American Indian Health Commission for Washington State

"Improving Indian Health through Tribal-State Collaboration"

July 18, 2012

Margaret Stanley, Chair
Washington Health Benefit Exchange
P.O. Box 657
Olympia, WA 98507

Mike Kriedler, Commissioner
Washington State Office of the Insurance Commissioner
Insurance Building, Capitol Campus,
Olympia, WA 98504

Dear Ms. Stanley and Mr. Kriedler:

On behalf of Washington's Tribes and the American Indian Health Commission (AIHC), I want to thank the Washington Health Benefit Exchange Board (WHBEB) and the Office of the Insurance Commissioner (OIC) for the opportunity to comment on your forthcoming work to develop the criteria for qualified health plans (QHP) to contract with essential community providers.

Washington's Indian health programs consists of Indian Health Services-operated programs (I), 638 tribal contracted and compacted programs (T) and urban Indian health programs (U). They are uniquely qualified to serve as essential community providers. Twenty-seven of our federally recognized tribes currently have medical clinics and our two urban Indian health programs serve American Indian (AI) and Alaska Native (AN) people living in the Seattle and Spokane areas. When a tribe operates its own health program its members nearly exclusively use that program and not a program operated by another tribe or the Indian Health Service. This fact is important to note as it is the basis for our request to require that all QHPs offer contracts to each of the state's Indian health programs.

As you know, the Affordable Care Act (ACA) and its l rules require that each Health Benefit Exchange (HBE) ensure that QHPs "… *must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards*." The ACA and enabling network adequacy rule also requires that QHPs are to "… *maintain a network that is sufficient in number and types of providers... to assure that all services will be accessible without unreasonable delay.*"

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We have been advised that the OIC will be responsible for determining network adequacy requirements and what constitutes a "sufficient number" of essential community providers that QHPs must contract with to meet the ACA standards. For the reasons outlined below, Washington's Tribes and the AIHC believe that the criteria should require that all QHPs offer network provider contracts with an Indian Addendum to all I/T/U programs in the QHP's service area.

I/T/U programs are best able to provide culturally appropriate primary care and other HBE essential health benefits to AI/AN people. Washington's I/T/U programs are nationally recognized for providing medical homes including care coordination for AI/AN people and other low-income people in their catchment areas. Tribal clinics are also able to provide other essential health benefits including pharmacy and behavioral health services. Washington's I/T/U providers with some 36 clinic locations are uniquely located to provide access to AI/AN people residing on the Washington's Indian reservations and critical locations for AI/AN people living in urban areas.

Washington's I/T/U programs have demonstrated capacity to work with a variety of federal programs and health carriers. All of Washington's tribal health programs have contracts with Washington's Medicaid program. I/T/U programs also contract with the Medicaid Healthy Options and Basic Health managed care programs that are targeted to serve low-income peoples across the state. Some of the I/T/U providers also contract with Medicare and other private insurers.

As a federal program, states' HBEs and QHPs must comport with provisions in the Indian Health Care Improvement Act (IHCIA). Under federal treaty and IHICA requirements, tribal members are to receive services from their tribe's programs, and I/T programs must serve eligible AI/AN s. In recognition of this trust responsibility, the IHCIA gives Indian health programs the authority to obtain reimbursement for services provider to AI/AN people from federal programs, including the ACA, and from health insurers, including QHPs, for whom the AI/AN person is enrolled. This obligation to receive payment for services rendered applies to both tribal programs that are QHP in-network providers or are non-network providers. Federal law also prohibits states from enacting laws that would prohibit or limit this right of recovery.

The IHICA sets forth payment rate obligations for services provided by I/T programs. An I/T program has the right to be paid by a health carrier (as well as by any employee benefit or other third party payer) the reasonable charges billed by the tribal program in providing health services through the program, or, if higher, the highest amount the payer would pay for care and services furnished by other providers (other than governmental entities). This applies for services provided to AI/AN people and non-native people alike.

It is important to note that Washington already recognizes the critical role that I/T/U programs have in serving AI/AN people. Washington's Medicaid program contracts with all federally recognized tribes that have medical clinics, as well as the two urban programs. Both the Healthy Options and Basic Health managed care programs require their participating health plans to reimburse I/T/U programs for services provided to AI/AN enrollees whether or not the I/T/U program is a network or non-network provider in their service areas.

Washington's rules governing health carriers also recognize the critical role that I/T/U providers play in serving AI/AN people. The rule (WAC 284-43-200) governing network adequacy requires health carriers to "… *maintain*

arrangements that insure that American Indians who are covered persons have access to Indian health services and facilities that are part of the Indian health system."

While federal provisions require I/T programs to serve AI/AN members enrolled in the HBE regardless of their network status, the benefits of in-network status are substantial for AI/AN patients and providers alike. In-network status will lead to greater coordination and timeliness of care to AI/ANs patients, and more certainty and timeliness of payment to I/T/U programs. For QHPs as well, including I/T/U programs as in-network providers, offers significant advantages as well, including: meeting network adequacy requirements for serving AI/ANs; reducing avoidable hospital emergency room use; timely inpatient discharge and placement; and, potential reduction in the overall volume of billed services to the QHP. Requiring QHPs to offer I/T/U programs network contracts would not create an undue burden on the QHP as the total number of I/T/U facilities is not large; there are only 36 care delivery sites in Washington.

Based on our experience with the Medicaid and BH programs, as well as private health plans, we understand that the relationship between I/T/U programs and private providers are different. To help exchanges and QHPs to contract with I/T/U programs, the Department of Health and Human Services (HHS) is developing an "Indian Addendum" template that state HBEs can use in their contracts with QHPs. The template could be adapted to include state-specific provisions for I/T/Us. The Indian Addendum is designed to list applicable Indian-specific Federal requirements. These provisions of Federal law apply whether or not the Indian Addendum is used.

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" has been successfully adopted by Medicare Prescription Drug Plans when contracting with I/T/U pharmacies. In order to ensure a productive relationship between QHPs and their network I/T/U providers, we are requesting that QHPs' contracts with I/T/U providers be required to include the Indian Addendum.

Part of Washington's recently approved Level 2 Establishment grant includes funding for the AIHC to work with the WHBEB to develop and implement policies and programs to ensure the successful enrollment of AI/AN people into the HBE, a WHBEB tribal consultation policy required in federal and state law, and to work with the WHBEB and OIC to develop QHP essential community provider requirements for I/T/U programs. This will include working with the HHS Tribal Technical Advisory Group (TTAG), and the Northwest Portland Area Indian Health Board (NPAIHB) to explain the benefits of the Indian Addendum template that can be adopted by both Washington and Oregon's exchanges.

I want to again thank you for supporting AIHC's work with the WHBEB and OIC to successfully implement Washington's HBE. If you have any questions about our recommendations, please contact either Sheryl Lowe, AHIC Executive Director at 360-775-5736 or slowe@aihc-wa.com; or myself at (360) 854-7039 or marilyns@upperskagit.com.

Sincerely,

Marilyn M. Scott

Marilyn Scott, Chair
American Indian Health Commission

cc:
WHBE Board Members
AIHC Delegates
Richard Onizuka
Molly Voris
Brad Finnegan
Michael Arnis
Beth Berendt
Barbara Fly
Joe Finkbonner
Jim Roberts

AMERICAN INDIAN HEALTH COMMISSION
INDIAN ESSENTIAL COMMUNITY PROVIDE REQUEST

REQUEST

On behalf of Washington's 29 federally recognized Tribes and two urban Indian health programs, the American Indian Health Commission (AIHC) is requesting that the Washington Health Benefit Exchange (WHBE) "essential community provider" rules require that all qualified health plans (QHP) shall:

1. Offer network provider contracts to all Indian Health Services, 638 contract/compact and urban Indian health program providers in their service areas. [1]

2. Contracts offered by QHPs shall include the federally approved Indian Addendum, which sets forth federal requirements for all federally financed health programs, including the Affordable Care Act's (ACA) Exchange, and health plans with Tribal and urban Indian health providers.

RATIONALE

To ensure that American Indian and Alaska Natives (AI/AN) and their non-native family members have timely access to culturally appropriate health care services. [2] For AI/AN people, this means having direct access to their Tribe's health programs. Requiring QHPs to contract with all Tribal programs is consistent with federal guidance to states. [3]

To ensure that WHBE comports with federal treaty rights and Indian Health Care Improvement Act (IHCIA) requirements that Tribal members and other AI/AN people have direct access to Tribal health care services. To support this treaty right, the IHCIA allows Tribal programs to bill insurance programs, including the ACA Exchanges, and health carriers for covered services they provide, even if the facility is not an in-network provider. Having all Tribal programs in a QHPs network harmonizes ACA and IHCIA objectives.

To ensure the WHBE fully recognizes state law that Tribal and urban Indian health programs are essential community provider status. [4]

To ensure that QHPs comply with existing Washington State's network adequacy requirements that AI/AN enrollees have access to Tribal services and facilities. [5]

To reduce AI/AN WHBE enrollment barriers. AI/AN people do not have a financial incentive to apply for health insurance because they have a right under federal law to IHS and Tribal program services. AI/AN

[1] Based on current Medicaid contract information, there are 36 I/T/U facilities providing medical care. In addition to medical services, 23 of the facilities provide dental care, 12 offer pharmacy services, 20 provide mental health services and 16 provide chemical dependency treatment services.

[2] Federal law (45 CFR 156.235(a)(1) (Essential community providers) requires ***"…*** *A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards*."

[3] The federal rule preamble states "…*We emphasize that Exchanges have the discretion to set higher, more stringent standards with respect to essential community provider participation, including a standard that QHP issuers offer a contract to any willing essential community provider." (Federal Register, Vol.77, No. 59, March 27, 2012 (page 18421).*

[4] E2SHB 2319, Section 8(1)(c) directs the Exchange to include Tribal and urban Indian as QHPs essential community providers.

[5] WAC 284-43-200(7)) governing network adequacy requires health carriers to "… *maintain arrangements that insure that American Indians who are covered persons have access to Indian health services and facilities that are part of the Indian health system*."

people also are not subject to ACA tax penalties for not having health insurance. [6] As network providers, Tribes will have new revenue and IHS direct services and contract health services (CHS) savings to help overcome this barrier by financially sponsoring their members' enrollment in WHBE and Medicaid.

To ensure greater coordination and timeliness of care for AI/AN patients, and more certainty and timeliness of payment for Tribal programs. If a Tribal member or other AI/AN WHBE enrollee obtains services from a non-network Tribal provider, the person may be required to obtain a second referral for specialty or inpatient services from a network provider. There could be lost coordination of care when the AI/AN member returns to their I/T/U facility for follow-up care. The QHP will incur duplicate costs.

To support QHPs ability to manage their enrollees care, including: meeting network adequacy requirements for serving AI/ANs; providing primary care capacity in rural areas and other limited access areas to non-native people [7]; reducing complexity and coordination of care between Tribal and urban Indian health providers and specialty providers; reducing avoidable hospital emergency room use; timely inpatient discharge and placement; and, potential reduction in the overall volume of billed services to the QHP. Requiring QHPs to offer Tribal and urban Indian providers network contracts should not create an undue burden on the QHP, as there are only 36 facilities.

To support Tribes and urban Indian Health programs ability to provide more health and long-term care services to AI/AN people by receiving WHBE and Medicaid payments for covered services. Receiving payments from QHPs and Medicaid will increase revenue to the Tribes and reduce use of IHS direct and contract heath services funds. [8] The combination of new revenue and freed-up IHS appropriations will allow funds to expand other critical health and long-term care services needed by AI/AN people.

DEMOGRAPHIC INFORMATION

There are an estimated 193,000 AI/ANs in Washington, approximately 2.9% of the total state population. Washington has the sixth largest AI/AN population - 3.9 % of the total 4.9 million AI/AN population in the United States. Over one-half of the population resides in urban areas.

Washington AI/AN Health Insurance Status

	Total		Uninsured		
	Number	%Total	Number	%Total	%Uninsured
Under 138%	67,836	35.2%	20,743	48.2%	30.6%
138% - 400%	77,350	40.1%	17,379	40.4%	22.5%
Over 400%	47,989	24.6%	4,877	11.4%	10.2%
Total	193,175	100.0%	43,000	100.0%	22.3%

Source: Fox-Boerner 33 State Database for American Indians and Alaska Natives, Alone and in Combination. American Community Survey. 2008-2010 pooled data.

Washington's AI/AN un-insured rate is 22.3%, approximately 43,000 individuals. Although Washington's AI/AN uninsured rate is the 11th lowest among the states, its AI/AN uninsured rate is nearly twice the 12.2% rate for the entire state. [9]

[6] Section 1501(b) amends the Internal Revenue Code to require that U.S. citizens and lawful legal residents have health insurance coverage. Section 1501(e) exempts certain persons from the penalty, including a member of an Indian Tribe.
[7] Washington's Tribes provided medical services to some 14,600 Medicaid clients in SFY 2011. 4,300 (29%) were non-natives.
[8] The Department of Health and Human Services' (HHS) Indian Health Services (IHS) has responsibility for providing health services to AI/AN people. While estimates vary, it is generally acknowledged that Congress has only funded IHS at one-half the estimated need for AI/AN people.
[9] The comparison of AI/AN insurance status to total state is based on ACS 2008-10 pooled data for the AI/AN rate and the 2010 Washington State Population Survey for total population.

American Indian Health Commission for Washington State

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October 19, 2012

Mike Kreidler, Commissioner
Washington State Office of the Insurance Commissioner
Insurance Building, Capitol Campus,
Olympia, WA 98504

Dear Commissioner Kreidler:

On behalf of the American Indian Health Commission (AIHC), I want to thank you for the opportunity for our Executive Committee to meet with you and your staff on October 8, 2012. At the meeting, AIHC presented you with our written request that Washington's Health Benefit Exchange (WHBE) require qualified health plans (QHPs) offer Tribal and urban Indian health providers network contracts that meet both federal and state essential community provider expectations (see enclosure titled "AIHC-OIC Document"). We were very pleased to hear that the Office of the Insurance Commission (OIC) supports this request and will work with AIHC and health carriers on how this requirement can be met.

Based on actions in other state administered Exchanges, we are requesting that the WHBE's written solicitation to health carriers interested in participating in the WHBE include the Affordable Care Act's (ACA) special Indian provisions. Enclosed for consideration is proposed language for the section (see enclosure titled "AIHC AI-AN Request Language").

We are further requesting that the OIC require carriers to include the federal Indian Addendum as part of their contract with Tribal and urban Indian programs. Our hope is that such an Addendum will alleviate administrative burdens upon the WHBE by preventing violations of federal requirements for qualified health plans in regard to contracting with Tribal and urban Indian health providers. We know that some carriers may not have experience contracting with Tribal programs, and most may not be familiar with federal treaty rights and laws governing federal programs, including the ACA requirements concerning the carrier's relationship with Tribal and urban Indian health programs.

At our meeting, Beth Berendt recommended that AIHC and your All-Filler group to discuss the requirement on contracting with Tribal and urban Indian health programs and the ACA special Indian provisions. Our Executive Committee would be glad to meet as soon as possible. At Beth's request, we will put together a contact list of Tribal and urban Indian persons for the carriers to initiate contracting.

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"Improving Indian Health through Tribal-State Collaboration"

The AIHC stands ready to work with OIC and WHBE staff on ensuring that AI/AN people are successfully enrolled in the WHBE and that Tribal and urban Indian health programs are able to serve as their medical home.

Sincerely,

Marilyn Scott, Chair
American Indian Health Commission

Enclosures

cc:

AIHC Delegates
WHBE Board Members
Sheryl Lowe, AIHC Executive Director
Beth Berendt
Barbara Flye
John Hamje
Richard Onizuka
Pam MacEwan
Brad Finnegan
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American Indian and Alaska Native Requirements for Contracting with Tribal and Urban Indian Health Care Providers

1. The Carrier will comply with all federally required laws and regulations specific to American Indians and Alaska Natives (AI/AN) and Indian Health Care Providers[i] in the Patient Protection and Affordable Care Act, P.L. 111-148 (ACA)[ii] and other federal regulations, including but not limited to the following:

    a. Monthly enrollment periods for AI/AN people to enroll in the Exchange;[iii]

    b. AI/AN enrollee able to change from qualified heath plan to another plan one time per month;[iv]

    c. No cost sharing for AI/AN enrollees with incomes under three hundred (300) percent of federal poverty level;[v]

    d. No cost sharing for item or service furnished through Indian Health Care Providers;[vi]

    e. Health programs operated by the Indian Health Care Providers will be the payer of last resort for services provided by such programs, notwithstanding any federal, state, or local law to the contrary;[vii] and,

    f. Compliance with federal Indian Health Care Improvement Act (IHCIA)[viii] Sections 206 and 408, including Section 206(a) provisions that Indian Health Care Providers have the right to recovery payments from Carriers for services provided to AI/AN people enrolled in their Qualified Health Plan, regardless of whether the Indian Health Care Provider is a network or non-network provider.

2. Carriers will offer to contract with all Indian Health Care Providers in the Carriers' service areas as in-network providers. Carrier contracts must include IHCIA Section 206(a) payment requirements that the Tribal Health Care Provider shall be paid payment rates agreed to by the Carrier and Indian Health Care Provider, except that such rates or amounts shall not be lower than the Carrier would pay to any other preferred or network provider.

3. Carrier contracts must include the Federal Indian Addendum when contracting with an Indian Health Care Provider.

4. If the Carrier contracts with an Indian Health Care Provider, the Carrier will notify the Exchange of this relationship. If the Carrier refuses to contract with the Indian Health Care Provider, the Carrier must submit a written explanation to the Provider.

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[i] As used in this section, "Indian Health Care Provider" means a health program administered directly by the Indian Health Service (IHS) or operated by an Indian tribe or tribal organization under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) or by an urban Indian organization that operates a health program under Title V of the Indian Health Care Improvement Act (25 U.S.C. §§ 1651 et seq.).

[ii] 124 Stat. 119 (2010) (to be codified in scattered sections of the Internal Revenue Code and of 42 U.S.C.).

[iii] ACA, Section 1311(c)(6)(D).

[iv] 45 CFR 155.420(d)(8).
[v] ACA, Section 1402(d)(1).
[vi] ACA, Section 1402(d)(2).
[vii] ACA, Section 2901(b).
[viii] ACA Section 10221, amends and enacts S. 1790, the "Indian Health Care Improvement Reauthorization and Extension Act of 2009," as reported by the Senate Committee on Indian Affairs on December 16, 2009 (hereinafter IHCIA).