National Indian Health Board

Submitted via *regulations.gov*

December 21, 2015

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: Comments on CMS-9937-P; Notice of Benefits and Payment Parameters for 2017

I am pleased to write on behalf of the National Indian Health Board (NIHB) regarding the proposed rule titled "Patient Protection and Affordable Care Act (ACA); HHS Notice of Benefit and Payment Parameters for 2017" (CMS-9937-P; Proposed Rule) and published in the Federal Register on December 2, 2015. This Proposed Rule requested comments on a range of provisions involving the implementation and administration of the Patient Protection and Affordable Care Act (Affordable Care Act or ACA), primarily for the 2017 coverage year.

The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance, or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

We appreciate the opportunity to provide comments on the Proposed Rule. In addition, NIHB would like to express its appreciation for the attention paid in this Proposed Rule to prior comments offered to CMS by NIHB, in particular the clarification that certain exemptions for Indians and IHS-eligibles, may be claimed directly through the tax-filing

process without first obtaining an exemption certificate number (ECN).[1] Under the proposed rule, the Exchange would no longer make eligibility determinations for these exemptions. Rather an individual would only need to file IRS Form 8965 with his or her tax return, noting the appropriate exemption code or a previously obtained ECN.

Summary of Recommendations

In summary, we are recommending the following:

- Recommendation 1: Retain the proposal that certain exemptions authorized under Section 5000(A) of the Internal Revenue Code, including the Indian exemption, may be claimed during the tax filing process without obtaining an ECN.
- Recommendation 2: Request that CMS, in consideration of giving Federally Facilitated Exchanges (FFEs) the authority to selectively contract with issuers to strengthen oversight, required that Qualified Health Plan (QHP) certification include an evaluation of the QHP's contracting with Indian health providers and a review of any complaints against the QHP regarding implementation of Indian cost-sharing provisions or other Indian-specific protections.
- Recommendation 3: Delay the proposed notification requirement for entities making third-party premium payments on behalf of enrollees in QHPs and stand-alone dental plans (SADPs) as it relates to Tribes.[2]

Analysis and Recommendations

ISSUE 1: **Retain the proposal that certain exemptions authorized under Section 5000(A) of the Internal Revenue Code, including the Indian exemption, may be claimed during the tax filing process without obtaining an ECN.**

The ACA exempts nine categories of individuals from the tax penalty for failure to have health insurance coverage. Members of Indian Tribes are one of those exemptions.[3] However, the Administration has interpreted the Indian exemption to only cover members of federally-recognized Tribes. This excludes those other individuals like spouses or children, who are not members of federally-recognized Tribes, even though they are eligible to receive services from an Indian health provider. Instead, these individuals may claim a hardship exemption if they do not purchase separate insurance.

[1] 80 Fed. Reg. 75535-36
[2] *Id.* at 75557
[3] 26 U.S.C. § 5000A(e)(3)

However, only those individuals who were members of federally-recognized Tribes could claim the exemption through the tax-filing process. Those individuals who may qualify for the hardship exemption had to file a separate application where they received an ECN. The ECN was then used to complete the tax-filing process. This process was changed in 2014 when HHS permitted those who qualify from the hardship exemption to use the tax-filing process to claim it, without requiring an ECN.

We strongly support the codification of this single process that permits IHS eligible beneficiaries to use the tax-filing process to claim an exemption from the mandate. The initial varying application requirements (for members of federally-recognized Tribes versus other Indian health care provider eligible persons) were unclear and disruptive to AI/AN families (for example, as federal taxes would not be able to be filed until an ECN was secured for those AI/AN family members who do not meet the definition of Indian under the ACA); and they greatly increased time and resources associated with assisting AI/AN families to comply with the requirements.

It is important to note that although this singular application process has been established for over a year, there has not been a formal campaign or enough training on the process. Many certified application counselors and assisters in the field are still encouraging enrollees to apply for an ECN. If this provision is codified as proposed by this rule, we encourage greater outreach and education on this process.

ISSUE 2: **Request that CMS, in consideration of giving Federally Facilitated Exchanges (FFEs) the authority to selectively contract with issuers to strengthen oversight, required that Qualified Health Plan (QHP) certification include an evaluation of the QHP's contracting with Indian health providers and a review of any complaints against the QHP regarding implementation of Indian cost-sharing provisions or other Indian-specific protections.**

CMS is proposing to give FFEs the ability to selectively contract with QHP issuers to strengthen its oversight. CMS states that the ACA empowers FFEs with the discretion to deny certification of QHPs that meet minimum certifications standards but are not "in the interests of qualified individuals and qualified employers."[4] Issues that could lead to non-certification may include material non-compliance with requirements, financial insolvency, or inaccurate data reporting. We would like to use this opportunity to request that QHP certification include an evaluation of QHP's contracting with Indian health providers and a review of complaints against the QHP regarding implementation of Indian cost-sharing provisions and protections.

[4] 80 Fed. Reg. 75541

NIHB has heard a number of concerns about the lack of compliance by QHP issuers with Indian health care provider specific contracting provisions. This lack of compliance impedes potential enrollees from being able to effectively evaluate their plan options. As indicated in the Center for Consumer Information and Insurance Oversight (CCIIO) 2015 Issuer Letter, QHP issuers in the FFEs are required to offer contracts to all IHCPs operating in the QHP service area, and the contract offers are to include the QHP (Indian) Addendum for IHCPs and meet minimum certification standards. The intent of these contracting requirements is to implement the network adequacy and essential community provider provisions of the ACA. More importantly, the goal is to further the federal Indian trust responsibility to Tribes with regard to providing needed health care services to eligible individuals. It is advanced by ensuring IHCPs receive adequate compensation for services rendered and by enabling IHCPs to gain in-network provider status.

In order to understand the lack of compliance, a study (Attachment 1) was completed by the Tribal Self-Governance Advisory Committee (TSGAC) and shared with CMS, CCIIO, and IHS.[5] We would like to ask that our concerns be taken into account and request that QHP certification include an evaluation of the QHPs contracting with IHCPs and review any complaints against the QHP regarding implementation of Indian cost-sharing provisions or other Indian-specific protections.

ISSUE 3: **Delay the proposed notification requirement for entities making third-party premium payments on behalf of enrollees in QHPs and stand-alone dental plans (SADPs) as it relates to Tribes.**

In the Proposed Rule, entities, including Indian Tribes, Tribal organizations, and urban Indian organizations, will be required to provide HHS with notification of their sponsorship activity.[6] CMS would require that this notification include a statement of the entity's intent to make premium payments and the number of consumers for whom these payments shall be made.

We respectfully request that CMS exempt or at least delay the notification requirements for Indian Tribes, Tribal organizations, and urban Indian organizations. Requiring notification could discourage sponsorship efforts by Tribal entities. Because premium tax credits are not available for individuals at this income level, Tribal sponsors are paying the full premium

[5] *Network Adequacy and Essential Community Provider Inclusion in Marketplace Health Plans Serving Indian Country*, *Findings and Recommendations*. Report prepared by Tribal Self-Governance Advisory Committee, May 26, 2015

[6] 80 Fed. Reg. 75557

for the Marketplace coverage. Tribal sponsorship in the marketplace is a cost-effective means for providing increased access to health care services.

Some Tribes in those states that have not expanded Medicaid using the new section 2001 authority established pursuant to the ACA, are investigating and allocating resources to provide health insurance coverage for those Tribal members barred from Medicaid coverage. A number of Tribes and Tribal health organizations are sponsoring individuals who have household income under 100 percent of the federal poverty level in Marketplace coverage. It is anticipated that Tribal sponsorship programs could save Tribes and Tribal organizations substantial amounts of money that could be used to provide other health care services. This lessens the burden on Indian Health Service, Tribally operated Facilities, and Urban Indian clinics (I/T/Us) that are often dependent on federal appropriations from IHS. It also saves valuable purchase and referred costs to Tribal programs. Sponsorship essentially shifts the financial risk of cost of care of Tribal members from the I/T/U system to health plans. Introducing burdensome notification requirements could cause Tribal sponsors to reconsider whether to continue sponsoring Tribal members because many Tribes are not sure how their systems are going to be implemented just yet. Putting more barriers in place could discourage them from investigating sponsorship further and prevent valuable health care savings as a result.

NIHB appreciates the opportunity to comment on the Proposed Rule and looks forward to working with CMS and CCIIO to refine and implement the tribal recommendations.

Sincerely,

Chair, National Indian Health Board

Cc: Kitty Marx, Director, CMS Division of Tribal Affairs

Attachment 1: *Network Adequacy and Essential Community Provider Inclusion in Marketplace Health Plans Serving Indian Country, Findings and Recommendations*. Report prepared by Tribal Self-Governance Advisory Committee, May 26, 2015

Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

Network Adequacy and Essential Community Provider Inclusion in Marketplace Health Plans Serving Indian Country

Findings and Recommendations

Report Prepared by:
Tribal Self-Governance Advisory Committee (TSGAC)

May 26, 2015

Network Adequacy and Essential Community Provider Inclusion in Marketplace Health Plans Serving Indian Country

Findings and Recommendations

May 26, 2015

Executive Summary

Members of the Tribal Self-Governance Advisory Committee (TSGAC) to the Indian Health Service (IHS) and members of the Tribal Technical Advisory Group (TTAG) to the Centers for Medicare and Medicaid Services (CMS) have heard a number of concerns about the lack of compliance by qualified health plan (QHP) issuers with Indian health care provider (IHCP)-specific contracting provisions. As indicated in the CMS Center for Consumer Information and Insurance Oversight (CCIIO) 2015 Issuer Letter, QHP issuers in the Federally-Facilitated Marketplace (FFM) are required to offer contracts to all IHCPs operating in the QHP service area, and the contract offers are to incorporate the QHP (Indian) Addendum for IHCPs and meet minimum "good faith" terms.

The intent of these contracting requirements is to implement the network adequacy and essential community provider (ECP) provisions of the Patient Protection and Affordable Care Act (Affordable Care Act or ACA). But more specifically, the aim is to further the federal Indian trust responsibility to Tribes with regard to providing needed health care services to eligible individuals. This trust responsibility is advanced by ensuring IHCPs receive adequate compensation for services rendered and by enabling IHCPs to gain in-network provider status.

In order to gain a more comprehensive—and systematic—understanding of QHP compliance with federal requirements, and to evaluate whether these provisions are having the intended impact, the TSGAC conducted a study of QHPs contracting with IHCPs.

The study focused on sub-state service areas in five states. The findings are likely to be representative of all states, although the states selected might *overstate* the extent of QHP compliance with federal requirements. This is due to the areas selected for study being represented by some of the most highly-engaged tribal representatives. Having tribal representatives highly engaged in Marketplace issues promotes greater awareness of IHCP-related provisions among QHP issuers and oftentimes leads to greater compliance by the QHP issuers.

A set of key findings and recommendations are shown below. A more expansive listing of findings with supporting data is contained in the full report that follows the Executive Summary.

Overall Finding (1): Many QHPs have been certified to offer coverage in a Marketplace despite including few, if any, available IHCPs as in-network providers.

> ***RECOMMENDATION****: With regard to QHPs with few or no in-network IHCPs, the TSGAC recommends that CCIIO take proactive action to determine the reasons for the provider network deficiencies and if the plans meet federal network adequacy (45 CFR § 156.230(b)) and ECP (45 CFR § 156.235) standards.*

Overall Finding (2): Government-established IHCP-specific regulations matter, as the existence of the IHCP-specific requirements in the FFM resulted in a substantially greater number of QHP contract offers to IHCPs in FFM states than in non-FFM states.

***RECOMMENDATION**: The TSGAC recommends that CCIIO require non-FFM states to adopt policies to ensure QHP issuers in their state meet the federal network adequacy (45 CFR § 156.230(b)) and ECP (45 CFR § 156.235) standards, and absent meeting the standards institute a back-up mechanism requiring the adoption of the requirements in the CCIIO 2015 and 2016 Issuer Letters if a state otherwise does not meet the standards.*

Finding in FFM States (1): Some QHP issuers in FFM states were found to be not in compliance with CCIIO requirements.

***RECOMMENDATION**: The TSGAC recommends that CCIIO review the detailed findings in this report to correct non-compliance and investigate in other (non-studied) states to determine if similar problems are occurring.*

Finding in FFM States (2): Even when there was compliance by QHP issuers with the requirement to offer contracts to IHCPs, there were few, if any, IHCPs in QHP provider networks.

***RECOMMENDATION**: The TSGAC recommends that CCIIO review a sample of contract offers to determine if the offers meet the "good faith" standard pertaining to payment rates.*

Finding in Non-FFM States: Non-FFM states have not adopted the key Indian-specific requirements that are applicable in FFM states.

***RECOMMENDATION**: See Overall Finding (2).*

IHS-Related Finding: As a general rule, IHS facilities did not attempt to contract with QHPs, which *might* be resulting in impediments to patients when attempting to access non-IHS providers and a loss of revenues to IHS.

***RECOMMENDATION**: The TSGAC recommends that IHS compare the rates offered to IHS providers by QHP issuers with either (1) the rates received when billing as non-in network providers or (2) the rates received when billing under Indian Health Care Improvement Act (IHCIA) Section 206 authority.*

Self-Governance Tribes-Related Finding: Interest and capacity of IHCPs to contract as in-network providers varied across the IHCPs studied, with some IHCPs working aggressively to gain in-network status and others not.

***RECOMMENDATION**: The TSGAC recommends that TSGAC members consider sharing experiences with QHP contracting, including identifying effective strategies to gain in-network status and comparing results from seeking IHCIA Section 206 compliance by QHP issuers.*

Introduction

Members of the TSGAC to IHS and members of the TTAG to CMS have heard a number of concerns about the lack of proactive action taken by QHP issuers with regard to contracting with IHCPs. In order to gain a more comprehensive—and systematic—understanding of this issue, the TSGAC conducted a study of QHPs contracting with IHCPs.

The TSGAC selected five geographically disperse sub-state regions for the study. The regions have a mix of tribal organizations, urban Indian organizations, and IHS facilities, collectively referred to in this report as IHCPs.[1] In addition, three of the regions are located in states with an FFM, and two of the regions are located in states with hybrid Marketplaces. In order to facilitate data gathering, a final criterion used to select regions for the study is that tribal representatives in the state are actively involved in Marketplace issues.

The three FFM states are Wisconsin, Maine, and Oklahoma. The other two states are Nevada, which has a federally-supported state-based Marketplace, and Oregon, which has a hybrid Marketplace. Each of these states has responsibility for "plan management" functions.

In the view of TSGAC leadership, the ultimate goals of the network adequacy and related ECP provisions contained in the ACA are two-fold:

- Further the federal Indian trust responsibility[2] to ensure AI/AN enrollees in QHPs have access to needed health services, including through available IHCPs;
- Ensure IHCPs receive adequate compensation for services rendered (which will enable IHCPs to meet the health care needs of tribal members) and allow IHCPs to participate as in-network providers (which will facilitate referrals, when needed, from IHCPs to other providers with minimum barriers).

The TSGAC is submitting this report to the CCIIO with the aim of furthering our joint responsibilities to ensure that AI/ANs have timely access to needed health care services and that IHCPs have the resources necessary to provide or arrange for such services.

Summary findings and recommendations are shown below. The IHCP-specific requirements applicable to QHPs offered in FFM states and non-FFM states also are detailed below. State-specific survey results are summarized in the tables and narratives contained in attachments. Additional detail from the surveys is available from the TSGAC for some measures.

Key Findings

◊ Compliance by QHP issuers with existing CCIIO IHCP-specific requirements, and inclusion of IHCPs in QHP networks, remains a work in progress.

[1] IHCPs also referred to as Indian Health Service, Indian Tribe, Tribal organization, and urban Indian organization providers, or I/T/Us.

[2] http://www.bia.gov/FAQs/

- Some QHP issuers (in FFM states) appear to have complied with CCIIO IHCP-specific contracting requirements and include numerous IHCPs in plan networks.
- Other QHP Issuers (in FFM and non-FFM states) offered no contracts to IHCPs, offered contracts without inclusion of the QHP Addendum, and/or included no IHCPs in plan networks.[3]
- For example, according to interviews with IHCPs in Wisconsin, at least two of the eight QHP Issuers did not offer contracts to IHCPs in their service areas, including Ambetter from MHS Wisconsin and Common Ground Health Coop.

◊ Many QHPs have been certified to offer coverage in a Marketplace despite including few, if any, available IHCPs as in-network providers.

- This finding is true even when multiple IHCPs operate within the QHP's service area.
- In Oklahoma, 50 percent (one of two) of the QHP issuers do not include an IHCP in their plan network.
- In Nevada, 80 percent of the QHP issuers operating in the region studied do not have IHCPs in their plan network.

◊ Even where there was at least partial compliance by QHP issuers with the requirement to offer contracts to IHCPs in the QHP's service area, there are few, if any, IHCPs in the QHP's provider network.

- For example, among the eight QHP issuers operating in the Wisconsin region studied, only one network (serving four of the QHP issuers) lists one of the twelve available IHCPs in their network. The other QHPs list zero IHCPs as in-network. As such, 60 percent of the QHPs on the FFM in the four Wisconsin zip codes included do not have any IHCPs in network.

◊ Interest and capacity of IHCPs to contract as in-network providers varied across the IHCPs studied, with some IHCPs working aggressively to gain in-network status and others not.

- Despite IHCP interest and efforts in Nevada, only one IHCP is in any of the QHP networks, and this one contract was in place prior to 2014 and does not include the QHP Addendum.

◊ In general, IHS facilities have chosen to not contract with QHPs and to secure reimbursement for services through IHCIA Section 206 authority.

- For example, the IHS Warm Springs Health & Wellness Center in Oregon is not part of any QHP network, and the IHS facilities in Oklahoma have not yet entered into contracts, with both reporting reliance on section 206.

[3] During the 2015 Coverage Year studied, QHP issuers were required to include the QHP Addendum in contract offers.

- ◊ Some QHPs were not in compliance with CCIIO's IHCP-specific requirements.
    - o At least two of the eight QHP issuers in Wisconsin did not offer contracts to the IHCPs in their service area.
    - o In Oklahoma, one QHP issuer did not include the QHP Addendum in contract offers.
    - o One IHCP in Wisconsin reported that only two of the eight QHP issuers included the QHP Addendum in their contract offers (a requirement in effect for the 2015 coverage year).
- ◊ Non-FFM states have not adopted the key IHCP-specific requirements that are applicable in FFM states.
    - o Only one non-FFM state (Oregon) adopted one of the core IHCP-specific provisions (*i.e.*, requirement for QHP Issuers to offer contracts to all IHCPs in the plan's service area). Oregon did not adopt a second companion provision (*i.e.*, requirement that QHP Issuers include the QHP Addendum with the contract offer).
- ◊ Government-established IHCP-specific regulations matter.
    - o In FFM states—where IHCP-specific standards contained in the CCIIO Issuer Letter apply—IHCPs are much more likely to be in-network providers, as compared with those in non-FFM states where these standards are not required.
    - o In Nevada, a non-FFM state, there are no Marketplace-imposed requirements to offer to contract with IHCPs or to use or include the contents of the QHP Addendum. To date, there have been no contract offers made by any of the QHP issuers to any of the IHCPs in Nevada.
- ◊ QHP issuers' understanding of, and compliance with, applicable IHCP-specific standards is highest in states with engaged tribal representatives.
    - o In Maine, tribal representatives educated one QHP Issuer that, initially, reported not being aware of some IHCP-specific contracting requirements. Ultimately, the three non-closed panel plans in Maine appear to have complied with the requirement to offer contracts using the QHP Addendum.
- ◊ In order to facilitate collection of needed data, states selected for inclusion in this study were states with some of the most active tribal representatives. Selection of these states is likely to have skewed the findings of this report, resulting in an overstatement of the degree to which states are complying with the federal network adequacy and ECP standards.
- ◊ Many IHCPs are uncertain if QHP issuers offered contracts to the IHCP.
    - o IHCPs were able to report when they are aware of QHP issuers offering contracts, but without knowing when and to whom contract offers were made (as represented

by QHP Issuers to CMS/CCIIO), the IHCPs were oftentimes not able to validate or refute general statements of compliance by QHP issuers.

◊ IHCPs rarely were able to determine if contract offers made by QHP Issuers were in compliance with the CMS/CCIIO "good faith" standard that payment rates and other terms are such "that a willing, similarly-situated, non-ECP provider would accept or has accepted."

- In Oklahoma, one IHCP was offered "very low" inpatient hospital rates (which were reported as being paid to an IHS facility in the state), although the IHCP was able to negotiate more acceptable rates.

◊ QHP issuer online information about in-network providers is oftentimes inconsistent with the understanding of IHCPs as to whether they are in network.

- When this is the case, such as occurred with IHCPs in Wisconsin, IHCPs typically understand that they are in network but the online directory does not include the IHCPs.

◊ "Closed panel" QHPs remained closed to IHCPs.

- Harvard Pilgrim Health Plan in Maine and Kaiser Permanente in Oregon do not include IHCPs.
- An IHCP in Wisconsin is using authority under IHCIA section 206 to secure payment from a closed panel QHP.

◊ Tribal representatives previously recommended that CMS/CCIIO apply the IHCP-specific contracting requirements applicable in FFM states to QHP issuers operating in non-FFM states, or at least "urge State-based Exchanges to employ the same standard" in order to signify that states have the authority to apply such standards.

- In the final rule on Benefits and Payment Parameters for 2016,[4] CMS stated, "We urge State Exchanges to employ the same standard when examining adequacy of ECPs as outlined in §156.235, including the requirement that issuers offer contracts to all IHCPs in the plan's service area."
- To date, there has not been further adoption of the FFM's IHCP-specific standards by non-FFM state Marketplaces.

◊ The decision by CCIIO to not share with the TSGAC a complementary set of QHP issuer-supplied information on contract offers made to IHPCs (*e.g.*, if, when, to whom, and whether the QHP Addendum was incorporated into the contract offer) hindered the ability of the TSGAC researchers to determine if contract offers were made to each IHCP.

<u>Recommendations</u>

[4] Preamble to the Final Rule on CMS-9944, Notice of Benefit and Payment Parameters for 2016, 80 FR 10837.

The TSGAC recommends that CCIIO:

- ◊ Retain IHCP-specific contracting requirements in FFM states.
- ◊ With regard to QHPs with few or no in-network IHCPs, determine the reasons for the provider network deficiencies and if the plans meet federal network adequacy and ECP standards.
- ◊ Require non-FFM states to adopt policies to ensure QHP issuers in their state meet the federal network adequacy (45 CFR § 156.230(b)) and ECP (45 CFR § 156.235) standards, and absent meeting the standards institute a back-up mechanism requiring the adoption of the requirements in the CCIIO 2015 and 2016 Issuer Letters if a state otherwise does not meet the standards.
- ◊ Review the detailed findings in this report to correct non-compliance and investigate in other (non-studied) states to determine if similar problems are occurring.
- ◊ Review a sample of contract offers to determine if the offers meet the "good faith" standard pertaining to payment rates.
- ◊ Establish alternative reference payment rates that enable IHCPs to determine if the QHP issuer's offer is in compliance with the regulations. Alternatively, CCIIO could perform a review of proposed rates if requested by an IHCP.

In addition to the above recommendations to CCIIO, the TSGAC recommends that IHS compare the rates offered to IHS providers by QHP issuers with either (1) the rates received when billing as non-in network providers or (2) the rates received when billing under Indian Health Care Improvement Act (IHCIA) Section 206 authority. The TSGAC also recommends that TSGAC members consider sharing experiences with QHP contracting, including identifying effective strategies to gain in-network status and comparing results from seeking IHCIA Section 206 compliance by QHP issuers.

Exhibit A: Standards for QHPs on Network Adequacy and ECPs

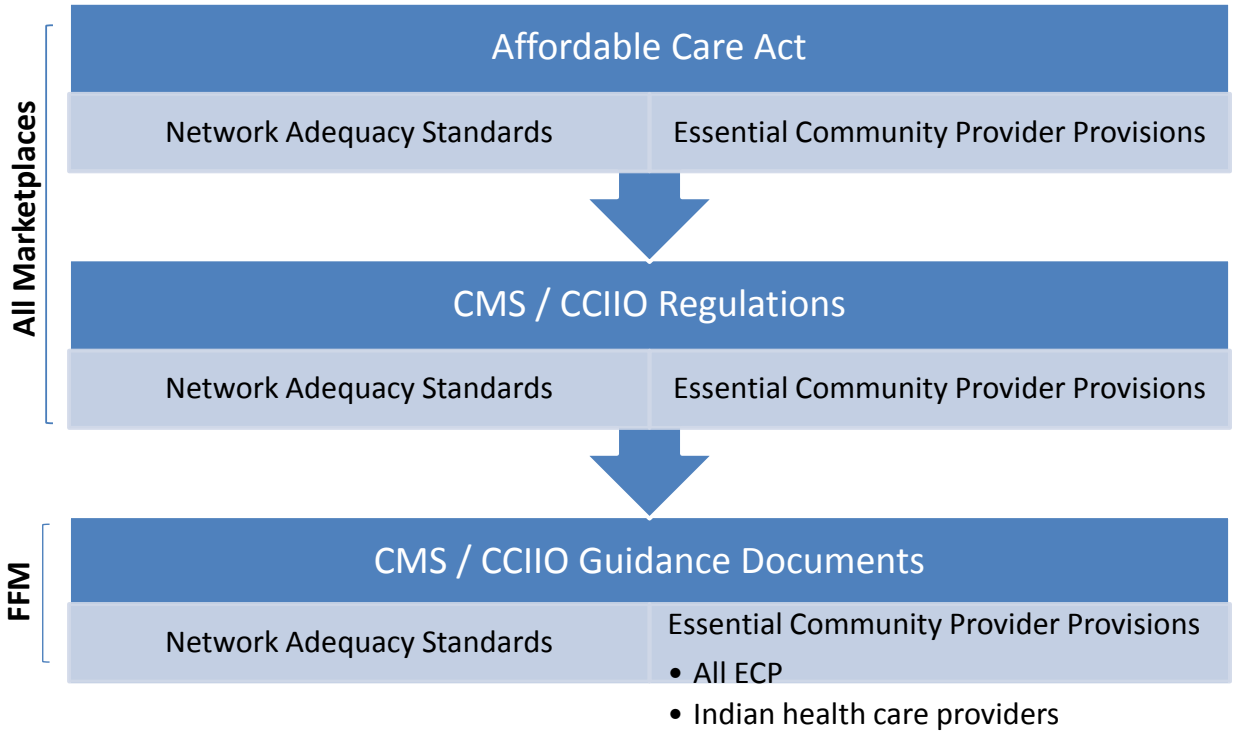
Applicable Standards

ACA includes broad standards for QHPs on network adequacy and inclusion of ECPs. These standards are found at ACA §1311(c)(1)(B) and (C).

CMS/CCIIO issued regulations implementing these requirements at 45 CFR §156.230 and 45 CFR §156.235.

In addition, CMS/CCIIO issued sub-regulations providing further guidance and specifications on the requirements for network adequacy and ECP inclusion. This guidance is contained in an "Issuer Letter," which is issued and updated annually by CMS/CCIIO and applicable to the subsequent Coverage Year (*e.g.*, the 2016 Issuer Letter was finalized in 2015 and applicable to the 2016 Coverage Year).

The hierarchy of the network adequacy and ECP requirements are displayed in the diagram below.



General Standards Applicable in All States: Network Adequacy and ECPs [ACA §1311(c)(1)(B) and (C)]

- Network adequacy [45 CFR §156.230]
  - A QHP issuer must ensure that the **provider network** for each of its QHPs is sufficient in numbers and types of providers, including providers that specialize in

mental health and substance abuse services, **to assure that all services will be accessible without unreasonable delay.**

- Provide information to enrollees on availability of in-network and out-of-network providers [45 CFR §156.230(b)]
  - A QHP **issuer must make its provider directory for a QHP available** to the Marketplace for publication online in accordance with guidance from the Marketplace and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.
- ECPs [45 CFR §156.235]
  - **A QHP issuer must have a sufficient number and geographic distribution of ECPs**, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Marketplace's network adequacy standards.
  - ECPs serve predominantly low-income, medically underserved populations and include, but are not limited to, safety net providers that are eligible to participate in the 340B Drug Pricing Program in these categories: Federally Qualified Health Centers (FQHCs), Ryan White providers, family planning providers, IHCPs, and specified hospitals.

Standards Applicable in Non-FFM States[5]

In non-FFM states, the specific implementing rules that operationalize the general standards on network adequacy and ECPs are to be determined by the respective state.

To date, CMS/CCIIO has not required application of the implementing rules described below for FFM states to non-FFM states.

Standards Applicable in FFM States

For a QHP to be certified for an FFM:

- The issuer must offer contracts to all IHCPs in the QHP's service area.
- Issuer contract offers must be in "good faith," meaning the offer must contain terms—including payment rates—that a willing, similarly-situated, non-ECP provider would accept or has accepted.
- The issuer must offer contracts "using the recommended model QHP Addendum for IHCPs developed by CMS."[6]

[5] In states with the state performing Plan Management functions, the State is able to apply state-developed standards and is not required to apply the FFM-specific regulations applicable in other FFM states.

- In addition, the issuer must "ensure at least 30 percent of available ECPs in each plan's service area participate in the provider network."[7]

For QHPs intending to operate in an FFM state but not meeting the above requirements, the QHP is permitted to **provide a narrative justification** that the network established provides an adequate level of service for low-income and medically underserved enrollees. The narrative is to include an attestation that the issuer has satisfied the "good faith" contract offer requirement with IHCPs and other ECPs.

[6] In the 2016 Issuer Letter (applicable to the 2016 Coverage Year), CMS/CCIIO modified the standard pertaining to the QHPAddendum. CMS/CCIIO required QHP issuers to, in the contract offers to IHCPs, "apply the special terms and conditions necessitated by Federal law and regulations as referenced in the recommended model QHP Addendum for IHCPs developed by CMS," rather than explicitly require use of the QHP Addendum (2016 Issuer Letter, page 67). But for the 2015 Coverage Year, the QHP Addendum is required to be included in the contract offers made by QHP Issuers.

[7] For an "Integrated Issuer," which is a QHP issuer that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group, an alternate standard on ECPs applies and is contained in federal regulations at 45 CFR §156.235(a)(2) and (b).

Exhibit B: State Summary Tables

Table 1:
STATE OF MAINE

Qualified Health Plan	Number of Plan Offerings by Zip Code					Network Provider Contracts Signed				
	4769	4730	4667	4668	4468	Micmac	Houlton	Pleasant Point	Indian Township	Penob-scot
Anthem BCBS	12	12	12	12	12	yes	yes	no	yes	yes
Harvard Pilgrim	4	4	4	4	4	no	no	no	yes	no
Maine Com-munity Health Options	9	9	9	9	9	yes	no	yes	yes	yes

Contract with Individual Providers
Contract with Tribal Facility
Only Physical Therapy Provider

Table 2:
STATE OF NEVADA

Qualified Health Plan	Number of Plan Offerings by Zip Code				Network Provider Contracts Signed			
	89427	89406	89502	89460	Schurz SU	Fallon	Reno Sparks	Wash-oe
Anthem BCBS	10	10	12	11	no	no	no	no
Nevada Health Co-op	4	4	4	4	no	no	no	no
Assurant Health			6	6			no	no
HPN-My HPN			14				yes	no
Prominence Health			12	12			yes	no

Contract with Individual Providers
Contract with Tribal Facility
Only Physical Therapy Provider

Table 3:
STATE OF OKLAHOMA

Qualified Health Plan	Number of Plan Offerings by Zip Code			Network Provider Contracts Signed		
	74820	74884	74859	Chickasaw	Wewoka	Creek
BCBS of OK	23	23	23	yes	no	yes
GlobalHealth	12	12	12	no	no	no

Contract with Individual Providers
Contract with Tribal Facility
Only Physical Therapy Provider

Table 4:
STATE OF OREGON

Qualified Health Plan	Number of Plan Offerings by Zip Code			Network Provider Contracts Signed		
	97761	97347	97801	Warm Springs	Grand Ronde	Yellow-hawk
ATRIO	0	6	0	no	yes	no
BrideSpan Health Co.	5	5	5	no	yes	no
Health Republic	13	16	13	no	yes	no
Kaiser Permanente	0	5	0	no	no	no
LifeWise HP of OR	9	9	9	no	yes	no
Moda Health	8	10	8	no	yes	yes
OR Health Co-op	9	9	9	no	yes	yes
PacificSource HP	10	10	10	no	yes	no
Providence HP	4	4	4	no	yes	yes

Contract with Individual Providers
Contract with Tribal Facility
Only Physical Therapy Provider

Table 5:
STATE OF WISCONSIN

Qualified Health Plan	Number of Plan Offerings by Zip Code				Network Provider Contracts Signed		
	54155	54520	54135	53204	Oneida	Forest County	Menom-inee
Ambetter from MHS Health Wisconsin	33			33	no		
Anthem BCBS	12			12	no		
Arise Health Plan	35			35	no		
Common Ground Healthcare Coop	18			18	no		
Dean Health Plan	9				no		
Molina Marketplace	3	3	3	3	yes	no	yes
Security Health Plan of Wisconsin, Inc.		8				yes	
UnitedHealthcare	10	10	10	10	no	yes	no

Contract with Individual Providers
Contract with Tribal Facility
Only Physical Therapy Provider

Attachment 1

STATE OF MAINE

The Tribal Self-Governance Advisory Committee commissioned a study on "Network Adequacy and Essential Community Provider Inclusion in Indian County". The State of Maine was one of the areas chosen to study. The State of Maine is a Federally-Facilitated Marketplace (FFM). Maine has expanded Medicaid. As a FFM, there is a requirement of Issuers of Qualified Health Plans (QHPs) to offer contracts to all Indian Health Care Providers (IHCPs). There is also a recommendation for the QHPs to use the QHP Indian Addendum when contracting with IHCPs.

For the study, we chose the eastern one-third side of Maine, including Aroostook, Washington, and Penobscot counties. This area is known for its farming, mostly producing potatoes and blueberries, and fishing. The Indian Health Service operates one outpatient health center, and three (3) Tribes operate a health center. It is worthy to note that the Passamaquoddy Tribe has three distinct self-governing communities within the tribe's ancestral homeland, two of which operate a health center. Zip codes were chosen for this study where the following IHCP facilities are located:

1. IHS Micmac Service Unit in Presque Isle, Maine
2. Houlton Band of Maliseet Indians in Houlton, Maine
3. Passamaquoddy Tribe of Pleasant Point in Perry, Maine
4. Passamaquoddy Tribe of Indian Township in Princeton, Maine
5. Penobscot Nation in Old Town, Maine

The following are the Qualified Health Plans that are offered in each of the zip codes for the above-referenced facilities:

1. Zip Code 04769 (IHS Micmac Service Unit)
    a. Anthem Blue Cross and Blue Shield has 12 plan offerings
    b. Harvard Pilgrim has 4 plan offerings
    c. Maine Community Health Options has 9 plan offerings
2. Zip Code 04730 (Houlton Band of Maliseet Indians)
    a. Anthem Blue Cross and Blue Shield has 12 plan offerings
    b. Harvard Pilgrim has 4 plan offerings
    c. Maine Community Health Options has 9 plan offerings
3. Zip Code 04667 (Passamaquoddy Tribe of Pleasant Point)
    a. Anthem Blue Cross and Blue Shield has 12 plan offerings
    b. Harvard Pilgrim has 4 plan offerings
    c. Maine Community Health Options has 9 plan offerings
4. Zip Code 04668 (Passamaquoddy Tribe of Indian Township)
    a. Anthem Blue Cross and Blue Shield has 12 plan offerings
    b. Harvard Pilgrim has 4 plan offerings
    c. Maine Community Health Options has 9 plan offerings
5. Zip Code 04468 (Penobscot Nation)
    a. Anthem Blue Cross and Blue Shield has 12 plan offerings

b. Harvard Pilgrim has 4 plan offerings
c. Maine Community Health Options has 9 plan offerings

In summary, there are three insurance companies operating in the five zip code areas. Among the three, two lists all except one of the IHCPs are in their network, according to the information offered online. All health centers except the Passamaquoddy Tribe at Pleasant Point are included in the Anthem Blue Cross and Blue Shield Provider networks (Blue Choice PPO, Pathway, and Pathway X). One health center (Passamaquoddy Tribe at Indian Township) reported they were in the Harvard Pilgrim provider network. However, after an extensive search of that network, they were not listed. Ms. Melanson reported to me they are in network because they are billing and getting paid for one patient who has Harvard Pilgrim. All health centers, except Houlton Band of Maliseet Indians are included in the Maine Community Health Options provider networks, and Houlton Band reports they are in the process of obtaining a contract with Maine Community Health Options. Currently 33% of the plans on the FFM in these five zip codes do not have any IHCPs in their network.

Four of the five health centers had existing contracts with two of the three qualified health plans in this region. The information reported was somewhat inconsistent, however, it appears two of the three, Anthem Blue Cross and Blue Shield and Maine Community Health Options, did offer a contract with an Indian Addendum to each of the health centers. Ms. Liz Neptune who is a Nashville Area TEOC-U representative reported that Maine Community Health Options did not know about the Indian Addendum, she shared a copy with them and all the health directors. It seems that was a beneficial activity. For the most part the rates offered were Medicare Like Rates and were non-negotiable, with one health center reporting that Maine Community Health Options offered 120% of Medicare rates.

Based on the survey, one of the three qualified health plans did not offer contracts to the IHCPs in their area, Harvard Pilgrim. It was reported that those contract offers did include the CMS Model Indian Addendum.

The factors for considering whether to enter into contracts with the QHP's included such items as the Insurer was also the Insurer for the employee's health insurance, the majority of patient's insurance is through Maine Community Health Options, and they wanted to ensure they would receive reimbursements for patient visits.

Attached to this narrative are the questions and answers that were obtained while performing the research on the State of Maine and IHCP.

Since Maine is a FFM, it seems the requirements imposed on Issuers to offer contracts to IHCPs with a recommendation to use the QHP Indian Addendum was followed, with the exception of Harvard Pilgrim.

NASHVILLE AREA (MAINE)					
Maine is a federally facilitated Marketplace. Maine did not expand Medicaid in 2014. As a FFM Maine QHP's are required to offer contracts to all I/T/U's in the state. IHS Nashville Area Office operates 1 federal/direct service program and four (4) tribes provide outpatient services. These facilities represent the Eastern Side of the state and includes IHS and tribal health systems.					
	I/T/U #1	**I/T/U #2**	**I/T/U #3**	**I/T/U #4**	**I/T/U #5**
List of IHCP in Region	**IHS Micmac Service Unit, Aroostook County, 8 Northern Road, Presque Isle, ME 04769, Tele 207-764-7219**	**Houlton Band of Maliseet Indians, Aroostook County, Maliseet Center for Health and Wellness, 3 Clover Circle, Houlton, ME 04730, Tele 207-532-2240**	**Passamaquoddy Tribe Pleasant Point, Pleasant Point Health Center, Washington County, PO Box 351, Perry, ME 04667, tele 207-853-0644**	**Passamaquoddy Health Center (Indian Township), Washington County, 401 Peter Dana Point Road, PO Box 97, Princeton, Maine 04668, tele 207-796-2321**	**Penobscot Nation, Penobscot County, Ruth Attean Davis Health Building, 23 Wabanaki Way, Old Town, Maine 04468, tele 207-827-6101**
Contact Person	**Theresa Cochran, Director (207-764-7219), email: Theresa.Cochran@ihs.gov; Katie M. Espling, Business Office, email: Katie.Espling@ihs.gov**	**Patti Bechard, Director (207-532-2240); email: pbechard@maliseets.com**	**Kirk Altvater, Asst. Director (207-854-0644); email: Kirk.Altvater@ihs.gov**	**Andrea Hanson, Director 207-796-2321, ext. 14; ahanson@nspitnashville.ihs.gov; Sandy Melanson, 207-796-2321 ext. 16**	**Jill MacDougall, Director (207-817-7404), email: Jill.MacDougall@ihs.gov**
List of QHPs Offering Coverage in Zip Code of IHCP Facility	Anthem BCBS - 12 plans; Harvard Pilgrim - 4 plans; Maine Community Health Options - 9 plans	Anthem BCBS - 12 plans; Harvard Pilgrim - 4 plans; Maine Community Health Options - 9 plans	Anthem BCBS - 12 plans; Harvard Pilgrim - 4 plans: Maine Community Health Options - 9 plans	Anthem BCBS - 12 plans; Harvard Pilgrim - 4 plans: Maine Community Health Options - 9 plans	Anthem BCBS - 12 plans; Harvard Pilgrim - 4 plans: Maine Community Health Options - 9 plans
List of IHCP in QHP Network	Anthem BCBS - Yes; Harvard Pilgrim - None; Maine Community Health Options - Yes	Anthem BCBS - Yes; Harvard Pilgrim - None; Maine Community Health Options - In progress	Anthem BCBS - None; Harvard Pilgrim - None; Maine Community Health Options - Yes	Anthem BCBS - Yes; Harvard Pilgrim - Yes; Maine Community Health Options - Yes	Anthem BCBS - Yes; Harvard Pilgrim - None; Maine Community Health Options - Yes
Provider Network Name	Maine Community Health Options; Blue Choice PPO, Pathway, and Pathway X	Blue Choice PPO, Pathway, and Pathway X		Maine Community Health Options; Blue Choice PPO, Pathway and Pathway X; Harvard Pilgrim	Maine Community Health Options; Blue Choice PPO, Pathway, and Pathway X
Did IHCP have contract with QHP/issuer prior to 2014? Does QHP/issuer consider consideration of old contract in compliance with requirements? (I understand some issuers may just keep operating with old contracts and consider having met requirements, which may mean old, low rates and no Indian Addendum.)	Anthem BCBS - Yes; Maine Community Health Options - Yes	Yes; Don't know	Yes with MCHO	Harvard Pilgrim and Anthem BCBS were both existing agreement	No
If yes, was the Indian Addendum used and were rates satisfactory?	BCBS - Yes	Unknown	Yes	Yes, accepted what was offered	No, No opportunity to negotiate
Contract Offer made by QHP to IHCP	MCHO - Yes	Unknown	MCHO - Yes	MCHO - Yes	MCHO and Anthem BCBS
Contract Offer accepted by IHCP	BCBS - Yes as existing agreement; MCHO - Yes	Unknown	MCHO - Yes	MCHO - Yes	Yes
Did Contract Offer include Model QHP Addendum	BCBS - Yes	Unknown	Yes	Not sure	Jill said it was unknown; Liz Neptune reported that MCHO did not know about the Indian Addendum so she shared a copy with both MCHO and the tribal health directors.
Were payment rates offered in contracts such that a willing, simiarly-situated, non-ECP would accept or has accepted	MCHO - 120% of Medicare	Unknown	Yes	Non-negotiable	Non-negotiable

What factors did IHCPs consider in determining whether to enter into a contract with QHP		Aetna, BCBS FEP and Anthem BCBS is offered to employees at the Houlton Band of Maliseet Indians	Wanted to contract with MCHO ahead of time before marketplace opened for enrollment where MCHO was most popular so likelihood of patients choosing them was high.	Wanted to make sure they received payment	Only two approached us
Evaluations of QHPs offered in non-FFM states, identify the requirements imposed on the QHPs pertianing to contracting with IHCPs and whether issuers complied with these requierments	See Above	See Above	See Above	See Above	See Above

STATE OF NEVADA

The Tribal Self-Governance Advisory Committee commissioned a study on "Network Adequacy and Essential Community Provider Inclusion in Indian County". The State of Nevada was one of the areas chosen to study. The State of Nevada is a federally-supported stated-based Marketplace called "Nevada Health Link." Nevada did expand Medicaid. Nevada Health Link does not require Issuers of Qualified Health Plans (QHPs) to offer contracts to all Indian Health Care Providers (IHCPs), nor do they require the QHPs to use the QHP Indian Addendum when contracting with IHCPs.

For the study, we chose the western side of Nevada, including Mineral, Churchill, Washoe, and Douglas counties. This area is largely rural, although Reno is located in Washoe County. The Indian Health Service operates one hospital and two outpatient health centers, and four (4) Tribes provide outpatient health services. Zip codes were chosen for this study where the following IHCP facilities are located:

1. Indian Health Service Schurz Service Unit Health Center in Schurz, Nevada
2. Fallon Paiute-Shoshone Tribe, Fallon Tribal Health Center in Fallon, Nevada
3. Reno Sparks Tribal Health Center in Reno, Nevada
4. Washoe Tribal Health Center in Gardnerville, Nevada

The following are the Qualified Health Plans that are offered in each of the zip codes for the above-referenced facilities:

1. Zip code 89427 (IHS Schurz Service Unit)
    a. Anthem Blue Cross Blue Shield has 10 plan offerings
    b. Nevada Health Co-op has 4 plan offerings
2. Zip code 89406 (Fallon Tribal Health Center)
    a. Anthem Blue Cross Blue Shield has 10 plan offerings
    b. Nevada Health CO-OP has 4 plan offerings
3. Zip code 89502 (Reno Sparks Tribal Health Center)
    a. Anthem Blue Cross Blue Shield has 12 plan offerings
    b. Nevada Health Co-op has 4 plan offerings
    c. Assurant Health has 6 plan offerings
    d. HPN-My HPN has 14 plan offerings
    e. Prominence Health Plan has 12 plan offerings
4. Zip code 89460 (Washoe Tribal Health Center)
    a. Anthem Blue Cross Blue Shield has 11 plan offerings
    b. Nevada Health Co-op has 4 plan offerings
    c. Assurant Health has 6 plan offerings
    d. Prominence Health Plan has 12 plan offerings

In summary there are five insurance companies operating in the four zip code areas. Among the five, only one IHCP is in any of the QHP provider networks. Reno Sparks Tribal Health

Center is a part of Health Plan of Nevada (HPN-My HPN) provider network referred to as “HMO Provider Directory for Northern Nevada” and Prominence Health provider network referred to as “Premier HMO North Network and HealthFirst HMO Network - "Choice Plus." And, the reason Reno Sparks is in these provider networks at all is due to an existing contract that was in place prior to 2014, which has no Indian Addendum included. This means that currently 80 percent of the plans in these four zip code areas do not have any IHCPs in network.

Angie Wilson, Director, Reno Sparks Tribal Health Center was the point of contact on this study. Ms. Wilson previously expressed her concerns with the lack of QHP offers to contract with IHCPs at the November Tribal Technical Advisory Group meeting in Washington, DC. Ms. Wilson and I reviewed the questions listed below. She agreed to discuss these with other Indian Health Care Providers at their next meeting, which was held on January 13, 2015. The meeting included IHCPs from the western side of the state (which our study is focused on), but also included the Paiute Tribe, the Northern Nevada Tribes, and the Indian Health Service Elko service unit, and the southern Nevada Tribes. A Nevada Health Link representative was also in attendance at the meeting.

All the Indian Health Care Providers in attendance reported that they were treated the same and had the same answers to the following questions. The answers are listed in the attached table, “IHS Phoenix Area (Nevada) Research Questionnaire”:

1. Does Nevada Health Link require Issuers to offer contracts to Indian Health Care Providers?
2. Does Nevada Health Link require Issuers to offer contracts to IHCP with the Model Indian Addendum?
3. Were there other requirements imposed on the Issuers/QHP’s pertaining to contracting with Indian Health Care Providers?
4. Do you believe those requirements were complied with by the Issuers/QHPs?
5. If no, why not?
6. Did your facility have a contract with each QHP/Issuer prior to 2014?
7. If yes, did the QHP/issuer consider the old contract to be in compliance with the requirements to have a contract with IHCP or ECP?
8. If yes, was the QHP Indian Addendum used and were rates satisfactory?
9. Was a contract offer made by each of the Issuers to your health center?
10. Was the contract offer accepted by the health center?
11. Did the contract offer include the Model QHP Indian Addendum?
12. Were payment rates offered in the contracts such that a willing, similarly-situated, non-ECP (Essential Community Provider) would accept or has accepted?
13. What factors did you consider in determining whether to enter into a contract with each QHP?

Nevada Health Link is governed by the Silver State Exchange Board (“Board”). The IHCPs located in Nevada have been advocating them (1) to have a Tribal Advocate on their Board as an Advisory position and (2) to have the Board make it mandatory to include the Indian

Addendum in any QHP contracts with IHCPs. When the IHCPs discussed with the Board the need for Issuers to offer contracts, the reply from the Board was, "Hopefully they will in the future." In addition, the Board's attitude has been that the Board wants all the IHCPs to contract or none of them to contract, even though the IHCPs have explained to the Board that Tribes are different, and contracting should be an individual choice of each Tribe / IHCP.

Currently, there are no requirements by Nevada Health Link imposed on Issuers pertaining to contracting with IHCPs, including no requirement on QHP issuers to offer contracts to IHCPs and no requirement to use the QHP Indian Addendum. It seems there is a lack of awareness and understanding at the Board about tribal health programs and the Indian Addendum.

To date, there have been no contract offers made by any of the QHP issuers to any of the IHCPs in Nevada.

The IHCPs in the State of Nevada do want to enter into agreements with the QHPs, and so do using the QHP Indian Addendum. It is important that the QHP issuers gain an understanding of the Indian Addendum and how many of the AI/ANs who are enrolled in QHPs access care through the tribal health delivery system, with subsequent referrals to outside providers. In addition, it is also important that the IHCPs are able to bill for services covered within their health programs, especially when some Tribes are sponsoring premiums for QHP enrollees who are AI/ANs in their Purchased Referred Care programs and/or tribal populations.

It is worth noting that one dental insurer (Liberty Dental) did reach out to the Reno Sparks Tribal Health Center about contracting, but no follow up has ensued.

Attached to this narrative are the questions and answers that were obtained while performing the research on the State of Nevada and IHCP. Since Nevada has no requirements imposed on issuers to offer a contract to all IHCPs there is no requirements to meet.

IHS PHOENIX AREA (NEVADA) RESEARCH QUESTIONNAIRE				
Nevada is a federally-supported state-based Marketplace called "Nevada Health Link." Nevada did expand Medicaid in 2014. Nevada Health Link has no requirements on Qualified Health Plan (QHP) issuers regarding Indian Health Care Providers (IHCPs). The Indian Health Service (IHS) operates one hospital and two outpatient health centers, and four (4) Tribes provide outpatient health services. The region selected is located in the western side of the State and is served by IHS and the tribal health system providers.				
	I/T/U #1	**I/T/U #2**	**I/T/U #3**	**I/T/U #4**
List of IHCPs in Region	**IHS Schurz Service Unit Health Center, Mineral County, Drawer A, Schurz, NV 89427; Tele 775.773.2345**	**Fallon Paiute-Shoshone Tribe, Churchill County, Fallon Tribal Health Center, 565 Rio Vista Drive, Fallon, NV 89406, Tele 775.423.6075** **QHP-11346-IHCP-ECP**	**Reno Sparks Tribal Health Center, Washoe County, 1715 Kuenzil St., Reno, NV 89502** **QHP-11401-IHCP-ECP**	**Washoe Tribal Health Center, Douglas County, 1588 Watasheamu Road, Gardnerville, NV 89460; Tele 775.265.4215** **QHP-11350-IHCP-ECP**
Contact Person:	**Loron Ellery, Acting CEO**	**Jolene Aleck – Business Manager; 775-423-3634**	**Angie Wilson, Director; 775-329-5162; awilson@rsicclinic.org**	**Andrea Lawrence; 775-265-4215**
List of QHPs Offering Coverage in Zip Code of IHCP Facility	Anthem BCBS-10 plans: Nevada Health CO-OP-4 plans	Anthem BCBS - 10 plans; Nevada Health CO-OP - 4 plans	Anthem BCBS-12 plans; Nevada Health CO-OP-4 plans; Assurant Health-6 plans; Health Plan of Nevada (HPN-My HPN)-14 plans; Prominence Health Plan-12 plans	Anthem BCBS-11 plans; Nevada Health CO-OP-4 plans; Assurant Health-6 plans; Prominence Health Plan-12 plans;
List of IHCP in QHP Network	Anthem BCBS - None; Nevada Health CO-OP - None	Anthem BCBS - None; Nevada Health CO-OP - None	Anthem BCBS - None; Nevada Health CO-OP - None; Assurant Health - None; Health Plan of Nevada (HPN-My HPN) - Yes (4 providers); Prominence Health - Yes	Anthem BCBS - None; Nevada Health CO-OP - None; Assurant Health - None; Prominence Health - None
Provider Network Name			Health Plan of Nevada (HPN-My HPN): HMO Provider Directory for Northern Nevada; and Prominence Health "Premier HMO North Network" and HealthFirst HMO Network - "Choice Plus"	
Does Nevada Health Link (state exchange) require Issuers to offer contracts to IHCP?	No, not that we are aware	No, not that we are aware	No, not that we are aware	No, not that we are aware
Does Nevada Health Link (state exchange) require Issuers to offer contracts to IHCP with the Model QHP Indian Addendum?	No	No	No	No
Were there other requirements imposed on the Issuers/QHP's pertaining to contracting with IHCP?	Not that we (tribal health programs) are aware	Not that we (tribal health programs) are aware	Not that we (tribal health programs) are aware	Not that we (tribal health programs) are aware
Do you believe requirements were complied with by the Issuers/QHP's?	If the issuers/QHP's were required, they have not complied	If the issuers/QHP's were required, they have not complied	If the issuers/QHP's were required, they have not complied	If the issuers/QHP's were required, they have not complied
If no, why not?	I think that they are unaware of or do not understand tribal health programs and/or the importance of the Indian Addendum	I think that they are unaware of or do not understand tribal health programs and/or the importance of the Indian Addendum	I think that they are unaware of or do not understand tribal health programs and/or the importance of the Indian Addendum	I think that they are unaware of or do not understand tribal health programs and/or the importance of the Indian Addendum
Did IHCP have contract with QHP/issuer prior to 2014? Does QHP/issuer consider consideration of old contract in compliance with requirements? (I understand some issuers may just keep operating with old contracts and consider having met requirements, which may mean old, low rates and no Indian Addendum.)	No	No	Yes, prior contracts with Health Plan of Nevada (HPN-My HPN) and Prominence Health. We do not know if QHP issuer believes they are in compliance with Essential Community Provider (ECP) requirements.	No
If yes, was the QHP Indian Addendum used and were rates satisfactory?			No the QHP Indian Addendum was not used	
Contract Offer made by QHP to IHCP	No	No	No	No

IHS PHOENIX AREA (NEVADA) RESEARCH QUESTIONNAIRE				
Nevada is a federally-supported state-based Marketplace called "Nevada Health Link." Nevada did expand Medicaid in 2014. Nevada Health Link has no requirements on Qualified Health Plan (QHP) issuers regarding Indian Health Care Providers (IHCPs). The Indian Health Service (IHS) operates one hospital and two outpatient health centers, and four (4) Tribes provide outpatient health services. The region selected is located in the western side of the State and is served by IHS and the tribal health system providers.				
	I/T/U #1	**I/T/U #2**	**I/T/U #3**	**I/T/U #4**
Contract Offer accepted by IHCP	N/A	N/A	N/A	N/A
Did Contract Offer include Model QHP Indian Addendum	N/A	N/A	N/A	N/A
Were payment rates offered in contracts such that a willing, similarly-situated, non-ECP would accept or has accepted	N/A	N/A	N/A	N/a
What factors did IHCPs consider in determining whether to enter into a contract with QHP			We want to enter into agreements with the QHP's using the Indian Addendum. It is important that QHP's understand the addendum and how many of our AI/AN access care through the tribal health delivery system, with referrals to outside providers. It is also important that we are able to bill for services covered within our tribal health programs, especially when tribes are sponsoring premiums for the PRC and/or tribal populations.	
Evaluations of QHPs offered in non-FFM states, identify the requirements imposed on the QHPs pertaining to contracting with IHCPs and whether issuers complied with these requirements	See Above	See Above	See Above	See Above

STATE OF OKLAHOMA

The Tribal Self-Governance Advisory Committee commissioned a study on "Network Adequacy and Essential Community Provider Inclusion in Indian County". The State of Oklahoma was one of the areas chosen to study. The State of Oklahoma is a Federally-Facilitated Marketplace (FFM). Oklahoma has not expanded Medicaid. As a FFM, there is a requirement of Issuers of Qualified Health Plans (QHPs) to offer contracts to all Indian Health Care Providers (IHCPs). There is also a recommendation for the QHPs to use the QHP Indian Addendum when contracting with IHCPs.

For the study, we chose the south central region of Oklahoma, including Pontotoc, Seminole, and Okfuskee counties. This area is rural, mostly farmland, that is southeast of Oklahoma City about 1-1/2 to 2 hours. The Indian Health Service operates one outpatient health center, and two (2) Tribes both have a health system, including a hospital with outlying outpatient health centers. Zip codes were chosen for this study where the following IHCP facilities are located:

1. Chickasaw Nation Medical Center in Ada, Oklahoma
2. IHS Wewoka Indian Health Center in Wewoka, Oklahoma
3. Muscogee (Creek) Medical Center in Okemah, Oklahoma

The following are the Qualified Health Plans that are offered in each of the zip codes for the above-referenced facilities:

1. Zip code 74820 (Chickasaw Nation Medical Center)
    a. Blue Cross and Blue Shield of Oklahoma has 23 plan offerings
    b. GlobalHealth has 12 plan offerings
2. Zip code 74884 (IHS Wewoka Indian Health Center)
    a. Blue Cross and Blue Shield of Oklahoma has 23 plan offerings
    b. GlobalHealth has 12 plan offerings
3. Zip code 74859 (Muscogee (Creek) Medical Center)
    a. Blue Cross and Blue Shield of Oklahoma has 23 plan offerings
    b. GlobalHealth has 12 plan offerings

In summary, there are two insurance companies in the three zip code areas. Among the two, only one lists both tribal IHCP as in their network, according to the information offered on line. After reviewing the networks in these plans, both tribal health systems are included in two of the three Blue Cross and Blue Shield of Oklahoma QHP provider networks. Those two QHP provider networks include the Blue Choice PPO and the Blue Preferred PPO. The Chickasaw Nation health system is also included in the QHP provider network "Blue Advantage PPO." It is interesting to note that the Indian Health Service Wewoka Indian Health Center does not have a contract with any of the Qualified Health Plans. I talked with the Oklahoma City Area Office Business Office Manager and she said that there might be a few service units in Oklahoma that have had a contract with an insurer but that it is not consistent throughout Oklahoma. However, she is in the process of working with Blue Cross and Blue Shield of Oklahoma to enter

into a contract that will cover all of the Oklahoma Area. The reason for no contracts is that there isn't a need since the Insurers pay the Indian Health Service facilities under Section 206 of the Indian Health Care Improvement Act. This means that currently fifty percent of the plans on the FFM in these three zip codes do not have IHCPs in network.

Both QHPs made contract offers to the IHCPs in Oklahoma, with only one, Blue Cross and Blue Shield, including the Indian Addendum. Only the Muscogee Creek Nation had existing contracts with both Insurers. Just as a note, Global Health knew about the Indian Addendum because the Policy Analyst for the Oklahoma City Area Indian Health Board met with both Insurers and went over the Indian Addendum and the contracting process for IHCP previous to the offers of contracting to the IHCP.

The factors for considering whether to enter into contracts with the QHPs included items as negotiating the contracts for satisfactory payment rates, and the insurers wanting the facilities to utilize their credentialing process.

Attached to this narrative are the questions and answers that were obtained while performing the research on the State of Oklahoma and IHCP.

Since Oklahoma is a FFM, it seems the requirement imposed on Issuers to offer a contract to all IHCPs with a recommendation to use the CMS Model Indian Addendum was followed in Oklahoma for the most part.

IHS OKLAHOMA AREA (OKLAHOMA) RESEARCH QUESTIONNAIRE			
Oklahoma is a federally facilitated Marketplace. Oklahoma did not expand Medicaid in 2014. As a FFM Oklahoma QHP's are required to offer contracts to all I/T/U's in the state. Oklahoma Area Office operates both inpatient and outpatient facilities in Oklahoma as well as numerous tribes. These facilities represent the South Central region of Oklahoma and includes IHS and two (2) tribal health systems.			
	I/T/U #1	**I/T/U #2**	**I/T/U #3**
List of IHCPS in Region	**Chickasaw Nation Medical Center, Pontotoc County, 1921 Stonecipher Blvd, Ada, Oklahoma 74820, Tele: (580) 436-3980**	**IHS Wewoka Indian Health Center, Seminole County, P.O. Box 1475, Wewoka, Oklahoma 74884, (405) 257-7326**	**Muscogee (Creek) Medical Center, Okfuskee County, 309 North 14th, Okemah Oklahoma 74859, Tele: (918) 758-3101 or (918) 623-1424**
Contact Person:	**Brenda Teel, Business Office Manager, email: brenda.teel@chickasaw.net**	**Millie Blackmon, CEO, millie.blackmon@ihs.gov; Pamela Strope, IHSAO Business Office**	**Karen Knight, Business Office Manager, cell: 918-752-8320; work: 918-756-4333, x245; karen.knight@creekhealth.org**
List of QHPs Offering Coverage in Zip Code of IHCP Facility	Blue Cross and Blue Shield of Oklahoma (23); GlobalHealth (12)	Blue Cross and Blue Shield of Oklahoma (23); GlobalHealth (12)	Blue Cross and Blue Shield of Oklahoma (23); GlobalHealth (12)
List of IHCP in QHP Network	BCBS - Yes; GH - No	None	BCBS - Yes; GH - No
Provider Network Name	Blue Advantage PPO; Blue Choice PPO; Blue Preferred PPO	N/A	Blue Choice PPO; Blue Preferred PPO
Did IHCP have contract with QHP/issuer prior to 2014? Does QHP/issuer consider consideration of old contract in compliance with requirements? (I understand some issuers may just keep operating with old contracts and consider having met requirements, which may mean old, low rates and no Indian Addendum.)	No	A few of OK service units had a contract, but basically said they don't need a contract because IHCIA says they will pay	Yes, both Insurers; No, both offered new contracts
If yes, was the QHP Indian Addendum used and were rates satisfactory?	N/A	Yes since the Indian Addendum was released by CMS	BCBS - Yes; GH - No, but MCN has requested an amendment
Contract Offer made by QHP to IHCP	Yes, both Insurers	BCBS - Yes; GH - No	Yes, both Insurers
Contract Offer accepted by IHCP	BCBS - Yes; GH - still working on contract	Oklahoma City Area IHS Office is working on an Area wide contract with BCBS	Yes
Did Contract Offer include Model QHP Indian Addendum	BCBS - Yes; GH - still working on contract	BCBS - Yes	BCBS - Yes; GH - No
Were payment rates offered in contracts such that a willing, similarly-situated, non-ECP would accept or has accepted	Yes	BCBS-Yes; all have been paying under Section 206	BCBS - For clinics. negotiation was not a choice as they have a state rate across the board; For hospital, we negotiated an increase; GH - negotiated; Overall a 25-60% increase in rates was negotiated; rates offered were for IHS and they were very low

What factors did IHCPs consider in determining whether to enter into a contract with QHP	Payment Rates	Credentialing - they wanted us to go through their credentialing process	Rates and Terms
Evaluations of QHPs offered in non-FFM states, identify the requirements imposed on the QHPs pertaining to contracting with IHCPs and whether issuers complied with these requirements	See Above	See Above	See Above

STATE OF OREGON

The Tribal Self-Governance Advisory Committee commissioned a study on "Network Adequacy and Essential Community Provider Inclusion in Indian County". The State of Oregon was one of the areas chosen to study. The State of Oregon is a state-based exchange called "Cover Oregon." However, in 2015 Cover Oregon transferred to the federally-facilitated marketplace. Oregon has expanded Medicaid. Cover Oregon required all Qualified Health Plans (QHPs) to offer contracts to all Indian Health Care Providers (IHCPs) but do not require the CMS Model Indian Addendum.

For the study, we chose the northern part of Oregon, including Jefferson, Polk, and Umatilla counties. The Portland Area Indian Health Service covers the states of Washington, Oregon, and Idaho and operates six Federal health facilities in five Tribal communities and one at Chemawa Indian School. Tribes operate health facilities under the authority of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended), Titles 1 and V. Twenty-three Tribes have Title V compacts and there are twenty-four Tribes or Tribal organizations that contract under Title 1. Overall, Tribes administer more than 74% of the Portland Area budget authority appropriation through Self-Determination contracts or Self-Governance compacts. In Oregon, the Indian Health Service operates two outpatient health centers, and four (4) Tribes provide outpatient health services. Zip codes were chosen for this study where the following IHCP facilities are located:

1. IHS Warm Springs Health & Wellness Center in Warm Springs, Oregon
2. Grand Ronde Health & Wellness Center in Grand Ronde, Oregon
3. Yellowhawk Tribal Health Center in Pendleton, Oregon

The following are the Qualified Health Plans that are offered in each of the zip codes for the above-referenced facilities:

1. Zip code 97761 (IHS Warm Springs Health & Wellness Center)
    a. BrideSpan Health Company has 5 plans
    b. Health Republic has 13 plans
    c. LifeWise Health Plan of Oregon has 9 plans
    d. Moda Health has 8 plans
    e. Oregon's Health Co-op has 9 plans
    f. PacificSource Health Plans has 10 plans
    g. Providence Health Plan has 4 plans
2. Zip code 97347 (Grand Ronde Health & Wellness Center)
    a. ATRIO Health Plan has 6 plans
    b. BrideSpan Health Company has 5 plans
    c. Health Republic has 16 plans
    d. Kaiser Permanente has 5 plans
    e. LifeWise Health Plan of Oregon has 9 plans
    f. Moda Health has 10 plans
    g. Oregon's Health Co-op has 9 plans

   h. PacificSource Health Plans has 10 plans
   i. Providence Health Plan has 4 plans
3. Zip code 97801 (Yellowhawk Tribal Health Center)
   a. BrideSpan Health Company has 5 plans
   b. Health Republic has 13 plans
   c. LifeWise Health Plan of Oregon has 9 plans
   d. Moda Health has 8 plans
   e. Oregon's Health Co-op has 9 plans
   f. PacificSource Health Plans has 10 plans
   g. Providence Health Plan has 4 plans

In summary, there are nine insurance companies operating in the three zip code areas. Among the nine, none lists all IHCPs in their networks. Eight of the nine lists one IHCP in their network, and three of the nine list two IHCPs in their network. The IHS Warm Springs Health & Wellness Center is not a part of any network. They said they have not signed any contract because of Section 206 of the IHCIA. The Grand Ronde Health & Wellness Center is in all networks, except Kaiser Permanente, which is a closed panel plan. The Yellowhawk Tribal Health Center is in three of the seven networks. Currently, only the closed panel plan in these three zip codes does not have any IHCPs in their network.

It seems that most of the Qualified Health Plans did offer to contract with each of the health centers, however, the Indian Addendum was not included, nor required. Grand Ronde said they thought the Indian Addendum had not been finalized but that the Indian Addendum would solve lots of the issues which result in them not having all contracts.

Yellowhawk Tribal Health Center said they have not worked to contract with all Qualified Health Plans since they have not gone forward with a Tribal Sponsorship Program.

The factors for considering whether to enter into contracts with the QHP's included such items as the number of patients served with insurance plans and the usage of the CMS Model Indian Addendum.

Attached to this narrative are the questions and answers that were obtained while performing the research on the State of Oregon and IHCP.

Under Cover Oregon, the Qualified Health Plans were required to offer a contract with all I/T/U's in the state. It seems that for the most part the regulations to offer a contract were followed in Oregon, except for Kaiser Permanente.

Portland Area (State of Oregon)			
Oregon is a state-based exchange called CoverOregon which will be transferring to the FFM in 2015. Oregon did Expand Medicaid in 2014. Cover Oregon requires all QHPs to offer contracts to all I/T/U's in the state with the CMS Model Indian Addendum. Indian Health Service provides Outpatient Services at two (2) facilities in Oregon. There are nine (9) tribes in Oregon who provide outpatient health services. These facilities represent the Northern Region of the state and includes both IHS and Tribal health systems.			
	I/T/U #1	**I/T/U #2**	**I/T/U #3**
List of IHCP in Region	**IHS Warm Springs Health & Wellness Center, Jefferson County, PO Box 1209, Warm Springs, OR 97761, Tele: 541-553-1196**	**Confederated Tribes of Grand Ronde Oregon, Polk County, 9605 Grand Ronde Road, Grand Ronde, OR 97347, Tele: 503-879-2075; email: GRHWC@grandronde.org**	**Yellowhawk Tribal Health Center, Umatilla County, PO Box 160, 73265 Confederated Way, Pendleton, OR 97801, Tele: 541-966-9830**
Contact Person	**Carol A. Prevost, MHSA, RN, CEO, email: carol.prevost@ihs.gov; Jeremiah Johnson, email: jeremiah.johnson@ihs.gov**	**Jeffrey D. Lorenz, Executive Director, Health Services, email: jeff.lorenz@grandronde.org; Jill Hafliger, Accreditation Coordinator, email: Jill.Hafliger@grandronde.org**	**Tim Gilbert. Health Director, email: timgilbert@yellowhawk.org; Linda Hettinga, email: LindaHettinga@yellowhawk.org**
List of QHP's Offering Coverage in the Zip Code of IHCP Facility	BridgeSpan Health Company-5 plans; Health Republic-13 plans; LifeWise Health Plan of Oregon-9 plans; Moda Health-8 plans; Oregon's Health COOP-9 plans; PacificSource Health Plans-10 plans; Providence Health Plan-4 plans	ATRIO Health Plans-6 plans; BridgeSpan Health Company-5 plans; Health Republic-16 plans; Kaiser Permanenta-5 plans; LifeWise Health Plan of Oregon-9 plans; Moda Health-10 plans; Oregon's Health COOP-9 plans; PacificSource Health Plans-10 plans; Providence Health Plan-4 plans	BridgeSpan Health Company-5 plans; Health Republic-13 plans; LifeWise Health Plan of Oregon-9 plans; Moda Health-8 plans; Oregon's Health COOP-9 plans; PacificSource Health Plans-10 plans; Providence Health Plan-4 plans
List of IHCP in QHP Network	None	ATRIO Health Plan - Facility is in First Choice Health PPO, Providers are in ATRIO Provider Directory; BridgeSpan Health Company - PT in ValuePPO Network; Health Republic - Providence Network; LifeWise Health Plan of Oregon - Bronze HSA EPO, Oregon EPO, Preferred or PPO; Moda Health - Connexus Network; Oregon's Health Co-op - Broad Network, Pharmacy is in Select Network; PacificSource Health Plan - Basic Health Plan PSN, BrightIdea, BrightPath, Choice PSN, Elect, HMO PSN, HMO PSN NW, Medishield PSN, NIHN PPO, Oregon Standard - SHN, Portability, Preferred PSN, Preferred PSN NW, Prime, Prime PSN, PSN, SmartAlliance, SmartChoice, SmartHealth; Providence Health Plan - Providence EPO Network, Providence Choice Network, and Providence Connect Network	Moda Health - Connexus Network; Oregon's Health Co-op - Broad Network & Select Network; Providence Health Plan - EPO Network, Choice Network, & Connect Network for Pharmacy Only
Did IHCP have contract with QHP/issuer prior to 2014? Does QHP/issuer consider consideration of old contract in compliance with requirements? (I understand some issuers may just keep operating with old contracts and consider having met requirements, which may mean old, low rates and no Indian Addendum.)	No, have not signed any contract because of Section 206 of the IHCIA; a large majority of our patient population is not covered by an employee based plan, and opted for exemption if they did not qualify for Medicaid vs. pay for any health benefits out of pocket. The QHP/Issuer considered old contracts for Pharmacy agreements to be in compliance.	No	No, and we still are not contracted with any QHP; We hve a contract with Moda Health which is specifically for Oregon Health Plan at the current time. This is our CCO in Umatilla County.
If yes, was the Indian Addendum used and were rates satisfactory?	Yes, pertaining to Pharmacy Agreements.	N/A	N/A
Contract Offer made by QHP to IHCP	Yes, but due to a lack of definitive instructions to contract, our service unit has depended on Section 206 to receive payment	Yes	No, we received a request to contract for three of the QHPs, not including Oregon Health Plan (our CCO) or Moda
Contract Offer accepted by IHCP	No	Have a "clinic" contract with LifeWise, PacificSource, and Moda. The Providence contract is with the individual providers.	No
Did Contract Offer include Model QHP Addendum	No this is something we have to insist upon and created some unwarranted confusion to the process	Generally no. LifeWise has offered something, but it has not been finalized at this time.	One from Pacific Source had the Indian Addendum, LifeWise totally refused when QHPs first came into play and they were required to reach out to Tribes. All requests Yellowhawk received was shared with NPAIHB.
Were payment rates offered in contracts such that a willing, simiarly-situated, non-ECP would accept or has accepted	N/A	As far as we know, yes.	No
What factors did IHCPs consider in determining whether to enter into a contract with QHP	Number of patients that would opt in for coverage, regional unemployment, resources, tribal 638 programs understanding of the system and implications of NOT contracting (tribal vs. fedeal portions of the practice)	One of the reasons we don't have ALL CLINIC contracts is because of the issues that an Addendum would fix, i.e., Trial sovereignty, etc.	Since we did not go forward yet with a Tribal Sponsorship Program, we have not worked with any QHP with regard to contracts
Evaluations of QHPs offered in non-FFM states, identify the requirements imposed on the QHPs pertianing to contracting with IHCPs and whether issuers complied with these requierments	See Above	See Above	See Above

STATE OF WISCONSIN

The Tribal Self-Governance Advisory Committee commissioned a study on "Network Adequacy and Essential Community Provider Inclusion in Indian County". The State of Wisconsin was one of the areas chosen to study. The State of Wisconsin has a Federally-Facilitated Marketplace (FFM). Wisconsin has not expanded Medicaid. As an FFM, there is a requirement of Issuers of Qualified Health Plans (QHPs) to offer contracts to all Indian Health Care Providers (IHCPs). There is also a recommendation for the QHPs to use the QHP Indian Addendum when contracting with IHCPs.

For the study, we chose the East Central region of Wisconsin, including Outagamie, Forest, Menominee and Milwaukee counties. This area is known for its farming and forestry. Tribes operate eleven (11) outpatient health centers, and there is one urban Indian health center in Wisconsin. It is worthy to note that the Gerald L. Ignace Urban Indian Health Center in Milwaukee was included in this study, but did not respond to the survey. Zip codes were chosen for this study where the following IHCP facilities are located:

1. Oneida Tribe of Indians of Wisconsin in Oneida, Wisconsin
2. Forest County Potawatomi Health & Wellness Center in Crandon, Wisconsin
3. Menominee Tribal Clinic in Keshena, Wisconsin
4. Gerald L. Ignace Urban Indian Health Center in Milwaukee, Wisconsin

The following are the Qualified Health Plans that are offered in each of the zip codes for the above-referenced facilities:

1. Zip code 54155 (Oneida Community Health Center)
    a. Ambetter from MHS Health Wisconsin has 33 plan offerings
    b. Anthem Blue Cross and Blue Shield has 12 plan offerings
    c. Arise Health Plan has 35 plan offerings
    d. Common Ground Healthcare Coop has 18 plan offerings
    e. Dean Health Plan has 9 plan offerings
    f. Molina Marketplace has 3 plan offerings
    g. United HealthCare has 10 plan offerings
2. Zip code 54520 (Forest County Potawatomi Health & Wellness Center)
    a. Molina Marketplace has 3 plan offerings
    b. Security Health Plan of Wisconsin, Inc. has 8 plan offerings
    c. United HealthCare has 10 plan offerings
3. Zip code 54135 (Menominee Tribal Clinic)
    a. Molina Marketplace has 3 plan offerings
    b. United HealthCare has 10 plan offerings
4. Zip code 53204 (Gerald L. Ignace Urban Indian Health Center)
    a. Ambetter from MHS Health Wisconsin has 33 plan offerings
    b. Anthem Blue Cross and Blue Shield has 12 plan offerings
    c. Arise Health Plan has 35 plan offerings
    d. Common Ground Healthcare Coop has 18 plan offerings

e. Molina Marketplace has 3 plan offerings
f. United HealthCare has 10 plan offerings

In summary, there are eight insurance companies operating in the four zip code areas. Among the eight, only the Aspirus Network, which includes Anthem BCBS, Arise Health Plan, Security Health Plan, and United HealthCare, lists one of the IHCP as in their network, according to the information offered on line. However, the survey of IHCPs indicates that three of the plans have IHCPs in network: Molina, Security Health Plan, and UnitedHealth Care. In addition, Oneida is in the process of signing contracts with Anthem BCBS, Arise Health Plan, and United HealthCare, which would bring the total to six out of eight. This means that currently over 60 percent of the plans on the FFM in these four zip codes do not have any IHCPs in network.

It is not clear whether all eight insurance companies offered contracts with the Indian Addendum to the ICHPs in their areas. Two of the three tribal facilities had existing contracts with Molina Marketplace, however, the IHCP's weren't listed in the networks, which could be that those existing contracts were for Medicare and Medicaid. The existing contract with Molina did include the CMS Model Indian Addendum and the rates were consistent with Medicaid and Medicare rates. Forest County said they have been in the Aspirus Network since 2007, which includes both the Security Health Plan and the United HealthCare plan. The Menominee Tribal Clinic doesn't seem to have any contracts for the Marketplace, only Molina for Medicaid & Medicare, although their facility is not listed in any of the Provider Directories.

Dean Health Plan refused to contract with the Wisconsin I/T/U's. After further research the Dean Health Plan is a closed panel plan. CMS Division of Tribal Affairs is working with Oneida Tribe to ensure they are receiving reimbursement under Section 206 for Dean Health Plan.

Based on the survey, at least two of the eight qualified health plans did not offer contracts to the I/T/U's in their area, including Ambetter from MHS Health Wisconsin and Common Ground Healthcare Coop. Oneida Tribe reported that only Molina Marketplace and Arise Health Plan offered the CMS Model Indian Addendum.

The factors for considering whether to enter into contracts with the QHP's included such items as the amount of business the I/T/U has done with the Insurer in the past and the amount of unpayable claims due to a lack of contract, reimbursement rates, and to receive some level of reimbursement for services as over 95% of their patients are Native American and eligible for direct care services and without the contract they would have written off 100% of the payment for services.

Attached to this narrative are the questions and answers that were obtained while performing the research on the State of Wisconsin and IHCP. Since Wisconsin is a FFM, it seems the requirement imposed on Issuers to offer a contract to all IHCPs with a recommendation to use the QHP Indian Addendum was not precisely followed in Wisconsin.

Bemidji Area (State of Wisconsin)				
Wisconsin is a federally facilitated Marketplace. Wisconsin did not expand Medicaid in 2014. As a FFM Wisconsin QHP's are required to offer contracts to all I/T/U's in the state. Bemidji Area Office doesn't operate any programs in Wisconsin. Eleven (11) tribes in Wisconsin provide outpatient services. These facilities represent the East Central region of the state and includes tribal health systems and an urban health center.				
	I/T/U #1	**I/T/U #2**	**I/T/U #3**	**I/T/U #4**
List of IHCP in Region	**Oneida Tribe of Indians of Wisconsin, Outagamie County, Oneida Community Health Center, PO Box 365, Oneida, WI 54155, Tele 920-869-2711**	**Forest County Potawatomi Health & Wellness Center, Forest County, Physical Address: 8201 Mish Ko Swen Drive, Mailing Address: PO Box 396, Crandon, WI 54520, Tele 715-478-4300**	**Menominee Tribal Clinic, Menominee County, PO Box 970, Keshena, WI 54135, Tele 715-799-3361**	**Gerald L. Ignace Urban Indian Health Center, Milwaukee County, 1711 South 11th Street, Milwaukee, WI 53204, Tele 414-383-9526**
Contact Person:	Debbie Danforth, email: ddanforth@oneidanation.org; David Larson, email: dlarson@oneidanation.org	Lynette Tahtinen email: lynette.tahtinen@fcpotawatomi-nsn.gov	Jerry Waukau, email: jerryw@mtclinic.net; Laurie Bolvin, email: laurieb@mtclinic.net	Brenda Duke, COO, email: Bduke@gliihc.net; Margie Makowski, email: mmakowski@gliihc.net
List of QHP's Offering Coverage in the Zip Code of IHCP Facility	Ambetter from MHS Health Wisconsin (33); Anthem BCBS (12); Arise Health Plan (35); Common Ground Healthcare Coop (18); Dean Health Plan (9); Molina Marketplace (3); UnitedHealthcare (10)	Molina Marketplace (3); Security Health Plan of Wisconsin, Inc. (8); UnitedHealthcare (10)	Molina Marketplace (3); UnitedHealthcare (10)	Ambetter from MHS Health Wisconsin (33); Anthem BCBS (12); Arise Health Plan (35); Common Ground Healthcare Coop (18); Molina Marketplace (3); UnitedHealthcare (10)
List of IHCP in QHP Network	Could not find any, however the Oneida Community Health Center says they are in Molina Marketplace.	Aspirus Network which includes Security Health Plan and United HealthCare	Molina for Medicaid/Medicare/Other products that we might agree on from time to time; HC Exchange (Didn't find in Provider Directory)	
Did IHCP have contract with QHP/issuer prior to 2014? Does QHP/issuer consider consideration of old contract in compliance with requirements? (I understand some issuers may just keep operating with old contracts and consider having met requirements, which may mean old, low rates and no Indian Addendum.)	Yes with Molina Marketplace	Yes, through Aspirus Network; We have been contracted with Aspirus Network in the area since 2007. The contract includes Security Health Plan and United HealthCare with the exception of Molina Marketplace. Aspirus does contract with the Molina Medicaid Plans.	Yes with Molina, entered into on 7/1/2013; We updated the contract, don't remember the exact reasons why	
If yes, was the Indian Addendum used and were rates satisfactory?	Molina and Arise included the Addendum in the new contracts	No	Yes, the Addendum was used and the rates are consistent with Medicaid and Medicare rates	
Contract Offer made by QHP to IHCP	No, Dean specifically refused after our request for a contract. We are in the process of signing contracts with Anthem BCBS, Unitedhealthcae and Arise.	Aspirus does not contract with Molina Marketplace, except for the Molina Medicaid Plans	Yes, we were unable to finalize one with UnitedHealthCare due to some language that needed to be changed at our request	No
Contract Offer accepted by IHCP	Yes	Aspirus does not contract with Molina Marketplace. Asprius does contract with the Molina Medicaid Plans	Yes	
Did Contract Offer include Model QHP Addendum	Molina and Arise included the Addendum	N/A	Yes	
Were payment rates offered in contracts such that a willing, similarly-situated, non-ECP would accept or has accepted	Yes	N/A	Not sure who might or has accepted	
What factors did IHCPs consider in determining whether to enter into a contract with QHP	The amount of business that we have done with them in the past, and the amount of unpayable claims due to lack of contract	Reimbursement Rates	We entered into the contract to receive some level of reimbursement for our services - over 95% of our patients are native American and eligible for direct care services. Without the contract we would have written off the services 100%	
Evaluations of QHPs offered in non-FFM states, identify the requirements imposed on the QHPs pertaining to contracting with IHCPs and whether issuers complied with these requirements	See Above	See Above	See Above	

State	Facility	FFM	State-Based	Require IHCP Contract	Recommend IA	Met IHCP Contract	Met IA
Wisconsin	Oneida Tribe	Yes		Yes	Yes	All except Dean Health Plan	Only Molina and Arise
	Forest Co Potawatomi					No	N/A
	Menominee Tribal					Yes	Yes
	Urban Center					No Answer	No Answer
Maine	IHS Micmac	Yes		Yes	Yes	Only MCHO	BCBS Yes
	Houlton Band of Maliseet					Unknown	Unknown
	Passamaquoddy Tribe of Pleasant Point					Only MCHO	Yes
	Passamaquoddy Tribe of Indian Township					Only MCHO	Not sure
	Penobscot Nation					All except Harvard Pilgrim	Unknown
Oklahoma	Chickasaw Nation	Yes		Yes	Yes	Yes	BCBS Yes
	IHS Wewoka					BCBS Yes	BCBS Yes
	Muscogee (Creek) Nation					Yes	BCBS Yes
Nevada	IHS Schurz		Nevada Health Link	No	No	No	No
	Fallon Paiute-Shoshone					No	No
	Reno Sparks					No	No
	Washoe Tribal					No	No
Oregon	IHS Warm Springs		Cover Oregon	Yes	No	Yes	No
	Grand Ronde					Yes	No
	Yellowhawk Tribal					All except Oregon Health Plan and Moda	No