December 19, 2012

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Ref: Comments on Draft Model Qualified Health Plan (QHP) Addendum

Dear Ms. Tavenner:

The Northwest Portland Area Indian Health Board (NPAIHB) is a Public Law 93-638 Tribal organization that represents health care issues of forty-three federally-recognized Tribes in the states of Idaho, Oregon, and Washington.¹

We are writing to submit comments on the Centers for Medicare and Medicaid Services (CMS) Draft Model Qualified Health Plan Addendum (Tribal Addendum) and companion document that outline the purpose and key provisions of the Tribal Addendum. Our comments should not be treated as one response, but rather the comments and position of 43 federally recognized Tribes of Idaho, Oregon and Washington. Our Tribal health programs provide health care services to over 106,372 registered American Indian and Alaska Native (AI/AN) users of our Portland Area Indian health system.

The model Tribal Addendum is necessary to help ensure that AI/ANs can access the Federal benefits offered through the Exchange while continuing to be served by the IHS, Tribal or urban Indian organization (I/T/U) provider of their choice. The Tribal Addendum will also assist Qualified Health Plans (QHP) issuers in complying with applicable Federal laws when contracting with I/T/U providers.

In order to achieve these important objectives, NPAIHB strongly urge CMS to reconsider to require QHPs to contract with Indian health providers in the service geography of QHPs and require the use of the Tribal Addendum as a condition of QHP certification. Without such requirements it will be difficult for QHPs to have a sufficient choice of providers to meet the cultural and linguistic needs of AI/AN people.

¹ A “tribal organization” is recognized under the Indian Self-Determination Education Assistance Act (P.L. 93-638; 25 U.S.C. § 450b(1)) as follows: “The recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities.”
A. Requirement to Contract with Indian Health Providers

Historically, the medical needs of AI/ANs were addressed through the Indian Health Service (IHS). IHS continues to play a central role in meeting the health care needs of AI/ANs, but additional vehicles have been employed by the Federal government over time. For instance, health care services for AI/ANs are now made available through the Medicare and Medicaid programs, and Tribally-operated programs provide a significant volume of the health care received by AI/ANs. As each additional coverage mechanism was put in place, there was a concerted effort by federal policymakers to ensure continued access to the network of Indian Health Care Providers (IHCPs) that is comprised of IHS, tribal and urban Indian health care programs. Although there have been missteps along the way, today AI/ANs are able to access IHCPs even when securing health care services through Medicare and Medicaid. This outcome has been achieved by weaving into Medicare and Medicaid program rules policies that remove impediments to, and ensure sufficient reimbursement for, IHCPs.

Beginning in 2014, AI/ANs may also access health care services through health plans offered through an Exchange. AI/ANs and their traditional providers have a well-founded concern that if the operating rules for an Exchange are not designed correctly, AI/ANs may find themselves with health insurance but reduced access to needed health care services. This need not occur, though, as the Affordable Care Act provides a range of options that, if exercised, will ensure AI/ANs who are insured by Exchange plans will be able to continue to access IHCPs, as well as have timely access to an expanded network of non-IHCPs.

Approaches Currently Employed in Medicare & Medicaid

Under both Medicare and Medicaid, policies have been instituted to maximize AI/ANs access to IHCPs. Under Medicare, an open network of providers (inclusive of IHCPs) is available to all Medicare fee-for-service enrollees. Medicare was directed to pay another Federal agency (IHS) for services provided by IHCPs (the only such requirement in place under Medicare), and Indian-specific payment rates have been established to ensure adequate reimbursement to IHCPs. In the one sector of Medicare where services are available only through a managed care setting (under private Prescription Drug Plans, or PDPs), contracting requirements were instituted by CMS to require PDPs to offer to contract with pharmacies operated by IHCPs and to use an “I/T/U Addendum” to facilitate enforcement of Indian-specific federal laws.

Under Medicaid, IHCPs are eligible to enroll under the program; there are enhanced cost-sharing and premium protections for AI/ANs; and Indian-specific reimbursement rates are authorized with 100% federal reimbursement for services provided to AI/ANs by IHCPs. Mandatory AI/AN enrollment in Medicaid managed care is not permitted, unless the managed care plan is an Indian entity, thereby guaranteeing access to IHCPs, or through a waiver. Tribal consultation was applied to Medicaid.

Ensuring Access to Indian Health Providers in Exchanges

Factors that influence health plans to either not actively court AI/AN enrollees or to actively exclude AI/ANs and their traditional providers include: a perception of greater medical needs of AI/ANs; AI/ANs comprising a relatively small percentage of the overall service population (AI/ANs comprise 2.5% of Oregon residents); and the perceived complexities of applicable Indian-specific federal laws.
In response, the ACA clarified and strengthened the right of IHCPs to be paid for services rendered to covered individuals under any health plan (see section 206 of the Indian Health Care Improvement Act (IHCIA)), a provision which applies whether the Indian Health Care Provider is or is not an in-network provider. Network adequacy and Essential Community Provider (ECP) requirements were established, with tribal and urban Indian providers designated by CMS as ECPs. And, CMS confirmed that tribal consultation requirements apply in the design, implementation and on-going operation of Exchanges.

AI/ANs could rely on the IHCIA § 206 protections to facilitate access to IHCPs, but doing so may limit the benefits that otherwise typically result from individuals securing comprehensive health insurance coverage. If in-network status is achieved by IHCPs, this will facilitate greater coordination and timeliness of care for AI/AN patients and more certainty and timeliness of payment for IHCPs. Bringing IHCPs in-network may also result in lower costs to health plans. For example, an AI/AN patient seen by an in-network Indian primary care provider could be referred directly to non-Indian specialty providers as needed. In contrast, if an AI/AN patient is seen by a non-network Indian primary care provider, the patient would then need to see an in-network primary care provider to receive a referral to a specialist. This scenario would result in duplicative billings to the health plan (for two primary care visits) and may delay – and potentially discourage – the patient from accessing the specialty services.

Instituting a requirement on health plans to offer to contract with IHCPs will not place an unreasonable burdened on the health plans. First, there is a finite number of IHCPs in the Indian health care delivery system, and likely only a subset of the IHCPs will contract with most plans, and a substantial number of these IHCPs would already be required to be included to meet general network adequacy and ECP requirements. Second, a universal requirement on health plans will lessen the risk that any individual health plan, particularly a health plan that puts out an effort to adequately serve AI/ANs, will enroll a “disproportionate” number of AI/ANs. With a contracting requirement in place, AI/ANs will more likely be more evenly dispersed across available health plans.

In contrast to creating a burden, requiring Exchange plans to offer to contract with IHCPs will likely generate a range of positive results: IHCPs will be empowered to contract with Exchange plans, increasing integration of services; potential AI/AN enrollees will know they can access traditional and non-traditional providers, as needed, if they choose to enroll in an Exchange plan; and the oversight burden on the insurance regulators will be lessened as IHCPs, where available, will take the initiative to join health plan networks when there is a patient base requiring their services.

The above reasons are why HHS/CMS should require QHPs to contract with Indian health providers and use the model Tribal addendum when doing so.

B. The Model Indian Addendum

NPAIHB strongly support the model Tribal Addendum and appreciates that CMS has issued a draft and is circulating it for comment and review. The Model QHP Addendum will help lower barriers to access to QHP provider networks by I/T/Us, thereby allowing more meaningful AI/AN participation in the Exchange program. Generally, NPAIHB concurs with the structure of the draft model QHP Addendum except in a few specific instances as noted below.

Section 2. Definitions
As general matter, while NPAIHB supports the proposed definitions in the Model Qualified Health Plan Addendum, we have made clear in numerous comments submitted to CMS that the definition of the term "Indian" to be used in connection with the Exchange plans should be consistent with the CMS Medicaid definition of that term at 42 C.F.R. § 447.50(b)(1). This is extremely important in Oregon and Washington where Tribes have been working to design Exchanges and adopting one definition aligned with the Medicaid program will provide states the flexibility and consistency to facilitate a single point of application for both Medicaid and participation in the health insurance exchange. Both the states of Oregon and Washington exchanges have sent letters to the HHS Secretary on this issue and the Oregon Governor has appealed to the Whitehouse for HHS/CMS to issue operational guidance to the States to address this issue. NPAIHB recommends this definition section of the model Tribal Addendum be revised as recommended above.

Sec. 9 – Licensure of Provider; Eligibility for Payments.

NPAIHB strongly urges CMS to review this provision and add a specific reference to Section 408 of the Indian Health Care Improvement Act (25 U.S.C. §1647a), which deems a health program operated by the IHS, an Indian tribe, tribal organization or urban Indian organization to be licensed under state or local law if it meets all requirements for such a license regardless of whether it obtains such a license. This provision is critically important, as QHPs will likely insist that an I/T/U be licensed as a condition for inclusion in the network. Section 408 accomplishes this by deeming the I/T/U to be licensed in the state if it meets all of the standards for licensing, but protects the I/T/U from arbitrary state refusal to issue a license, or to condition the issuance of a license for unrelated reasons.

Sec. 10 – Dispute Resolution

The draft provision would provide that "If the provider is an IHS provider, the laws of the United States shall apply to any problem or dispute hereunder that cannot be resolved by and between the parties in good faith." By stating only that the laws of the United States apply to disputes involving the IHS, the strong implication is that the laws of the United States do not apply to Tribal disputes. Tribes are not generally subject to State laws. This choice of laws provision should not be limited to the IHS, and should simply state that "The laws of the United States shall apply to any problem or dispute hereunder that cannot be resolved by and between the parties in good faith."

Sec. 14 – Payment of Claims.

This provision correctly cites an important provision related to certain Indian specific cost-sharing exemptions made by Section 1402(d) of the ACA. Section 1402(d)(2) provides, in relevant part:

(d) SPECIAL RULES FOR INDIANS.—

* * *

(2) ITEMS OR SERVICES FURNISHED THROUGH INDIAN HEALTH PROVIDERS.—If an Indian (as so defined) enrolled in a
qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services—

(A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and

(B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A).

The Model QHP Addendum correctly recognizes that Section 1402(d)(2)(B) provides that an issuer may not reduce payments to an I/T/U for services rendered at an I/T/U or another non-tribal health care provider through contract health services by the amount that would have been due but for the cost-sharing exemption in Section 1402(d)(2)(A). It provides, "[f]urther, payments to the Provider shall be in accordance with Section 1402(d)(2)(B) of the Affordable Care Act, 42 U.S.C. § 18071(d)(2)(B)." However, nowhere in the Model QHP Addendum is there any statement that AI/ANs who receive care at an I/T/U or through contract health services are exempt from cost-sharing under the Act. Without a specific reference to the statutory cost-sharing exclusion in Section 1402(d)(2)(A) in the Addendum, Qualified Health Plans may not be aware of it, and may not understand how to implement the payment requirements in Section 1402(d)(2)(B). We suggest that the following language be added to the Model QHP Addendum:

If an Indian enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services—

(a) No cost-sharing under the plan shall be imposed under the plan for such item or service; and

(b) The issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for subparagraph (a). ACA §1402(d) (2) (42 USC 18071(d)(2)).

C. Requiring use of the Addendum

NPAIHB strongly supports the TTAG position that the QHP Addendum be required as a condition of QHP certification, just as in the Medicare Part D program CMS required use of an Indian addendum by all Part D plan providers. The Model QHP Addendum is important to ensure that I/T/U providers are included in the QHP provider networks. This, in turn, is essential because I/T/U providers may be the only provider available as a practical matter, and certainly will be the most culturally competent provider available. CMS indicates it will review QHP certification applications with consideration for I/T/U participation in plan networks when it states that "[i]n adhering to QHP certification
standards, QHP issuers should reach out to I/T/U providers," and that "[a]n important consideration in evaluating network adequacy and essential community provider accessibility will be the extent to which a QHP includes I/T/U providers and whether it can assure that services to AI/ANs will be accessible without unreasonable delay."

NPAIHB appreciates the opportunity to comment on the model Tribal Addendum. We believe that the process for developing this Addendum has been the most successful example of Tribal Consultation at the federal level for implementation of Health Insurance Exchanges and should serve as a model for working on other important issues that still must be resolved to assure that AI/ANs will be able benefit from the Affordable Care Act.

Sincerely,

Andy Joseph, Jr.
NPAIHB Chairperson and
Colville Tribal Council Member

Cc: Dr. Yvette Roubideaux, Director
Indian Health Service