S-3699.1

SENATE BILL 6472

State of Washington 65th Legislature 2018 Regular Session

By Senators McCoy, Cleveland, Keiser, Hasegawa, Hunt, Conway, Chase, and Saldaña

Read first time 01/18/18. Referred to Committee on Health & Long Term Care.

AN ACT Relating to Indian health care in Washington state; amending RCW 38.52.040, 41.05.690, and 70.320.020; reenacting and amending RCW 43.84.092; and adding a new chapter to Title 70 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** The legislature declares it is the policy of this state, in fulfillment of the state's unique relationships and shared respect between sovereign governments to:

(1) Recognize the United States' trust responsibility to provide health care to American Indians and Alaska Natives including those individuals who are citizens of this state;

(2) Recognize that American Indians and Alaska Natives as citizens of this state should have equitable access to any health care benefits provided by the state;

(3) Improve upon and rectify unintended consequences of prior state policies and actions that have limited American Indian and Alaska Native access to health care that is part of the federal trust responsibility and to health care benefits provided by the state to its citizens;

(4) Assure that when the state delegates health care responsibilities to nongovernmental entities, actions of those entities that impact American Indian and Alaska Native access to

health care are consistent with maintaining the federal trust responsibility to provide health care to American Indians and Alaska Natives and consistent with the policies contained in this section;

(5) Assure that the state and tribes work in a government-to-government relationship to provide quality health care for all tribal members;

(6) Require that implementation of this chapter and all actions under this chapter are carried out with active and meaningful consultation with tribes and conference with urban Indian health programs in accordance with the national policy of Indian self-determination;

(7) Assure the highest possible health status for American Indians and Alaska Natives by providing resources necessary to effect that policy;

(8) Raise the health status of American Indians and Alaska Natives to at least the levels set forth in the goals contained within the federal healthy people 2020 initiative or successor objectives;

(9) Assure maximum American Indian and Alaska Native participation in the direction of health care services so as to render the persons administering such services more responsive to the needs and desires of American Indian and Alaskan Native individuals and communities; and

(10) Assure that savings realized by the state for services which are received through an Indian health service facility whether operated by the Indian health service or by an Indian tribe or tribal organization pursuant to 42 U.S.C. Sec. 1396d (b), are reinvested back into the Indian health care delivery system within the state as provided in section 11 of this act.

NEW SECTION. **Sec. 2.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "American Indian" or "Alaska Native" means any individual who is: (a) A member of a federally recognized tribe; or (b) eligible for the Indian health service.

(2) "American Indian health commission for Washington state" means a Washington nonprofit corporation wholly controlled by the tribes and urban Indian health programs in the state.

(3) "Authority" means the health care authority as the single state medicaid agency.

(4) "Community health aide" means a health care worker certified by a community health aide program of the Indian health service or an Indian tribe or tribal organization consistent with the requirements of 25 U.S.C. Sec. 1616 who can perform a wide range of duties within the worker's scope of certified practice in health programs of an Indian tribe or tribal organization to improve access to quality care for American Indians and Alaska Natives and their families and communities.

(5) "Fee-for-service" means the state's medicaid program for which payments are made under the state plan in accordance with the fee-for-service payment methodology.

(6) "Indian health care provider" means a health care program operated by the Indian health service or by an Indian tribe, tribal organization, or urban Indian organization as those terms are defined in 25 U.S.C. Sec. 1603.

(7) "Indian health service" means a federal agency within the United States department of health and human services.

(8) "Indian tribe" or "tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native claims settlement act (43 U.S.C. Sec. 1601 et seq.) which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(9) "Medicaid managed care entity" means a managed care entity as defined in 42 U.S.C. Sec. 1396u-2 (a)(1)(B).

(10) "Traditional healing services" means culturally appropriate healing methods developed and practiced by generations of tribal healers who apply methods for physical, mental, and emotional healing. The array of practices provided by traditional healers must be in accordance with an individual tribe's established and accepted traditional healing practices.

(11) "Tribal organization" has the meaning set forth in 25 U.S.C. Sec. 5304.

(12) "Urban Indian" means any individual who resides in an urban center and is: (a) A member of a tribe terminated since 1940 and those tribes recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree,

of any such member; (b) an Eskimo or Aleut or other Alaska Native; (c) considered by the secretary of the interior to be an Indian for any purpose; or (d) considered by the United States secretary of health and human services to be an Indian for purposes of eligibility for Indian health services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

(13) "Urban Indian health program" means an urban Indian organization, as defined by 25 U.S.C. Sec. 1603(29), that is operating a facility delivering health care.

NEW SECTION. **Sec. 3.** (1) The governor's Indian health council is established. It is the intent of the legislature to implement the national policy of Indian self-determination and to assure the highest possible health status for American Indians and Alaska Natives by providing resources necessary to effect this policy through the creation of the governor's Indian health council. This council shall create an action plan to raise the health status of American Indians and Alaska Natives to at least the levels set forth in the goals contained within the federal healthy people 2020 initiative or successor objectives.

(2) In collaboration with staff whom the authority may assign, the authority must assist the governor by convening and providing assistance to the council. The council must consist of the following representatives:

(a) The tribal liaisons from each of the following state agencies: The authority; the department of children, youth, and families; the department of commerce; the department of corrections; the department of health; the department of social and health services; the office of the insurance commissioner; the office of the superintendent of public instruction; and the Washington health benefit exchange;

(b) One individual from each tribe, designated by the tribal council, who is either the tribe's American Indian health commission for Washington state delegate or an individual specifically designated for this role, or his or her designee;

(c) The chief operating officer of each Indian health service area office and service unit, or his or her designee;

(d) The chief operating officer of each urban Indian health program, or the urban Indian health program's American Indian health commission for Washington state delegate, or his or her designee;

(e) The executive director of the American Indian health commission for Washington state, or his or her designee;

(f) The executive director of the northwest Portland area Indian health board, or his or her designee;

(g) One member from each of the two largest caucuses of the house of representatives, appointed by the speaker of the house of representatives;

(h) One member from each of the two largest caucuses of the senate, appointed by the president of the senate; and

(i) Two designees representing the governor's office.

(3) With assistance from the authority, the council must convene to:

(a) Address current or proposed policies or actions that have tribal implications and are not able to be resolved or addressed at the agency level;

(b) Facilitate training for agency leadership, staff, and legislators on the Indian health system and tribal sovereignty; and

(c) Provide oversight of contracting and performance of service coordination organizations or service contracting entities as defined in RCW 70.320.010 in order to address their impacts on services to American Indians and Alaska Natives and relationships with Indian health care providers.

(4) The governor's Indian health council meetings, recommendations, and other forms of collaboration support the consultation process established in section 4 of this act but are not a substitute for the requirement for state agencies to conduct consultation under federal and state law.

(5) The governor's Indian health council must establish an Indian health improvement reinvestment account committee to provide oversight over the Indian health improvement reinvestment account established in section 8 of this act. The tribal and Indian health care provider representatives of the committee must determine which projects should receive funding from the Indian health improvement reinvestment account, in what amounts, and under what reporting requirements. This committee must consist of the following representatives:

(a) Each federally recognized tribe in the state of Washington must be represented in a voting capacity by an individual designated by tribal council, either the tribe's delegate to the American Indian

health commission for Washington state or an individual specifically designated for this role by the tribal council;

(b) Each urban Indian health program must be represented in a voting capacity by an individual designated by the governing board of the program, either the program's delegate to the American Indian health commission for Washington state or an individual specifically designated for this role by the board of the program;

(c) Each Indian health service unit must be represented in a nonvoting capacity by the chief executive officer or his or her designee who is also an officer of the Indian health service unit;

(d) One or more representatives from the office of financial management;

(e) The American Indian health commission for Washington state must be represented in a nonvoting capacity by the executive director or an individual specifically designated for this role by the American Indian health commission for Washington state; and

(f) The northwest Portland area Indian health board must be represented in a nonvoting capacity by the executive director or an individual specifically designated for this role by the governing board of the northwest Portland Indian area health board.

NEW SECTION. **Sec. 4.** (1) The tribal consultation policy of the authority applies to all medicaid matters, including medicaid state plan amendments, waivers, and program-related contracts. Under this consultation policy, the authority must provide tribes and Indian health care providers the opportunity and resources to be fully informed of all medicaid waivers and state plan amendments and their impacts on tribes, Indian health care providers, and American Indians and Alaska Natives. The authority must give tribes and Indian health care providers sufficient information to determine the impacts of these medicaid waivers and state plan amendments on their individual health care delivery systems. The authority must consult with the tribes and Indian health care providers and seek advice regarding any medicaid managed care contracts between the state and a medicaid managed care entity.

(2) State agencies must consult with tribes and confer with urban Indian health programs in the design and implementation of health transformation initiatives to assure coordination between Indian and non-Indian health systems and include approaches focused on

effectiveness in addressing the needs of American Indian and Alaska Native people.

NEW SECTION. **Sec. 5.** As a condition of state funding, including federal funding received through the state, the authority must require the accountable communities of health to: (1) Provide one seat on the governing board of each accountable community of health for each of the tribes and urban Indian health programs within their region; (2) appoint a tribal liaison within each accountable community of health; and (3) establish mutually agreed upon written engagement and communication protocols with the tribes and urban Indian health programs within their regions or jurisdictions. The tribal representatives, tribes, urban Indian health program representatives, and urban Indian health programs are exempt from liability for the actions of the accountable communities of health and their governing boards.

NEW SECTION. **Sec. 6.** As a condition of state funding, service coordination organizations or service contracting entities as defined in RCW 70.320.010 must: (1) Appoint a tribal liaison within the organization; (2) establish mutually agreed upon written engagement and communication protocols with the tribes and urban Indian health programs within their regions or jurisdictions; and (3) follow recommendations from the governor's Indian health council regarding services to American Indians and Alaska Natives and relationships with Indian health care providers.

NEW SECTION. **Sec. 7.** (1) The legislature finds that costs of medicaid services are shared between the federal and state government. The federal government pays the state a percentage of its total medicaid expenditures referred to as the federal medical assistance percentage. However, services which are received by an eligible American Indian or Alaska Native through an Indian health service facility, whether operated by the Indian health service or by an Indian tribe or tribal organization pursuant to 42 U.S.C. Sec. 1396d (b), can be reimbursed at one hundred percent of the federal medical assistance percentage resulting in the state receiving increased federal funds.

(2) Beginning July 1, 2018, one hundred percent of the savings that result from the state not having to pay its normal share of the

federal medical assistance percentage under this section, less the cost to administer these claims, must be reinvested in the Indian health improvement reinvestment account created in section 8 of this act. Beginning July 1, 2018, one hundred percent of the savings that result from the state not having to pay its normal share of the federal medical assistance percentage under this section, less the cost to administer these claims, must be reinvested in the Indian health improvement reinvestment account pursuant to section 9 of this act.

NEW SECTION. **Sec. 8.** (1) The Indian health improvement reinvestment account is created in the state treasury. Moneys in the account may be expended solely for improving outcomes related to the following: (a) Reducing health inequities of American Indians and Alaska Natives in the state; and (b) increasing access to quality and culturally appropriate health care for American Indians and Alaska Natives in the state.

(2) The following amounts must be deposited into the Indian health improvement reinvestment account:

(a) All savings to the state general fund, pursuant to section 11 of this act, resulting from the one hundred percent federal medical assistance percentage applicable to services which are received through an Indian health service facility whether operated by the Indian health service or by an Indian tribe or tribal organization pursuant to 42 U.S.C. Sec. 1396d (b). The authority and the department of social and health services must pursue such savings for medicaid managed care premiums on an actuarial basis and in consultation with tribes;

(b) Twelve percent of all state annual funding allocated to community mental health funding; and

(c) Any other public or private funds appropriated to or deposited in the account.

(3) The state must work with the tribes and Indian health care providers to develop a tracking and data reporting system to track claims and revenue generated under subsection (2) of this section.

(4) The Indian health improvement reinvestment account committee established in section 3 of this act determines expenditures of funds in the Indian health improvement reinvestment account. Funds in the account may not be used for any purpose other than one or more of the following programs or activities:

(a) Evaluation and treatment centers operated by a tribe or tribal organization;

(b) Contracting with a third-party administrative entity to provide, arrange, and make payment for services for American Indians and Alaska Natives enrolled in the state's medicaid fee-for-service program;

(c) Medicaid fee-for-service rate enhancement for providers who are trained in providing trauma-informed and culturally appropriate care to provide services to American Indians and Alaska Natives;

(d) Psychiatric services, including medication consultation, provided by child and adult psychiatrists, and psychiatrists certified in addiction or geriatric psychiatry;

(e) Designated crisis responders who are designated by the state's behavioral health authority in consultation with specific tribes;

(f) Licensing, training, and certification of designated crisis responders who are designated by the state of Washington in consultation with specific tribes;

(g) Traditional healing services;

(h) Development of a community health aide program, including a community health aide certification board for the state consistent with 25 U.S.C. Sec. 1616;

(i) Services of a community health aide program consistent with 25 U.S.C. Sec. 1616, including community health aides, behavioral health aides, dental health aide therapists, and other types of aides for which certifications or standards are established and enforced by an Indian health service or tribal community health aide program certification board;

(j) Health information technology capability within tribes and urban Indian health programs to assure the technological capacity to: (i) Produce sound evidence for Indian health care provider best practices; (ii) effectively coordinate care between Indian health care providers and non-Indian health care providers; (iii) provide interoperability with state claims and reportable data systems, such as for immunizations and reportable conditions; and (iv) support patient-centered medical home models, including sufficient resources to purchase and implement certified electronic health record systems, such as hardware, software, training, and staffing;

(k) Indian health care provider care coordination administrative duties to mitigate barriers to access to care for American Indians

and Alaska Natives. Such duties include, but are not limited to: (i) Follow-up of referred appointments; (ii) routine follow-up care for management of chronic disease; (iii) transportation; and (iv) increasing patient understanding of provider instructions;

(l) Indian epidemiology centers to create a system of epidemiological analysis that meets the needs of the state's American Indian and Alaska Native population; and

(m) Other health care services and public health services that contribute to reducing health inequities for American Indians and Alaska Natives in the state and increasing access to quality, culturally appropriate health care for American Indians and Alaska Natives in the state.

NEW SECTION. **Sec. 9.** (1) The legislature finds that the United States funds the state of Washington at one hundred percent federal medical assistance percentage for medicaid services provided through an Indian health provider as part of the federal government's responsibility to provide health care to American Indians and Alaska Natives. This trust responsibility ensures that one hundred percent of the medicaid costs for American Indians and Alaska Natives are paid for by the federal government. State administration of medicaid services to American Indians and Alaska Natives must be consistent with the fulfillment of the trust responsibility to provide health care to American Indians and Alaska Natives including removing barriers to their participation in medicaid programs.

(2) The authority must, subject to federal restrictions, reimburse tribes and Indian health service facilities at the applicable encounter rate published annually in the federal register by the Indian health service or the rate specified in the medicaid state plan for services provided to non-American Indian and non-Alaska Native patients, including medical, dental, and behavioral health services provided to clinical family members of American Indians and Alaska Natives.

(3) The authority must, subject to federal restrictions, reimburse Indian health care providers at the Indian health services outpatient encounter rate for up to five outpatient visits per medicaid beneficiary per calendar day for professional services.

(4) The legislature recognizes that access to traditional healing services and culturally appropriate care are essential components to maintaining and sustaining health and wellness for American Indians

and Alaska Natives. The authority is directed to coordinate with the federal centers for medicare and medicaid services to provide that traditional healing services are eligible for federal funding of up to one hundred percent.

(5) The authority is directed to coordinate with the federal centers for medicare and medicaid services to provide that services of community health aides certified under an Indian health service or tribal community health aid program are eligible for federal funding of up to one hundred percent. The authority may not require, as a condition of reimbursement, additional licensure or certification of such community health aides who are certified under an Indian health services or tribal community health aide program.

NEW SECTION. **Sec. 10.** (1) American Indians and Alaska Natives must be enrolled in the state medicaid fee-for-service system. The authority must enable American Indian and Alaska Native beneficiaries to enroll in medicaid managed care. American Indians and Alaska Natives are eligible to select an Indian health care provider or a fee-for-service provider as their behavioral health care provider or their physical health provider. American Indians and Alaska Natives may not be automatically assigned into medicaid managed care.

(2) The authority must provide notice to American Indian and Alaska Native medicaid enrollees explaining that American Indians and Alaska Natives may choose to opt-in to a managed care plan.

(3) The authority must contract with a third-party administrator to:

(a) Provide, arrange, and make payment for services for American Indians and Alaska Natives through the state medicaid fee-for-service system;

(b) Recruit from existing tribes' purchased or referred care program networks;

(c) Assure that claims submitted by nontribal providers to tribal programs, such as the catastrophic health emergency fund, and purchased and referred care programs, are paid at rates similar to medicare;

(d) Provide or contract with Indian health care providers to provide coordination of benefits for American Indian and Alaska Native clients and repricing of purchased and referred care services;

(e) Contract with Indian health care providers to provide services where possible;

(f) Prepare a report to Indian health care providers and to the authority on various measures agreed upon with Indian health care providers;

(g) Provide assistance with American Indian and Alaska Native and non-American Indian and Alaska Native client eligibility to receive care at different Indian health care providers;

(h) Maintain updated knowledge of Indian health care provider eligibility requirements;

(i) Maintain an updated list from the northwest tribal registry from the northwest Portland area Indian health board;

(j) If a client is not on the northwest tribal registry, validate the client according to Indian health services requirements;

(k) Assign clients to Indian health care provider patient-centered medical homes;

(l) Provide training for providers and staff on how to deliver culturally appropriate services;

(m) Support bringing specialist services to Indian health care providers rather than sending patients to specialists; and

(n) Monitor timeliness of access to care for referrals to non-Indian health care providers.

(4) The authority must provide technical assistance to Indian health care providers to develop networks that utilize federally qualified health center rates and purchased and referred care rates for services provided by non-Indian health care specialty providers within the fee-for-service system and managed care programs.

NEW SECTION. **Sec. 11.** (1) The authority must require medicaid managed care entities to pay directly to Indian health care providers the applicable encounter rate published annually in the federal register by the Indian health service or the rate specified in the medicaid state plan. For any Indian health care provider that does not have a published encounter rate, medicaid managed care entities must pay the amount the Indian health care provider would receive if the services were provided under the state plan's fee-for-service payment methodology.

(2) Medicaid managed care entities must treat every Indian health care provider as an in-network provider, whether participating or not, to ensure timely access to services for Indian enrollees eligible to receive services from such providers.

(3) Medicaid managed care entities must include all Indian health care providers on any in-network provider lists via their web sites and through their customer service lines. The authority must provide medicaid managed care entities with an updated Indian health care provider list.

(4) Medicaid managed care entities must ensure that American Indian and Alaska Native enrollees may: (a) Obtain covered services from any Indian health care provider, regardless of whether the Indian health care provider participates in the network of the medicaid managed care entities; and (b) choose an Indian health care provider as his or her primary care provider if he or she is eligible to receive primary care services from that Indian health care provider and that Indian health care provider is participating as an in-network provider.

(5) Medicaid managed care entities must pay every Indian health care provider for covered services provided to American Indian and Alaska Native enrollees who are eligible to receive services from that Indian health care provider as follows:

(a) When an Indian health care provider is not enrolled in medicaid as a federally qualified health center, regardless of whether or not it participates in the network of the medicaid managed care entity, the medicaid managed care entity must pay the Indian health care provider the full applicable Indian health services encounter rate published annually in the federal register by the Indian health service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under medicaid fee-for-service (the applicable Indian health care provider rate) provided that, when the amount an Indian health care provider receives from the medicaid managed care entity is less than the full applicable Indian health care provider rate, the authority must make a supplemental payment to the Indian health care provider to make up the difference between the amount the medicaid managed care entity pays and the amount the Indian health care provider would have received under medicaid fee-for-service or the applicable encounter rate.

(b) When an Indian health care provider is enrolled in medicaid as a federally qualified health center and is a participating provider of the medicaid managed care entity, the medicaid managed care entity must pay the Indian health care provider at a rate negotiated between the medicaid managed care entity and the Indian

health care provider or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment that the medicaid managed care entity would make for the services to a participating provider which is a federally qualified health center but not an Indian health care provider.

(c) The United States, including the Indian health service, each tribe, and each tribal organization has the right to recover from liable third parties, including the medicaid managed care entity, notwithstanding network restrictions, pursuant to 25 U.S.C. Sec. 1621e.

(d) Any contract between the authority or the department of social and health services and a medicaid managed care entity must require that as a condition of receiving payment under such contract, the medicaid managed care entity agrees to make prompt payment to Indian health care providers, whether such Indian health care providers are participating providers or nonparticipating providers.

(e) A medicaid managed care entity may not require prior authorization for any services provided by an Indian health care provider to an American Indian or Alaska Native enrollee by referral from an Indian health care provider.

(6) A medicaid managed care entity must accept referrals by an Indian health care provider, regardless of whether the Indian health care provider participates in the network of the medicaid managed care entity, for an American Indian and Alaska Native enrollee to receive services from a network provider without requiring prior authorization or a referral from a participating network provider for the same or substantially similar service. A medicaid managed care entity may not require documentation from an Indian health care provider that is more burdensome than documentation required from non-Indian health care providers or non-American Indian or Alaska Native enrollees.

(7) Medicaid managed care entities must provide only the services requested by the Indian health care provider or the American Indian or Alaska Native enrollee and maintain the Indian health care provider as the American Indian or Alaska Native enrollee's medical home through care coordination with the Indian health care provider including the Indian health care provider's purchased and referred care program. The medicaid managed care entity must provide non-Indian health care providers with the authority's written guidance on the critical role played by Indian health care providers for the care

of American Indian and Alaska Native enrollees. Subject to the American Indian and Alaska Native enrollee's release of information, the medicaid managed care entity must require non-Indian health care providers to deliver progress notes, including any referrals made, to the American Indian or Alaska Native enrollee's Indian health care provider medical home.

(8) Medicaid managed care entities must require staff to receive, at least once per calendar year, Indian health care delivery system and cultural humility training that is applicable to the respective American Indian and Alaska Native communities they serve. Each medicaid managed care entity must provide written documentation of efforts to obtain this training from tribes and urban Indian health programs in the medicaid managed care entity's service area, the American Indian health commission for Washington state, the Indian policy advisory committee, or the department of social and health service's office of Indian policy.

(9) Each medicaid managed care entity must develop protocols with each tribe in the medicaid managed care entity's service area for accessing tribal land to provide crisis services, including coordination of outreach and debriefing of crisis review and outcome with the Indian health care provider. The protocols must include agreed upon time frames and participation for debrief and review, in compliance with the health insurance portability and accountability act (P.L. 104-191; 110 Stat. 1936) and 42 C.F.R. Part 2 requirements.

(10) To the extent permitted by law, medicaid managed care entities must make reasonable efforts to require participating psychiatric hospitals and evaluation and treatment facilities to notify and coordinate discharge planning with Indian health care providers for Indian health service eligible American Indian and Alaska Native clients.

(11) Each medicaid managed care entity must designate a tribal liaison to facilitate resolution of any issue between a medicaid managed care entity and an Indian health care provider including, but not limited to, billing and provider enrollment or credentialing. The tribal liaison's function may be an additional duty assigned to existing medicaid managed care entity staff. The medicaid managed care entity must document with the authority every such issue presented by an Indian health care provider or identified by the tribal liaison. The medicaid managed care entity must make the tribal liaison available for training by tribes and urban Indian health

programs in the medicaid managed care entity's service area, the Indian policy advisory committee of the department of social and health services, or the American Indian health commission for Washington state.

(12) The authority must establish a resolution process for each Indian health care provider to submit complaints to the authority regarding unresolved issues including, but not limited to, crisis coordination between the Indian health care providers and a medicaid managed care entity. The authority must facilitate resolution directly with the medicaid managed care entity. The medicaid managed care entity must include reference in any contract between the medicaid managed care entity and the Indian health care provider to the resolution process maintained by the authority. Prior to the development of any plan with an Indian health care provider that is required by the state agreement with the medicaid managed care entity, the medicaid managed care entity must meet with the authority and the Indian health care provider to identify and resolve issues related to the medicaid managed care entity's performance of services under its agreement with the authority.

(13) A medicaid managed care entity is subject to corrective action and penalties against the medicaid managed care entity by the authority if the medicaid managed care entity fails to: (a) Perform any obligation under the medicaid managed care entity state agreement or the requirements within this section; or (b) ensure that American Indians and Alaska Natives are afforded access to care, rights, and benefits on par with all other medicaid managed care entity enrollees.

(14) To the extent that such reporting does not risk exposure of personal information, the authority must, in consultation with tribes and conferral with Indian health care providers, prepare reports on Indian health care providers and the American Indian and Alaska Native population using data on American Indian and Alaska Native enrollment and the health care effectiveness data and information set measures that the medicaid managed care entities are required to report to the authority. The authority must provide these reports to each tribe and Indian health care provider within the state.

(15)(a) The authority must submit a report to all Indian health care providers in the state detailing its implementation and coordination of efforts with the tribes on managing the care of American Indians and Alaska Natives in a format to be agreed upon by

the authority and the tribes and Indian health care providers in the state. The reporting is required to occur no less than annually. The reports must include at a minimum:

(i) Description of concerns raised by the tribes and Indian health care providers and the authority's efforts to address each concern;

(ii) Managed care entities' compliance with section 1932(h) of the social security act and 42 C.F.R. Sec. 438.14;

(iii) Information on Indian health care providers and the Indian population using data on Indian enrollment and the behavioral health performance measures that the medicaid managed care entities are required by contract to report to the authority. Such reporting must not risk exposure of personal information; and

(iv) The effect of medicaid waivers on the accessibility and quality of services as well as the anticipated impact of the project on the state's medicaid program as required. Such analysis must include the impacts that the expansion of managed care will have upon the fee-for-service system.

(b) The authority must allow tribes and Indian health care providers the opportunity to provide recommendations at least sixty days prior to finalizing each report.

(16) The authority must consult with the tribes and seek advice regarding the state agreements with medicaid managed care entities.

(17) The authority must meet with and solicit advice and guidance from the tribes and urban Indian health programs on at least a quarterly basis to ensure that American Indians and Alaska Natives receive access to quality care in a timely manner. These meetings are not a substitute for formal government-to-government tribal consultation.

NEW SECTION. **Sec. 12.** (1) The authority, in consultation with tribes and urban Indian health programs, must develop a plan to assure written and verbal technical assistance is available to support the incorporation of cultural awareness and development of strategies to address historical trauma and intergenerational trauma in treatment planning for services covered by medicaid and other services provided by the state.

(2) The department of social and health services must require all designated crisis responders to receive training in historical trauma and intergenerational trauma and ensure that historical trauma and

intergenerational trauma are addressed in treatment planning for services covered by medicaid.

NEW SECTION. **Sec. 13.** (1) The secretary of the department of health shall include tribes in the development of a public health system that acknowledges tribal authority and responsibility for their community.

(2) The department of health, in consultation with the tribes and conferral with Indian health care providers, must identify and define how: (a) The department of health funding and delivery framework apply to Indian public health programs; and (b) the tribes, Indian public health programs, the department of health, and local health jurisdictions can work together to serve all people in Washington.

(3) The department of health must work with tribes and Indian health care providers to establish an Indian health care provider track within the state's efforts to transform the practice of health care professionals. The Indian health care provider track must assure an appropriate level of expertise on Indian health and the capacity to properly assist Indian health care providers.

(4) The department of health must work with tribes and Indian health care providers to assure that state resources for improving population health include tribally determined practices and resources that support tribal concepts of health using the "pulling together for wellness" framework, which is a tribally driven, culturally grounded prevention framework developed through the guidance of Washington tribal and urban Indian leaders, adapting evidence-based practice by integrating western science and native epistemology.

(5) The department of health must work with Indian epidemiology centers to create a system of epidemiological analysis that meets the needs of the state's tribal population.

NEW SECTION. **Sec. 14.** Sections 1 through 13 of this act constitute a new chapter in Title 70 RCW.

Sec. 15. RCW 38.52.040 and 2015 c 274 s 17 are each amended to read as follows:

(1) There is hereby created the emergency management council (hereinafter called the council), to consist of not more than seventeen members who shall be appointed by the adjutant general. The membership of the council shall include, but not be limited to,

representatives of city ((~~and~~)), county, and tribal governments, sheriffs and police chiefs, the Washington state patrol, the military department, the department of ecology, state and local fire chiefs, seismic safety experts, state and local emergency management directors, search and rescue volunteers, medical professions who have expertise in emergency medical care, building officials, and private industry. The representatives of private industry shall include persons knowledgeable in emergency and hazardous materials management. The councilmembers shall elect a chair from within the council membership. The members of the council shall serve without compensation, but may be reimbursed for their travel expenses incurred in the performance of their duties in accordance with RCW 43.03.050 and 43.03.060 as now existing or hereafter amended.

(2) The emergency management council shall advise the governor and the director on all matters pertaining to state and local emergency management. The council may appoint such ad hoc committees, subcommittees, and working groups as are required to develop specific recommendations for the improvement of emergency management practices, standards, policies, or procedures. The council shall ensure that the governor receives an annual assessment of statewide emergency preparedness including, but not limited to, specific progress on hazard mitigation and reduction efforts, implementation of seismic safety improvements, reduction of flood hazards, and coordination of hazardous materials planning and response activities. The council shall review administrative rules governing state and local emergency management practices and recommend necessary revisions to the director.

(3) The council or a council subcommittee shall serve and periodically convene in special session as the state emergency response commission required by the emergency planning and community right-to-know act (42 U.S.C. Sec. 11001 et seq.). The state emergency response commission shall conduct those activities specified in federal statutes and regulations and state administrative rules governing the coordination of hazardous materials policy including, but not limited to, review of local emergency planning committee emergency response plans for compliance with the planning requirements in the emergency planning and community right-to-know act (42 U.S.C. Sec. 11001 et seq.). Committees shall annually review their plans to address changed conditions, and submit their plans to the state emergency response commission for review when updated, but

not less than at least once every five years. The department may employ staff to assist local emergency planning committees in the development and annual review of these emergency response plans, with an initial focus on the highest risk communities through which trains that transport oil in bulk travel. By March 1, 2018, the department shall report to the governor and legislature on progress towards compliance with planning requirements. The report must also provide budget and policy recommendations for continued support of local emergency planning.

(4)(a) The intrastate mutual aid committee is created and is a subcommittee of the emergency management council. The intrastate mutual aid committee consists of not more than five members who must be appointed by the council chair from council membership. The chair of the intrastate mutual aid committee is the military department representative appointed as a member of the council. Meetings of the intrastate mutual aid committee must be held at least annually.

(b) In support of the intrastate mutual aid system established in chapter 38.56 RCW, the intrastate mutual aid committee shall develop and update guidelines and procedures to facilitate implementation of the intrastate mutual aid system by member jurisdictions, including but not limited to the following: Projected or anticipated costs; checklists and forms for requesting and providing assistance; recordkeeping; reimbursement procedures; and other implementation issues. These guidelines and procedures are not subject to the rule-making requirements of chapter 34.05 RCW.

Sec. 16. RCW 41.05.690 and 2014 c 223 s 6 are each amended to read as follows:

(1) There is created a performance measures committee, the purpose of which is to identify and recommend standard statewide measures of health performance to inform public and private health care purchasers and to propose benchmarks to track costs and improvements in health outcomes.

(2) Members of the committee must include representation from state agencies, small and large employers, health plans, patient groups, federally recognized tribes, consumers, academic experts on health care measurement, hospitals, physicians, and other providers. The governor shall appoint the members of the committee, except that a statewide association representing hospitals may appoint a member representing hospitals, and a statewide association representing

physicians may appoint a member representing physicians. The governor shall ensure that members represent diverse geographic locations and both rural and urban communities. The chief executive officer of the lead organization must also serve on the committee. The committee must be chaired by the director of the authority.

(3) The committee shall develop a transparent process for selecting performance measures, and the process must include opportunities for public comment.

(4) By January 1, 2015, the committee shall submit the performance measures to the authority. The measures must include dimensions of:

(a) Prevention and screening;

(b) Effective management of chronic conditions;

(c) Key health outcomes;

(d) Care coordination and patient safety; and

(e) Use of the lowest cost, highest quality care for preventive care and acute and chronic conditions.

(5) The committee shall develop a measure set that:

(a) Is of manageable size;

(b) Is based on readily available claims and clinical data;

(c) Gives preference to nationally reported measures and, where nationally reported measures may not be appropriate, measures used by state agencies that purchase health care or commercial health plans;

(d) Focuses on the overall performance of the system, including outcomes and total cost;

(e) Is aligned with the governor's performance management system measures and common measure requirements specific to medicaid delivery systems under RCW 70.320.020 and 43.20A.895;

(f) Considers the needs of different stakeholders and the populations served; and

(g) Is usable by multiple payers, providers, hospitals, purchasers, public health, and communities as part of health improvement, care improvement, provider payment systems, benefit design, and administrative simplification for providers and hospitals.

(6) State agencies shall use the measure set developed under this section to inform and set benchmarks for purchasing decisions.

(7) The committee shall establish a public process to periodically evaluate the measure set and make additions or changes to the measure set as needed.

(8) Because performance measures are publicly reported and can be integrated in financial incentive programs or value-based payment models, it is important that they accurately convey relative provider performance and appropriately consider providers' patient populations. To control for the effect of factors outside of the control of providers, including patient-related factors, the committee must establish a risk adjustment methodology that risk adjusts performance measure results when calculating results.

(9) The committee must identify a range of tools and policies that can address potential unintended consequences resulting from the use of performance measures including, but not limited to, the following:

(a) Identifying and adequately paying for nonmedical support services that have been shown to improve patient outcomes for people who face economic and social barriers to good health;

(b) On a targeted basis, financially rewarding improvement in quality performance more strongly than absolute goals;

(c) Comparing the performance of clinics that have similar features and see similar types of patients; and

(d) Examining the unmeasured impact of patient-complexity factors that include a broader range of sociodemographic characteristics, such as patients facing housing and food insecurity, patients who are suffering from historical trauma, or patients who are more likely to experience disparities in health outcomes.

Sec. 17. RCW 70.320.020 and 2017 c 226 s 8 are each amended to read as follows:

(1) The authority and the department shall base contract performance measures developed under RCW 70.320.030 on the following outcomes when contracting with service contracting entities: Improvements in client health status and wellness; increases in client participation in meaningful activities; reductions in client involvement with criminal justice systems; reductions in avoidable costs in hospitals, emergency rooms, crisis services, and jails and prisons; increases in stable housing in the community; improvements in client satisfaction with quality of life; and reductions in population-level health disparities.

(2) The performance measures must demonstrate the manner in which the following principles are achieved within each of the outcomes under subsection (1) of this section:

(a) Maximization of the use of evidence-based practices will be given priority over the use of research-based and promising practices, and research-based practices will be given priority over the use of promising practices. The agencies will develop strategies to identify programs that are effective with ethnically diverse clients and to consult with tribal governments, experts within ethnically diverse communities and community organizations that serve diverse communities;

(b) The maximization of the client's independence, recovery, and employment;

(c) The maximization of the client's participation in treatment decisions; and

(d) The collaboration between consumer-based support programs in providing services to the client.

(3) In developing performance measures under RCW 70.320.030, the authority and the department shall consider expected outcomes relevant to the general populations that each agency serves. The authority and the department may adapt the outcomes to account for the unique needs and characteristics of discrete subcategories of populations receiving services, including ethnically diverse communities.

(4) The authority and the department shall coordinate the establishment of the expected outcomes and the performance measures between each agency as well as each program to identify expected outcomes and performance measures that are common to the clients enrolled in multiple programs and to eliminate conflicting standards among the agencies and programs.

(5)(a) The authority and the department shall establish timelines and mechanisms for service contracting entities to report data related to performance measures and outcomes, including phased implementation of public reporting of outcome and performance measures in a form that allows for comparison of performance measures and levels of improvement between geographic regions of Washington.

(b) The authority and the department may not release any public reports of client outcomes unless the data has been deidentified and aggregated in such a way that the identity of individual clients cannot be determined through directly identifiable data or the combination of multiple data elements.

(6) The authority and department must establish a performance measure to be integrated into the statewide common measure set which

tracks effective integration practices of behavioral health services in primary care settings.

(7) The authority and the department must develop performance measures and a risk adjustment methodology for all medicaid enrollees, including American Indian and Alaska Native enrollees, that meets the requirements of RCW 41.05.690.

Sec. 18. RCW 43.84.092 and 2017 3rd sp.s. c 25 s 50, 2017 3rd sp.s. c 12 s 12, and 2017 c 290 s 8 are each reenacted and amended to read as follows:

(1) All earnings of investments of surplus balances in the state treasury shall be deposited to the treasury income account, which account is hereby established in the state treasury.

(2) The treasury income account shall be utilized to pay or receive funds associated with federal programs as required by the federal cash management improvement act of 1990. The treasury income account is subject in all respects to chapter 43.88 RCW, but no appropriation is required for refunds or allocations of interest earnings required by the cash management improvement act. Refunds of interest to the federal treasury required under the cash management improvement act fall under RCW 43.88.180 and shall not require appropriation. The office of financial management shall determine the amounts due to or from the federal government pursuant to the cash management improvement act. The office of financial management may direct transfers of funds between accounts as deemed necessary to implement the provisions of the cash management improvement act, and this subsection. Refunds or allocations shall occur prior to the distributions of earnings set forth in subsection (4) of this section.

(3) Except for the provisions of RCW 43.84.160, the treasury income account may be utilized for the payment of purchased banking services on behalf of treasury funds including, but not limited to, depository, safekeeping, and disbursement functions for the state treasury and affected state agencies. The treasury income account is subject in all respects to chapter 43.88 RCW, but no appropriation is required for payments to financial institutions. Payments shall occur prior to distribution of earnings set forth in subsection (4) of this section.

(4) Monthly, the state treasurer shall distribute the earnings credited to the treasury income account. The state treasurer shall

credit the general fund with all the earnings credited to the treasury income account except:

(a) The following accounts and funds shall receive their proportionate share of earnings based upon each account's and fund's average daily balance for the period: The aeronautics account, the aircraft search and rescue account, the Alaskan Way viaduct replacement project account, the brownfield redevelopment trust fund account, the budget stabilization account, the capital vessel replacement account, the capitol building construction account, the Cedar River channel construction and operation account, the Central Washington University capital projects account, the charitable, educational, penal and reformatory institutions account, the Chehalis basin account, the cleanup settlement account, the Columbia river basin water supply development account, the Columbia river basin taxable bond water supply development account, the Columbia river basin water supply revenue recovery account, the common school construction fund, the community forest trust account, the connecting Washington account, the county arterial preservation account, the county criminal justice assistance account, the deferred compensation administrative account, the deferred compensation principal account, the department of licensing services account, the department of retirement systems expense account, the developmental disabilities community trust account, the diesel idle reduction account, the drinking water assistance account, the drinking water assistance administrative account, the early learning facilities development account, the early learning facilities revolving account, the Eastern Washington University capital projects account, the Interstate 405 express toll lanes operations account, the education construction fund, the education legacy trust account, the election account, the electric vehicle charging infrastructure account, the energy freedom account, the energy recovery act account, the essential rail assistance account, The Evergreen State College capital projects account, the federal forest revolving account, the ferry bond retirement fund, the freight mobility investment account, the freight mobility multimodal account, the grade crossing protective fund, the public health services account, ((~~the high capacity transportation account,~~)) the state higher education construction account, the higher education construction account, the highway bond retirement fund, the highway infrastructure account, the highway safety fund, the high occupancy toll lanes operations account, the hospital safety

net assessment fund, the Indian health improvement reinvestment account, the industrial insurance premium refund account, the judges' retirement account, the judicial retirement administrative account, the judicial retirement principal account, the local leasehold excise tax account, the local real estate excise tax account, the local sales and use tax account, the marine resources stewardship trust account, the medical aid account, the mobile home park relocation fund, the money-purchase retirement savings administrative account, the money-purchase retirement savings principal account, the motor vehicle fund, the motorcycle safety education account, the multimodal transportation account, the multiuse roadway safety account, the municipal criminal justice assistance account, the natural resources deposit account, the oyster reserve land account, the pension funding stabilization account, the perpetual surveillance and maintenance account, the pollution liability insurance agency underground storage tank revolving account, the public employees' retirement system plan 1 account, the public employees' retirement system combined plan 2 and plan 3 account, the public facilities construction loan revolving account beginning July 1, 2004, the public health supplemental account, the public works assistance account, the Puget Sound capital construction account, the Puget Sound ferry operations account, the Puget Sound taxpayer accountability account, the real estate appraiser commission account, the recreational vehicle account, the regional mobility grant program account, the resource management cost account, the rural arterial trust account, the rural mobility grant program account, the rural Washington loan fund, the sexual assault prevention and response account, the site closure account, the skilled nursing facility safety net trust fund, the small city pavement and sidewalk account, the special category C account, the special wildlife account, the state employees' insurance account, the state employees' insurance reserve account, the state investment board expense account, the state investment board commingled trust fund accounts, the state patrol highway account, the state route number 520 civil penalties account, the state route number 520 corridor account, the state wildlife account, the supplemental pension account, the Tacoma Narrows toll bridge account, the teachers' retirement system plan 1 account, the teachers' retirement system combined plan 2 and plan 3 account, the tobacco prevention and control account, the tobacco settlement account, the toll facility bond retirement account, the transportation 2003 account (nickel

account), the transportation equipment fund, the transportation future funding program account, the transportation improvement account, the transportation improvement board bond retirement account, the transportation infrastructure account, the transportation partnership account, the traumatic brain injury account, the tuition recovery trust fund, the University of Washington bond retirement fund, the University of Washington building account, the volunteer firefighters' and reserve officers' relief and pension principal fund, the volunteer firefighters' and reserve officers' administrative fund, the Washington judicial retirement system account, the Washington law enforcement officers' and firefighters' system plan 1 retirement account, the Washington law enforcement officers' and firefighters' system plan 2 retirement account, the Washington public safety employees' plan 2 retirement account, the Washington school employees' retirement system combined plan 2 and 3 account, the Washington state health insurance pool account, the Washington state patrol retirement account, the Washington State University building account, the Washington State University bond retirement fund, the water pollution control revolving administration account, the water pollution control revolving fund, the Western Washington University capital projects account, the Yakima integrated plan implementation account, the Yakima integrated plan implementation revenue recovery account, and the Yakima integrated plan implementation taxable bond account. Earnings derived from investing balances of the agricultural permanent fund, the normal school permanent fund, the permanent common school fund, the scientific permanent fund, the state university permanent fund, and the state reclamation revolving account shall be allocated to their respective beneficiary accounts.

(b) Any state agency that has independent authority over accounts or funds not statutorily required to be held in the state treasury that deposits funds into a fund or account in the state treasury pursuant to an agreement with the office of the state treasurer shall receive its proportionate share of earnings based upon each account's or fund's average daily balance for the period.

(5) In conformance with Article II, section 37 of the state Constitution, no treasury accounts or funds shall be allocated earnings without the specific affirmative directive of this section.

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