

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

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Submitted via to FFEcomments@cms.hhs.gov

February 25, 2014

Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
U. S. Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-08010

RE: Comments on Draft 2015 CCHIO Letter to Issuers in the Federally-facilitated Marketplaces

On behalf of the Tribal Self-Governance Advisory Committee (TSGAC), I write to provide comment on CMS-9958-P, Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions (Proposed Rule). Established in 1996, the TSGAC provides information, education advocacy and policy guidance for implementation of Self-Governance within the Indian Health Service (IHS). We appreciate the opportunity to provide comments on the proposed methodology for determining Federal payments to states for BHP.

As a preliminary matter, we want to express our appreciation for the focus on issues that affect Indian Health Care Providers and AI/AN's. And, as requested we present our comments in the order in which the provisions are organized in the subsections in the Letter.

Chapter 1 – Certification Process.

We understand the flexibility that the Draft Issuer Letter indicates States will have when they are providing some plan management functions. We are pleased to see, however, that the Letter clearly states that “CMS is responsible for the final QHP certification decisions in each FFM state.” (p. 7). We discuss in subsequent comments below certain requirements that have the greatest impact on Indian Health Care Providers (IHPs)¹ and services to AI/AN's. We think it important to emphasize in the initial parts of the letter that since IHPs and services to AI/ANs are ultimately a Federal responsibility that requirements that specifically address their needs must be addressed expressly in State reviews and will be reviewed closely and directly by CMS.

¹ In the Draft 2015 Letter to Issuers the term “Indian Health Providers” is used. In these comments, the terms are used interchangeably. And as used in these comments, the term is inclusive of all providers operating under the health programs of the Indian Health Service, Indian Tribes, Tribal organizations and urban Indian organizations.

Chapter 2 – QHP and Stand-Alone Dental Plan Certification Standards, Section 2 – Service Area.

State Flexibility. The opening sentence of this section says “States performing plan management functions in an FFM may use a similar approach [to that CMS will use].” (p. 17). This begs the question about to what extent states may choose different approaches and contributes to the concerns expressed in our comment regarding Chapter 1. We reiterate our request that all requirements associated expressly with IHPs should be subject to close Federal oversight to ensure full compliance by states performing plan management functions.

Counties in service areas. We support the requirement that QHPs serve areas generally no smaller than counties, or a group of counties defined by the Marketplace, and that requests to serve smaller areas will be denied

Unless the Marketplace determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers. The Marketplace must also ensure that the service area of a QHP has been established without regard to racial, ethnic, language, or health status-related factors as specified under section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

(p. 18). Due to the poorer average health status of AI/ANs, there is always a risk that insurers will try to avoid areas where there are concentrations of Indians.

On a more positive note, however, we hope that Marketplaces will encourage QHP applicants to consider serving areas large enough to encompass an entire reservation so that the same plans may be available to all AI/ANs who live on a reservation regardless of the county in which they may live where the reservation is large enough to be in more than one county. Keeping a reservation intact within a plan should also be considered when assessing whether an applicant may choose to serve only part of a county, if the objective is to keep a reservation area intact, but it does not correspond to the boundaries of one or more full counties.

Chapter 2, Section 4. Essential Community Providers (ECPs), Subsection i. Evaluation of Network Adequacy with respect to ECP.

Contract Offers to IHPs with Addendum. As you know from previous comments submitted by the TSGAC, we are concerned with the adequacy of culturally appropriate services that will be available to AI/ANs through QHPs that may be certified through state and federal marketplaces. We appreciate, and are very supportive of, the decision announced in the Draft Issuer Letter that CMS intends to propose regulations requiring QHPs seeking to meet the ECP Standard, for certification

to offer contracts in good faith prior to the benefit year to [a]ll available Indian health providers in the service area using the model QHP Addendum for Indian health providers developed by CMS.

Letter to CMS

**Re: Comments on Draft 2015 CCIIO Letter to Issuers in the Federally-facilitated Marketplaces
February 25, 2014**

Page 3

(p. 20.) Given the fact that many Indian Health Care Providers received few, if any, offers in 2014 and generally those they did receive did not include the model QHP Addendum, making the offers and Addendum mandatory seems as if it may be the only way Indian Health Care Providers will have a genuine opportunity to participate in the QHPs.

We also note favorably that the rule that CMS intends to propose will:

- require that the issuer's QHP application "list the offers that it has extended to all available Indian health providers. . . in each country in the service area;"
- include an expectation that "issuers . . . be able to provide verification of such offers if CMS chooses to verify the offers;" and
- consider offers to be "in good faith" if the contract "offer[s] terms that a willing, similarly-situated, non-ECP provider would accept or has accepted."

(p. 20-21.) We look forward to reviewing and commenting on the notice of proposed rulemaking that will implement these requirements. Because of the experiences of Indian health care providers and the importance of ensuring a level playing field for them, we have included some additional recommendations below regarding these aspects of the letter and the corresponding proposed rule that is intended.

Recommendations:

(1) We recommend that the definition of Indian Health Providers be revised to reference the full range of providers operating under the health programs of the Indian Health Service, Indian Tribes, Tribal organizations and urban Indian organizations. At present, as listed in Table 2.1, the term "Indian Health Providers" is described as including "Indian tribes, Tribal and Urban Indian Organization Providers" but does not include in the list Indian Health Service (IHS) providers. We request that CCIIO replace the description of Indian Health Providers in the 2015 Draft Issuer Letter with the language used on page 49 of CCIIO's 2014 "Letter to Issuers on Federally-facilitated and State Partnership Exchanges," which was issued on March 1, 2013.

For example, in Chapter 7 of the 2014 Issuer Letter (p. 49), CCIIO wrote,

To promote contracting between issuers and Indian health care providers, CMS developed a Model QHP Addendum (Addendum) to facilitate the inclusion of Indian Health Service, Tribal Organization, and Urban Indian Organization providers (Indian health care providers) in QHP provider networks.

In requiring QHPs to offer contracts in good faith prior to the benefit year to "[a]ll available Indian health providers in the service area," many Indian communities would be left out if IHS providers were not included in this directive. Although tribes, Tribal organizations and urban Indian organizations deliver health services in a majority of American Indian and Alaska

Letter to CMS

**Re: Comments on Draft 2015 CCIIO Letter to Issuers in the Federally-facilitated Marketplaces
February 25, 2014**

Page 4

Native communities, IHS providers continue to deliver all or a substantial portion of health care services in many communities.

(2) We recommend that the 2015 Issuer Letter and proposed rule expressly state that the requirements to offer to contract with all IHPs in the service area under the conditions set out above must be satisfied by any QHP that relies on a narrative justification to obtain approval for a plan that does not otherwise satisfy the 30 percent ECP standard for 2015. Although, the attestation of having made such offers appears in each example, it does not appear in the listed criteria on p. 21 and 22, which may lead some QHP applicants to think that they can delay or forego meeting those requirements if relying on a narrative discussion.

(3) We are very pleased to see a definition of “in good faith” stated, however we believe it should be less euphemistic in its language. The critical “terms” are those associated with payment, especially given that Indian health care providers must be offered the Indian Addendum, which will address many of the inconsistencies with the federal rights of IHPs found in standard contract provisions. We recommend that for a contract to be offered in good faith to an Indian health provider, the offer should include rates at least equal to the generally applicable payment rates of the issuer for network providers.

(4) We also ask that you state specifically that you intend to review each QHP’s application for compliance with the provision of Section 4 regarding offers to Indian health providers and that you expect to confirm that all offers to Indian Health Providers listed by the QHP on its QHP application have, in fact, been extended to the Indian Health Providers listed, and that they constitute good faith offers including the Indian Health Addendum and rates as discussed above. CMS review is critical to ensuring this provision has its intended effect, *i.e.* that QHPs begin offering contracts to I/T/Us in their service areas including the Indian Addendum.

We understand that for the 2014 Plan Year, only one QHP submitted a narrative justification. Yet we know that many I/T/Us have yet to be offered a contract in good faith by QHPs, which calls into question whether more QHPs should have submitted narrative justifications and not been allowed to rely on the ECP safe harbor in 2014. In order to make this standard at all meaningful, we expect that CMS will impose a reporting and compliance requirement to this certification standard

Alternate ECP Standard of 45 C.F.R. § 156.235(a)(2) and (b). We wish to express concern about the requirements to satisfy the alternate ECP standard. A QHP issuer who seeks to meet the alternate standard

must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

Letter to CMS

**Re: Comments on Draft 2015 CCIIO Letter to Issuers in the Federally-facilitated Marketplaces
February 25, 2014**

Page 5

45 C.F.R. § 156.235(b). CMS interprets this requirement in the Draft Letter. The interpretation does not explicitly include the requirement to make good faith offers of a contract to all Indian health care providers in the service area or in the areas located in or contiguous to Health Professional Shortage Areas (HPSA) and areas in which more than 30 percent of the population falls below 200 percent of the poverty level. We are uncertain about CMS's intention here, but it would be ironic if the Indian health care providers contract offer requirement were not included since "[g]roups of members of Indian tribes . . . are automatically designated [as a population group with a shortage of primary medical care professional(s)]" Appendix A to Part 5 of 42 C.F.R., Part II, A.2(a). *Also see*, Appendix B, Part II, A.2(a) (dental).

These plans should be required to offer IHPs in the service area a chance to be part of the plan on the same basis as is required to satisfy the other ECP standards. Failing to do so makes it likely that the most culturally competent care will not be available through the QHP and that duplicate diagnosis, if not treatment, will be required for AI/ANs covered by such plans to obtain referral care to which they are entitled.

Accordingly, we recommend that the requirement of an offer to all Indian health care providers equivalent to that described in the Letter at p. 20-21 be expressly stated as a condition of qualifying under the alternate standards.

Chapter 2, Section 4. Essential Community Providers (ECPs), Subsection ii. Requirement for Payment of Federally Qualified Health Centers (FQHCs).

CMS should include a subsection iii in Chapter 2, Section 4, to address payment to Indian health care providers. In that subsection the requirements of Section 206 of the Indian Health Care Improvement Act, 25 U.S.C. § 1621e, would be stated, which establishes the right of Indian health care providers

to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) [their] reasonable charges . . . or, if higher, the highest amount the third party would pay for care and services furnished by providers . . .

25 U.S.C. § 1621e (a) (IHS and Tribal providers) and (e) (urban Indian organizations). Reminding QHP issuers of their legal obligations to Indian health care providers, as it does for FQHCs, and encouraging "mutually beneficial business relationships that promote effect care for medically underserved an vulnerable populations" with Indian health care providers would be very effective in achieving better opportunities for participation by such providers for the benefit of AI/ANs. This is especially true given the IHP's right of recovery under the IHICIA, which applies without regard to whether an IHP has a contract with a QHP or not.

Chapter 3 – Qualified Health Plan and SADP Design, Section 7 - Coverage of Primary Care: 2015 Approach.

We encourage CMS to require through rulemaking issuers make available plans in which three primary care office visits are permitted before the patient is required to meet any deductible. We believe that nurturing the relationship between patients and their primary care providers is essential for health promotion and disease prevention and will ultimately reduce the incidence of more expensive types of health care.

Chapter 6 – Consumer Support and Related Issues, Section 1 – Provider Directory.

We appreciate the requirements proposed regarding provider directories and especially the encouragement that the issuers identify language spoken and whether the provider is an Indian health care provider. We believe the latter of these should be mandatory, as should the information described about Indian health providers at the end of this section. Doing so will help ensure great satisfaction with the Marketplace and the Plans acquired through it at nominal, if any, cost. Whether mandatory or optional, we recommend that the QHPs be encouraged to obtain the information about the extent to which each IHP serves non-IHS beneficiaries, perhaps at the time contracts are completed. That will be the only way to assure the published information is accurate and up-to-date.

Chapter 6, Section 2 – Complaints Tracking and Resolution and Section 3 – Coverage Appeals.

In each of these sections we believe that the QHP issuers should be required to track complaints and appeals by individuals who are identified as AI/AN (whether self-identified or by reference to their qualification for the special benefits that accrue to AI/ANs), including the subject of the complaint and the resolution. Roll-out of the AI/AN exemptions and of the specific provisions provided for AI/ANs under the ACA has been particularly problematic and difficult to overcome. Tracking will create an opportunity to determine the extent to which issues continue to arise and to identify more effective ways to overcome those challenges in the future.

Chapter 7 – Tribal Relations and Support, Section 1 – Model Contract Addendum for Issuers Working with Indian Health Providers.

We are very pleased to see the focus on Tribal relations in the Draft 2015 Issuer Letter. We do have some concern, however. In Chapter 2, Section 4, it states that CMS is intending to propose a rule under which a condition of certification is that the issuer offers

contracts in good faith prior to the benefit year to [a]ll available Indian health providers in the service area **using the model QHP Addendum for Indian health providers developed by CMS.**

(p. 20, emphasis added). We read this to require the Addendum be included in all contracts offered to Indian health care providers. We strongly endorse CMS acting on this intention and look forward to commenting on the proposed rule. We are, thus, puzzled that in Section 1 of this Chapter on Tribal Relations it says that “CMS is continuing to recommend the use of the Model QHP Addendum

Letter to CMS

**Re: Comments on Draft 2015 CCIIO Letter to Issuers in the Federally-facilitated Marketplaces
February 25, 2014**

Page 7

(Addendum) as described in the 2014 Letter to Issuers.” (p. 51.) We hope this is simply an oversight in the drafting. **We recommend that this section be revised to correspond to the language in Chapter 2, Section 4.**

Chapter 7, Section 2 – Tribal Sponsorship of Premiums.

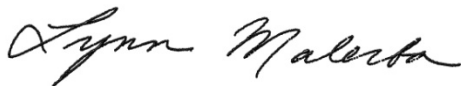
As noted in the Draft Issuer Letter, the ability to aggregate premiums made by Tribal sponsors is “an effective mechanism for increasing enrollment of AI/ANs in QHPs.” We recommend that CMS require issuers to facilitate and accept aggregation premiums from Tribal sponsors.

Conclusion.

The comments and recommendations made in this letter are intended to ensure that all American Indians and Alaska Natives have access to the benefits that may be available through enrollment in Qualified Health Plans and that those who do enroll have access to geographically accessible, culturally competent care that Indian health care providers are uniquely qualified to provide under conditions consistent with the protections afforded to such providers in fulfillment of the special trust relationship the United States owes to American Indians and Alaska Natives and to their Tribes.

Thank you once again for providing an opportunity to comment on the Proposed Rule. TSGAC remains willing to assist CMS in these endeavors. Please feel free to contact me if you are in need of additional information at (860) 862-6192; or via email: lmalerba@moheganmail.com.

Sincerely,



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