American Indian Health Commission for Washington State

"Improving Indian Health through Tribal-State Collaboration"

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Cowlitz Tribe

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Executive Director
Brent Simcosky (Interim)
Jamestown S'Klallam Tribe

Member Tribes:
Chehalis
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Lummi
Makah
Muckleshoot
Nisqually
Nooksack
Puyallup
Quileute
Quinault
Samish
Saux-Suiattle
Shoalwater Bay
Skokomish
Snoqualmie
Spokane
Squaxin Island
Stillaguamish
Suquamish
Swinomish
Tulalip
Upper Skagit

Member Organizations:
Seattle Indian Health Board
NATIVE Project of Spokane

January 17, 2013

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

Dear Commissioner Kreidler:

The American Indian Health Commission (AIHC), on behalf of Washington's Tribes and urban Indian health programs, would like to thank you for hosting the first Office of Insurance Commissioner (OIC) Tribal Consultation on January 8, 2013. We truly appreciate the effort you and your staff made to listen to the tribes' and urban Indian health programs' concerns and feedback regarding the OIC's proposed rules for health coverage issuer provider network adequacy.

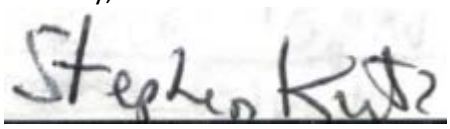
During the January 8, 2013, Consultation, parties to the Consultation conducted an in-depth discussion of AIHC's preliminary comments submitted in response to CR-101 WSR 13-19-092. Two major issues were highlighted during the discussion: (1) the Washington State Indian Health Care Provider Addendum (Addendum); and (2) the implementation of the Indian Health Care Improvement Act, Section 206(a), 25 U.S.C. 1621e(a);. Based on these discussions, the AIHC requested further feedback from Tribal leaders and Indian Health Care Providers, and subsequently, made several revisions to each of the pertinent proposed WACs. Enclosed are the AIHC's final recommended changes to the OIC's December 4, 2013 "Stakeholder Exposure Draft" as well as a revised Addendum. The changes are in redline.

First, with regard to 25 USC 1621e(a), we made revisions to mirror more closely federal statutory language. The proposed language in WAC 284-43-200(7), provides additional clarity for both Indian Health Providers and issuers, as to federal requirements for the reimbursement of Indian Health Care Providers.

Second, the proposed language makes clear that all issuers including issuers who operate outside the Exchange must incorporate the Washington Issuer Indian Health Care Addendum provided by reference within the WAC. We believe the revised Addendum will bring greater clarity to both parties as to what federal requirements they must follow when carrying out the unique and sometimes legally complex relationship between an issuer and an Indian Health Care provider.

Once again, we greatly appreciate your sincere dedication to developing a government-to-government relationship with the tribes and urban Indian health organizations of Washington State. We look forward to working with you in the future in these endeavors. Please contact Brent Simcosky, AIHC's Interim Executive Director, if you have any questions or your staff would like to hold further discussions. Brent can be reached at 360-582-4870 or bsimcosky@jamestowntribe.org.

Sincerely,



Steven Kutz, Chair
American Indian Health Commission

Enclosure

cc:

Tribal Leaders
AIHC Delegates
John Hamje, OIC Tribal Liaison
Molley Nollette, OIC Deputy Commissioner
Jennifer Kreitier, OIC
Andrea Philhower, OIC
Jeannette Plitt, OIC
Richard Onizuka, WHBE CEO
Sheryl Lowe, WHBE Tribal Liaison
Joe Finkbonner, NPAIHB
Jim Roberts, NPAIHB

*E-mail bsimcosky@jamestowntribe.org** Website: www.aihc-wa.com*
**Phone: 360-582-4870*

AMENDATORY SECTION

WAC 284-43-130 Definitions.

(XX) "Indian Health Care Provider" means:

(a) the Indian Health Service, an agency operated by the U.S. Department of Health and Human Services established by the Indian Health Care Improvement Act, Section 601, 25 USC § 1661;

(b) an Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. §450 et seq.;

(c) a tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the ISDEAA, 25 U.S.C. §450 et seq.;

(d) an Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), or tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act); or,

(e) an urban Indian organization that operates a health program with funds in whole or part provided by Indian Health Service under a grant or contract awarded pursuant to Title V of the Indian Health Care Improvement Act, Section 4(29), 25 U.S.C. §1603(29).

AMENDATORY SECTION

WAC 284-43-200 Network adequacy – General standards

(7) To provide adequate choice to ((~~covered persons~~)) enrollees who are American Indian/Alaska Natives, each health ((~~carrier shall~~)) issuer must maintain arrangements that ensure that American Indian/Alaska Natives who are ((~~covered persons~~)) enrollees have access to covered medical and behavioral health services provided by ((~~to~~)) Indian ((~~and tribal~~)) health care providers as defined in WAC 284-43-130(xx) (~~services and facilities that are part of the Indian health system~~)). ((~~Carriers shall~~)) Issuers must ensure that such ((~~covered persons~~)) enrollees may obtain covered medical and behavioral health services from the Indian health ((~~system~~)) care provider at no greater cost to the ((~~covered person~~)) enrollee than if the service were obtained from network providers and facilities, even if the Indian health ((~~system~~)) care provider is not a contracted provider. As set forth in Section 206(a) of the Indian Health Care Improvement Act, 25 U.S.C. 1621e(a), the issuer shall reimburse the Indian health care provider the reasonable charges billed or, if higher, the highest amount the

issuer would pay for equivalent care and services furnished by nongovernmental providers who are within that service area even if the Indian health care provider is not a contract provider. Pursuant to Sec. 206(c), 25 U.S.C. 1621e(c), no provision of any State, or of any political subdivision of a State and no provision of any contract, insurance or health maintenance organization policy, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program entered into or renewed after November 23, 1988, shall prevent or hinder the right of recovery of an Indian health care provider under this section. Issuers shall incorporate the Washington State Indian Health Care Provider Addendum defined in WAC 284-43-130(xx), which sets forth the special protections and providers in federal law for Indian health care providers, in the contracts with Indian health care providers. ((~~Carriers~~)) Issuers are not responsible for credentialing Indian health care providers ((~~and facilities that are part of the Indian health system~~)). Nothing in this subsection prohibits ((~~a carrier~~)) an issuer from limiting coverage to those health services that meet ((~~carrier~~)) issuer standards for medical necessity, care management, and claims administration ((~~or from limiting payment~~

~~to that amount payable if the health service were obtained from a network provider or facility~~)).

NEW SECTION

WAC 284-43-201 Alternate network standards. (1) An issuer may propose a network adequacy standard as an alternate to the requirements of this subchapter for the commissioner's review and approval.

(a) Copayments and deductible requirements must apply to alternate network standards at the same level they are applied to in-network services. This means that the alternate network standard may result in issuer payment of billed charges to ensure network adequacy. Alternate network adequacy standards, or alternate network standards, address such provider network strategies as use of out-of-state and out of county or service area providers, agreements to pay billed charges when a critical provider is not part of the network, exceptions to network standards based on rural locations in the service area, or limitations on authority to refer enrollees to specialty care.

(b) An issuer must demonstrate in its alternate network standard proposal a reasonable basis for not meeting a standard as part of its filing for approval of an alternate network standard, and include an explanation of why the alternate network standard provides a sufficient number or type of the provider, practitioner, or facility to which the standard applies to enrollees.

(c) An issuer must demonstrate a plan and practice to assist enrollees to locate available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs.

(d) An issuer must arrange for the provision of specialty services from specialists outside the contracted network if such specialists are not available within the network and the services are medically necessary for the enrollee's condition.

(e) An issuer must comply with WAC 284-43-200(7) requirements for American Indian/Alaska Natives who are enrollees.

NEW SECTION

WAC 284-43-221 Essential community providers—Definition.

(6) ((~~Federally designated 638 Tribal Health programs, and Title V Urban Indian Health programs~~)) Indian health care providers defined in WAC 284-43-130(xx);

NEW SECTION

WAC 284-43-222 Essential community providers—Network adequacy.

(3) The following minimum standards apply to establish adequate qualified health plan inclusion of essential community providers:

(b) Issuers must offer one hundred percent of ((~~urban tribal health centers and Indian health centers~~)) Indian health care providers (as defined in WAC 284-43-130(xx))in a service area ((~~included in~~)) a provider network contract on a basis that satisfies RCW 43.71.065 and WAC 284-43-200(7).

NEW SECTION

WAC 284-43-XXX Washington State Indian Health Care Provider Addendum.

(1) "Washington State Indian Health Care Provider Addendum" is an addendum to an issuer's network contract that specifies the special protections and provisions in federal law and rule for contracting with Indian health care providers;

(2) Office of the Insurance Commissioner adopts by reference the Washington State Indian Health Care Provider Addendum;

(3) The Office of the Insurance Commissioner reserves the right to amend the Washington State Indian Health Care Provider Addendum using the rulemaking process.

DRAFT
Washington State Indian Health Care Provider Addendum

1. Purpose of Addendum; Supersession.

The purpose of this Addendum for Indian Health Care Providers is to apply special terms and conditions necessitated by Federal law and regulations to the network provider agreement by and between _____ (herein "issuer") and _____ (herein "Provider"). To the extent that any provision of the Issuer's network provider agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.

2. Definitions.

For purposes of the Issuer's agreement, any other addendum thereto, and this Addendum for Indian Health Care Providers, the following terms and definitions shall apply:

(a) "Contract health services" has the meaning given in IHCIA Sec. 4(5), 25 U.S.C. §1603(5).
(b) "Indian," has the meaning given in the IHCIA Section 4, 25 U.S.C. § 1603 and the Indian Self-Determination and Education Assistance Act (ISDEAA) Section 4(d), 25 U.S.C. § 450b.
(c) "Provider" means a health program administered by the Indian Health Service (IHS), a tribal health program, an Indian tribe or tribal organization to which funding is provided pursuant to 25 U.S.C. § 47 (commonly known as the "Buy Indian Act"), or an urban Indian organization that receives funding from the IHS pursuant to Title V of the IHCIA (Pub. L. 94-437), as amended, and is identified by name in Section 1 of this Addendum.
(d) "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by IHCIA Section 601, 25 USC § 1661.
(e) "Indian tribe" has the meaning given in IHCIA Section 4(14), 25 USC § 1603(14).
(f) "Qualified Health Plan" has the meaning given in Section 1301 of the Patient Protection and Affordable Care Act (ACA), 42 U.S.C. §18021.
(g) "Tribal health program" has the meaning given in IHCIA Section 4(25), 25 U.S.C. § 1603(25).
(h) "Tribal organization" has the meaning given in IHCIA Section 4(26), 25 U.S.C. §1603(26).
(f) "Urban Indian organization" has the meaning given in IHCIA Section 4(29), 25 U.S.C. §1603(29).

3. Description Provider.

The Provider identified in Section 1 of this Addendum is (check appropriate box):

/_/ The IHS.

/_/ An Indian tribe that operates a health program under a contract or compact to carry out programs of the IHS pursuant to the ISDEAA, 25 U.S.C. §450 et seq.

/_/ A tribal organization that operates a health program under a contract or compact to carry out programs of the IHS pursuant to the ISDEAA, 25 U.S.C. §450 et seq.

/_/ A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).

/_/ An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.

4. Persons eligible for items and services from Indian Health Care Provider.

(a) The parties acknowledge that eligibility for services at the Provider's facilities is determined by federal law, including the IHCIA, 25 U.S.C. § 1680c, et seq. and/or 42 C.F.R. Part 136. Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the Provider's programs.

(b) No term or condition of the Issuer's agreement or any addendum thereto shall be construed to require the Provider to serve individuals who are ineligible under federal law for services from the Provider. The Issuer acknowledges that pursuant to 45 C.F.R. 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the Provider.

5. Applicability of Other Federal laws.

Federal laws and regulations affecting the Provider, include but are not limited to the following:

(a) The IHS as a Provider:

(1) Anti-Deficiency Act 31 U.S.C. § 1341;
(2) ISDEAA; 25 USC § 450 et seq.;
(3) Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§2651-2653;
(5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. §552a, 45 C.F.R. Part 5b;
(6) Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2;
(7) Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164; and
(8) IHCIA, 25 U.S.C. §1601 *et seq*.

(b) An Indian tribe or a tribal organization that is an Indian Health Care Provider:

(1) ISDEAA, 25 U.S.C. §450 *et seq.;*
(2) IHCIA, 25 U.S.C. §1601, *et seq.;*
(3) FTCA, 28 U.S.C. §§2671-2680;
(4) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is an Indian Health Care Provider:

(1) IHCIA, 25 USC §1601, et seq. (including without limitation pursuant to IHCIA Section 206(e)(3), 25 U.S.C. § 1621e(e)(3), regarding recovery from tortfeasors);
(2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b; and
(3) HIPAA, 45 CFR parts 160 and 164.

6. Non-taxable entity.

To the extent the Provider is a non-taxable entity, such Provider shall not be required by an issuer to collect or remit any Federal, State, or local tax.

7. Insurance and Indemnification.

(a) *Indian Health Service*. IHS is covered by the FTCA which obviates the requirement that IHS carry private malpractice insurance as the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. 28 U.S.C. §2671-2680. Nothing in the issuer's agreement shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment. The IHS shall not be required to acquire insurance, provide indemnification, or guarantee that the issuer will be held harmless from liability.

(b) *Indian Tribes and Tribal Organizations*. A Provider which is an Indian tribe or a tribal organization shall not be required to obtain or maintain professional liability insurance to the extent such Provider is covered by the FTCA pursuant to Federal law (Pub. L. 101-512, Title III, § 314, as amended by Pub .L. 103-138, Title III, §308 (codified at 25 U.S.C. §450f note); and regulations at 25 C.F.R. Part 900, Sub. pt. M. Nothing in the issuer network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such Provider or any employee of such Provider to operate outside of the scope of employment of such employee. Such Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the issuer will be held harmless from liability.

(c) *Urban Indian Organizations*. To the extent a Provider that is an urban Indian organization is covered by the FTCA pursuant to section 224(g)-(n) of the Public Health Service Act, as amended by the Federally Supported Health Centers Assistance Act, Pub. L. 104-73, (codified at 42 USC §233(g)-(n)), 42 CFR Part 6, such Provider shall not be required to obtain or maintain professional liability insurance. Nothing in the issuer network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such Provider or any employee of such Provider to operate outside of the scope of employment of such employee. Such Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the issuer will be held harmless from liability.

8. Licensure of Health Care Professionals.

(a) *Indian Health Service. S*tates may not regulate the activities of IHS-operated health care programs nor require that IHS health care professionals be licensed in the state where they are providing services, whether the IHS employee is working at an IHS-operated facility or has been assigned to a health care program of a tribe, tribal organization or urban Indian organization. The parties agree that during the term of the issuer's agreement, IHS health care professionals shall hold state licenses in accordance with applicable federal law, and that IHS facilities shall be accredited in accordance with federal statutes and regulations.

(b) *Indian tribes and tribal organizations.* Sec. 221 of the IHCIA, 25 U.S.C. §1621t, exempts a health care professional employed by an Indian tribe or tribal organization from the licensing requirements of the state in which such tribe or organization performs services, provided the health care professional is licensed in any state. The parties agree that these federal laws, including 25 U.S.C. § 1647a, apply to the issuer's agreement and any addenda thereto.

(c) *Urban Indian organizations.* To the extent that any health care professional of an urban Indian Provider is exempt from state regulation, such professional shall be deemed qualified to perform

services under the issuer's agreement and all addenda thereto, provided such employee is licensed to practice in any state. The parties agree that this federal law applies to the issuer's agreement and any addenda thereto.

9. Licensure of Provider; Eligibility for payments.

To the extent that the Provider is exempt from state licensing requirements, such Provider shall not be required to hold a state license to receive any payments under the issuer network provider agreement and any addendum thereto.

10. Dispute Resolution.

In the event of any dispute arising under the issuer's agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. The laws of the United States shall apply to any problem or dispute hereunder that cannot be resolved by and between the parties in good faith. Notwithstanding any provision in the Issuer's agreement or any addendum thereto to the contrary, the Indian Health Care Provider shall not be required to submit any disputes between the parties to binding arbitration.

11. Governing Law.

The issuer's network provider agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail. Nothing in the issuer's network provider agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

10. Medical Quality Assurance Requirements.

To the extent the issuer imposes any medical quality assurance requirements on its network providers, any such requirements applicable to the Provider shall be subject to Section 805 of the IHCIA, 25 U.S.C. §1675.

11. Claims Format.

Pursuant to Sec. 206(h) of the IHCIA, 25 USC §1621e(h), the issuer may not deny a claim submitted by the Provider based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

12. Payment of Claims.

As set forth in Section 206(a) of the Indian Health Care Improvement Act, 25 U.S.C. 1621e(a), the issuer shall reimburse the Indian health care provider the reasonable charges billed or, if higher, the highest amount the issuer would pay for equivalent care and services furnished by nongovernmental providers who are within that service area even if the Indian health care provider is not a contract provider. Pursuant to Sec. 206(c), 25 U.S.C. 1621e(c), no provision of any contract, insurance or health maintenance organization policy, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program entered into or renewed after November 23, 1988, shall prevent or hinder the right of recovery of an Indian health care provider under this section. A qualified health plan issuer's

payments to an Indian provider shall be in accordance with Section 1402(d)(2)(B) of the Affordable Care Act, 42 U.S.C. 18071(d)(2)(B) which provides that the issuer of the plan shall not reduce the payment to any entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for the cost-sharing provisions in Section 1402(d)(2)(A).

15. Hours and Days of Service.

The hours and days of service of the Provider shall be established by such Provider. At the request of the issuer, such Provider shall provide written notification of its hours and days of service.

16. Contract Health Service Referral Requirements.

The issuer may not require the Provider to make referrals to the issuer's participating network providers if the Provider determines that such referrals would conflict with federal law or referral requirements under the contract health service program.

17. Sovereign Immunity.

Nothing in the issuer network provider agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

18. Endorsement.

An endorsement of a non-federal entity, event, product, service, or enterprise may be neither stated nor implied by the IHS Provider or IHS employees in their official capacities and titles. Such agency names and positions may not be used to suggest official endorsement or preferential treatment of any non-federal entity under this agreement.

APPROVALS

For the Issuer: **For the Provider:**

_____ _____

Date _____ Date _____