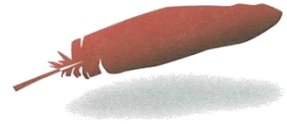


National Indian Health Board



Via Email to TribalAffairs@cms.hhs.gov

December 19, 2012

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

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

Dear Ms. Tavenner:

I am writing on behalf of the National Indian Health Board (NIHB)¹, to submit comments on the Draft Model Qualified Health Plan Addendum (QHP) and companion document that outlines the purposes and key provisions of the Addendum.

The NIHB strongly supports the Model QHP Addendum, and commends CMS and the Indian Health Service (IHS) for issuing a draft Model QHP Addendum and circulating it for tribal comment. We would like to thank Pete Nakahata for working closely with the Tribal Technical Advisory Group (TTAG) Affordable Care Act (ACA) Policy Subcommittee in the development of the Addendum and the companion piece. The Model QHP Addendum will be critical to ensure that American Indians and Alaska Natives (AI/ANs) can access the federal benefits offered through the Exchange while continuing to be served by the Indian Health Service, Tribal or urban Indian organization (I/T/U) provider of their choice. It will also assist QHP issuers to comply with key federal laws that apply when contracting with I/T/U providers. The NIHB strongly encourages CMS to require its use as a condition of QHP certification.

¹ Established 40 years ago, NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives. 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 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 Act ("ISDEAA"), or continue to also rely on IHS for delivery of some, or even most, of their health care, NIHB is their advocate



I. The Model Indian Addendum

The NIHB believes that, as a whole, 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. The NIHB agrees with the wording of the draft Model QHP Addendum except in a few specific instances as noted below.

Section 2. Definitions

As a general matter, while the NIHB 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).

Sec. 9 – Licensure of Provider; Eligibility for Payments

The NIHB 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)).

II. Requiring use of the Addendum

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."

While we appreciate this language strongly supporting use of the Addendum, the NIHB maintains its position that the QHP Addendum must be required as a condition of QHP certification. The QHP Addendum is modeled on the success of the standardized Indian contract addendum used in the Medicare Part D program. The success of that program is due in large part to the fact that CMS made offering to contract using an Indian addendum a requirement for all Part D plan providers. CMS found ample justification for requiring Part D plans to offer to contract with I/T/U providers using an Indian addendum:

It is our understanding that I/T/U pharmacies are not currently well integrated in commercial pharmacy networks. We agree with the commenters who believe that—in the absence of a contracting requirement— Part D plans may make assumptions regarding the administrative costs (whether real or perceived) of contracting with I/T/U pharmacies and may not actively solicit the inclusion of these pharmacies in their networks. The lack of I/T/U pharmacies in Part D plan networks would render enrollment in Part D of little use to AI/AN beneficiaries who rely primarily on I/T/U facilities for their health care. For this reason, we have added a provision to our final regulations, at § 423.120(a)(6), requiring that Part D plans offer contracts to all I/T/U pharmacies in their service areas. However, we recognize that contracting with I/T/U pharmacies is potentially more complex than contracting with retail pharmacies given that there are a number of provisions in the standard contracts of commercial health plans that would likely need to be modified or deleted given statutory or regulatory restrictions to which I/T/U pharmacies are subject, as well as the particular circumstances of I/T/U pharmacies (for example, I/T/U pharmacies purchase drugs off the Federal Supply Schedule (FSS) or through the 340B program; can only serve AI/ANs; may have less experience than retail pharmacies, or none at all, with point-of-sale technology; are not typically well integrated into commercial pharmacy networks; generally stock a more limited range of drugs than would be required under a Part D formulary; and always waive copays). Thus, standard contracting terms and conditions will not be sufficient for Part D plans to obtain the participation of I/T/U pharmacies in their networks. We are therefore requiring Part D plans to include a special addendum to their standard contracting terms and conditions in order to account for these differences. We will work with major stakeholders to develop a model special addendum that will take the special circumstances of I/T/U pharmacies into account. 70 Fed. Reg. 4194, 4253 (Jan. 28, 2005).

The same issues and obstacles are present here today with regard to QHPs offering to contract with I/T/Us, and as a result CMS is equally justified in requiring the QHPs offer to contract with I/T/Us using the Model QHP Addendum.

Although not specifically designed to address the alarming health disparities in Indian country, the premium exchange subsidies offered only through the Health Insurance Exchanges

represent a significant new opportunity to improve health outcomes for AI/AN people. Congress clearly intended AI/ANs to benefit from this significant new source of federal funding at no cost to them when it enacted Section 1402(d) of the ACA, which provides cost-sharing exemptions for AI/ANs. The Model QHP Addendum will be key to ensuring that AI/ANs are able to participate in the Exchanges and take advantage of these new resources. Without such an Addendum, it will be difficult to ensure that I/T/U providers are included in the QHP provider networks. Because AI/ANs are often only able to get care at an I/T/U, and only able to obtain culturally competent care at an I/T/U provider, they will be unlikely to participate in the Exchange program if the I/T/U provider of their choice is not included in the QHP provider network. Should that occur, it is unlikely that the significant federal resources offered only through the Exchanges would be accessed by AI/ANs.

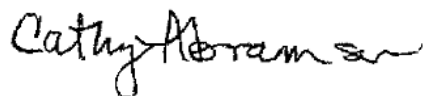
III. Long Term Goals

This Addendum is a significant step forward in meeting one of the objectives in the CMS AI/AN Strategic Plan for 2013-2018, which the TTAG will be presenting to you at our meeting February 21, 2013.

Objective 2.b., Task 1: CMS will work with the TTAG to develop a prototype Indian Addendum that can be used with managed care provider contracts in all programs of CMS to acknowledge the federal laws that are specific to the I/T/U and that can affect provider contracts.

The NIHB appreciates the opportunity to comment on this critically-important document. 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,



Cathy Abramson
Chair, NIHB

Cc: Dr. Yvette Roubideaux, Director, IHS
Stacy A. Bohlen, Executive Director, NIHB
H. Sally Smith, Chair, MMPC
Jennifer Cooper, Legislative Director, NIHB