed.
37	**Continue to use IHS encounter rate** to reimburse Tribal mental health and chemical dependency programs (Medicaid funded). *State Response: This is not changing for IHS or Tribal facilities. For UIHOs, they will continue to get the FQHC encounter rate, but will need to contract with the BHO to receive payment for SUD services. BHO will pay the contract rate, and HCA will pay the enhancement.*	1. HCA is updating the Tribal Billing Guide to include the current SUD billing instructions that will no longer apply with BHO/BHSOs. 2. HCA will give UIHOs guidance on how to bill for SUD services starting on April 1, 2016.	1. HCA still working on billing guide. 2. ASAP
38	Increase access to primary and specialty care in FFS • Rent a network/MCO acceptance of ITU referrals for FFS clients • Work through ACHs • Idea for Medicaid System Transformation Project	HCA/BHA are researching how to increase access to primary care and specialty care in fee-for-service, potentially under existing rules or under an 1115 Waiver demonstration project.	To be addressed in MTM.

39	Billing manual; tribes want to make sure that there no any changes to the billing manual that causes barriers. *From Consultation 3/9/16*	HCA is currently revising the tribal billing guide to include SUD FFS billing. HCA will share with the Tribes. Access to care standards is being expanded to cover SUD diagnoses (~110 diagnoses).	4/1/16
40	**Require MCOs to:** • **Contract with every ITU** on request and to use the Indian addendum • **Participate in training on ITU system** and to participate in tribal roundtables	1. HCA has amended all of the HCA-MCO contracts (except for the Foster Care MCO contract), starting April 1, 2016, requiring an MCO Indian Addendum and adding a mechanism to support MCO-ITU contracting – as HCA presented during the HCA-BHA MTM on February 22, 2016. 2. HCA will amend the Foster Care MCO contract with the same provisions – effective July 1, 2016. 3. HCA will send a Dear Tribal Leader Letter with the Tribal provisions in the HCA-MCO contracts and the MCO Indian Addendum.	1. Completed 2. 7/1/16 3. ASAP
41	ITUs should have the same opportunity as other providers and ACHs to receive incentive payments for transformation activities	HCA will work with the ITUs on this.	TBD
42	Need to develop separate measures methodology to determine supplemental payments to ITUs	HCA will work with the ITUs on this.	TBD
43	Need to ensure that State will not require ITUs to participate in the value-based payment system	HCA will work with the ITUs on this.	TBD
44	**Uncompensated care waiver** for the following services provided by ITUs: • Chiropractic • Adult vision hardware The state restored non-emergent dental and adult vision exams in 2014.	**1. ITUs – Please confirm that chiropractic care and adult vision hardware are the two benefits that are not covered by the State Plan but available as optional benefits under CMS rules.**	TBD

45	Need **full Tribal consultation in design and implementation of the 1115 waiver**	1. HCA/DSHS: Create workgroup (or use MTM?) to advise on formal consultation needs 2. HCA/DSHS: Email to ITUs/Harbage the minutes of Medicaid Transformation Tribal workgroup meetings, with running list of highlighted issues 3. HCA/DSHS: Email to each ITU with their own specific issues and status updates	TBD
46	**Exclude AI/ANs from 1115 waiver projects unless they opt in** (under managed care exemption in Section 1932 of SSA), with notices explaining this to AI/ANs *State Response: AI/AN managed care exemption under Section 1932 will continue; 1115 waiver will complement – not override – State Plan*	HCA will work with the ITUs on this.	TBD
47	Require coordination of care and prior authorization **MCO requirements to be consistent with ITU requirements** for coordination of care and referrals	HCA/BHA: Work with ITUs on "Medicaid System Transformation Project" (and supportive rule changes) to support: • Better coordination of care with ITUs; • Alignment of MCO prior authorization/IHS referral requirements between ITUs and MCOs; • Better cultural competence at MCOs through training on ITU system and tribal roundtables with MCOs; • [OTHER COMPONENTS TO BE DETERMINED]	TBD
48	**Use GPRA measures or other IHS clinical data** to reduce duplication and over-reporting by ITUs	HCA: Work with ITUs to use existing ITU measures for any Medicaid transformation project.	TBD
49	**Need to reinvest savings** to prevent federal and state recoupment of savings and to support non-project/community reinvestment	HCA: Work with CMS to ensure that savings can be reinvested to sustain transformations.	TBD

50	**Improve Medicaid reimbursement system** to reduce administrative burden on ITUs	1. HCA is currently working on reconfiguring ProviderOne to support HCA reimbursement to MCO payments of the IHS encounter rate. 2. After (1) is completed: (a) HCA will develop a process to reimburse MCOs for their payments of the IHS encounter rate. (b) MCOs will need to reconfigure their systems to enable correct payment of the IHS encounter rate for claims submitted by IHS and Tribal facilities. 3. After (2) is completed, IHS and Tribal facilities will be able to bill the MCOs and receive the IHS encounter rate without secondary billing to ProviderOne.	1. Summary 2016 2. Spring 2017 3. Summer 2017
52	**State needs to invest in competent analysis, planning, and technical assistance** to: 1. Ensure AI/AN and ITU needs are adequately addressed 2. Help ITUs determine whether they want to work with a TCE or an ACH 3. Help ITUs determine how they will work with ACHs Any Tribal Coordinating Entity (TCE) will need funding to develop capacity, potentially through the 1115 waiver	1. HCA has contracted with AIHC on for technical assistance on: (a) Meetings of ITUs and ACHs to develop mutual understanding (b) Individual meetings with each ITU to understand they want and need to engage with: (a) regional ACH, (b) one or more Tribal Coordinating Entities (TCEs), or (c) both. (c) Report on findings due January 31, 2017. 2. HCA is working with CMS to keep placeholder in 1115 waiver for ITUs, pending AIHC Report. **3. ITUs – Please give HCA an estimate of the total amount of Tribal funds, including IHS funds, that might be available to match the federal waiver funds.** **(a) Is $50,000,000 over 5 years a fair estimate?**	1(a). Spring – Summer 2016 1(b). Summer – Fall 2016 1(c). Due January 31, 2017 2. Ongoing 3. As soon as possible

53	**ACHs need to be educated about ITU system** in order to engage effectively with ITUs and Tribes	HCA has contracted with AIHC on for technical assistance on: 1. Meetings of ITUs and ACHs to develop mutual understanding 2. Individual meetings with each ITU to understand they want and need to engage with: (a) regional ACH, (b) one or more Tribal Coordinating Entities (TCEs), or (c) both. 3. Report on findings due January 31, 2017.	
54	**Ensure ACHs are designed and implemented in a parallel, complementary and coordinated manner with the ITU system**	HCA has contracted with AIHC on for technical assistance on: 1. Meetings of ITUs and ACHs to develop mutual understanding 2. Individual meetings with each ITU to understand they want and need to engage with: (a) regional ACH, (b) one or more Tribal Coordinating Entities (TCEs), or (c) both. 3. Report on findings due January 31, 2017.	
55	Request for **in-patient IHS encounter rate for long-term care services**	HCA/ALTSA will work with CMS to determine (1) whether and how to authorize an in-patient IHS encounter rate in the State Plan, and (2) if long-term supports and services would be eligible for this encounter rate (or if there is a different IHS encounter rate for LTSS).	TBD

BHA & HCA Capacity to Address			
56	Develop a list of culturally appropriate evidence-based AI/AN practice treatments for BHOs and MCOs to provide. Program development should include a plan for reimbursement for providing the service. As part of 2SSB 5732, tribal representatives will participate in developing culturally appropriate evidence-based and promising AI/AN practice treatments that BHOs and MCOs will be required to provide.		This item will be brought to the HCA-BHA MTM workgroup.
57	DSHS and HCA should work with the Tribes to develop treatment modalities and payment policies for persons with co-occurring conditions (Medicaid funded through separate encounter rates).	BHA/HCA would like to discuss with HCA-BHA MTM workgroup what the ITUs are looking for in this request. If the new treatment modalities do not fall under current Medicaid State Plan Amendments, the state would need CMS review and approval for implementation.	Work with MTM.
58	State will work with ITUs to analyze complications for ITU behavioral health programs and AI/AN health care needs due to (1) the integration of SUD services with mental health managed care (BHOs), and (2) the coordination of the BHO system with physical health care. *State Response: State Plan and covered services for Medicaid enrollees are not changing. IHS and Tribal facilities will continue to bill HCA directly for MH/SUD services and will continue to receive the IHS encounter rate.*	1. HCA/BHA will work with ITUs to understand the issues with integration and how they affect ITUs. HCA/BHA needs the advice and technical assistance from ITUs. 2. BHA will review legislative authority to require BHOs to coordinate care with physical health care providers for AI/ANs.	1. Ongoing 2. TBD
59	Review the Tribal Centric Report to the Legislature for updates and follow up.	DBHR/HCA believes they have incorporated those recommendations into this grid. Grid to be reviewed at March MTM meeting.	BHA will add this item to the agenda for the HCA-BHA MTM workgroup.

60	DSHS and HCA should establish an ongoing project with Tribes and urban Indian health programs to develop and reimburse for AI/AN culturally appropriate evidence-based practices (EBPs) and promising practices (State funded).	1. Traditional healing practices – Developing DOH/Medicaid Criteria — There are many competing considerations. This will require program-specific collaboration with the individual tribes to determine if developing Medicaid supportable criteria is even culturally appropriate. Technical assistance from HCA/BHA is available. 2. Traditional healing practices – Using Existing Medicaid Criteria – It is possible today to fit culturally appropriate practices within current Medicaid criteria for covered services. Technical assistance from HCA/BHA is available. 3. Culturally appropriate practices at non-ITUs: a. *HCA* – Beginning in 2015, HCA began adding Culturally and Linguistically Appropriate Service (CLAS) standards into the HCA-MCO contracts. HCA has also added new language to the HCA-MCO contracts for the MCOs to improve AI/AN access to culturally appropriate physical and behavioral health care at non-ITU providers. HCA will continue to develop this guidance. b. *BHA* – BHA is looking to add similar language to the BHSC. 4. Developing AI/AN EBPs – To develop AI/AN EBPs, funding will require legislative and Governor support.	1. Technical assistance available today 2. Technical assistance available today 3. Below a. 4/1/16 b. TBD 4. Legislative cycle
61	Amend list of covered provider services eligible for the encounter rate to include the new provider services that will be reimbursed under the integration of mental health and chemical dependency system and other provider services that support AI/AN.	Please provide more information on what is meant by “new provider services that will be reimbursed under…integration”?	

62	Reimburse I/T/Us for the cost to I/T/Us of providing case management in coordinating AI/AN care through the BHOs and MCOs.	Case management is not a covered service for mental health in the Mental Health SPA. DBHR and HCA will explore this issue with the HCA-BHA MTM workgroup.	
63	Accept AI/AN patients at any point in time regardless of whether the AI/AN patient is currently receiving mental health, chemical dependency, or physical health services at an I/T/U and needs additional care within the State BHO/MCO systems. AI/AN patients should be able to transition care between both the BHO/MCO and I/T/U systems with minimum disruption. For example, there should be no required referrals or unnecessary paperwork required.	DBHR and HCA agree that there should be minimum disruption for an individual transitioning from one service to another and unnecessary paperwork should be minimized.	
64	**Increase access to primary and specialty care in FFS** • Rent a network/MCO acceptance of ITU referrals for FFS clients • Work through ACHs Idea for Medicaid System Transformation Project	HCA/BHA are researching how to increase access to primary care and specialty care in fee-for-service, potentially under existing rules or under an 1115 Waiver demonstration project. Also see “Medicaid System Transformation Project” in “Waiver” category below.	

65	State will work with ITUs to **analyze complications for ITU behavioral health programs and AI/AN health care needs** due to (1) the integration of SUD services with mental health managed care (BHOs), and (2) the coordination of the BHO system with physical health care. *State Response: State Plan and covered services for Medicaid enrollees are not changing. IHS and Tribal facilities will continue to bill HCA directly for MH/SUD services and will continue to receive the IHS encounter rate.*	1. HCA/BHA will work with ITUs to understand the issues with integration and how they affect ITUs. HCA/BHA needs the advice and technical assistance from ITUs. 2. BHA will review legislative authority to require BHOs to coordinate care with physical health care providers for AI/ANs.	1. Ongoing 2. TBD
66	Consultation process for Medicaid service delivery.	HCA and DSHS will work with Tribes on a monthly basis through the HCA-BHA MTM to draft a Medicaid State Plan consultation policy.	Consultation process for Medicaid service delivery.
67	**Ensure compliance with federal protections** 1. No cost-sharing (42 USC 1396o(j); 42 USC 1396o-1(b)(3)(A)(vii)) 2. AI/AN MCO-enrollee may choose ITU as PCP (42 USC 1396u-2(h)(1)) 3. Sufficient ITUs in MCO/BHO network (42 USC 1396u-2(h)(2)(A)) 4. Payments to ITUs notwithstanding network restrictions (42 USC 1396u-2(h)(2)(C)) 5. Prompt payments to ITUs by MCOs/BHOs (42 USC 1396u-2(h)(2)(B))	**1. ITUs – Please report to HCA the details of any incident where an ITU client is asked for a copayment or other cost-sharing.** **2. ITUs – Please report to HCA the details of any incident where an ITU client is not able to choose an ITU as PCP.** 3. Below: (a) Rule: CMS has not yet issued guidance on this law. (b) MCOs: HCA has added language in the HCA-MCO contract to support MCO-ITU contracting. (c) BHOs: BHA is looking to add language in the BHSC to support BHO-tribal contracting. 4. Below: (a) MCOs: HCA has always had language in the HCA-MCO contract in compliance with for all ITUs. (b) BHOs: BHA is looking into this matter. **5. ITUs – Please report to HCA the details of any incident where an MCO has not complied with 42 USC 1396a(a)(37)(A).**	1. TBD 2. TBD 3. Below: (a) Federal (b) 4/1/16 (c) 7/1/16 4. Below: (a) Done (b) TBD 5. TBD

68	Include historical trauma and its resultant disorders, in all their complexity for AI/AN people, in BHO Access to Care Standards and list of Medicaid-covered diagnoses.	Historical trauma/generational trauma are not actual ICD 10/DSM 5 diagnoses. HCA and DSHS recognize the critical impact these factors can have on the whole person. HCA and DSHS will sponsor training for clinicians conducting mental health diagnoses and treatment so that they can address these factors in diagnosing and providing treatment. HCA and DSHS will work with the Monthly Tribal Meeting group to identify potential trainers and content for the training.	12/1/16
69	**Inconsistent interpretation of IMD rule.**	1. BHA/HCA will add this to the MTM workgroup. 2. BHA/HCA will research this issue, including what other states are doing with regard to this rule.	
70	Using/Not Using MAT; Tribes do not want to be forced to use MAT if their program doesn't support it.	BHA will research this issue. Follow up on whether prescription support requirements for clients in IP SUD treatment can exclude MAT if the IP treatment program does not support MAT. HCA also would like to have a broader conversation with experts on this issue.	
71	**Expand tribal assister program** to apply to Classic and MAGI Medicaid: 1. Access to Washington Connection 2. HCA/DSHS trainings on Classic Medicaid eligibility 3. Funding to support tribal assisters who assist with	1. DSHS will work on giving tribal assisters access to Washington Connection 2. HCA/DSHS participated in Classic Medicaid training for tribal assisters on March 2, 2016. HCA/DSHS are open to participating in future trainings. 3. The Medicaid Administrative Claiming program is available to tribes to provide funds for Medicaid administrative functions, including Medicaid eligibility support. Please contact HCA for more information.	1. TBD 2. Done and ongoing 3. Available now