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SENT VIA EMAIL: Victoria.Wachino1@cms.hhs.gov; kitty.marx@cms.hhs.gov

October 9, 2015

Victoria Wachino, Director
Center for Medicaid and CHIP Services
Department of Health and Human Services
Attn: CMS-2327-FC
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Ms. Wachino,

As you are aware, the Northwest Portland Area Indian Health Board (NPAIHB) is a Public Law 93-638 Tribal organization that represents health care issues of forty-three federally-recognized Tribes in the states of Idaho, Oregon, and Washington. [1] On behalf of our twenty-nine member Tribes in Washington, we are writing to provide our recommendations on Washington State's new requested 1115 demonstration titled, "Washington State Medicaid Transformation Waiver" submitted to the Centers for Medicare & Medicaid Services (CMS). We applaud the State for submitting this innovative waiver request and support the waiver with conditions to integrate the Indian health system.

Washington Tribes in collaboration with the American Indian Health Commission of Washington (AIHC) and NPAIHB have collaborated over many meetings to provide the attached recommendations. We respectfully request CMS to include our recommendations as Special Terms and Conditions (STCs) in the State's 1115 waiver. The State requests 1115 authority to transform the state's healthcare payment and delivery system through the implementation of Accountable Communities of Health (ACHs). The request also includes changes to the state's Long Term Services & Supports program that will tailor long-term care benefits to meet the needs of the state's ageing population; and the use of Medicaid funding to implement programs that address social determinants of health, such as homelessness and unemployment to prevent avoidable institutionalization. Washington State Tribe believe that the State's proposal under this waiver authority will have direct effect on American Indian and Alaska Native (AI/AN) access to Medicaid services as well as the ability of Indian health providers to participate in the proposed changes. The inclusion of our recommendations as STCs will ensure that AI/AN continue to have access to Medicaid services and will in include Indian health providers in the changed system.

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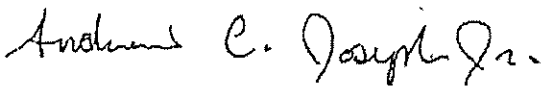
[1] A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.L. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

As a backdrop to our recommended STCs to integrate the Indian health system, it is important to underscore that Congress authorized the Indian Health Service (IHS), and Tribal health facilities to participate in Medicaid as a way to provide critically important resources to the underfunded Indian health system and help meet its federal trust responsibility for the health care of AI/AN people. Since then, Medicaid resources have become a critically important component of the Indian health funding stream, and allowed many IHS and Tribal facilities to begin to address some of the chronic health disparities faced by Indian people in the United States. Without meaningful access to Medicaid resources, many Indian health programs would be unable to maintain current levels of service.

The proposed ACHs in many ways represent Medicaid managed care systems. Medicaid managed care has not succeeded in Indian country. Medicaid managed care systems have little to no familiarity with the Indian health system and routinely disregard the rights of AI/ANs and Indian health providers under the Medicaid statute, the Indian Health Care Improvement Act, and other federal law. AI/ANs continue to find it difficult to access Indian health care providers in managed care settings, and Indian health care providers continue to have difficulties being reimbursed by the Medicaid program from managed care entities. These issues and others pose insurmountable barriers for AI/ANs in accessing the Medicaid program. This is why it is important to include our recommendations as STCs in the State's waiver request.

We thank you for this opportunity to provide our recommended STCs for the Waiver. If you should have any questions concerning our request, please do not hesitate to contact Jim Roberts, Policy Analyst, at (503) 347-7664 or email jroberts@npaihb.org.

Sincerely,



Andy Joseph, Jr., NPAIHB Chair
Colville Tribal Council Member

cc: Kitty Marx, CMS Tribal Affairs Group
John Hammerlund, CMS Region X Administrator
Cecile Greenway, CMS Region X Medicaid
Priya Helweg, CMS Region X, Acting Native American Contact
Dorothy Teeter, Director, WA Health Care Authority
Nathan Johnson, Chief Policy Officer, WA Health Care Authority

Enclosure: AI/AN Standard Terms and Conditions

AI/AN Special Standard Terms and Conditions

Submitted on October 9, 2015

by the Northwest Portland Area Indian Health Board and the American Indian Health Commission for Washington State

1. State will comply with tribal consultation. The State will consult and collaborate with the twenty-nine tribes and two urban Indian health programs. In addition, the State will require all nine regional Accountable Communities of Health (ACHs) to adopt uniform consultation protocols for engaging with tribal governments and urban Indian health programs within their region.

2. State will enforce American Indians/Alaska Natives exclusion from mandatory managed care per 42 U.S.C. § 1396u-2(a)(2)(C). Individuals identified as American Indian/Alaska Native (AI/AN) shall be excluded from this demonstration unless an individual chooses to opt into the demonstration and access coverage pursuant to all the terms and conditions of this demonstration. Individuals who are AI/AN and who have not opted in to a managed care plan will receive the health benefits generally available to enrollees of the managed care plan in which they are enrolled.

3. State will preserve the fee-for-service system within Indian Health Programs. Indian health programs as defined by 25 U.S.C. 25 § 1603(12) shall continue to be eligible for fee-for-service reimbursement at the established Office of Management and Budget's federal encounter rate or the established FQHC rate. The State will ensure the transition to a value-based purchasing system will not negatively impact the fee-for-service system within Indian health programs. The State will establish a tribal coordinating entity who will make recommendations for maintaining the fee-for-service system (see Section 10 below).

4. State will enforce of ARRA 5006(a) Cost Sharing and Premium Protections. AI/AN individuals who receive services directly by an I/T/U or through referral under Purchased/Referred Care services shall not be imposed any enrollment fee, premiums, or similar charges if they are furnished an item or service by an I/T/U or through referral under CHS. Also, AI/AN will remain exempt from deductibles, copayment, coinsurance, cost sharing or similar charges. Payments to an I/T/U or a health care provider through referral under Purchased/Referred care services for services provided to an eligible AI/AN shall not be reduced by the amount of any enrollment fee, premium, deduction, copayment, or similar charges.

5. State will improve Managed Care Plan Network Adequacy, Contracting, Reimbursement, and Coordination of Care. The State will take the following steps to improve Managed Care network adequacy, contracting, reimbursement, and coordination of care:

    a. Require MCOs to offer contracts to all I/T/Us and use the Indian Addendum;

    b. Ensure MCO coordination of care and prior authorization requirements are consistent with I/T/U system's coordination of care requirements (e.g. referrals). Full faith and credit will be given for referrals from I/T/Us as if all I/T/U providers were authorized in any given managed care entity;

    c. Require MCOs to provide increased access to specialty and primary care;

d. Comply with 42 C.F.R. § 447.45 timely claims payment requirement; and ensure MCOs comply with § 447.46 timely claims payment requirements in order to improve the wraparound supplemental payment system;

e. Permit any Indian who is enrolled in a non-Indian managed care entity and eligible to receive services from a participating I/T/U provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services. ARRA 5006(d);

f. Require each managed care entity to demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers. ARRA 5006(d);

g. Require that I/T/U providers, whether participating in the network or not, be paid for covered Medicaid or CHIP managed care services provided to Indian enrollees who are eligible to receive services from such providers either (1) at a rate negotiated between the managed care entity and the I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider. ARRA 5006(d). See also, 25 U.S.C. § 1621e;

h. Provide that the managed care entity must make prompt payment to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under federal regulations at 42 C.F.R. sections 447.45 and 447.46.

i. Require MCOs participate in Indian health care delivery system training and tribal roundtables; and

j. Utilize the tribal assister program model used by the Washington Health Benefit Exchange and the Office of Insurance Commissioner to assist with coverage and access questions for AI/AN beneficiaries.

6. Plan for Improving Population Health. In forging a stronger link between public health and the delivery system, Washington plans to develop a state-wide strategy to improve population health, and more broadly infuse health equity and population health into delivery system and payment reforms. This plan shall recognize and allow the use of GPRA clinical quality measures or other Indian health performance measures to reduce duplication and administrative burden associated with over reporting by I/T/Us.

7. State will incorporate tribal centric behavioral health system with the medical and behavioral health integration set forth in state law and embraced in the Plan. The State and tribes have developed a tribal centric behavioral health system that should be incorporated into the overall integration of medical and behavioral health under the demonstration. In consultation with the tribes, the State will develop a one-year plan on how this integration will be achieved.

8. State will provide AI/AN Specific Provisions for Targeted Foundational Community Supports. The State will exempt AI/AN from the requirement to obtain Target Foundational Community Support services through the MCO system. In order to make these services effective and culturally competent for AI/AN, services should be obtained within their own communities when available. In addition to this exemption, the State will

a. allow tribes and urban Indian health organizations who have the capacity to provide these services to remain outside the managed care organizations and be reimbursed directly by the State; and

b. provide technical assistance to those tribes who do not yet have the capacity to provide Targeted Foundational Community Supports in order to ensure AI/AN have access to culturally competent services within their own communities.

9. State will develop ACHs in a manner that is parallel, complimentary, and coordinates with the Indian health care delivery system. The State will ensure the following:

   a. the design and implementation of Healthier Washington and ACHs meets the needs of the AI/AN communities in Washington state through I/T/U engagement and creation of a tribal coordinating entity (see Section 10 below); and

   b. all Regional ACH will receive training on the Indian health care delivery system with a particular focus on their local I/T/U systems and the needs of Tribal and urban Indian populations.

10. State will establish a Tribal/Urban Coordinating Entity. The State will create an entity that reflects the needs of the tribes and two urban Indian health organizations. This entity should be comprised of tribes, urban Indian health programs, and tribal organizations. The formation of tribal/urban entity will assist the State in the following:

    a. preserving the current Indian health care delivery system including the fee-for-service model and the encounter rate reimbursement;

    b. improving managed care organization compliance with federal legal protections for AI/AN and I/T/Us and improved coordination with the Indian health care delivery system;

    c. determination and implementation of transformation projects; and

    d. ensuring the regional accountable communities of health are designed and implemented in a parallel, complementary and coordinated manner with the Indian health care delivery system.

11. State will work with tribes to develop an uncompensated care waiver. The State shall work with tribes to develop an amendment to this Waiver to make supplemental payments that recognize the burden of uncompensated primary care provided by Indian Health Service (IHS) and tribal health facilities. Such services may include Medicaid optional services that may have been eliminated, or not included in the State's Alternative Benefit Plan or contain service limitations (e.g. number of visits per year) that restrict timely access to needed care to Medicaid enrollees.