Attachment H
Indian Health Care Provider (IHCP) Protocol (formerly known as the Tribal Protocol)

I. RESTATEMENT OF NATIONAL POLICY

In Section 3 of the Indian Health Care Improvement Act (codified at 25 U.S. Code § 1602), Congress declared that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to American Indians:

1. To ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;
2. To raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives;
3. To ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;
4. To increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population;
5. To require that all actions under this chapter shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this chapter and the national policy of Indian self-determination;
6. To ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and
7. To provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service."

II. DEFINED TERMS

1. **Accountable Community of Health** or **ACH** has the meaning set forth in the Special Terms and Conditions for the Washington State Medicaid Transformation Project Section 1115(a) Medicaid Demonstration.

2. **American Indian/Alaska Native** or **AI/AN** means "Indian" as defined in 25 U.S. Code § 1603(13).

3. **Community Health Aide Program** or **CHAP** refers to that program authorized under 25 U.S. Code § 1616*ℓ*.

4. **Indian Health Care Provider** or **IHCP** has the meaning set forth in 42 C.F.R. § 438.14(a).

5. **Indian Health Service or IHS** means the agency within the U.S. Department of Health and Human Services responsible for providing federal health services to AI/ANs.

6. **Tribe** means "Indian tribe" as defined in 25 U.S. Code § 1603(14).

7. **Urban Indian Health Program** or **UIHP** means an Urban Indian Organization as defined in 25 U.S. Code § 1603(29) that receives IHS funding to provide health care services to AI/ANs.

III. DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM

1. **Objectives.** With the IHCP specific projects, the state and the tribes and UIHPs seek to achieve the following interests in Medicaid transformation.

    a. ***Collaborative Medicaid Transformation***. Due to treaty obligations and the special trust responsibility, tribes have government-to-government relations with both federal and state governments and IHS facilities and UIHPs have the right to be solicited for advice on Medicaid matters that affect them or their AI/AN patients. In addition, under chapter 43.376 of the Revised Code of Washington, state agencies are required to make reasonable efforts to collaborate with Indian tribes in the development of policies, agreements, and program implementation that directly affect tribes. In recognition of these relationships and requirements, the Medicaid Transformation Demonstration will support the tribes', IHS facilities', and UIHPs' planning efforts by allocating a total of $5,400,000 of Demonstration Year 1 (DY1) incentive payment funds to support the planning and various infrastructure investments related to IHCP-specific projects.

    b. ***IHCP Health Systems and Capacity.*** In recognition of the complexity of IHCP health systems due to the legacy of the IHS Resource and Patient Management System (RPMS) and federal reporting requirements under the Government Performance and Results Act of 1993, the Medicaid Transformation Demonstration will provide incentive payments for achieving milestones that reflect the development of more effective health systems and greater capacity within IHCPs to support and expand the coordination of physical and behavioral health care and social services for Medicid clients and to enable IHCPs to help reduce unnecessary use of intensive services and settings by Medicaid clients without impairing health outcomes. To support financial sustainability, investments in IHCP health systems and capacity will be made in ways that maximize their access and availability to as many tribes, IHS facilities, and UIHPs as possible using information technology protocols and platforms in common use with the state Medicaid program and providers, while respecting individual tribal government needs. Potential investments areas include:

        i. <u>Workforce Capacity and Innovation</u>

            A. *CHAP Board*. Support for the creation of a certification board, similar to the Community Health Aide Certification Board (as defined in 25 U.S. Code § 1616*l*) in Alaska, to oversee the training and continuing education for Dental Health Aide Therapists, Behavioral Health Aides, Community Health Aides, and other mid-level providers.

            B. *CHAP Education*. Support for the creation of an education program, housed within an established institution of higher education, for various community health aides, including behavioral health aides.

C. *CHAP Provider Implementation*. Support for incorporating new CHAP Board-certified providers into tribal health programs.

ii. Health Systems

A. *Electronic Behavioral Health Records*. Support for the installation of electronic behavioral health records that interface with electronic health records.

B. *Clinical Data Repository*. Support for the creation of the system interfaces for tribal health programs, IHS facilities, and UIHPs to export and import client clinical data into one or more clinical data repositories including state-contracted data repositories (such as Link4Health operated by OneHealthPort and the Emergency Department Information Exchange (EDIE) operated by CollectiveMedical Technologies, Inc.).

C. *Population Health Management*. Support for the creation of a population health management tool for tribal health programs, IHS facilities, and UIHPs to use, drawing data from clinical data repositories and other state-contracted data repositories (such as Link4Health operated by OneHealthPort and the Emergency Department Information Exchange (EDIE) operated by CollectiveMedical Technologies, Inc.).

c. ***Financial Sustainability***. The tribes, IHS facilities, and UIHPs will be given greater flexibility in how they assure the sustainability of the transformation projects undertaken through the Medicaid Transformation Project demonstration in recognition of the special trust responsibility and the following recent CMS guidance, which the state is in the process of implementing:

i. CMS State Health Official Letter #16-002, dated February 26, 2016; and

ii. CMS Frequently Asked Questions (FAQs): Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives (SHO #16-002), dated January 18, 2017.

d. ***Statewide Improvement of Behavioral Health for AI/AN Medicaid Clients***. In recognition of the significant health disparities in AI/AN mental health and substance use disorder and intergenerational trauma (collectively, behavioral health), the special trust responsibility, and the significant investments tribes and UIHPs have made in integrating physical and behavioral health despite enduring decades of severe underfunding, the Medicaid Transformation Project demonstration will take a more flexible approach toward IHCPs and seek to improve the behavioral health of Medicaid-enrolled AI/ANs statewide by providing directed support for each IHCP to implement IHCP-specific physical and behavioral health and social service innovations identified in:

i. The National Tribal Behavioral Health Agenda (https://www.nihb.org/behavioral_health/behavioral_health_agenda.php);

ii. The Urban Indian Health Institute (UIHI) Report: "Supporting Sobriety Among American Indians and Alaska Natives: A Literature Review – February 2014" (http://www.uihi.org/download/supporting-sobriety-among-american-indians-alaska-natives-literature-review-february-2014/?wpdmdl=11604); and

iii. The UIHI Report: "Addressing Depression Among American Indians and Alaska Natives: A Literature Review – August 2012" (http://www.uihi.org/download/addressing-depression-among-american-indians-alaska-natives-literature-review/?wpdmdl=11408).

e. ***Other Tribal- or IHCP-Specific Objectives*** as may be agreed upon by the Centers for Medicare and Medicaid Services, the state, and the proposing tribes and/or IHCPs.

2. **Timeline.**

a. ***IHCP Planning Funds Plan***. No later than December 31, 2017, the tribes and IHCPs will submit to the state a consolidated IHCP Planning Funds Plan. Upon review and acceptance of the IHCP Planning Funds Plan, the state will issue $5,400,000 out of Demonstration Year 1 incentive payment funds in accordance with the instructions received from the tribes and IHCPs. To be accepted by the state, the IHCP Planning Funds Plan must include:

i. Statewide Inventory of Indian Health and Indian Health Care, which includes:

A. An inventory of the health needs, including the behavioral health needs, of the different AI/AN communities in Washington State, both tribal and non-tribal (such as urban), with a particular focus on the barriers to care for Medicaid-covered AI/ANs;

B. An inventory of the physical health care, behavioral health care, dental care, and social service resources available at tribes, IHS facilities, and UIHPs in Washington State;

C. An inventory of the data, health information technology, and population health management systems at tribes, IHS facilities, and UIHPs in Washington State and analogous social service/case management data and information systems at tribes in Washington State;

D. An inventory of the evidence-based and promising practices, including behavioral health-related practices, that have been used by tribes, IHS facilities, and UIHPs to improve health care and health outcomes for their clients; and

E. An inventory of the barriers (federal and state laws and regulations, practical impacts of Medicaid and Medicare programs, etc.) to implementing these evidence-based and promising practices, including behavioral health-related practices.

ii. Plan for Statewide Improvement of AI/AN Behavioral Health, which includes:

A. A framework based on the National Tribal Behavioral Health Agenda;

B. Strategies within the framework that build on the services available at tribes, IHS facilities, and UIHPs, and on the evidence-based and promising practices that have been used by tribes, IHS facilities, and UIHPs to improve AI/AN behavioral health and behavioral health care;

C. Anticipated investments in data, health information technology, and population health management systems at tribes, IHS facilities, and UIHPs and analogous social service/case management data and information systems at tribes to enable tribes, IHS facilities, and UIHPs to implement the strategies and evidence-based and promising practices; and

D. Explanations of how these strategies and investments will achieve the objectives of the Medicaid Transformation Demonstration.

iii. Instructions for Payment of Earned IHCP Planning Funds, including:

A. *Decision Making*. The tribes and UIHPs have agreed that decisions regarding payment of earned IHCP Planning Funds will be made by majority vote of tribes and UIHPs, with each having one vote to be held by the AIHC delegate from the tribe or UIHP unless the tribe or UIHP directs that vote to be held by someone else. If the IHCP Planning Funds are earned before the tribes and UIHPs agree on how to allocate the funds, the state will not allocate the earned funds until the tribes and UIHPs instruct the state on whom will receive the funds and in what amounts.

B. *Funding Priorities*. The tribes and UIHPs have agreed that the IHCP Planning Funds will be allocated to support the following:

- Work that was done to earn the IHCP Planning Funds, including completion of the Tribal Protocol;

- Work that needs to be done to complete the IHCP Projects Plan, with one portion allocated equally to every tribe and UIHP in the state and the remaining portion allocated based on percentage of a total, such AI/AN Medicaid clients or IHS User Population; and

- Infrastructure investments to increase the ability of all tribes and UIHPs to attain the milestones in the IHCP Projects Plan, such as the CHAP Board and the clinical data repository/population health management.

b. ***IHCP Projects Plan***. No later than March 31, 2018, the tribes and IHCPs will submit to the state a consolidated IHCP Projects Plan, which will include both a statewide default project focused on statewide improvement of behavioral health for AI/AN and any additional projects that the tribes and IHCPs agree upon. Upon acceptance of the IHCP Projects Plan, the state will issue incentive payments upon achievement of the milestones in the IHCP Projects Plan in accordance with the instructions received from the tribes and IHCPs.

3. **Process.** The following provisions supercede the various protocols related to the DSRIP program:

a. ***ACH Certification - Tribal Requirement***. The State will require every ACH to adopt and demonstrate compliance with the Model ACH Tribal Collaboration and Communication Policy, attached hereto as Exhibit A, or a policy agreed upon in writing by the ACH and every IHCP in the ACH region, as part of the ACH certification process.

b. ***Application to IHCPs***. The term "ACH" in the DSRIP Planning Protocol will be interpreted to include IHCPs where appropriate to enable IHCPs to participate in the DSRIP Program in accordance with the terms of this Tribal Protocol.

c. ***No Requirement for Tribal Certification***. The State will not require any IHCP to undergo the ACH certification process in order to participate in the DSRIP Program. HCA will work with IHCPs to maintain compliance with federal requirements applicable to IHCPs participating in the DSRIP Program.

d. ***DSRIP Program Models***. For IHCPs participating in the DSRIP Program, the State will accept evidence-based or promising care models developed for, or tailored to, AI/AN clients that otherwise meet the requirements of the Transformation Project Toolkit (Attachment C to the Special Terms and Conditions for the Washington State Medicaid Transformation Project Section 1115(a) Medicaid Demonstration).

e. ***DSRIP Program Guidance and Technical Assistance for IHCPs***. The State will work with the Tribal Coordinating Entity to provide targeted guidance and technical assistance to help IHCPs implement one or more projects in the IHCP's regional ACH Project Plan or the IHCP Projects Plan or both, including appropriate milestones and outcome measurement goals that qualify for incentive payments.

f. ***Regional Health Needs Inventories (RHNIs) and Regional Health Improvement Plans (RHIPs)***. In respect for the sovereignty and representative governmental processes of tribes and their knowledge of their citizens and their systems, the State will accept tribe-developed alternatives to formal RHNIs or RHIPs as a demonstration of population health needs for participation in the DSRIP Program. In respect for the complex systems of IHCPs and their unique role in helping the U.S. Department of Health and Human Services meet its federal trust responsibility to AI/ANs (including urban Indians and AI/ANs not living near their Indian reservations or villages), the State will accept IHCP-developed alternatives to formal RHNIs or RHIPs as a demonstration of population health needs for participation in the DSRIP Program.

g. ***No Required Projects for IHCPs***. The State will support tribes and IHCPs in their choices of DSRIP Program projects. IHCPs will not be required to implement either of the required projects listed in the Transformation Project Toolkit, nor will they be required to implement a minimum number of projects as provided for in the Transformation Project Toolkit.

h. ***Statewide Tribal-IHCP Projects***. The State encourages and will support IHCPs in a statewide IHCP effort to implement one or more projects in the IHCP Projects Plan, with incentive payments for collaborative sharing of expertise and individual IHCP efforts.

i. ***Financial Sustainability***. In respect for the sovereignty of Tribes and their responsibility in meeting the health needs of their clients, the State will not require IHCPs to adopt value-based payment methodologies, nor will the State be required to include IHCPs in value-based payment incentive programs, in meeting the financial sustainability requirements of the demonstration. In respect for the complex systems of IHCPs and their unique role in helping the U.S. Department of Health and Human Services meet its federal trust responsibility to AI/ANs (including urban Indians and AI/ANs not living near their Indian reservations or villages), the State will not require IHCPs to adopt value-based payment methodologies in meeting the financial sustainability requirements of the demonstration. For IHCPs, the State will accept alternative financial sustainability models.

j. ***Performance Measurement***. The State will accept Government Performance and Results Act (GPRA), and/or Universal Data System (UDS) measures in lieu of comparable statewide common performance measures when such substitution will reduce duplicative reporting and avoid excessive administrative burden on IHCPs.

4. **Funding and Mechanics.** The following provisions supercede the various protocols related to the DSRIP program:

a. ***Application to IHCPs***. The term "ACH" in the DSRIP Program Funding and Mechanics Protocol will be interpreted to include IHCPs where appropriate to enable IHCPs to participate in the DSRIP Program in accordance with the terms of this Tribal Protocol.

b. ***IHCP Incentive Funds***. Notwithstanding STC 28 and STC 35(b) and in accordance with DSRIP Funding and Mechanics Protocol III(c), the state will use the ratio of AI/AN Medicaid enrollees to total Medicaid enrollees to determine the percentage of the maximum statewide amount of DSRIP project funding to allocate to IHCP-specific projects (also referred to in the DSRIP Funding and Mechanics Protocol as tribal-specific projects).

IV. MEDICAID ALTERNATIVE CARE AND TAILORED SUPPORTS FOR OLDER ADULTS

1. **Eligibility to Provide Health Care Services and Acceptance of Tribal Attestation.** To the extent that services provided under the Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) programs are health care services, the state will accept any IHCP as a provider eligible to receive payment under the MAC and TSOA programs for health care services furnished to an AI/AN on the same basis as any other provider qualified to participate as a

provider of health care services under the MAC and TSOA programs in accordance with 25 U.S.C. § 1647a(a)(1). To the extent permitted by federal and state law, the state will accept tribal attestation of compliance with state provider requirements for health care services if a tribe establishes provider entity standards with comparable client protections.

2. **Exemption from Washington State Licensure.** To the extent that services provided under the MAC and TSOA programs are provided by licensed health professionals, the state will accept health professionals employed by the tribe who are licensed in another state and are performing services described in the contract or compact of the Indian health program under Indian Self-Determination and Education Assistance Act in accordance with 25 U.S.C. § 1621t.

3. **Client Presumptive Eligibility Assessments.** To the extent that any IHCP has the capacity and desire to perform presumptive eligibility assessments under the MAC and TSOA programs in accordance with federal and state requirements, the state will pay the standard case management rate for such activity.

4. **Client Services.** To the extent that any IHCP has the capacity and desire to provide client services under the MAC and TSOA programs in accordance with federal and state requirements (including federal conflict of interest rules), the state will pay the Medicaid contracted provider rate for each service.

5. **Coordination with IHCPs.** The state will make available to IHCPs training dates, information, and curriculum pertaining to the MAC and TSOA programs.

V. FOUNDATIONAL COMMUNITY SUPPORTS

1. **Eligibility to Provide Health Care Services and Acceptance of Tribal Attestation.** To the extent that services provided under the Foundational Community Supports program are health care services, the state and its administrative entity will accept any IHCP as a provider eligible to receive payment under the Foundational Community Supports program for health care services furnished to an AI/AN on the same basis as any other provider qualified to participate as a provider of health care services under the Foundational Community Supports program in accordance with 25 U.S.C. § 1647a(a)(1). To the extent permitted by federal and state law, the state will accept tribal attestation of compliance with state provider requirements for health care services if a tribe establishes provider entity standards with comparable client protections.

2. **Exemption from Washington State Licensure.** To the extent that services provided under the Foundational Community Supports program are provided by licensed health professionals, the state will accept health professionals employed by the tribe who are licensed in another state and are performing services described in the contract or compact of the Indian health program under Indian Self-Determination and Education Assistance Act in accordance with 25 U.S.C. § 1621t.

3. **Client Services.** To the extent that any IHCP has the capacity and desire to provide client services under the Foundational Community Supports program in accordance with federal and state requirements, the state will pay the Medicaid contracted provider rate for each service through the administrative entity.

4. **Coordination with IHCPs.** The state will make available to IHCPs training dates, information, and curriculum pertaining to the Foundational Community Supports program. The state will facilitate one or more meetings between IHCPs and the Foundational Community Supports program administrative entity and providers to increase mutual understanding of capacity and systems related to the Foundational Community Supports program.