

## Qualified Health Plans and Indian Health Providers

Prepared by Northwest Tribal-State Exchange Planning Network\*

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The Patient Protection and Affordable Care Act (“ACA”)<sup>1</sup> requires the establishment of health benefit exchanges (“Exchanges”) to serve each State.<sup>2</sup> Each state has the opportunity to establish the Exchange that will serve its residents, rather than rely on a federally established Exchange, so long as its Exchange complies with applicable law, which includes certain provisions of the Indian Health Care Improvement Act (“IHCA”)<sup>3</sup> relevant to payment for services provided by Indian Health Providers. Indian Health Providers are the Indian Health Service (“IHS”), Tribes and Tribal Organizations carrying out programs of the IHS (“Tribal Health Programs”), and urban Indian organizations receiving funding from the IHS pursuant to Title V of the IHCA (“UIOs”).<sup>4</sup>

To ensure compliance with the Indian-specific provisions of law and simplify administration of qualified health plans (“QHPs”),<sup>5</sup> Tribal Health Programs and UIOs urge that Exchanges adopt the following conditions of participations for QHPs:

- (1) Require compliance with IHCA Sections 206 and 408<sup>6</sup> as a condition of certification and recertification;
- (2) Require QHPs to *offer* to contract with all Indian Health Providers in the QHP’s service area as in-network providers;
- (3) Require QHPs to use the Centers for Medicare and Medicaid Services (CMS)-approved “Indian Addendum” when contracting with Indian Health Providers.

These proposed conditions are allowable under CMS rules. CMS has made it clear in its regulations regarding the establishment of Exchanges that States may direct Exchanges to implement State-specific conditions for QHPs, so long as those conditions are not inconsistent with federal requirements.<sup>7</sup> As discussed below, States have the authority to fulfill each of the recommendations above and the concerns they address<sup>5</sup> are commented on directly in CMS’s implementing regulations regarding implementation of Exchanges.<sup>8</sup>

Section 408(a) of the IHCA, a new provision adopted in the ACA, requires all Federal Health Care Programs<sup>9</sup> to accept Indian Health Providers “as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity meets generally applicable State or other requirements for participation as a provider of health care services under the program.” Section 408 goes on to specify that state and local requirements for entities like the Indian Health Provider are not applicable to such providers so long as they meet the applicable standards for such a license and that health professionals of IHS and Tribal Health Programs need not have a license in the state in which they are practicing so long as they meet the requirements of Section 221<sup>10</sup> to be licensed in some state. This new provision of the IHCA clarifies issues that have historically plagued relationships between Indian Health Providers and various payers.

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Section 206 of the IHCIA establishes a right of all Indian Health Providers to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State).<sup>11</sup> This requirement, which was amended in the ACA, was originally enacted in 1988, to assure that insurers and other responsible third-parties would not benefit unfairly from the fact that American Indians and Alaska Natives (“AI/ANs”) have a right to receive services of the IHS without incurring any personal obligation to pay.<sup>12</sup> This right arises from the special trust responsibilities and legal obligations of the United States to AI/ANs.<sup>13</sup> These trust and legal obligations also require IHS and Tribal Health Programs to serve their members and other AI/ANs. Section 206 also prohibits States, other subdivisions of a State, or health plan from enacting laws or contract requirements that limit this right to payment.<sup>14</sup>

CMS has affirmed in rulemaking that IHCIA Section 206 and 408 requirements apply to federal and State operated Exchange by stating:

The primary purpose of section 408 of IHCIA is to deem Indian health providers as eligible to receive payment from Federal Health Care Programs for health care services provided to Indians if certain standards are met. Eligibility to receive payment under section 408 of IHCIA does not depend on in-network status with a QHP. Section 206 of IHCIA provides that all Indian providers have the right to recover from third party payers, including QHPs, up to the reasonable charges billed for providing health services, or, if higher, the highest amount an insurer would pay to other providers to the extent that the patient or another provider would be eligible for such recoveries.<sup>15</sup>

Given that AI/ANs enrolled in Exchanges are not subject to in-network access limitations to health services of Indian Health Providers and that those Providers must be reimbursed for those services, it is in the best interests of States to require all QHPs to certify that they will comply with IHCIA Sections 206 and 408 and to require them to offer network contracts to all Indian Health Providers in their service area(s).

In-network status will lead to greater coordination and timeliness of care to AI/AN patients, and more certainty and timeliness of payment to Indian Health Providers.<sup>16</sup> For QHPs as well, including Indian Health Providers as in-network providers offers significant advantages, including meeting network adequacy requirements for serving AI/ANs; reducing avoidable emergency department use; timely inpatient discharge and placement; and, potential reduction in the overall volume of billed services to the QHP. Requiring QHPs to offer Indian Health Providers network contracts would not create an undue burden on the QHP as the total number of Indian Health Providers facilities is not large.

To facilitate QHPs offering contracts to Indian Health Providers, CMS has determined that it will develop an Indian Addendum template for use by Exchanges and QHPs. CMS also stated that, at its option, an Exchange may require all QHPs to use the Indian Addendum when contracting with Indian Health Providers. CMS further commented that “we believe that QHP issuers will find it in their interest to adopt such a template when contracting with Indian providers.”<sup>17</sup>

An Indian Addendum is designed to list applicable Indian-specific Federal requirements and to conform a health plan’s standard contract to the Indian-specific requirements of Federal law. These provisions of

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Federal law apply whether or not the Indian Addendum is used, but use of an Indian Addendum has proven to simplify and clarify the identification and application of these provisions for contracting health plans. Under Medicare, a similar “I/T/U Addendum” is being used successfully by Medicare Prescription Drug Plans when contracting with I/T/U pharmacies. Implementing the CMS Addendum as a State requirement of QHPs will substantially improve understanding and the ease of administration.

These recommendations for State requirements for QHPs are based in Federal law, but also will assist States and their Exchanges to assure quality health services to AI/ANs who suffer from poor health status.<sup>18</sup> Indian Health Providers routinely report on quality measures under the Government Performance and Results Act (“GPRA”). These reveal significant accomplishments despite the persistent underfunding for these programs. Indian Health Providers also must meet quality and accreditation standards for the purposes of participating in the Medicare, Medicaid and CHIP programs. As a measure of their level of compliance, many Indian Health Providers are accredited through such organizations as the Accreditation Association for Ambulatory Care or the Joint Commission on Accreditation of Health Care Organizations.

Implementation of the requirements proposed and discussed in this paper, should be addressed by the States and Exchanges as they fulfill their obligations to engage in consultation. Exchanges must consult on an ongoing basis with a list of stakeholders, including “(f) Federally-recognized Tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 USC 479a, that are located within such Exchange’s geographic area.”<sup>19</sup>

The Final Rule referred back to the Proposed Rule for a discussion on how Exchanges are to interact with Tribes—

Each Exchange that has one or more Federally-recognized tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a, located within the Exchange’s geographic area must engage in regular and meaningful consultation and collaboration with such tribes and their tribal officials on all Exchange policies that have tribal implications. We encourage Exchanges to also seek input from all tribal organizations and urban Indian organizations. While the **Exchanges will be charged with the consultation**, tribal consultation is a government-to-government process, and therefore the State should have a role in the process. We encourage States to develop a tribal consultation policy that is approved by the State, the Exchange, and tribe(s).<sup>20</sup>

It was noted in the preamble to the Final Rule that “future guidance will be provided to States regarding key milestones, including tribal consultation, for approval of a State-based Exchange.”<sup>21</sup> Although there is no Federal requirement for Exchanges to fund technical assistance provided by Tribes and tribal organizations to States, this type of expenditure by an Exchange is a permissible use of Exchange establishment grant funding.<sup>22</sup>

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<sup>1</sup> Refers collectively to the Patient Protection and Affordable Care Act (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), and referred to herein as the Affordable Care Act or ACA. Section 36B, contained in section 1401 of the ACA, was subsequently amended by the Medicare and Medicaid Extenders Act of

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2010 (Pub. L. 111-309), the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (Pub. L. 112-9), and the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (Pub. L. 112-10).

<sup>2</sup> State-based health insurance exchanges (Exchanges) will be available in each State in time to allow enrollment in new health insurance coverage options beginning January 1, 2014. Exchanges are marketplaces for the offering of health insurance coverage, mechanisms for determining eligibility for various government health insurance programs, and vehicles for securing government assistance, if eligible, with covering all or a portion of the health insurance plan monthly premiums.

<sup>3</sup> Pub. L. 94-437, as amended and permanently reauthorized by Section 10211 of the ACA, which enacted, as amended, the Indian Health Care Improvement Reauthorization and Extension Act of 2009, S. 1790, as reported by the U.S. Senate Committee on Indian Affairs.

<sup>4</sup> Collectively, these entities are often referred to as "I/T/Us". The term "IHS" means the agency of that name within the U.S. Department of Health and Human Services ("HHS") established by IHCA § 601 (25 USC §1661). The terms "Indian tribe," "tribal organization," and "UIO" have the meaning given those terms in IHCA § 4 (25 USC §1603).

<sup>5</sup> QHPs are established under § 1301 of the ACA. A health plan is considered a QHP if it is certified as meeting the applicable Federal standards, as well any State-specific standards added by a State and/or Exchange, and is offered through an Exchange. *Also see*, 45 C.F.R. § Part 156.

<sup>6</sup> 25 U.S.C. §§ 1621e and 1647a, respectively.

<sup>7</sup> 45 C.F.R. § 156.200(d) ("A QHP issuer certified by an Exchange must adhere to the requirements of this subpart and any provisions imposed by the Exchange, or a State in connection with its Exchange, that are conditions of participation or certification with respect to each of its QHPs"). *Also see*, 77 Fed. Reg. 18406.

<sup>8</sup> *Federal Register*, March 27, 2012, CMS, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," (CMS-9989-F), 77 Fed. Reg. 18310 et seq. ("Final Rule").

<sup>9</sup> The term Federal Health Care Program has the meaning given that term under section 1128B(f) of the Social Security Act (42 U.S.C. 1320a-7b(f)), except that, for purposes of this subsection, such term shall include the health insurance program under chapter 89 of title 5, United States Code (i.e., the Federal Employees Health Benefits Program).

<sup>10</sup> 25 U.S.C. § 1621t.

<sup>11</sup> 25 U.S.C. § 1621e(a) (IHS and Tribal Health Programs) and (i) (application of all provisions of § 1621e to UIOs).

<sup>12</sup> IHS is not permitted to impose any charges on AI/ANs, nor may it require any Tribal Health Program to do so. 25 U.S.C. 25 U.S.C. §§ 458aaa-14, 1621e(f), 1681, and 1681r(b).

<sup>13</sup> 25 U.S.C. § 1602.

<sup>14</sup> 25 U.S.C. § 1621e(c).

<sup>15</sup> Final Rule, 77 Fed. Reg. 18420.

<sup>16</sup> AI/AN enrollees may have needed health care services delayed or denied if they are required, after being served by an out-of-network Indian Health Care Provider, to meet with an in-network primary care provider in order to receive a referral to an in-network specialist.

<sup>17</sup> Final Rule, 77 Fed. Reg. 18423.

<sup>18</sup> 25 U.S.C. § 1601 ("The Congress finds the following: . . . (5) Despite such services, the unmet health needs of American Indian people is far below that of the general population of the United States.")

<sup>19</sup> Final Rule, § 155.130, 77 Fed. Reg. 18447.

<sup>20</sup> *Federal Register*, July 15, 2011, CMS, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," (CMS-9989-P), Vol. 76, No. 136, page 41873 ("Proposed Rule").

<sup>21</sup> Final Rule, 77 Fed. Reg. 18320.

<sup>22</sup> Final Rule, 77 Fed. Reg. 18321.