Washington Insurance Issuer Requirements for American Indian/Alaska Native Enrollees and Enrollees Seeking Services at Indian Health Care Providers

Introduction

The State of Washington requires health insurance issuers (hereafter referred to as "issuers") to comply with all state and federal laws relating to the acts and practices of issuers and laws relating to health plan benefits.[1] The purpose of this guidance document is to provide Indian health care providers, non-Indian health care providers, and health insurance issuers an overview of the state and federal requirements for issuers with American Indian/ Alaska Native (AI/AN)[2] enrollees and/or with enrollees utilizing Indian health care providers.[3] This guidance document addresses the federal and state rules for (1) AI/AN Access to Care; (2) AI/AN cost of services and Indian health care provider's right to recovery; (3) provider and facility licensure requirements; (4) Qualified Health Plan (QHP) issuer contracting requirements; and (5) enforcement of issuer requirements. Washington State's Office of the Insurance Commissioner (OIC) has reviewed the guidance document's sections on state laws and rules for accuracy.

1. AI/AN Access to Indian Health Care Providers

Generally. The State of Washington requires all issuers to maintain arrangements to ensure that all AI/AN enrollees have access to Indian health care providers for both medical and behavioral health services.[4] This rule, often referred to as the "network access" rule, requires that all AI/AN enrolled in an issuer's plan have access to Indian health care providers even if an Indian health care provider is not a contracted network provider.[5]

Qualified Health Plans and Essential Community Providers. QHPs must include essential community providers (ECP) within their networks for QHPs and qualified stand-alone dental plans.[6]

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[1] WAC 284-43-125.

[2] For purposes of this guidance and unless other stated in the federal Affordable Care Act, AI/AN means: (1) Member of a Federally Recognized Tribe, Band, Pueblo or Rancheria; Shareholder in an Alaska Native Regional or Village Corporation; (2) Descendant of a Federally Recognized Tribe, Band, Pueblo or Rancheria; Shareholder in an Alaska Native Regional or Village Corporation; or (3) Eligible for Indian Health Services, Tribal Health Services or Urban Indian Health Services, including as a California Indian, Eskimo, Aleut or other Alaska Native.

[3] WAC 284-43-130(16). For purposes of this guidance, an "Indian health care provider" means an Indian Health Services operated program, a Tribal owned and operated program authorized under 638 contract and compact, and an Indian Health services recognized urban Indian health program.

[4] WAC 284-43-200.

[5] WAC 284-43-200(9).

[6] WAC 284-43-222(1).

Indian health care providers are considered ECPs.[7] The issuer's QHP provider network must include access to one hundred percent of Indian health care providers in its service area.[8]

Apple Health (Medicaid) managed care contractors have the same requirements to allow AI/AN free access to Indian health care providers regardless of whether the provider is a contract network provider or a non-network provider.[9]

Office of the Insurance Commissioner's Assessment of Access. If the Commissioner determines that an issuer's proposed or current provider network is not adequate, the Commissioner may permit the issuer to propose changes sufficient to make the network adequate within a sixty-day period of time.[10] The proposal must include a procedure to ensure that new enrollees have access to an open primary care provider within ten business days of enrolling in the plan while the proposed changes are being implemented. This requirement is in addition to enforcement action permitted under Title 48 RCW.[11]

2. Qualified Health Plan Contracting with Indian Health Care Providers

Requirement to Offer to Contract. The OIC requires QHP issuers (rule does not apply to non-QHP issuers) to offer to contract with Indian health care providers who request a contract for reimbursement of covered health care services delivered to qualified enrollees under the QHP issuer's plan.[12] The rule does not place specific time requirements; therefore, an Indian health care provider may seek a contract with an issuer at any time during a year.

Good Faith Exception. If an Indian health care provider requests a contract and a contract is not entered into, the issuer must provide substantial evidence of good faith efforts on its part to contract with the Indian health care provider. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.[13]

State rules do not define what constitutes a "good faith effort" or what documentation would provide substantial evidence of a QHP's good faith efforts to contract with an Indian health care provider.[14] OIC's guidance to issuers states that, " … The assessment of whether the issuer has

[7] RCW 43.71.065(1)(c) and WAC 284-43-221(6).

[8] WAC 284-43-222(3)(b).

[9] Public Health Service Act, Pub. L. No 78-410, 42 U.S.C. § 1396u-2(h)(2)(A)(ii). See also, Washington State HealthCare Authority, Washington Apple Health Managed Care Contract, Section 15.4, effective October 2014.

[10] WAC 284-43-230(3).

[11] WAC 284-43-230(3).

[12] WAC 284-43-222(5).

[13] WAC 284-43-222(5)(b).

[14] WAC 284-43-222(5)(b).

made good faith efforts to contract is an assessment of the efforts to contract, not an assessment of the particular terms being offered by either party."[15]

However, the Department of Health and Human Services (HHS) has defined a good faith contract with an ECP, which includes Indian health care providers, as one that "offers the same rates and contract provisions as other contracts accepted by or offered to similarly situated providers that are not ECPs."[16] Per HHS requirements and forthcoming federal rules, satisfaction of the ECP standard would include a QHP's verification of contracts "that include terms that a willing, similarly-situated, non ECP provider would accept or has accepted." For Indian health care providers, it would also include a contract that applied the special terms and conditions necessitated by federal law and regulations as referenced in the recommended model QHP addendum for Indian health providers.[17]

Model Washington State Indian Health Care Provider Contract Addendum. The Washington Indian Addendum was developed for Indian health care providers in contracting with issuers and to help issuers comply with federal laws governing Indian health care and to comply with QHP certification standards set forth in 45 C.F.R. Part 156. QHP issuers are encouraged to use the current version of the Model Washington State Indian Health Care Provider Addendum, as posted on http://www.aihc-wa.com to supplement the existing provider contracts when contracting with an Indian health care provider.[18] In their Concise Explanation Statement (R-2013-22), OIC has also stated that they "*expect*" issues to use the Addendum.[19]

3. Cost of Services to AI/AN

All Issuers. WAC 284-43-200(9) requires issuers to ensure all AI/AN enrollees can obtain medical and behavioral health services from an Indian health care provider "at no greater cost to the enrollee than if the service were obtained from network providers and facilities, even if the Indian health care provider is not a contracted provider." NOTE: Issuers can limit coverage for AI/AN to health services that "meet issuer standards for medical necessity, care management, and claims administration"[20] subject to 25 U.S.C. 1621t and for Medicaid managed contractors, 25 U.S.C. 1647a(a)(2)). Issuers can also limit payment to that amount payable if the health service were obtained from a network provider or facility. See Section 4 below.

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[15] Office of Insurance Commissioner's "Alternative Access Delivery Request Form C". The form describes four things that document evidence of issuers efforts to contract with Essential Community Providers (see Appendix C).

[16] HHS Notice of Benefit and Payment Parameters for 2016; Proposed Rule, 79 Fed. Reg. 228, 70727 (Nov. 26, 2014)(to be codified at 45 C.F.R. pt. 156).

[17] HHS Notice of Benefit and Payment Parameters for 2016; Proposed Rule, 79 Fed. Reg. 228, 70727 (Nov. 26, 2014)(to be codified at 45 C.F.R. pt. 156),45 CFR 156.235(a)(ii)(A).

[18] WAC 284-43-222(5)(a).

[19] Under existing state law, the OIC does not have authority to require issuers use the Addendum when contracting with Indian health care providers. State law (RCW 43.71.080(6)) also prohibits the WHBE from adding new QHP certification standards without legislative approval. The state legislature is the only entity that can establish requirements that issuers use the Indian Addendum when contracting with Indian health care providers.

[20] WAC 284-200(9).

Qualified Health Plans. Members of federally-recognized tribes or Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders qualify for special cost sharing benefits as outlined below when they enroll in a Washington Health Benefit Exchange (WHBE) QHP.[21]

i. **Zero Cost Sharing**. If the WHBE determines an AI/AN enrolled in QHP has household income under 300% of the federal poverty level (FPL), the QHP issuer must assign the individual to a zero cost sharing plan variation. The zero cost sharing plan variation has no cost sharing for items or services provided directly by the Indian health care provider, through referral under contract health services, or any other QHP health care provider.[22] In Washington, these plans are referred to as "Cost-Sharing Reduction (CSR) Tier 2 plan variations."

ii. **Limited Cost Sharing**. AI/AN of any income can be enrolled in a QHP limited cost sharing plan, and such individuals shall have no cost sharing for essential health benefits received from an Indian health care provider or through referral from an Indian health care provider. [23] It is important to note that cost sharing benefits for referrals may be subject to the terms of the issuer's plan such as network provider requirements. The issuer of the plan may not reduce the payment to an Indian health care provider for services or items.[24] In Washington, these plans are referred to as "Cost-Sharing Reduction (CSR) Tier 3 plan variations."

iii. **Payment by HHS Secretary.** The Secretary of HHS shall directly pay the QHP issuer an amount necessary to reflect the increase in actuarial value of the plan required by the zero and limited cost sharing plans.[25]

4. Indian Health Care Provider Reimbursement

i. Indian Health Provider Right to Recovery.

a. Generally. Federal law[26] requires issuers to reimburse Indian health care providers for services they provide to their AI/AN enrollees.[27] This "right of

[21] Under the Patient Protection and Affordable Care Act (ACA), individuals who are Indian descendants but not enrolled members of a federally recognized tribe or ANCSA shareholder are not eligible for these cost sharing benefits.

[22] Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified in scattered sections of 42 U.S.C.) § 1402(d)(1) and 45 CFR 156.410(b)(2). This rule is subject to the special rule for family policies set forth in 45 CFR 155.305(g)(3).

[23] ACA, § 1402(d)(2). See also Health Insurance Issuer Standards, 45 C.F.R. § 156.410(b)(3). This rule is subject to the special rule for family policies set forth in 45 C.F.R. § 155.305(g)(3).

[24] ACA, § 1402(d)(2).

[25] ACA, § 1402(d)(3).

[26] Indian Health Care Improvement Reauthorization and Extension Act of 2009, as enacted (in amended form) by § 10221 of ACA (IHCIA), § 206(a) (25 U.S.C. § 1621e(a)).

[27] IHCIA, § 206(c) (25 U.S.C. § 1621e(a)).

recovery" applies to AI/AN enrolled in any "… insurance company, health maintenance organization, employee benefit plan…." This includes insurance offered in any health insurance market regulated by the OIC, as well has federal programs including Medicare, Medicaid, Veteran's Administration and the WHBE. No state law or issuer contract provision, entered into or renewed after November 23, 1988, shall prevent or hinder an Indian health care provider the right of recovery under this section.[28]

b. Federal Health Care Program Contractors. Federal law requires federal health care programs' (e.g., Medicare, Medicaid, Veteran's Administration and the WHBE) contractors to accept an Indian health care provider as a provider eligible to receive payment for health care services furnished to an AI/AN on the same basis as any other provider if the entity meets generally applicable State or other requirements for participation as a provider of health care services under the program.[29] See Section 4 for facility/provider licensure requirements.[30]

ii. Federal Statutory Reimbursement Rate by All Issuers.

The federal law requires the issuer to reimburse the Indian health care provide their "reasonable charges billed" or, if greater, the "highest amount" the issuers would pay for care and services furnished by nongovernmental providers.[31] The WHBE's QHP guidance for participation requires QHPs to comply with this provision in order to meet certification requirements.[32] No state law or issuer contract provision entered into or renewed after November 23, 1988, shall prevent or hinder the right of recovery under this section.[33]

iii. Prohibition on Reduction of QHP Issuer Payments to Indian Providers. The issuer of the plan may not reduce the payment to an Indian health care provider for such services or items.[34]

5. Indian Health Care Provider and State Licensure Requirements

All Issuers

[28] IHCIA, § 206(a) (25 U.S.C. Sec. 1621e(c))

[29] IHCIA, § 408(a)(1) (§ 25 U.S.C. 1647a(a)(1).

[30] See also, Washington State Health Care Authority, Washington Apple Health Managed Care Contract, Section 15.4, effective October 2014.

[31] IHCIA, § 206(a) (25 U.S.C. Sec. 1621e(a)).

[32] The WHBE's 2015 "Guidance for Participation in the Washington Health Benefit," page 23.

[33] IHCIA, § 206(c) (25 U.S.C. Sec. 1621e(c)). [34] ACA, § 1402(d)(2)(B).

[34] ACA, § 1402(d)(2)(B).

Washington state law requires that all health care professionals have a valid license issued by the Department of Health to practice medicine, nursing care pharmacy, dentistry, behavioral health care and other health related services. However, federal law allows an Indian health care provider's employed health professionals to be exempt from the Washington State licensure requirements if the professionals are licensed in another state and are performing the services described in the contract or compact of the Indian health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).[35]

Issuers' Credentialing

Under Washington state rule, "Issuers are not responsible for credentialing providers and facilities that are part of the Indian health system."[36] However as part of their accreditation requirements, issuers credential their network health care providers, including employees of Indian health care providers. The credentialing process includes validating that the health professional has a valid Washington State license. As stated above, health professionals employed by an Indian health care provider do not have to have a Washington state license if they have a license in another state performs and are performing the services described in the contract or compact of the tribal health program under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

Federal Health Programs

A Federal health care program [e.g., Medicare, Medicaid, Children's Health Insurance Program, Veterans Administration] must accept an entity that is operated by the Indian Health Service, an Indian tribe, tribal organization, or urban Indian organization as a provider eligible for reimbursement of health care services furnished to an AI/AN on the same basis as any other qualified provider 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. [37]

Any requirement under a Federal health care program that an entity operated by Indian Health Service, an Indian tribe, tribal organization, or urban Indian organization be licensed or recognized under the State or local law where the entity is located shall be deemed to have been met if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law. The entity's health professionals must be licensed. However in accordance with section 221, the absence of the licensure of a health professional employed by such an entity under the State or local law where the entity is located shall not be taken into account for purposes of determining whether the entity meets such standards, if the professional is licensed in another State.[38]

6. Claims Format

[35] IHCIA, § 221, (25 U.S.C. 1621t).

[36] WAC 284-43-200(9).

[37] IHCIA, § 408(a)(1), (25 U.S.C. 1647a(a)(1)).

[38] IHCIA, § 408(a)(2), (25 U.S.C. 1647a(2)).

Under federal law, all issuers including Medicaid and Medicare managed care contractors are prohibited from denying a claim for benefits submitted by an Indian health care provider based on the format in which the claim is submitted if such format complies with the format required for submission of claims under title XVIII of the Social Security Act [42 U.S.C. 1395 et. Seq.] or recognized under section 1175 of such Act [42 U.S.C. 1320d-4].[39]

7. Medical Quality Assurance Requirements

Federal law requires that all medical quality assurance records created by or for an Indian health care provider as part of a medical quality assurance program are confidential and privileged and may not be disclosed to any person or entity except under certain statutory exceptions.[40] Any entity creating medical quality assurance records are subject to this requirement and all other requirements found in Section 805 of the IHCIA, 25 U.S.C. § 1675.

8. Payer of Last Resort

Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)) shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary.[41] Therefore, all alternate resources that are available and accessible such as Medicare, Medicaid, SCHIP, private insurance, etc. are used before IHS funds can be expended.

9. Enrollee Eligibility for Indian Health Care Provider Services

Indian health programs are established under the IHCIA to serve their AI/AN community and/or other populations (including non-Indians) as they so establish pursuant to 42 Part 136 and IHCIA Section 813(a) and (b) of the IHCIA (25 U.S.C. § 1680c). Pursuant to 45 C.F.R. 80.3(d), an individual shall not be deemed as subjected to discrimination by reason of his or her exclusion from benefits limited by federal law to individuals eligible for services from an Indian health program.

10. Indian Health Care Providers and the Federal Tort Claims Act

The Federal Tort Claims Act (FTCA),[42] allows parties claiming to have been injured by negligent actions of employees of the United States to file claims against the federal government and provides authority for the federal government to defend against such claims. Congress extended the FTCA

[39] IHCIA § 206(h) (25 U.S.C. § 1621e(h)).

[40] IHCIA § 805(b) (25 U.S.C. § 1675(b)).

[41] ACA, § 2901(b).

[42] 28 U.S.C. §§ 2671-2680.

to the negligent acts of tribal employees acting within the scope of their employment and within the scope of the Tribe's contract or compact with the Indian Health Service.[43] The coverage also extends under certain circumstances to personal services contractors and independent contractors acting within the scope of their employment and within the scope of the Tribe's contract or compact with Indian Health Services. FTCA coverage is also included for Urban Indian Organizations who are Federally Qualified Health Centers under Section 224 of the Public Health Service Act. Per the U.S. Department of Health and Human Services (HHS), since a claim under the FTCA is the exclusive remedy for actions against Indian health care providers that are covered by the FTCA, those entities are not required to obtain separate professional liability insurance.[44]

The Centers for Medicare and Medicaid Services' (CMS) QHP Indian Addendum and the Model Washington State QHP Indian Addendum provides the following requirements:

A. Indian health care providers shall not be required to obtain or maintain professional liability insurance to the extent such Provider is covered by the FTCA;

B. Nothing in the QHP 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; and

C. Such Provider shall not be required to acquire insurance, provide indemnification, or guarantee that the QHP will be held harmless from liability.

11. OIC Enforcement of Issuer Requirements

State law requires OIC regulated issuers to comply with all state and federal laws relating to the acts and practices of issuers and laws relating to health plan benefits.[45] The OIC has a formal complaint process for insurance enrollees, providers and others when issuers are not following state rules. The complaint process applies to entities regulated by OIC including licensed insurers selling health insurance policies, including QHPs sold through the WHBE. It covers violations of the OIC network access rules set forth in WAC 284-43, Subchapter B – Heath Care Networks. The complaint process does not cover complaints regarding Medicare, Medicaid, federal employee plans, or Indian Health Services. It also does not cover actions by licensed health care professionals, such as physicians, dentist, therapies and mental health professionals, who are regulated by Washington State's Department of Health.

In general, complaints filed with the OIC deal with: an insurance policies benefit coverage issues; insurance policy cancellations and renewals; medical necessity of a service or benefit; and, payment claims delays, denials or disputes. Complaints can be filed online at: http://www.insurance.wa.gov/complaints-and-fraud/file-a-complaint/insurance-company/. They also can be filed by mail, fax or email. The OIC has a complaint form that can be obtained online at the address above. The OIC Online Complaint Center allows persons to track the status of their complaint, get progress emails and upload documents needed for the complaint filing.

[43] 25 U.S.C. § 450f (d).

[44] Overview of the Model QHP Addendum for Indian Health Care Providers Final Explanatory Document, Department of Health and Human Services, April 4, 2013, p. 2-3.

[45] WAC 284-43-125.

Once a complaint has been filed, the OIC will first determine if they have jurisdiction on the complaint matter. If they do not have jurisdiction, they will notify the person filing the complaint and offer refers to the correct agency or entity. If the OIC has jurisdiction, they will send the complaint to the issuer and request a response. The issuer has 15 business days to respond to the complaint. Given the specifics of the complaint, they may ask for more information and will work with the issuers to address the issue. According to the OIC, it takes approximately 22 days from the date of filing to get information from the issuer and to review the complaint and their response. The OIC will then provide an explanation of the issuer's response and OIC review of the response to the entity filing the complaint. Tribal governments and Indian health care providers may seek assistance from the OIC's tribal liaison in the filling of the complaint.

Appendix A
Definitions and Terms

1. **American Indians/Alaska Natives (AI/AN)**: Except for special Indian provisions in the Affordable Care Individuals and Patient Protection Act (ACA), AI/AN are persons who is: (1) Member of a Federally Recognized Tribe, Band, Pueblo or Rancheria; Shareholder in an Alaska Native Regional or Village Corporation; (2) Descendant of a Federally Recognized Tribe, Band, Pueblo or Rancheria; Shareholder in an Alaska Native Regional or Village Corporation; or, (3) Eligible for Indian Health Services, Tribal Health Services or Urban Indian Health Services, including as a California Indian, Eskimo, Aleut or other Alaska Native. Shareholder in an Alaska Native Regional or Village Corporation.

2. **Indian Health Care Improvement Act (IHCIA):** The Indian Health Care Improvement Act is federal law reauthorized under the ACA in 2010 and codified in 25 U.S Code, Chapter 18. The IHCIA was originally enacted in 1976 to address the deplorable health conditions in Indian Country. Along with the Snyder Act of 1921, the IHCIA forms the statutory basis for the delivery of health care to AI/ANs, by the Indian Health Service (IHS), an agency with the Department of Health and Human Services.

3. **Indian health care provider**: These are health care related providers who are operated by Indian Health Services, 638 contract/compact Tribal providers and urban Indian health program providers. The April 2014 network access rules include a formal definition in WAC 284-43-130(16) (see below).

4. **Issuer**: Issuer is a term used in the Patient Protection and Affordable Care Act (P.L. 111-148, as amended (2010)) and refers to a health insurance company regulated by the Office of the Insurance Commissioner (OIC) under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020. **Note**: OIC rules refer to disability insurance companies, which include health insurance companies.

5. **Office of the Insurance Commissioner (OIC):** The OIC is responsible for overseeing Washington's insurance industry to ensure that companies and producers follow the rules, and to protect consumers. Under Washington State law, the OIC is responsible for regulating vehicle, home, life insurance, as well as health insurance. The OIC regulates health insurance offered in the WHBE, individual health insurance market, small group insurance market and large group insurance market. The OIC does not regulate the Medicare program, Medicaid program, federal employee plans, Veteran's Administration, or self-insured plans.

6. **Washington Health Benefit Exchange (WHBE):** The Washington Health Benefit Exchange was created in state statute (SSB 5445) in 2011 and was established as a "public-private partnership." In 2012, legislation was passed (ESSHB 2319), which established market rules, requirements for Qualified Health Plans, essential health benefits and other provisions. WHBE is responsible creating and administering a "Health Benefit Exchange", which is marketplace for each state to offer health benefits to individuals, families and small businesses. Under national health reform, states were required to have an Exchange in place by Jan. 1, 2014. Exchanges can be developed and implemented by the state or by the federal Department of Health and Human Services (called the Federal Facilitated Market (FFM). Washington State chose to implement a state-based exchange. The WHBE administers the *Washington Healthplanfinder*, which is an online marketplace for individuals, families and small businesses to find, compare and enroll in Qualified Health Plans. Persons can also enroll through the WHBE call center or hard copy applications.

7. **Washington State Model Indian Health Care Provider Addendum (Indian Addendum):** The Washington Indian Addendum was developed for Indian health care providers in contracting with issuers and to help issuers comply with federal laws governing Indian health care and to comply with QHP certification standards set forth in 45 C.F.R. Part 156. The model Addendum is intended to assist QHPs and Indian health care providers by outlining in a single document relevant provisions in federal law that impact the relationship between issuers and a network provider. The Addendum is intended to help issuers more efficiently and effectively contract with Indian health care providers and help insure that AI/AN will be served by their Indian health care provider of choice. Washington's Addendum is based on the federal Centers for Medicare and Medicaid Services' (CMS) November 15, 2012, draft Addendum that was issued on the November 19, 2012. This draft addendum was developed with the Center's for Medicare and Medicaid Services' (CMS) Tribal Technical Advisory Group (TTAG) and Indian Health Services, and was reviewed by the Tribes. The Washington Addendum differs from the CMS final model Addendum that was issued on April 4, 2013. The Washington Addendum does not use contested language in the final CMS Addendum dealing nondiscrimination provisions, dispute resolutions, and payment provisions. The Washington Addendum is posted on the AIHC website at http://www.aihc-wa.com/.

Other definitions used in the network access rules can be found in WAC 284-43-130 at

http://apps.leg.wa.gov/wac/default.aspx?cite=284-43-130.

APPENDIX B

Excerpts from Washington Administrative Code Issuer Requirements

Requirements Applicable to All Issuers[46]

WAC 284-43-130(16) Indian health care provider.

Except as defined in other subchapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

(16) "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 U.S.C. §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).

WAC 284-43-200(9) Network access – General standards

To provide adequate choice to enrollees who are American Indians/Alaska Natives, each health issuer must maintain arrangements that ensure that American Indians/Alaska Natives who are enrollees have access to covered medical and behavioral health services provided by Indian health care providers.

Issuers must ensure that such enrollees may obtain covered medical and behavioral health services from the Indian health care provider at no greater cost to the enrollee than if the service were obtained from network providers and facilities, even if the Indian health care provider is not a contracted provider.

[46] This rule applies to all health plans and issuers subject to OIC regulation. This includes the Washington Health Benefit Exchange, individual market, small group and large group markets. It does not apply to federal programs including the Medicare and Medicaid programs.

Issuers are not responsible for credentialing providers and facilities that are part of the Indian health system. Nothing in this subsection prohibits an issuer from limiting coverage to those health services that meet 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.

Requirements for Qualified Health Plans Only[47]

WAC 284-43-221(6) Essential community providers for exchange plans – Definition

"Essential community provider" means providers listed on the Centers for Medicare and Medicaid Services Non-Exhaustive List of Essential Community Providers. This list includes providers and facilities that have demonstrated service to Medicaid, low-income, and medically underserved populations in addition to those that meet the federal minimum standard, which includes: (6) Indian health care providers as defined in WAC 284-43-130(16);

WAC 284-43-222(3)(b) Essential community providers for exchange plans – Network access

(1) An issuer must include essential community providers in its provider network for qualified health plans and qualified stand-alone dental plans in compliance with this section and as defined in WAC 284-43-221.

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

(b) The issuer's provider network must include access to one hundred percent of Indian health care providers in a service area, as defined in WAC 284-43-130 (17), such that qualified enrollees obtain all covered services at no greater cost than if the service was obtained from network providers or facilities;

WAC 284-43-222(5)(b) Essential community providers for exchange plans – Network access

(5) An issuer must, at the request of an Indian health care provider, offer to contract with such a provider to reimburse covered health care services delivered to qualified enrollees under an issuer's health plan

(b) If an Indian health care provider requests a contract and a contract is not entered into, the issuer must provide substantial evidence of good faith efforts on its part to contract with the Indian health care provider. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

WAC 284-43-222(5)(a) Essential community providers for exchange plans – Network access

[47] The following rules applies only to QHPs in the Washington Exchange. It does not apply to other health insurance markets regulated by the OIC, nor does it apply to federal programs including the Medicare and Medicaid programs.

(5) An issuer must, at the request of an Indian health care provider, offer to contract with such a provider to reimburse covered health care services delivered to qualified enrollees under an issuer's health plan.

(a) Issuers are encouraged to use the current version of the Washington State Indian Health Care Provider Addendum, as posted on http://www.aihc-wa.com, to supplement the existing provider contracts when contracting with an Indian health care provider.

APPENDIX C

Excerpts from Office of the Insurance Commissioner's Alternative Access Delivery Request Form C (April 22, 2014)

Essential Community Provider [ECP] – Narrative Justification requests must include:

2. Documentation fully describing and demonstrating why the issuer's plan does not meet the requirements of WAC 284-43-222:
    a. If the request is based, at least in part, upon a lack of sufficient ECPs with whom to contract, the issuer should include information demonstrating the number and location of available ECPs.
    b. If the request is based, at least in part, upon an inability to contract with certain ECPs, the request should include substantial evidence of the issuer's good faith efforts to contract with additional ECP's and state why those efforts have been unsuccessful.
    - Evidence of the issuer's good faith efforts to contract will include, at a minimum:
        i. Provider information identifying the provider organization name and affiliates name(s), business address, mailing address, telephone number(s), email address, organizations representative name and title.
        ii. Issuer's information identifying the issuer representative's name and title, mailing address, telephone number, and email address.
        iii. If a contract was offered, a list that identifies contract offer dates and a record of the communication between the issuer and provider. For example, you should indicate whether contract negotiations are still in progress or the extent to which you are not able to agree on contract terms. "Extent to which you are not able to agree" means quantification by some means of the distance between the parties' positions. For example, "After working together for two weeks, the parties still had several contract provisions upon which they were unable to come to agreement, and neither party was able to compromise further" or "The parties exchanged draft contract provisions and met in person, but their positions were widely divergent and we were unable to come to agreement."
        iv. If a contract was not offered, explain why the issuer did not offer to contract. Documentation must be as specific as possible.

- The assessment of whether the issuer has made good faith efforts to contract is an assessment of the efforts to contract, not an assessment of the particular terms being offered by either party. Evidence regarding the parties' positions on particular terms, or the reasonableness of terms, should not be included.

3. Documentation identifying how the issuer plans to increase ECP participation in the provider network during the current plan year and subsequent Exchange filing certification request.
4. Documentation describing how the issuer's provider network(s), as currently structured, provides an adequate level of service for low-income and medically underserved individuals. Your request must specify:
   a. How the current network(s) provide adequate access to care for individuals with HIV/AIDS (including those with co-morbid behavioral health conditions).
   b. How the current network(s) provide adequate access to care for American Indians and Alaska Natives.
   c. How the current network(s) provide adequate access to care for low-income and underserved individuals seeking women's health and reproductive health services.