



# Joint Legislative Select Committee on Health Reform Implementation

## *Washington's Tribal Work to Implement ACA Exchange & Medicaid Expansion*



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# Overview of Washington State's AI/AN Population

## ● General Washington AI/AN population

- 6 largest in country
  - Comparatively to three largest: CA (662,000 AI/AN), Oklahoma (482,000), Arizona (334,000)
  - (Approximately 192,000 people - 2.9% of total state population)
- Disbursed throughout state
- Reservation, Urban, Rural

## ● Higher Health Disparity Rates

- Highest mortality rate overall of all populations
- Highest morbidity rates, chronic disease

## ● Significantly higher health un-insurance rates than non-natives

- AI/AN uninsured rate is 21.3% (41,000) compared to 13.4% statewide (892,000)

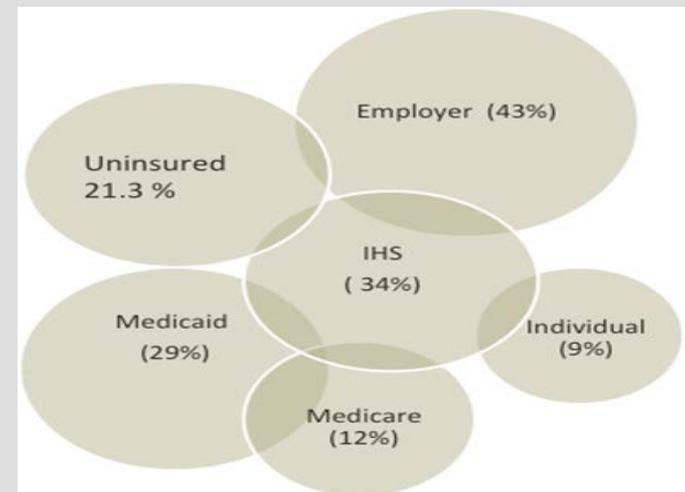


Figure 1: Washington state health insurance status of American Indians and Alaska Natives, American Community Survey, 2008-2010

- Washington's AI/AN uninsured rate is the 12<sup>th</sup> lowest among the 34 states with AI/AN people – Massachusetts has lowest (6.6%) and New Mexico the highest (39.2%).





## Overview of AI/AN Population continued

- ACA and Medicaid expansion will have significant impact on improving health coverage for AI/AN people
  - Medicaid Expansion to 138% of FPL: over 17,000 uninsured AI/AN adults will be newly eligible
  - Health Benefit Exchange: An estimated 23,000 adults will be eligible for coverage
  - Of AI/AN eligible for the HBE, 70% will be eligible for tax credit subsidies.

2009 Health Insurance Status by ACA income category for Washington's AI/AN					
FPL	Total	Uninsured	Insured	% uninsured	% insured
Total	181,196	40,154	141,042	22%	78%
0% - 138% FPL	58,511	17,310	41,201	30%	70%
138% - 400% FPL	71,595	15,320	56,275	21%	79%
+400% FPL	51,090	7,524	43,566	15%	85%

Source: Unpublished Data compiled by Ed Fox from data set developed by the California Rural Indian Health Board, November, 2011 from the 2009 ACS.



# Washington State Indian Health Delivery System



- 29 Federally-recognized Tribes, 2 Urban Indian Health Organizations: an Indian health delivery system in Washington
- 90% of Washington's 29 tribes have multi-service medical clinics
- State-wide Distribution
- Primary Care (some specialty) Medical Services enhanced by:
  - 34 medical clinics (22 of the clinics have dental services, 12 have pharmacy services, 19 have mental health services, and 15 provide chemical dependency services)
  - 2 Urban Indian health programs
  - Services to non-natives
  - WA Tribal/Urban Health Clinics as Essential Community Providers





# ACA – HBE Indian Provisions

- **Cost-Sharing Exemption**

- AI/AN persons with incomes up to 300% of FPL (\$33,510 for a single person and \$69,150 for a family of four) exempted from HBE cost-sharing.

- **Tribal Program Cost-Sharing Provisions**

- QHP cannot reduce payments to tribal programs or any other provider for AI/AN cost-sharing exemption.

- **Insurance Exemption**

- AI/AN people are exempt from health insurance penalties.

- **QHP Enrollment**

- AI/AN people can enroll monthly and change plans at least once a month.

- **Payer of Last Resort**

- Tribal and urban Indian health programs are payer of last resort for services to AI/AN people.



# Other ACA Provisions Impacting AI/AN HBE Enrollment



- **Consultation**

- HBE on-going consultation with specific entities, including federally recognized tribes in their geographic area.

- **Premium Payments**

- Federal rules allow HBE to adopt provisions to allow Tribes and urban Indian health programs to pay premiums for AI/AN people.

- **Navigator Program**

- HBE required to pay grants to entities to serve as “Navigators, including Tribes, tribal programs and urban Indian health programs.

- **Essential Community Providers**

- QHPs required to contract with essential community providers, includes “ .... *facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services.*”

- **Essential Community Provider Contract Requirements**

- QHPs must include, “. . .*within the provider network. . . have a sufficient number of essential community providers. . .that serve predominately low-income, medically underserved individuals.*” Definition of sufficient number left to the States to determine.





# Indian Health Care Improvement Act Reauthorization

ACA further prompts goal of improving health care for the AI/AN population by permanently re-authorizing IHICIA. Includes set of provisions to assist tribal programs participating in federal programs, including the ACA HBE, intended to support tribal capacity to serve AI/AN people

- **Tribal and Urban Indian Program Licensing Requirements**
  - Tribal programs must meet federal/state requirements, but do not need to be licensed.
  
- **Tribal Provider Licensing Requirements**
  - Tribal program's professional staff can be licensed in another state.
  
- **Tribal Program Payments**
  - Indian health providers have the right to recover from third party payers, including insurance companies up to the reasonable charges billed for providing health services or, if higher, the highest amount the insurer would pay to other providers to the extent that the patient or another provider would be eligible for such recoveries.





# Tribal Work within Washington State on HBE

- Use of American Indian Health Commission for WA state
  - Works on behalf of the 29 Federally recognized Tribes and 2 Urban Indian Health Programs.
  - Forum for tribal-state collaboration on key Indian health policy/advocacy/prioritized issues.
  
- Partnership with the Northwest Portland Area Indian Health Board
  - Tribal-state alignment with national ACA and HBE issues.
  - Education and Outreach
  
- Tribal Provisions in Legislation
  - Positive relations with Senate and House Health Care Committees.
  - Consultation, Essential Community Providers, Tribal Premium Sponsorships.
  
- Tribal-Focused Funding from HBE
  - Tribal resources included in HBE Level 2 Establishment Grant Proposal to CCIIO.
  - Received full funding request; contract to start July 1, 2012
  
- Tribal Education of Exchange Board
  - Keeping Board members apprised of progress on Indian provisions.
  - Exchange Staff/Tribal Relations
  
- Tribal Representation on HBE Advisory Committees
  - WHBE Advisory Committee
  - Navigator Technical Advisory Committee



# Work with WA HBE: Level 2 Establishment Grant

## AI/AN Enrollment in HBE

- **IT Requirements**
  - Provide technical assistance on the IT design requirements for HBE's on-line website to support AI/AN enrollment, including ability to pass AI/AN membership information to QHPs for cost-sharing and tribal essential community provider enrollment
- **Call Center Technical Assistance**
  - Provide technical assistance on the design of HBE Call Center to assist AI/AN applicant enrollment in the HBE, including training and education program for Call Center staff and coordination with tribal and urban Indian program Navigators
- **AI/AN Definition/Verification**
  - Work with HBE to develop definition of AI/AN people and method to verify AI/AN status. Definition and document requirements will need to be the same for HBE and Medicaid
  - Legislative Fix needed; Tribal advocacy with Congressional delegations
  - Options for Tribal enrollment data accessible to Exchange
- **“Tribal Assister” model**
  - Develop for Tribes and urban Indian health programs that meets federal and state Navigator requirements.
  - Model(s) will need to be able to serve IHS tribes, 638 tribes and urban Indian programs and are essential for successful enrollment of AI/AN people
- **Premium Sponsorship Work with HBE**
  - design and implement E2SHB 2319 premium sponsorship program for Tribes, urban Indian health programs and other entities, including local government and foundations. Existing BH program sponsorship can serve as a model
- **Tribal Programs as Default**
  - Work with HBE to develop QHP requirement for tribal programs be default choice for tribal members enrolled in their plan
- **Tribal Education/Outreach Program**
  - Develop and finance Tribal education program in coordination with the Northwest Portland Area Indian Health Board (NPAIHB) to prepare tribal leaders and tribal programs for the HEB implementation
  - Education program will be provided at each of Washington's 29 federally recognized tribes during
  - CY 2013



# Work with WA HBE - Level 2 Establishment Grant

## Tribal and Urban Indian Programs Participation in QHP Provider Network

- Defining “Essential Community Provider”
  - Consistent with federal and state requirements, work with the Insurance Commissioner (OIC), other provider organization and health plans to define Washington’s essential community provider definition.
  
- Indian Addendum
  - In coordination with NPAIHB and HHS Tribal Technical Advisory Group (TTAB), develop HBE “Indian Addendum” to facilitate identification and enforcement of Indian-specific provisions of Federal law and rules
  - Addendum would contain all conditions that would apply to QHP issuers and tribal programs when contracting with Indian health providers
  - Also would address such issues as IHCIA licensing requirements, Federal Tort Claims Act provisions, tribal employment provisions and Indian cost-sharing.
  
- Network Standards
  - Work with HBE, OIC, other provider organizations and health plans to develop essential community provider network standards
  
- Payment Rates
  - Work with WHBEB, OIC, and other provider organizations to develop federally required payment rates for essential community providers





# Work with WA HBE - Level 2 Establishment Grant

## HBE Tribal Consultation Policy

- In coordination with WHBEB, develop a draft consultation policy
  - Policy based on HHS-CMS consultation requirements, as well as new HCA policy and other state's HBE consultation policies
  - Policy would also prescribe on-going working relationship between WHBEB and AIHC.
  
- Obtain approved consultation policy
  - Through a consultation process facilitated by AHIC
  - Consultation Policy must meet Washington's Centennial Accord and RCW 43.71.020(9) requirements.

## Assist HBE to implement ACA Indian requirements

- Essential Health Benefits Design
  - Participate with OIC and WHBEB to develop HBE essential health benefits design.
  
- Work with WHBEB to develop and promulgate state rules needed to implement AI/AN provisions prescribed in federal and state law.



# Work with State Medicaid Programs



- Critical for Tribes to work with their state's Medicaid agency on the implementation of the ACA 2014 Medicaid expansion.
  - For many Tribes, more of their uninsured members will be eligible for Medicaid ((\$15,415 for one person and \$31,809 for a family of four) than for the HBE.
- Tribes will want to ensure that existing AI/AN Medicaid protections are carried forward to the “new” eligibility group.
  - Premium and cost-sharing exemptions for AI/AN people.
  - Managed care AI/AN enrollment exemptions
  - FQHC and IHS encounter payment to Tribal programs serving AI/AN people enrolled in Medicaid managed care programs.
- Work with HCA in their development of health benefits/services for new eligibility group
  - (Note: Benefit Requirements for new eligible group are different than mandatory coverage requirements for existing groups)
- AI/AN Definition/Verification – same issues for Medicaid Expansion as for HBE.
- Develop common HBE/Medicaid Tribal Assister (Navigator ) Program.
- AIHC/HCA Retreat to identify key Indian policies issues and work plan.





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## EXHIBIT A

# Affordable Care Act & Indian Health Care Improvement Act – HBE AI/AN Provisions



# ACA Indian Provisions

## ● **AI/AN Cost-Sharing Exemption**

- Up to 300% Federal Poverty level (FPL), exempt from any point-of-service cost sharing requirements (Section 1402(d) and 2901(a))

## ● **Tribal Program Cost-Sharing Provisions**

- Adds other cost-sharing protections for Indian & Urban Indian health programs (Sec. 1402(d)(2))
  - Prohibit HBE Qualified Health Plans (QHP) from reducing payments to programs to off-set cost of AI/AN cost-sharing exemptions
  - HHS responsible for paying QHP for any such costs associated with exemption

## ● **AI/AN Exemption from Health Insurance Penalties**

- Individuals subject to fine collected through federal income tax obligations
- ACA Section 1501(e) exempts certain persons from the penalty, including a member of an Indian Tribe

## ● **AI/AN Monthly Enrollment Periods**

- Special monthly enrollment periods for AI/AN to prompt enrollment in the HBE (Section 1311(e)(5)(D))
  - HHS proposed rule further defines provisions: an AI/AN may enroll in a QHP or change from one QHP to another 1 time per month (45 155.420(d)(8))

## ● **Payer of Last Resort.**

- Health programs operated by I/T/Us shall be payer of last resort for services provided to AI/AN individual's eligible for services through these programs (Section 2901(b))



# Other ACA Provisions Impacting AI/AN Enrollment



## ● HBE Consultation

- Must consult with stakeholders relevant to Exchange implementation/administration (Section 1311(d)(6))
- HHS rules require on-going consultation with specified entities, including Federally-recognized tribe(s) (45 CFR 155.130(f)).

## ● Premium Payments

- Individuals enrolled in a QHP may pay any premium directly to the Plan (Section 1312(b))
- HHS rules expand this provision to Tribes, tribal organizations, and urban Indian organization (45 CFR 155.240(b))

## ● Navigator Program

- Requires HBEs to have programs that award grants to entities to serve as “navigators (Section 1311(i))
- HHS proposed rules list entities eligible for being navigators – includes Tribes, Tribal organizations, and urban Indian organizations (45 CFR 155.210.b(2)(viii))

## ● Program Essential Community Provider Status

- Requires that QHPs contract with “essential community providers that “. . .serve predominately low-income, medically-underserved individuals (Subsection 1301(c)(1)(c))”
- Providers defined in Section 340B(a)(4) of the Public Health Service Act and providers described in Section 1927(c)(1)(D)(i)(IV) of the Social Security Act (SSA). This includes, “ . . . facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act for the provision of primary health services.”

## ● QHP Essential Community Provider Requirements

- QHPs must include, “. . .within the provider network. . .a sufficient number of essential community providers. . .that serve predominately low-income, medically underserved individuals (Subsection 1301(c)(1)(C) and 45 CFR 156.235)”
- Rule does not define what constitutes sufficient number of essential community providers
- Pre-amble notes states may elect to adopt a “blanket” contract requirement the QHP issuers would be required to offer contracts to all essential community providers (e.g., any-willing provider). HHS is continuing to solicit comments on how to define the “sufficient number “ standard.



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## ● Tribal and Urban Indian Program Licensing Requirements

- Section 408(a)(2) requires federal health care programs to accept an entity operated by IHS, Tribes or urban Indian organizations as a provider on same basis as other qualified providers, if it meets the applicable licensure requirements for its provider type, regardless of whether the facility obtains the applicable license. These licensing exemption provisions also apply to tribal programs that contract with HBE QHPs

## ● Tribal Provider Licensing Requirements

- To increase clinical recruitment and retention, Section 221 of IHCIA provides that licensed health professionals that are employed by a tribal health program are exempt, if licensed in any State, from the licensing requirements of the State in which the tribal health program performs the services described in the contract or compact of the tribal health program. These provisions apply to professionals working for tribal programs that are QHP providers.

## ● Tribal Program Payments

- Section 206 of the IHCIA provides requires that all Indian health providers have the right to recover from third party payers, including insurance companies up to the reasonable charges billed for providing health services or, if higher, the highest amount the insurer would pay to other providers to the extent that the patient or another provider would be eligible for such recoveries. HHS' rule pre-ample states that the payment requirements under section 206 of IHCIA apply to QHP issuers, as well as to any insurer, employee benefit plan or other third party payer.





# Washington State Indian Provisions

In addition to federal requirements, Washington has adopted requirements to support AI/AN people to access care and tribal programs to be QHP care providers.

- **Washington Health Benefit Exchange Board (WHBEB) Tribal Consultation**

- Washington’s exchange law specifically requires the Board to consult with the American Indian Health Commission (RCW 43.71.020(9))

- **WAC 284-43-200(7) – Network adequacy**

- To provide adequate choice to covered AI/AN persons, health carriers must maintain arrangements that ensure that AI/AN members have access to Indian health care services and facilities that are part of the Indian health system. Carriers are not responsible for credentialing providers and facilities that are part of the Indian health system

- **Essential Community Providers**

- E2SHB 2319 re-affirms federal requirements that tribal programs and urban Indian health programs are HBE essential community providers (ESHB 2319, Sec.8(1)(c))

- **Sponsorship**

- E2SHB 2319 directs the Board is to establish rules or policies that permit city and county governments, Indian tribes, tribal organizations, urban Indian organizations, private foundations, and other entities to pay premiums on behalf of qualified individuals (ESHB 2319, Sec.4(3))





## EXHIBIT B

# Medicaid AI/AN Provisions



# Medicaid AI/AN Provisions

Like the ACA, Medicaid has special AI/AN provisions designed to assist AI/AN people to participate in these federal programs and support tribal and urban Indian health programs to serve AI/AN beneficiaries.

- The IHCA of 1976 allowed IHS and tribal health programs to begin billing Medicaid for services provided to AI/AN people.
- In the IHCA, Congress authorized the Centers for Medicare and Medicaid Services (CMS), to pay states 100 % of the federal medical assistance percentage (FMAP) for AI/AN beneficiaries receiving services at tribal health programs (Section 1905(b)).
- Federal law prohibits point-of-service costs (copayments, deductible, co-insurance) to be imposed on AI/AN Medicaid or CHIP beneficiaries when they receive services at tribal, IHS or urban Indian operated programs, or when they receive services that were referred by that program (Section 1916(j) and Section 1916A(b)(3)(B)(x)). Washington has expanded this exemption to all Medicaid and CHIP services.
- Federal law prohibits premium requirements for AI/AN beneficiaries who receive services from tribal or urban Indian health programs (Section 1916A(b)(3)(vii)). Washington has expanded the exemption to all AI/AN beneficiaries regardless of where they receive services.
- Federal law allows states to require certain Medicaid beneficiaries enroll in managed care. Law prohibits requiring enrollment for AI/AN unless the entity is a tribal or urban Indian health program (Section 1932(a)(2)(C)) . Washington's Medicaid program has long standing policy of not requiring AI/AN beneficiaries to enroll in managed care under any circumstances. AI/AN people may, however, voluntarily elect to enroll in managed care (so-called "opt in provisions").



# Medicaid AI/AN Provisions



- Medicaid law defines tribal programs and urban Indian health programs to be FQHCs (Section 1905(l)(2)). This allows tribal and urban Indian clinics to be paid on a cost-related reimbursement system, resulting in higher payments than would be received by physicians and other health professionals.
- The CMS/IHS 1996 MOA affirms 638 tribal clinics and IHS programs could: (1) continue to operate as a FQHC under the state plan and receive the FQHC reimbursement rate; (2) if it so qualifies, operate as any other provider type recognized under the state plan and receive that respective reimbursement rate; or (3) choose to be designated as an IHS provider.
- If the facility chooses to be designated as an IHS provider for purposes of the payment policy it will receive the IHS encounter payment rate for services to AI/ANs; however, at state option, the IHS encounter rate may not be available for services to non-Indian Medicaid beneficiaries as the state will not receive 100 % FMAP for services to non-Indians. Washington's Medicaid program pays tribal programs at the same rate for both AI/AN and non-native Medicaid clients.
- The 1996 CMS/IHS MOA also reaffirmed IHClA provisions that IHS and tribal operated facilities would be eligible for reimbursement for Medicaid services provided under a state plan so long as it meets all the conditions and requirements generally applicable to such facilities under the Medicaid statute. It does not however need to be licensed by the state. While not specifically referenced in the MOA, tribal health professionals also did not have to be licensed by the state in which the program was located so long as the professional has a valid license in another state and was practicing within the scope of that license.
- Federal law requires that FQHCs in managed care provider networks be paid the same amount for a Medicaid member as the FQHC would be paid for a Medicaid beneficiary in the fee-for-service (FFS) system. Recent law now also requires that Non-FQHC Indian health care providers under managed care be paid by the managed care entity or State, at a rate that is at least equal to what providers would be paid under FFS .

