



**RESOLUTION # 11-04-07  
NORTHWEST PORTLAND AREA  
INDIAN HEALTH BOARD**



**RESOLUTION # 291-07-11  
CALIFORNIA RURAL INDIAN  
HEALTH BOARD**

**JOINT RESOLUTION**

**Recommendation that CCIIO include IHS programs as  
“essential community providers” in the final regulations  
to establish Insurance Exchanges**

- WHEREAS,** the Northwest Portland Area Indian Health Board (NPAIHB) is a tribal organization under P.L. 93-638 that represents 43 Federally-recognized Indian tribes in Oregon, Washington and Idaho and is dedicated to assisting and promoting the health needs and concerns of Indian people in the Northwest; **AND**
- WHEREAS,** the California Rural Indian Health Board, Inc. (CRIHB), founded in 1969 for the purpose of bringing back health services to Indians of California; is a tribal organization in accordance with Public Law 93-638, is a statewide tribal health organization representing 31 Federally recognized tribes in 21 counties through its membership of 12 Indian Health Programs throughout California’s Indian Country; **AND**
- WHEREAS,** the NPAIHB and CRIHB are dedicated to assisting and promoting the health needs and concerns of Indian people; **AND**
- WHEREAS,** the primary goal of the NPAIHB and CRIHB is to improve the health and quality of life of its member tribes; **AND**
- WHEREAS,** a central goal of the Patient Protection and Affordable Care Act (ACA) is to ensure that all Americans, regardless of income or location, have access to a sufficient choice of health care providers, which will be achieved, in part, by requiring that a health plan’s network include “essential community providers” who provide care to predominantly low-income and medically-underserved populations to be certified as a Qualified Health Plan; **AND**
- WHEREAS,** since its inception in 1954, the Indian Health Service (IHS), and Tribes and Tribal organizations carrying out health programs under the Indian Self-Determination and Education Assistance Act of 1975, have worked to develop the capacity to serve the traditionally medically-underserved communities of American Indians and Alaska Natives (AI/ANs) and have long been recognized as “essential” providers by the AI/AN communities they serve; **AND**
- WHEREAS,** IHS and Tribal health programs provide health care in the most remote locations in the United States where, without the presence of an IHS or tribal health program, no services would be available and to which these programs are able to provide culturally competent care that take into consideration the unique needs of Indian people to understand their language, culture, and special health needs; **AND**
- WHEREAS,** the ACA at Sec. 1311 requires qualified health plans to offer a sufficient choice of providers, and to include essential community providers in their networks in order that insured individuals can

fully utilize their insurance coverage and the law gives examples of essential community providers, but does not restrict the term to those examples, and include:

- Providers described in PHSA Sec. 340B(a)(4) [42 USC 256b(a)(4)] – Entities eligible to obtain discounted drugs from the 340B program. These include: FQHCs; family planning projects under PHSA 1001(a); HIV outpatient grantees; AIDS drug purchasing assistance programs; black lung clinics; hemophilia treatment centers; Native Hawaiian Health Centers; urban Indian organizations; HIV health care centers; STD and tuberculosis programs; certain hospitals serving low-income individuals.
- Providers described in Sec. 1927(c)(1)(D)(i)(IV) of the Social Security Act – tax-exempt entities; entities that serve the same types of populations as the providers described in PHSA Sec. 340B(a)(4); and public, non-profit, or college health centers that offer family planning services.

**WHEREAS,** as 340B-eligible providers, urban Indian organizations are clearly among the entities Congress had in mind for "essential community providers" and Tribally-operated outpatient clinics are also eligible for FQHC status and many have acquired this designation, with both types of programs explicitly defined as FQHCs in both the Medicare and Medicaid laws; **AND**

**WHEREAS,** IHS programs have been determined to serve communities that are predominantly medically-underserved by the Health Resources and Services Administration (HRSA), who has automatically designated Indian communities as Health Profession Shortage Areas (HPSAs) and National Health Service Corps approved sites; **AND**

**WHEREAS,** the Indian Health Care Improvement Act (IHCIA) was included as an amendment to the ACA, at which Sec. 206 of the IHCIA requires a third-party payer, including an insurance plan, to pay Indian health system providers "the reasonable charges billed", or, if higher, the highest amount the plan would pay for care provided by other providers. This payment requirement applies to providers that are (i) Indian Health Service-operated programs; (ii) health programs operated by Indian tribes or tribal organizations through Indian Self-Determination and Education Assistance Act agreements; and (iii) urban Indian organizations assisted by grants issued pursuant to Title V of the IHCIA; **AND**

**THEREFORE BE IT RESOLVED,** we do hereby recommend that the Center for Consumer Insurance Information and Oversight (CCIIO) include IHS, Tribal and Urban Indian Health Programs (I/T/U) in the definition of "essential community providers" so that Indians enrolled in exchange plans can fully utilize the coverage provided, and further recommend that the final regulations for the exchanges must include the following requirements:

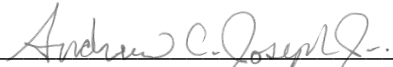
1. Include I/T/Us in the definition of "essential community provider".
2. Require qualified health plans to include special provisions in their network provider agreements with I/T/Us that take into account the unique circumstances of I/T/Us under Federal law and regulations. Such provisions are needed to overcome barriers that could otherwise impede participation by ITUs in provider networks.
3. Require qualified health plans to reimburse I/T/U providers the reasonable charges billed or, if higher, at the highest rates paid to any provider, regardless of whether I/T/Us are in provider networks, pursuant to Sec. 206 of the IHCIA.

**CERTIFICATION**

The foregoing joint resolution was adopted at a duly called regular joint meeting of the Board of Directors of Northwest Portland Area Indian Health Board and California Rural Indian Health Board (**NPAIHB** vote 25 For and 0 Against and 0 Abstain; **CRIHB** vote 20 For and 0 Against and 0 Abstain) held this 21<sup>st</sup> day of July 2011 in Lincoln, CA and shall remain in full force and effect until rescinded.

**NORTHWEST PORTLAND AREA  
INDIAN HEALTH BOARD**


527 SW Hall, Suite 300  
Portland, OR 97201  
(503) 228-4185

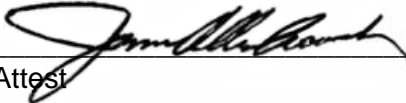
  
\_\_\_\_\_  
Chairperson of the Board

  
\_\_\_\_\_  
Attest

**CALIFORNIA RURAL  
INDIAN HEALTH BOARD**

4400 Auburn Blvd, 2<sup>nd</sup> Floor  
Sacramento, CA 95841  
(916) 929-9761

  
\_\_\_\_\_  
Chairperson of the Board

  
\_\_\_\_\_  
Attest