SENATE BILL REPORT
SB 6472

As of January 23, 2018

Title: An act relating to Indian health care in Washington state.

Brief Description: Concerning Indian health care in Washington state.

Sponsors: Senators McCoy, Cleveland, Keiser, Hasegawa, Hunt, Conway, Chase and Saldaña.

Brief History:
Committee Activity: Health & Long Term Care: 1/23/18.

Brief Summary of Bill

- Creates the Governor's Indian Health Council to provide oversight and recommendations on policies affecting Indian health care.
- Creates the Indian Health Improvement Reinvestment Account.
- Requires the Health Care Authority (HCA) to contract with a third party administrator to administer a Medicaid fee-for-service plan for American Indians and Alaska Natives (AI/AN).
- Establishes coverage and reimbursement requirements for Medicaid managed care entities with regard to AI/AN people and Indian health care providers (IHCP).

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Staff: Greg Attanasio (786-7410)

Background: The Indian Health Service (IHS), part of the US Department of Health and Human Services, is the federal agency with primary responsibility for fulfilling the United States' trust obligation to provide health care for AI/AN people. The IHS and tribes have developed a system of hospitals, clinics, field stations, and other programs in the attempt to fulfill the federal trust responsibility and meet the health care needs of AI/AN people. Washington's tribal health delivery system provides care to AI/AN people residing in both rural and urban areas. Twenty-eight of the 29 tribes have clinics that provide medical or behavioral health services. There are two urban Indian health clinics in Seattle and Spokane that provide care to urban AI/AN people.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

To meet the needs of the population, Indian health care facilities rely on third party payers, including Medicaid, to reduce shortfalls in funding. All of the tribes in Washington that have tribal health clinics contract with the HCA to be Medicaid providers and access financing to help provide health services to tribal members.

The HCA administers Medicaid in Washington. While most Medicaid enrollees are covered through managed care organizations (MCOs), some are covered under a fee-for-service (FFS) model. AI/AN Medicaid recipients may receive care through an MCO, FFS, or enrollment with an IHS facility or Urban Indian Federally Qualified Health Center (FQHC). When an AI/AN enrollee receives qualifying care from an IHS facility or FQHC, the HCA must pay the facility a facility-specific encounter rate.

In 1976, the Indian Health Care Improvement Act (IHCIA) amended the Social Security Act to permit reimbursement at a 100 percent Federal Medical Assistance Percentage (FMAP) for Medicaid services provided to AI/AN people at IHS and tribal health care facilities. The IHCIA became permanent in 2010. However, states are reimbursed for payments made to Urban Indian Health Programs or non-Indian health providers for Medicaid services provided to AI/AN people on the basis of the state-specific FMAP. Washington's reimbursement rate for these services is 50 percent.

Each tribe also receives a fixed amount of Purchased/Referred Care (PRC) funding from IHS to pay for specialty care not available through tribal clinics. The amount is based on the number of eligible users, the availability of direct care services, and other historical circumstances. When PRC funding is insufficient to provide all needed services, a priority system is used to determine what care is purchased and what is deferred until funding is available or until the medical condition is serious enough for treatment. Federal policy dictates that IHS is a payer of last resort. If an AI/AN requires care outside the Indian health care facility and is eligible for Medicaid, Medicare, has private insurance, or if there is any other payer, all of these must pay before the Indian health program is obligated to use PRC funds.

Amendments to the Social Security Act created a direct relationship between the Centers for Medicare and Medicaid Services (CMS) and the IHS delivery system, including a formal consultation policy with tribes. The HCA also has a tribal consultation policy that requires communication between the HCA and tribes concerning all issues that impact Indian health.

Summary of Bill: Governor's Indian Health Council (Council). The Council must create an action plan to raise the health status of AI/AN people to at least the levels set within the Healthy People 2020 initiative. It must address current and proposed health policies that have tribal implications and cannot be resolved at the agency level and facilitate training on the Indian health system and tribal sovereignty. The Council must consist of:

- tribal liaisons from the HCA, Department of Children, Youth, and Families, Department of Commerce, Department of Health, Department of Social and Health Services, Office of the Insurance Commissioner, Office of the Superintendent of Public Instruction, and the Washington Health Benefit Exchange;
- a delegate from each tribe;
- the chief operating officer of each Indian health service area office;

- the chief operating officer of each urban Indian health program;
- the executive director of the American Indian Health Commission for Washington;
- the executive director of the Northwest Portland Area Indian Health Board;
- a democrat and republican from the House of Representatives and the Senate; and
- two representatives from the Governor's Office.

Tribal Representation and Communication. As a condition of state funding, the HCA must require that each accountable community of health (ACH) provide one seat on its board for each tribe and urban Indian health program in its region. Each ACH must also appoint a tribal liaison and establish written engagement and communication protocols with tribes and urban Indian health programs.

As a condition of state funding, service coordination organizations and service contracting entities must appoint a tribal liaison, establish written engagement and communication protocols with tribes and urban Indian health programs, and follow recommendations from the Council regarding services to AI/ANs and relationships with IHCPs.

Indian Health Improvement Reinvestment Account (Account). The Account is created in the state treasury to fund programs to improve health outcomes from AI/AN people. The Account must be funded with:
- all savings to the state general fund resulting from the 100 percent FMAP received for Medicaid services provided to AI/AN people;
- 12 percent of all annual state community mental health funding; and
- any other public or private funds deposited in the account.

The state must work with tribes to develop a data reporting system to track funds generated for the Account. The Council must establish a committee to determine expenditures from the fund. Expenditures may only be used to fund specified programs related to improving or delivering health services to AI/AN people, including Medicaid administration, mental health programs, traditional healing services, and reducing barriers to care.

Medicaid FFS. The HCA must enroll AI/AN Medicaid enrollees in the state FFS system as a default. HCA must allow AI/AN enrollees to opt-in to managed care. AI/AN enrollees may select an IHCP or FFS provider as their behavioral health and physical health provider. The HCA must contract with a third party administrator to administer the FFS system for AI/AN enrollees. The administrator must:
- make payments for services;
- manage PRC networks and assure proper payment for PRC services;
- provide assistance to AI/AN enrollees regarding eligibility for care;
- assign enrollees to Indian health care provider patient-centered medical homes (PCMH);
- work to bring specialist services to Indian health care providers; and
- provide training on delivering culturally appropriate services.

Medicaid Managed Care. If an IHCP is not a FQHC, the HCA must require MCOs to pay the provider's published encounter rate or, if the provider does not have an encounter rate, MCOs must pay the FFS rate for the service provided. If the IHCP is a FQHC, MCOs must pay the negotiated rate. MCOs must treat every IHCP as an in-network provider, include them on

their in-network provider lists available to patients, and allow AI/AN enrollees to choose an IHCP as their primary care provider. MCOs must designate a tribal liaison to address any billing issues with IHCPs. MCOs must also:

- accept all referrals from an IHCP for AI/AN patients without requiring prior authorization;
- provide only the services requested by an IHCP or AI/AN patient, and coordinate care to maintain the AI/AN's PCMH;
- require staff to receive Indian health care delivery system and cultural humility training; and
- develop protocols for accessing tribal land to provide crisis services.

The HCA must establish a process for IHCPs to submit complaints regarding any unresolved issues with an MCO and the HCA must directly facilitate a resolution. The HCA must produce an annual report that includes:

- a description of the concerns raised by IHCPs and the HCA's efforts to resolve them;
- information on whether MCOs are meeting federal requirements concerning IHCP participation in their networks and payment requirements; and
- the effect of Medicaid waivers on the accessibility and quality of services, including the effect the expansion of managed care will have on the FFS system.

Cultural Awareness. The HCA must consult with tribes and urban Indian health programs to develop a plan to address historical trauma and intergenerational trauma in treatment planning for Medicaid services, including crisis services.

Consultation. The secretary of the Department of Health (DOH) must include tribes in the development of a public health system that acknowledges tribal authority and responsibility for their community. The DOH must include an IHCP track in its effort to transform the practice of healthcare professionals and must work with IHCPs to ensure that efforts for improving population health include tribally determined practices.

Appropriation: None.

Fiscal Note: Requested on January 19, 2018.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: Indian country has significant health care needs that are not being met through IHS alone. The Congressional Budget Office estimates that IHS is funded at 32 percent of need. The federal government spends less per capita on American Indian health care than any other minority group. The bill represents the American Indian community's effort to fully provide health care for its people. Tribal health programs have improved over the years and the American Indian Heath Commission has worked at the agency level to address as many issues as possible, but some improvements to the system must be done legislatively. Changes to the Medicaid delivery system, in particular a shift toward managed care, have negatively impacted AI/AN Medicaid enrollees. This bill would address many of the remaining roadblocks to better health care for AI/ANs.

OTHER: The Military Department supports including tribal representatives on the Emergency Management Council; however, it requests an amendment to increase the number of members of the council so the addition of tribal representatives would not be at the expense of other stakeholders. The Military Department also requests an amendment that includes direction for a selection process for tribal representatives.

Persons Testifying: PRO: Senator John McCoy, Prime Sponsor; Vicki Lowe, American Indian Health Commission; Maria Gardipee, American Indian Health Commission; Heather Erb, American Indian Health Commission; Andrew Shogren, American Indian Health Commission; Stephen Kutz, American Indian Health Commission, Cowlitz Indian Tribe.

OTHER: Jason Marquiss, Emergency Management Division.

Persons Signed In To Testify But Not Testifying: No one.