Washington State Health Care Authority

Washington State Department of Social & Health Services

Transforming lives

Monthly Tribal Meeting

March 28, 2016

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WELCOME, BLESSING, INTRODUCTIONS

Agenda

9:00 am Welcome, Blessing, Introductions

Agenda Setting

9:10 am **Two Options for 1915(b) Waiver Amendment for April 1, 2016**

1. American Indians Carved Out of BHO Substance Use Disorder Services
2. American Indians Carved Into BHO Substance Use Disorder Services

10:15 am **BHO and MCO Contracts and Indian Addenda**

- BHO and MCO Contracts
- BHO and MCO Indian Addenda

11:15 am **ITU Issues Grid**

- Behavioral Health Issues

11:50 am **Miscellaneous**

Noon Closing

Two Options for April 1, 2016

1915(B) WAIVER AMENDMENT

1915(b) Waiver Amendment

Following up on Friday's tribal/UIHO meeting on the 1915(b) waiver amendment and the State's call that afternoon with CMS:

- With all of the changes made to the behavioral health system for April 1, the State cannot support delaying implementation after April 1.
- The State is very concerned that a delay after April 1 poses greater risks to people's health and to the behavioral health system, particularly substance use disorder (SUD) treatment, than moving forward with the 1915(b) Waiver Amendment on April 1.

1915(b) Waiver Amendment

	Option 1: AI/ANs carved out of BHO SUD services	Option 2: AI/ANs carved into BHO SUD services
What does this mean for the waiver amendment?	CMS approves the waiver amendment with AI/ANs excluded from BHO system for SUD services (the State will still take the actions agreed to in Friday's meeting)	CMS approves the waiver amendment with AI/ANs included in the BHO system on the condition that the State takes the actions the State agreed to in Friday's meeting
How will AI/ANs access non-Tribal SUD services?	Fee-for-service system	BHO system
How does this option affect Tribes/UIHOs providing care for AI/ANs?	Need to work in 2 systems: • BHOs for mental health services and • Fee-for-service for SUD services	Need to work in 1 system – BHOs – for both mental health and SUD services

1915(b) Waiver Amendment

	Option 1: AI/ANs carved out of BHO SUD services	Option 2: AI/ANs carved into BHO SUD services
What are the risks for AI/ANs getting SUD services?	With the rest of the state in the BHO system, AI/ANs could find it more difficult to get access to non-Tribal SUD outpatient and residential treatment services	AI/ANs could experience similar difficulties with BHOs in getting access to SUD care as with mental health care
How will the State mitigate those risks?	Fee-for-service system	BHO system
How does this option affect Tribes/UIHOs providing care for AI/ANs?	The State will: • Create team to help clients gain access to SUD providers who are willing to accept fee-for-service • Make fee-for-service rates comparable to BHO rates	The State will: • Create team to help clients gain access to SUD providers through the BHOs

1915(b) Waiver Amendment

	Option 1: AI/ANs carved out of BHO SUD services	Option 2: AI/ANs carved into BHO SUD services
How will non-AI/ANs access non-Tribal SUD services?	BHO system	BHO system
How does this option affect Tribes/UIHOs providing care for AI/ANs and non-AI/ANs?	• For AI/ANs, need to work in 2 systems: o BHOs for mental health services o Fee-for-service for SUD services • For non-AI/ANs, need to work in BHOs for both mental health and SUD services	For everyone, need to work in 1 system – BHOs – for both mental health and SUD services

1915(b) Waiver Amendment

	Option 1: AI/ANs carved out of BHO SUD services	Option 2: AI/ANs carved into BHO SUD services
Will there be any transition issues after April 1?	Transition issues for entire BHO system plus: • State will reprogram ProviderOne to accept SUD fee-for-service claims from non-Tribal providers for all AI/AN clients and to permit non-Tribal providers to see if client is AI/AN or not o 4-6 weeks before non-Tribal SUD providers can bill ProviderOne for AI/AN clients o No estimate for when ProviderOne can show who is AI/AN or not	Transition issues for entire BHO system

1915(b) Waiver Amendment

	Option 1: AI/ANs carved out of BHO SUD services	Option 2: AI/ANs carved into BHO SUD services
Will there be any transition issues after April 1? *(continued)*	• State will develop fee-for-service rates for SUD services that are comparable to BHO rates for SUD services • State will develop roster of providers who are willing to accept fee-for-service clients • BHOs and providers will need to learn fee-for-service billing system for AI/AN clients	
What will both options not do?	AI/AN clients will continue to access mental health services through the BHOs through September 30	

1915(b) Waiver Amendment

	Option 1: AI/ANs carved out of BHO SUD services	Option 2: AI/ANs carved into BHO SUD services
Can AI/ANs choose BHO or fee-for-service?	No. Unlike the Medicaid managed care program which permits AI/ANs to choose fee-for-service or managed care under Section 1932 of the Social Security Act, the BHO system operates under Section 1915(b) of the Social Security Act which provides for carve-in or carve-out	
What is CMS looking for from Tribes/UIHOs?	CMS is leaning toward this option If Tribes/UIHOs prefer this option, they could tell CMS before CMS makes its decision	If Tribes/UIHOs prefer this option, they need to tell CMS before CMS makes its decision
When is CMS making its decision?	Tuesday, March 29	

1915(b) Waiver Amendment

Which option do tribes/UIHOs prefer?

Tribal Provisions and Indian Addenda

BHO AND MCO CONTRACTS

BHSC and MCO Contracts and Amendments

What contracts become effective on April 1?

- Statewide Behavioral Health Service Contracts with BHOs (BHSCs)
- Statewide HCA contracts with MCOs
- HCA contracts with MCOs for Fully Integrated Managed Care in Clark and Skamania Counties

When do amendments become effective?

- HCA MCO contracts and BHSCs will be amended next on July 1, 2016

BHSC Tribal Provisions

Contract Section	Tribal Provision
15.1 BHO Tribal Contact	1. BHO must designate a specific person for tribal communication.
15.2 Coordination Plans	1. BHO must reach out to Tribes/RAIOs within its service area and develop a Coordination of Services Plan (similar to a 7.01 Plan). Plan is due March 1 of every year. 2. BHO must reach out to Tribes/RAIOs within its service area and develop a Crisis Coordination Plan. Plan due July 1, 2016, then by March 1 of following year. 3. BHO must extend an invitation for Tribes within its service area to sit on the BHO Governing **and/or** Advisory Board, according to RCW 71.24.300. 1. **looking into if we can change "and/or"

BHSC Tribal Provisions

Contract Section	Tribal Provisions
15.3 Subcontracts	1. BHOs can subcontract with Tribes, UIHOs, or Tribal Providers. However, Tribes, UIHOs, or Tribal Providers **do not have to contract** with a BHO. 2. Subcontracts will include the Indian Addendum. 3. Subcontracts must me be consistent with the laws and regulations that are applicable to Tribes and RAIOs. 4. General terms and conditions (GT&Cs) can: a. Mirror the DSHS Indian Nation Agreement GT&Cs (for Tribes only) b. Mirror the Intergovernmental Agreement for Social and Health Services between Tribes and WA DSHS (for Tribes only) c. Can be developed through a process with the DBHR Tribal Liaison (for Tribes or UIHOs) d. Or can be developed between the Tribe and BHO with a written statement from the Tribe's governing authority of consent of the GT&Cs (for Tribes or UIHOs)

BHSC Tribal Provisions

Contract Section	Tribal Provisions
15.3 Ethnic Minority Specialists	1. BHO must have a policy and procedure that requires efforts to recruit and maintain AI/AN Ethnic Minority Mental Health Specialists from each Tribe or RAIO within the BHO service area.
15.3 Client Right to Choose Behavioral Health Care Provider	1. If the BHO finds out a client is a tribal member of a Federally Recognized tribe, or the AI/AN client is receiving care from a tribal behavioral health or UIHO behavioral health program, the BHO must notify that Tribe or UIHO and assist in discharge and transition planning. *Client must consent and sign a release of information for this to occur.*

BHSC Tribal Provisions

Contract Section	Tribal Provisions
15.4 Individual presents for non-crisis services	1. If a AI/AN presents for non-crisis services, and gives consent, BHO must notify the Tribe or UIHO to assist in treatment planning and service provision. If the client chooses to be served by the tribal or UIHO behavioral health program only, and is not under a LRA requiring them to receive treatment from a BHO provider, a referral to a contracted network behavioral health agency is not required.

BHSC Tribal Provisions

Contract Section	Tribal Provisions
15.5 BHO-Tribal Crisis Coordination Plan	1. BHO must reach out to Tribes/RAIOs within its service area to develop a crisis coordination plan. Tribes/RAIOs can choose to decline. 2. Plan must be reviewed annually. 3. Plan must cover procedures for crisis services, ITA-MH and ITA-SUD evaluations, voluntary inpatient authorization, and discharge planning. 4. Tribes whose lands lie within multiple BHO service areas can choose to create one plan to include all BHOs in the area, or one plan with each BHO. 5. Plan must include procedures for if crisis occurs on weekends, after hours, or holidays. 6. Plan must include response to tribal ITA court orders for ITA-SUD evaluations. 7. Plan must include coordination between non-tribal DMHPs and tribal behavioral health provider.

BHSC Tribal Provisions

Contract Section	Tribal Provisions
Continued… ***15.5 BHO-Tribal Crisis Coordination Plan***	8. Plan must include coordination for ITA-MH and ITA-SUD evaluations on tribal land. If the evaluation cannot be conducted on tribal land, then a process must be described on transporting the client to an E&T facility off tribal land. 9. Plan must include who a non-tribal DMHP should contact to get permission to come onto tribal land. 10. Plan must include a timeframe for the non-tribal DMHP to consult with the tribal behavioral health provider regarding determination to detain or not. 11. Plan must specify where clients will be held and under what authority, if no E&T beds are available. 12. Plan must include how BHO would like the tribal behavioral health provider to request payment authorization, appeals, and expedited appeals. BHOs will provide this information to the Tribes/RAIOs.

BHSC Tribal Provisions

Contract Section	Tribal Provisions
Continued… ***15.5 BHO-Tribal Crisis Coordination Plan***	13. Plan must address procedures and protocols for coordinating discharge planning with tribal behavioral health providers. Plan shall address hospitals, free-standing E&Ts, and SUD residential facilities. 14. Plan must address process for identifying the tribal behavioral health provider as a liaison for inpatient coordination of care when client is identified as a tribal member and has not expressed a preference regarding involvement by the Tribe in their care.

MCO Contract: Section 18.1
"Special Provisions for Subcontracts with I/T/U Providers"

18.1.1 If at any time during the term of this Contract an I/T/U Provider submits a written request to the Contractor at the mailing address set forth on the cover page of this Contract indicating such I/T/U Provider's intent to enter into a subcontract with the Contractor, the Contractor must negotiate in good faith with the I/T/U Provider.

18.1.1.1 Such subcontract must include The Special Terms and Conditions set forth in the I/T/U Provider Addendum, to be developed in consultation with the I/U/T Providers and Tribes, based on the Model QHP Addendum for Indian Health Care Providers issued by the U.S. Department of Health Services on April 4, 2013. To the extent that any provision set forth in the subcontract between the Contractor and the I/T/U Provider conflicts with the provisions set forth in the I/T/U Provider Addendum, the provisions of the I/T/U Provider Addendum shall prevail.

18.1.1.2 Such subcontract may include additional Special Terms and Conditions that are approved by the I/T/U Provider 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 Agency, and a written statement that both parties have agreed to such Additional Special Terms and Conditions.

MCO Contract: Section 18.1
"Special Provisions for Subcontracts with I/T/U Providers"

18.1.2 Any subcontracts with I/T/U Providers must be consistent with the laws and regulations that are applicable to the I/T/U Provider. The Contractor must work with each I/T/U Provider to prevent the Contractor's business operations from placing requirements on the I/T/U Provider that are not consistent with applicable law or any of the special terms and conditions in the subcontract between the Contractor and the I/T/U Provider.

18.1.3 The Contractor may seek technical assistance from the HCA Tribal Liaison to understand the legal protections applicable to I/T/U Providers and American Indian/Alaska Native Medicaid recipients.

18.1.4 In the event that (a) the Contractor and the I/T/U Provider fail to reach an agreement on a subcontract within 90 days from the date of the I/T/U Provider's written request (as described in Subsection 18.1.1) and (b) the I/T/U Provider submits a written request to HCA for a consultation with the Contractor, the Contractor and the I/T/U Provider shall meet in person with HCA in Olympia within thirty (30) days from the date of the I/T/U Provider'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.

MCO Contract: Section 18.1
"Special Provisions for Subcontracts with I/T/U Providers"

18.1.2 Any subcontracts with I/T/U Providers must be consistent with the laws and regulations that are applicable to the I/T/U Provider. The Contractor must work with each I/T/U Provider to prevent the Contractor's business operations from placing requirements on the I/T/U Provider that are not consistent with applicable law or any of the special terms and conditions in the subcontract between the Contractor and the I/T/U Provider.

18.1.3 The Contractor may seek technical assistance from the HCA Tribal Liaison to understand the legal protections applicable to I/T/U Providers and American Indian/Alaska Native Medicaid recipients.

18.1.4 In the event that (a) the Contractor and the I/T/U Provider fail to reach an agreement on a subcontract within 90 days from the date of the I/T/U Provider's written request (as described in Subsection 18.1.1) and (b) the I/T/U Provider submits a written request to HCA for a consultation with the Contractor, the Contractor and the I/T/U Provider shall meet in person with HCA in Olympia within thirty (30) days from the date of the I/T/U Provider'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.

MCO Contract: Section 18.2
"Other Special Provisions for I/T/U Providers"

18.2.1 No later than 180 days after the Contract Start Date, the Contractor shall submit to the HCA Tribal Liaison a plan that describes various services, financing models, and other activities for the Contractor to:

18.2.1.1 Support the recommendations set forth in the Tribal Centric Behavioral Health Report to the Washington State Legislature under 2SSB 5732, Section 7, Chapter 388, Laws of 2013, issued on November 30, 2013.

18.2.1.2 Support and enhance the care coordination services provided by I/T/U Providers for enrollees, both American Indian/Alaska Native and non-American Indian/Alaska Native, including coordination with non-I/T/U Provider:

18.2.1.2.1 Mental health services,

18.2.1.2.2 Substance use disorder treatment services,

18.2.1.2.3 Crisis services,

18.2.1.2.4 Voluntary inpatient services,

18.2.1.2.5 Involuntary commitment evaluation services, and

18.2.1.2.6 Inpatient discharge services.

MCO Contract: Section 18.2
"Other Special Provisions for I/T/U Providers"

18.2.1.3 Improve access for American Indian/Alaska Native enrollees (including those who do not receive care at I/T/U Providers) to receive:

18.2.1.3.1 Behavioral health prevention services,

18.2.1.3.2 Physical and behavioral health care services for co-occurring disorders, and

18.2.1.3.3 Culturally appropriate physical and behavioral health care.

MCO Contract: Section 18.3
"Special Provisions for AI/AN Enrollees"

18.3.1 If an American Indian/Alaska Native enrollee indicates to the Contractor that he or she wishes to have an I/T/U Provider as his or her PCP, the Contractor must treat the I/T/U Provider as an in-network PCP under this Contract for such enrollee regardless of whether or not such I/T/U Provider has entered into a subcontract with the Contractor.

18.3.2 In accord 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 I/T/U Providers for contracted services provided to American Indian/Alaska Native enrollees at a rate equal to the rate negotiated between the Contractor and the I/T/U Provider. 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 I/T/U Provider.

BHSC INDIAN ADDENDUM
COMPARED TO
MCO INDIAN ADDENDUM

BHO/MCO Indian Addendum

Some of the differences between the MCO Indian Addendum and the BHO Indian Addendum are due to HCA's use of the "Model Medicaid Managed Care Addendum for Indian Health Care Providers" found on pp. 31 – 38 of the IHS Tribal Self-Governance Advisory Committee's Comments on CMS-2390-P submitted to the Centers for Medicare and Medicaid Services on July 27, 2015.

BHO/MCO Indian Addendum

MCO Indian Addendum	BHO Indian Addendum
1. Purpose	
This Addendum is intended to become part of any written agreement between the Managed Care Organization and the Indian Health Care Provider for the provision of services to enrollees under the terms of the Washington Apple Health – Fully Integrated Managed Care Contract between the MCO and the Washington State Health Care Authority, as may be amended from time to time. This Addendum applies special terms and conditions necessitated by federal law and regulations to the MCO Provider Agreement. To the extent that any provision of the MCO Provider Agreement (including any other addendum thereto) is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.	This Addendum is intended to become part of any written agreement between the BHO and Tribal BH Provider for the provision of services to Medicaid enrollees under the terms of the Washington Medicaid State Plan. This Addendum applies special terms and conditions necessitated by federal law and regulations to the Behavioral Health State Contract (BHSC). To the extent that any provision of the BHSC (including any other addendum thereto) is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.

BHO/MCO Indian Addendum

MCO Indian Addendum	BHO Indian Addendum
2. Definitions	
"Contract health services"	"Purchased and Referred Care (previous Contract Health Services)"
"American Indian or Alaska Native"	"Indian Health Care Provider"
"Indian Health Care Provider"	"Indian Health Service or IHS"
"Indian Health Service or IHS"	"Indian tribe"
"Indian tribe"	"Behavioral Health Organization or "BHO"
"Managed care organization"	"Tribal health program"
"Tribal health program"	"Tribal organization"
"Tribal organization"	"Urban Indian organization"
"Urban Indian organization"	

MCO Indian Addendum	BHO Indian Addendum
3. Description of Indian Health Care Provider	
The Indian Health Service An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS… A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS… A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to…the Buy Indian Act An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA	Indian Health Service (clinics that are directly federally operated by IHS; services may vary by individual Tribe or Tribal Organization, or Urban Indian Organization) An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS... A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS… A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to…the Buy Indian Act An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA

MCO Indian Addendum	BHO Indian Addendum
4. Cost-Sharing Exemption for Indians; No Reduction in Payments. The MCO shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an American Indian/Alaska Native who is furnished an item or service directly by IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under purchased/referred care. Payments due to IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care provider through referral under purchased/referred care for the furnishing of an item or service to an American Indian/Alaska Native who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. 42 U.S.C. § 1396o(j).	

MCO Indian Addendum	BHO Indian Addendum
6. Agreement to Pay Indian Health Provider. The MCO agrees to pay the Indian Health Care Provider for covered Medicaid managed care services in accordance with the requirements set out in Sec. 1932(h) of the Social Security Act. 42 U.S.C. § 1396u-2(h).	

MCO Indian Addendum	BHO Indian Addendum
7. Persons Eligible for Items and Services from Indian Health Care Provider. The parties acknowledge that eligibility for services at the Indian Health Care Provider's facilities is determined by federal law…Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the Indian Health Care Provider's programs. No term or condition of the MCO Provider Agreement or any addendum thereto shall be construed to require the Indian Health Care Provider to serve individuals who are ineligible under federal law for services from the Indian Health Care Provider. The MCO acknowledges that…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 Indian Health Care Provider. The Indian Health Care Provider acknowledges that the nondiscrimination provisions of federal law may apply.	**4. Persons eligible for items and services from Indian Health Care Provider:** The parties acknowledge that eligibility for services at the Indian Health Care Provider's facilities is determined by federal law…Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the Indian Health Care Provider's programs No term or condition of the BHO or any addendum thereto shall be construed to require the Indian Health Care Provider to serve individuals who are ineligible under federal law for services from the Indian Health Care Provider. Eligibility at the Indian Health Care Provider facility is determined by the Tribe and should no be limited or circumscribed in this agreement. The BHO acknowledges that…an individual shall not be deemed subjected to discrimination…

MCO Indian Addendum	BHO Indian Addendum
8. Applicability of Other Federal Laws: The IHS: • Anti-Deficiency Act, 31 U.S.C. § 1341; • ISDEAA, 25 U.S.C. § 450 et seq.; • Federal Tort Claims Act, 28 U.S.C. §§ 2671-2680; • Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653; • Federal Privacy Act of 1974, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; • Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2; • HIPPA Act of 1996 , 45 C.F.R. Parts 160 and 164; • IHCIA, 25 U.S.C. § 1601 et seq. An Indian tribe or a Tribal organization: • ISDEAA, 25 U.S.C. § 450 et seq.; • IHCIA, 25 U.S.C. § 1601 et seq.; • FTCA, 28 U.S.C. §§ 2671-2680; • Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; • HIPAA, 45 C.F.R. Parts 160 and 164.	**5. Applicability of Other Federal Laws:** The IHS: • Anti-Deficiency Act, 31 U.S.C. § 1341; • ISDEAA, 25 U.S.C. § 450 et seq.; • Federal Tort Claims Act, 28 U.S.C. §§ 2671-2680; • Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653; • Federal Privacy Act of 1974, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; • Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2; • HIPPA Act of 1996 , 45 C.F.R. Parts 160 and 164; • IHCIA, 25 U.S.C. § 1601 et seq. An Indian tribe or a Tribal organization: • ISDEAA, 25 U.S.C. § 450 et seq.; • IHCIA, 25 U.S.C. § 1601 et seq.; • FTCA, 28 U.S.C. §§ 2671-2680; • Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; • HIPAA, 45 C.F.R. Parts 160 and 164.

BHO/MCO Indian Addendum

MCO Indian Addendum	BHO Indian Addendum
8. Applicability of Other Federal Laws (Cont.) An urban Indian organization: • IHCIA, 25 U.S.C. § 1601 et seq. (including without limitation pursuant to the IHCIA Section 206(e)(3), 25 U.S.C. § 1621e(e)(3), regarding recovery from tortfeasors); • Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; • HIPAA, 45 C.F.R. Parts 160 and 164	**5. Applicability of Other Federal Laws (Cont.):** An urban Indian organization: • IHCIA, 25 U.S.C. § 1601 et seq. (including without limitation pursuant to the IHCIA Section 206(e)(3), 25 U.S.C. § 1621e(e)(3), regarding recovery from tortfeasors); • Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; • HIPAA, 45 C.F.R. Parts 160 and 164
9. Non-Taxable Entity To the extent the Indian Health Care Provider is a non-taxable entity, the Indian Health Care Provider shall not be required by the MCO to collect or remit any federal, state, or local tax.	**6. Non-Taxable Entity:** To the extent the Indian Health Care Provider is a non-taxable entity, the Indian Health Care Provider shall not be required by the BHO to collect or remit any federal, state, or local tax.

BHO/MCO Indian Addendum

MCO Indian Addendum	BHO Indian Addendum
10. Insurance and Indemnification Indian Health Service…. The IHS shall not be required to acquire insurance, provide indemnification, or guarantee that the MCO will be held harmless from liability. Indian Tribes and Tribal Organizations….Such Indian Health Care Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the MCO will be held harmless from liability. Urban Indian organizations. Such Indian Health Care Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the MCO will be held harmless from liability.	**7. Insurance and Indemnification:** Indian Health Service…The IHS shall not be required to acquire insurance, provide indemnification, or guarantee that the BHO will be held harmless from liability. Indian Tribes and Tribal Organizations...Such Indian Health Care Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the BHO will be held harmless from liability. Urban Indian organizations…Such Indian Health Care Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the BHO will be held harmless from liability.

MCO Indian Addendum	BHO Indian Addendum
11. Licensure of Health Care Professionals. Indian Health Service…The parties agree that during the term of the MCO Provider Agreement, IHS health care professionals shall hold state licenses in accordance with applicable federal law, and that IHS facilities shall be accredited in accordance with federal statutes and regulations. Indian tribes and tribal organizations…Section 221 of the IHCIA, 25 U.S.C. § 1621t, exempts a health care professional employed by an Indian tribe or tribal organization from the licensing requirements of the state in which such tribe or organization performs services, provided the health care professional is licensed in any state. Urban Indian organizations…. To the extent that any health care professional of an urban Indian organization provider is exempt from state regulation, such professional shall be deemed qualified to perform services under the MCO Provider Agreement and any addendum thereto, provided such employee is licensed to practice in any state.	**8. Licensure of Health Care Professionals:** Indian Health Service…The parties agree that IHS health care professionals shall hold State or Indian tribal licenses in accordance with applicable federal law, and that IHS facilities shall be accredited in accordance with federal statutes and regulations. Indian tribes and tribal organizations. Section 221 of the IHCIA, 25 U.S.C. § 1621t, exempts a health care professional employed by an Indian tribe or tribal organization from the licensing requirements of the state in which such tribe or organization performs services, provided the health care professional is licensed by a state or Indian tribal government. *Need CMS guidance Urban Indian organizations. To the extent that any health care professional of an urban Indian organization provider is exempt from state regulation, such professional shall be deemed qualified to perform services under the BHO Agreement and any addenda thereto, provided such employee is licensed to practice in any state.

BHO Indian Addendum

MCO Indian Addendum	BHO Indian Addendum
12. Licensure of Indian Health Care Provider; Eligibility for Payments. To the extent that the Indian Health Care Provider is exempt from state licensing requirements, such Indian Health Care Provider shall not be required to hold a state license to receive any payments under the MCO Provider Agreement and any addendum thereto.	**9. Licensure of Indian Health Care Provider; Eligibility for Payments:** To the extent that the Indian Health Care Provider is exempt from state licensing requirements, such Indian Health Care Provider shall not be required to hold a state license to receive any payments under the BHO Agreement and any addendum thereto.

BHO Indian Addendum

MCO Indian Addendum	BHO Indian Addendum
13. Dispute Resolution In the event of any dispute arising under the MCO Provider Agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. The laws of the United States shall apply to any problem or dispute hereunder that cannot be resolved by and between the parties in good faith. Notwithstanding any provision in the MCO Provider Agreement or any addendum thereto to the contrary, the Indian Health Care Provider shall not be required to submit any disputes between the parties to binding arbitration.	**10. Dispute Resolution:** In the event of any dispute arising under the BHO Agreement or any addenda thereto, the parties agree to meet and confer in good faith to resolve any such disputes. The laws of the United States shall apply to any problem or dispute hereunder that cannot be resolved by and between the parties in good faith. Notwithstanding any provision in the BHO Agreement or any addenda thereto to the contrary, the Indian Health Care Provider shall not be required to submit any disputes between the parties to binding arbitration.

BHO Indian Addendum

MCO Indian Addendum	BHO Indian Addendum
14. Governing Law. The MCO Provider Agreement and any addendum thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and any addendum thereto and federal law, federal law shall prevail. Nothing in the MCO Provider Agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.	**11. Governing Law:** The BHO Agreement and any addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and any addenda thereto and federal law, federal law shall prevail. Nothing in the BHO Agreement or any addenda thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

BHO Indian Addendum

MCO Indian Addendum	BHO Indian Addendum
15. Medical Quality Assurance Requirements. To the extent the MCO imposes any medical quality assurance requirements on its network providers, any such requirements applicable to the Indian Health Care Provider shall be subject to Section 805 of the IHCIA, 25 U.S.C. § 1675.	**12. Medical Quality Assurance Requirements:** To the extent the BHO imposes any medical quality assurance requirements on its network providers, any such requirements applicable to the Indian Health Care Provider shall be subject to Section 805 of the IHCIA, 25 U.S.C. § 1675.

BHO Indian Addendum

MCO Indian Addendum	BHO Indian Addendum
16. Claims Format. The MCO shall process claims from the Indian Health Care Provider in accordance with Section 206(h) of the IHCIA, 25 U.S.C. § 1621e(h), which does not permit an issuer to deny a claim submitted by an Indian Health Care Provider based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.	**13. Claims Format:** The BHO shall process claims from the Indian Health Care Provider in accordance with Section 206(h) of the IHCIA, 25 U.S.C. § 1621e(h), which does not permit an issuer to deny a claim submitted by an Indian Health Care Provider based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act. **Does this apply to BHOs?*

BHO Indian Addendum

MCO Indian Addendum	BHO Indian Addendum
17. Payment of Claims. The MCO shall pay claims from the Indian Health Care Provider in accordance with federal law, including Section 206 of the IHCIA (25 U.S.C. §1621e), and 45 C.F.R., Part 156, Subpart E. The MCO shall be deemed compliant with Section 206 to the extent the MCO and Indian Health Care Provider mutually agree to the rates or amounts specified in the MCO Provider Agreement as payment in full.	**14. Payment of Claims:** The BHO shall pay claims from the Indian Health Care Provider in accordance with federal law, including Section 206 of the IHCIA (25 U.S.C. §1621e), and 45 C.F.R., Part 156, Subpart E. The BHO shall be deemed compliant with Section 206 to the extent the BHO and Indian Health Care Provider mutually agree to the rates or amounts specified in the BHO Agreement as payment in full. *Does this cover this issue?

BHO Indian Addendum

MCO Indian Addendum	BHO Indian Addendum
18. Hours and Days of Service. The hours and days of service of the Indian Health Care Provider shall be established by the Indian Health Care Provider. At the request of the MCO, such Indian Health Care Provider shall provide written notification of its hours and days of service.	**15. Hours and Days of Service:** The hours and days of service of the Indian Health Care Provider shall be established by the Indian Health Care Provider. At the request of the BHO, such Indian Health Care Provider shall provide written notification of its hours and days of service.

BHO Indian Addendum

MCO Indian Addendum	BHO Indian Addendum
19. Purchased/Referred Care Requirements. The Indian Health Care Provider shall be able to make other referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the MCO.	**16. ~~Contract Health Service~~ Referral Requirements:** The BHO may not require the Indian Health Care Provider to make referrals to the BHO's participating network providers if the Indian Health Care Provider determines that such referrals would conflict with federal law or referral requirements applicable to Contract Health Services, or best interests of the patient. The BHO will honor the tribal assessments and referrals without requiring a referral by a BHO-network provider. *move this language to a MOU?

BHO/MCO Indian Addendum

MCO Indian Addendum	BHO Indian Addendum
20. Sovereign Immunity. Nothing in the MCO Provider Agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.	**17. Sovereign Immunity:** Nothing in the BHO Agreement or in any addenda thereto shall constitute a waiver of federal or tribal sovereign immunity.

BHO/MCO Indian Addendum

MCO Indian Addendum	BHO Indian Addendum
21. Endorsement. An endorsement of a non-federal entity, event, product, service, or enterprise may be neither stated nor implied by the IHS provider or IHS employees in their official capacities and titles. Such agency names and positions may not be used to suggest official endorsement or preferential treatment of any non-federal entity under this MCO Provider Agreement.	**18. Endorsement:** An endorsement of a non-federal entity, event, product, service, or enterprise may be neither stated nor implied by the IHS provider or IHS employees in their official capacities and titles. Such agency names and positions may not be used to suggest official endorsement or preferential treatment of any non-federal entity under this BHO Agreement.

BHO/MCO Indian Addendum

MCO Indian Addendum	BHO Indian Addendum
22. Permitted Uses and Disclosures of Protected Health Information. The MCO acknowledges that an Indian tribe may be a public health authority or health oversight agency with respect to permitted uses and disclosures of protected health information under 45 C.F.R. 164.512.	**19. Permitted Uses and Disclosures of Protected Health Information:** The BHO acknowledges that an Indian tribe may be a public health authority or health oversight agency with respect to permitted uses and disclosures of protected health information under 45 C.F.R. 164.512.

BHO/MCO Indian Addendum

MCO Indian Addendum	BHO Indian Addendum
5. Enrollee Option to Select the Indian Health Care Provider as Primary Care Provider. The MCO agrees that any American Indian/Alaska Native otherwise eligible to receive services from the Indian Health Care Provider may be allowed to choose the Indian Health Care Provider as the American Indian's/Alaska Native's primary care provider if the Indian Health Care Provider has the capacity to provide primary care services to such American Indian/Alaska Native, and any referral from such Indian Health Care Provider shall be deemed to satisfy any coordination of care or referral requirement of the MCO. 42 U.S.C. §1396u-2(h).	**20. Indian Health Care Provider as Primary Care Provider.** The BHO shall designate the Indian Health Care Provider as the primary care provider of an American Indian or Alaska Native enrollee without any time limitations if: Such American Indian or Alaska Native enrollee indicates to the BHO that he or she chooses the Indian Health Care Provider as his or her primary care provider; and The Indian Health Care Provider agrees to serve as such American Indian or Alaska Native enrollee's primary care provider. 42 U.S.C. 1396u-2(h)(1).

BHO Indian Addendum

MCO Indian Addendum	BHO Indian Addendum
	21. Claims Submission: *Who pays? How do we bill? How do we bill for Title 19?*

Behavioral Health

ITU ISSUES GRID

ITU Issues Grid – Medicaid SUD

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
1	BH	HCA	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
2	BH-BHO	BHA	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. This will be further discussed at the HCA-DBHR Monthly Tribal Meeting.	TBA

ITU Issues Grid – Medicaid SUD

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
3	BH-BHO	BHA	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.	TBD
4	BH-TCBH	BHA	Using/Not Using MAT; Tribes do not want to be forced to use MAT if their program doesn't support it. From Consultation 3/9/16	BHA will review this issue and identify any policy, funding or legal drivers. DBHR will report its findings to the Monthly Tribal Meeting	7/1/16
5	BH-TCBH*	BHA/HCA	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 support.	Legislative cycle

ITU Issues Grid – Medicaid Mental Health

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
1	BH-BHO	BHA	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. This will be further discussed at the HCA-DBHR Monthly Tribal Meeting.	TBA

ITU Issues Grid – Medicaid Mental Health

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
2	BH-BHO*	BHA	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 would be willing to participate in this workgroup. Consider collaboration between BHO and local tribes/UIHOs for cultural competency training curricula and delivery. We should include care coordination/discharge planning in this training.	TBD

ITU Issues Grid – Medicaid Mental Health

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
3	BH-BHO/BHSO/ State Plan*	BHA/HCA	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

ITU Issues Grid – Non-Medicaid SUD

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
1	BH-SUD	Federal SAMHSA	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.	No Date – Federal action required

ITU Issues Grid – Non-Medicaid Mental Health

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
1	BH-BHO*	BHA	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.	7/16
2	BH-BHO	BHA	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.	3/28/16

ITU Issues Grid – Non-Medicaid Mental Health

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
3	BH-TCBH*	BHA	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*
4	BH-TCBH*	BHA	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.*	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

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
1	BH-BHO	BHA	Tribes want to make sure BHOs follow Gov. to Gov. *From Consultation 3/9/16*	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.
2	FFS/MCO	HCA/BHA	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) .

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
3	FFS*	HCA/BHA	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.	To be addressed in MTM.
4	BH-BHO	BHA	BHOs not reaching out to Tribes/RAIOs for governing boards, advisory boards, crisis coordination plans, or information on how to access services *From Consultation 3/9/16*	The BHSC requires BHOs to reach out to Tribes. 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.

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
5	BH-BHO	BHA	Tribes being asked to waive sovereign immunity or partial immunity in BHO contracts. *From Consultation 3/9/16*	Tribes do not have to contract with a BHO if they do not want to. 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.. DBHR will amend contracts to add more explicit term that BHOs are required to provide medically necessary Behavioral Health services to all Medicaid individuals, including Tribal members, who request behavioral health treatment services from the BHO.	Indian Addendum required in BHO contracts. Explicit instructions re: Medicaid coverage for Tribal members to be in July amendment .
6	BH-BHO	BHA	Give tribes the funds that were given to BHOs for AI/ANs. *From Consultation 3/9/16*	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

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
7	BH-BHO*	BHA	Require BHOs to identify BHO staff as Tribal liaison.	This is required in the BHSC and PIHP contracts.	In current contract.
8	BH-BHO*†	BHA	Define and clarify role/scope of governing boards. Require BHOs to include Tribal representatives in their decision/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*	DSHS is seeking a legal opinion as to how to address this statute in contract. DSHS will present topic at June MTM. BHO funding is sufficient to provide medically necessary behavioral health treatment services. This item should be explored and discussed through MTM.	Legislative cycle

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
9	BH-TCBH*	BHA	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.	Funds expended and returned.
10	BH-TCBH*‡	BHA	DBHR dedicated FTE to provide technical assistance to Tribes and monitor Tribal relations in BHO contracts (State funded).	Done - Loni Greninger hired on July 1, 2015.	Done
11	Consultation Policy	DSHS	Request to change the DSHS 7.01 policy to include RAIOs (Urbans). *From Consultation 3/9/16*	This will need to go through IPAC, and other approval processes.	Sunset review date of the 7.01 policy is March 31, 2019; will follow up if the policy can be reviewed earlier.
12	BH-BHO	BHA	Remedial action for BHOs, including reduction of funding to BHOs. *From Consultation 3/9/16*	BHA can place a BHO on a corrective action plan if the BHO does not meet its contractual obligations.	Available after 4/1/16

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
13	BH-BHO	BHA	Care coordination; BHOs and subcontractors should notify tribes to coordinate client discharge planning and care coordination. *From Consultation 3/9/16*	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.	3/28/16
14	BH-BHO/BHSO*	BHA/HCA	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

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
15	BH-TCBH	BHA	Review the Tribal Centric Report to the Legislature for updates and follow up. *From Consultation 3/9/16*	BHA will add this item to the agenda for the HCA-BHA MTM workgroup. DBHR/HCA believe they have incorporated those recommendations into this grid. Grid to be reviewed at March MTM meeting.	3/28/16
16	BH-TCBH	BHA/ HCA	Interest in a Tribal BHO. *From Consultation 3/9/16*	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.	Legislative cycle

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
17	BH-TCBH*	BHA	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, this request requires legislative and Governor funding support. Timeframe to be discussed at MTM.	TBD

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
18	BH-TCBH*	BHA/HCA	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	N/A

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
19	BH-TCBH*	BHA/HCA	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

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
20	BH-TCBH*	BHA/HCA	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.	3/28/16
21	BH-TCBH*	HCA	**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. 4/1/16 2. ASAP

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
22	BH-TCBH*†	BHA	Obtain necessary statutory and/or regulatory changes that will allow Tribal Courts to make ITA commitments for Tribal members. *State Response: 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.	Legislative cycle

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
23	Compliance*	HCA/BHA	**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
24	Consultation Policy	DSHS/HCA	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.	Starting 3/28/16

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
25	FFS/MCO	HCA/BHA	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.	TBD
26	BH-BHO	BHA	Tribes want to make sure BHOs follow Gov. to Gov. *From Consultation 3/9/16*	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.	Ongoing

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
27	BH-TCBH*	BHA	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.*	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
28	BH-BHO*	BHA	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. We should include care coordination/discharge planning in this training.	Timeframe to be established at March MTM meeting.

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
29	BH-BHO*‡	BHA	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.	3/28/16
30	BH-BHO/BHSO*	BHA/HCA	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. BHA will review legislative authority to require BHOs to coordinate care with physical health care providers for AI/ANs.	1. Ongoing TBD

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
31	BH-TCBH*	BHA/HCA	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
32	FFS*	HCA/BHA	**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.	TBD

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
33	BHO Contracting	BHA	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.	
34	Client Rights	BHA	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

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
35	Access to Care	BHA/HCA	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.	
36	Case Management	HCA/BHA	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.	

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
37	Service Expansion	BHA/HCA	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"?	
38	Tribal EBPs	HCA/BHA	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.	

ITU Issues Grid – BHO

#	Category	Agency	Issue Description/Analysis	Next Steps	Target Date
39	Crisis Coordination	BHA	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 currently in contract with the BHOs. The DBHR Tribal Liaison is monitoring BHO compliance.	

MISCELLANEOUS

HCA and BHA Meetings
Q2 2016

Date	Meeting
April 13 (Wed)	TBWG
April 25 (Mon)	MTM (HCA+BHA)
May 11 (Wed)	TBWG
May 23 (Mon)	MTM (HCA+BHA)
May [TBA]	MCO-Tribal Meeting
June 8 (Wed)	TBWG
June 27 (Mon)	MTM (HCA+BHA)
Key	
TBWG	Tribal Billing Workgroup – Second Wednesday of the Month (webinar and HCA)
MTM (HCA+BHA)	Monthly Tribal Meeting with HCA+BHA – Fourth Monday of the Month (webinar and HCA Sue Crystal)
MCO-Tribal Meeting	Quarterly MCO-Tribal Meeting (webinar and HCA Sue Crystal)
[TBA]	[To Be Announced]

HCA and BHA Meetings
Q3 2016

Date	Meeting
July 13 (Wed)	TBWG
July 25 (Mon)	MTM (HCA+BHA)
August 10 (Wed)	TBWG
August 22 (Mon)	MTM (HCA+BHA)
August [TBA]	MCO-Tribal Meeting
September 14 (Wed)	TBWG
September 26 (Mon)	MTM (HCA+BHA)
Key	
TBWG	Tribal Billing Workgroup – Second Wednesday of the Month (webinar and HCA)
MTM (HCA+BHA)	Monthly Tribal Meeting with HCA+BHA – Fourth Monday of the Month (webinar and HCA Sue Crystal)
MCO-Tribal Meeting	Quarterly MCO-Tribal Meeting (webinar and HCA Sue Crystal)
[TBA]	[To Be Announced]

HCA and BHA Meetings
Q4 2016

Date	Meeting
October 12 (Wed)	TBWG
October 24 (Mon)	MTM (HCA+BHA)
November 9 (Wed)	TBWG
November 28 (Mon)	MTM (HCA+BHA)
November [TBA]	MCO-Tribal Meeting
December 14 (Wed)	TBWG
December 19 (Mon)	MTM (HCA+BHA)
Key	
TBWG	Tribal Billing Workgroup – Second Wednesday of the Month (webinar and HCA)
MTM (HCA+BHA)	Monthly Tribal Meeting with HCA+BHA – Fourth Monday of the Month (webinar and HCA Sue Crystal)
MCO-Tribal Meeting	Quarterly MCO-Tribal Meeting (webinar and HCA Sue Crystal)
[TBA]	[To Be Announced]

Thank you!

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