



Overview of the Model QHP Addendum for Indian Health Care Providers

I. Purpose

CMS has developed the attached Model QHP Addendum for Indian health care providers to facilitate the inclusion of Indian Health Service (IHS), tribes and tribal organizations, and urban Indian organization (I/T/U) providers in qualified health plan (QHP) provider networks and help health insurance issuers comply with the QHP certification standards set forth in 45 C.F.R. Part 156. Similar to the standardized contract addendum used in the Medicare Part D program, this Model QHP Addendum has been developed for QHP issuers to use when contracting with I/T/U providers. This Model QHP Addendum is not required, but the U.S. Department of Health and Human Services (HHS) received several comments supporting the development and issuance of a model addendum for this purpose to assist QHP issuers in including I/T/U providers in their networks.

The federal government has a historic and unique government-to-government relationship with Indian tribes. In adhering to QHP certification standards, QHP issuers should reach out to I/T/U providers. A significant portion of American Indians and Alaska Natives (AI/ANs) access care through longstanding relationships with providers in the Indian health system. An important consideration in evaluating network adequacy and essential community provider accessibility will be the extent to which a QHP includes I/T/U providers and whether it can assure that services to AI/ANs will be accessible without unreasonable delay.

It is anticipated that the Model QHP Addendum will assist issuers to meet the QHP certification standards and facilitate acceptance of network contracts by I/T/U providers. We anticipate that offering contracts that include the Model QHP Addendum will provide QHP issuers with an efficient way to establish contract relationships with I/T/U providers, and also ensure that AI/ANs can continue to be served by their Indian provider of choice.

Indian tribes are entitled to special protections and provisions under federal law, which are described further in Section II. The Addendum identifies several specific provisions that have been established in federal law that apply when contracting with I/T/U providers. The use of this Model QHP Addendum benefits both QHP issuers and the I/T/U providers by lowering the perceived barriers to contracting, assuring QHP issuers comply with key federal laws that apply when contracting with I/T/U providers, and minimizing potential disputes. AI/ANs enrolled in QHPs will be better served when I/T/U providers can coordinate their care through the QHP issuer provider network.

II. Background on Indian Health Care

Indian tribes are afforded specific protections and provisions under federal laws, including the Indian Health Care Improvement Act (IHCA), the Indian Self-Determination and Education Assistance Act (ISDEAA), and the Patient Protection and Affordable Care Act (ACA). In order

to carry out its obligation to provide health care to American Indians and Alaska Natives (AI/ANs), the federal government has established a unique health care delivery system through the Indian Health Service (IHS). As part of the Indian health care system, health care services to AI/ANs are provided either directly by the IHS, by tribes or tribal organizations, or by urban Indian programs.

Today the Indian health care system includes 44 Indian hospitals (16 of which are tribally-operated and all of which are accredited) and nearly 570 Indian health centers, clinics, and health stations (of which 83 percent are tribally-operated). When specialized services are not available at these sites, health services are purchased from public and private providers through the IHS-funded Contract Health Services (CHS) program. Additionally, 33 urban programs offer services ranging from community health to comprehensive primary care.

III. Key Provisions in the Addendum

The following is a synopsis of key provisions outlined in the Addendum.

Persons Eligible for Items and Services from an Indian Health Care Provider: This section acknowledges that Indian health programs are generally not available to the public; they are established to serve AI/ANs, as provided in the IHCA. The applicable eligibility rules are generally set out in the IHS regulations at 42 C.F.R. Part 136. The IHCA § 813 (25 U.S.C. §1680c) sets out the circumstances under which certain non-AI/ANs connected with an AI/AN (such as minor children or a spouse) can receive services as beneficiaries. Also, the IHCA § 813 authorizes services to certain other non-AI/ANs if defined requirements are satisfied. Pursuant to 45 C.F.R. 80.3(d), an individual shall not be deemed as subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from an Indian health program.

Providers should note that 45 C.F.R. 80.3(d) is not an exemption from civil rights obligations generally. It simply clarifies that certain types of exclusions are not considered discrimination under Title VI of the Civil Rights Act of 1964. Providers may be subject to applicable federal nondiscrimination statutes.

Applicability of Other Federal Law: This section describes several federal laws that apply variously when contracting with I/T/U providers.

- *Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 450 et seq.* This law directs HHS at the request of an Indian tribe, to enter into a contract or compact with a tribe, a tribal organization, or an inter-tribal consortium to operate federal health programs for AI/ANs with the funds the IHS would have otherwise used to carry out the program directly. Through this law, many Indian tribes and tribal organizations have taken over direct operation of health programs from the IHS.
- *Federal Tort Claims Act (FTCA), 28 U.S.C. §§ 2671-2680.* Congress generally extended the FTCA to cover Indian tribes and tribal organizations operating federal programs pursuant to contracts or compacts under the ISDEAA, 25 U.S.C. § 450f. Urban Indian organization health providers who acquire Federally Qualified Health Center status under Section 224 of the Public Health Service Act can acquire FTCA coverage. 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.

- *Federal Medical Care Recovery Act (FMCRA)*, 42 U.S.C. §§ 2651-2653. This law authorizes federal agencies, including the IHS, to recover from a tortfeasor (or an insurer of a tortfeasor) the reasonable value of health services furnished to a tortfeasor's victim. The right of recovery under the FMCRA extends to Indian tribes and tribal organizations operating ISDEAA contracts and compacts. 25 U.S.C. § 1621.
- *Federal Privacy Act*, 5 U.S.C. § 552a, 45 C.F.R. Part 5b. This law and its regulations apply to the IHS, and may apply Indian tribes, tribal organizations, and urban Indian organizations that operate federally-funded health care programs. The Privacy Act governs the use and disclosure of personally identifiable information about individuals that is maintained in a federal system of records. While the Privacy Act generally applies to federal records maintained by a government contractor, patient records of a Tribal health program are not considered federal records for the purposes of chapter 5 of title 5 of the United States Code (including the Privacy Act and the Freedom of Information Act - see 25 U.S.C. § 4501).
- *Confidentiality of Alcohol and Drug Abuse Patient Records*, 42 C.F.R. Part 2. These regulations restrict disclosure and use of drug abuse patient records that are maintained in connection with the performance of any federally assisted alcohol or drug abuse program. The restrictions would apply to any such records maintained by the IHS, an Indian tribe, tribal organization, or urban Indian organization.
- *Health Insurance Portability and Accountability Act (HIPAA)*, (45 C.F.R. Parts 160 and 164). These regulations restrict access to and disclosure of protected health information maintained by covered entities, including covered health care providers operated by the IHS, Indian tribes, tribal organizations, and urban Indian organizations.
- *Indian Health Care Improvement Act (IHCIA)*, 25 U.S.C. § 1601 et seq. This law provides the comprehensive statutory framework for delivery of health care services to AI/ANs. It applies to all Indian health providers operating ISDEAA contracts and compacts from the Secretary of the HHS; and urban Indian organizations that receive grants from IHS under Title V of the IHCIA. Specific provisions of the IHCIA that would impact contracts between Indian health care providers and QHPs issuers are cited in various provisions of the Addendum.

Insurance and Indemnification: IHS, tribes and tribal organization providers are generally covered by the FTCA. Some urban Indian organizations are also covered under FTCA. Since a claim under the FTCA is the exclusive remedy for actions against FTCA covered I/T/U providers, those entities are not required to obtain professional liability insurance.

Licensure of Health Care Professionals: Section 221 of the IHCIA, 25 U.S.C. § 1621t, permits an Indian tribe or tribal organization to employ a health care professional who is subject to licensure if that individual is licensed in any state. Employees of the IHS obtain their "licensed in any state" status through other federal law.

Medical Quality Assurance Requirements: Section 805 of the IHCA, 25 U.S.C. § 1675, facilitates internal medical program quality reviews; shields participants in those reviews; and restricts disclosure of medical quality assurance records, subject to the exceptions in 25 U.S.C. 1675(d), which provides that medical quality assurance records created by or for I/T/U providers may not be disclosed to any person or entity. These disclosure limitations are also applicable to anyone to whom the I/T/U provider discloses such medical quality assurance records under the authority of 25 U.S.C. 1675(d). Although restrictive, we expect these limitations will have limited applicability to QHPs because there will be few, if any circumstances, where such records may be disclosed to a QHP under the law.

Claims Format: Section 206(h) of the IHCA, 25 U.S.C. § 1621e(h) is applicable to issuers when processing claims from an I/T/U provider. Section 206(h) of IHCA states that a health insurance issuer may not deny a claim submitted by the IHS, an Indian tribe or tribal organization based on the format on which the claim is submitted if the format complies with the Medicare claims format requirements.

Payment of Claims: Federal laws, including Section 206(a) and (i) of the IHCA, 25 U.S.C. § 1621e(a) and (i) and Title 45 Code of Federal Regulation, Part 156, Subpart E¹, are applicable to health insurance issuers when paying claims from I/T/U providers. Section 206(a) and (i) of IHCA provide that the IHS, an Indian tribe, tribal organization, and urban Indian organization have a right to recover the reasonable charges billed, or, if higher, the highest amount an insurance carrier would pay to other providers. However, this paragraph also notes if the issuer and I/T/U Provider mutually agree to rates or amounts specified in the QHP agreement as payment in full, the QHP issuer is deemed to be compliant with Section 206 of IHCA.

Contract Health Service Referral Requirements: In some instances, I/T/U providers may be subject to referral requirements under the contract health services program. For example, IHS may have existing contractual arrangements that require IHS to refer to specific providers and suppliers; or IHS may be prohibited from referring to a provider that has been excluded from Federal Health Care Programs, as defined in § 1128 of the Social Security Act. We believe these circumstances will be rare, but to the extent that they occur, the I/T/U provider may not be able to adhere to QHP issuer referral requirements to use in-network providers. This section acknowledges the potential for conflicting requirements, and that I/T/U providers may be prevented from following QHP issuer referral requirements in such instances. This section affirms that the I/T/U provider will otherwise comply with in network coordination of care and referral requirements.

IV. Database of Indian Providers

To assist issuers in identifying I/T/U providers in their service areas, please use the attached link to obtain a database of I/T/U provider locations, developed with the assistance of the Indian Health Service: <http://cciio.cms.gov/programs/exchanges/qhp.html>.

¹ Title 45 Code of Federal Regulation, Part 156, Subpart E describes rules for the elimination of cost sharing for EHB, for Indians at or below 300% of the Federal Poverty Level, and for no cost sharing for Indians receiving an item or service that is an EHB furnished by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization, or through referral under contract health services. 78 Fed. Reg. 15410, 15535-39 (Mar. 11, 2013).