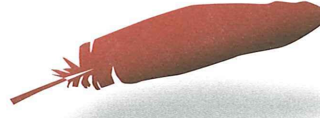
National Indian
Health Board



Submitted via *http://www.regulations.gov*.

April 21, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9949–P
P.O. Box 8016
Baltimore, MD 21244–8016

RE: Comments on Exchange and Insurance Market Standards for 2015 and Beyond, CMS-9949-P

I write on behalf of the National Indian Health Board (NIHB)[1] to comment on CMS-9949-P, Exchange and Insurance Market Standards for 2015 and Beyond (the "Proposed Rule"). We appreciate the opportunity to comment on this important rule.

BACKGROUND

The Proposed Rule was issued in conjunction with the Final 2015 Letter to Issuers in the Federally-facilitated Marketplaces (March 14, 2014). As an initial matter, NIHB would like to express its appreciation that the Final 2015 Letter to Issuers contains a number of provisions and requirements that will be extraordinarily helpful in lowering barriers to access for AI/ANs seeking to participate in the new Health Insurance Exchanges.

In particular, we wish to indicate our support for the following provisions in the Final 2015 Letter to Issuers:

[1] Established 42 years ago, the 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 (AI/AN). 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 rely on IHS for delivery of some, or even most, of their health care, NIHB is their advocate.

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- That CMS "expect[s] the issuer to offer contracts in good faith" to "all available Indian health providers in the service area, to include Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations, using the recommended model QHP Addendum for Indian health providers."

- That CMS has required any narrative justification to include "[a]ttestation that the issuer has satisfied the 'good faith' contracting requirement with respect to offering contracts to all available Indian health providers…."

- That CMS expects that "[a]s part of the issuer's QHP application … the issuer list the contract offers that it has extended to all available Indian health providers and at least one ECP in each ECP category in each county in the service area. To be offered in good faith, a contract should offer terms that a willing, similarly situated, non-ECP provider would accept or has accepted. We would expect issuers to be able to provide verification of such offers if CMS chooses to verify the offers."

- That CMS specifically added the Indian Health Service to the definition of Indian Health Providers.

However, as explained below in our comments on the Proposed Rule, there are several aspects of these provisions that must be clarified in the Final Rule.

There were a number of other tribal recommendations that were not accepted by CCIIO. We believe these recommendations remain critically important and look forward to a continued dialogue with CCIIO and the Department to explore ways those recommendations may be implemented either through this Proposed Rule when it is finalized, in a subsequent letter to issuers, or through other guidance.

We offer the following comments on the Proposed Rule.

THE REQUIREMENT TO OFFER CONTRACTS IN GOOD FAITH TO INDIAN HEALTH PROVIDERS USING THE INDIAN ADDENDUM

As discussed above, NIHB believes that the requirement that QHPs offer contracts in good faith to Indian Health Providers is a critical component to ensuring that AI/ANs can continue to see the Indian Health Provider of their choice while enrolled in a QHP. This requirement will go a long way to reduce barriers to access to the QHPs for AI/ANs who might otherwise be reluctant to enroll if their access to the Indian Health Provider of their choice is perceived in any way to be diminished. As a result, we strongly support the requirements announced in the Final 2015 Draft Letter to Issuers that would impose such a requirement on the QHPs, the requirement that they list the contract offers to Indian Health Providers they have extended as part of their application and attest to having done so, and that they be able to provide verification of having done so to CMS.

NIHB was disappointed to see, however, that these requirements were included only in the Final 2015 Letter to Issuers, and not in the Proposed Rule. In the Draft 2015 Letter to Issuers, CMS

indicated that it intended to propose a rule that would (1) require QHP issuers to "list the offers that [issuers have] extended to all available Indian health providers … in each county in the service area," (2) include the expectation that "issuers … be able to provide verification of such offers if CMS chooses to verify the offers," and (3) consider offers "in good faith" if they include terms that a willing, similarly situated, non-ECP provider would accept or has accepted. Those requirements were not included in the Proposed Rule, but only in the Final 2015 Letter to Issuers, however.

NIHB strongly believes that these requirements must be included in the Final Rule, and codified in a regulatory standard that must be met for all issuers who wish to qualify as a QHP authorized to participate in the Exchanges. We are concerned that the demonstrated track record of the QHPs with in response to the 2014 Issuer Letter indicates that many QHPs are not meeting the requirement to offer contracts in good faith with Indian Health Providers, and will continue to disregard this requirement unless and until it is codified as a regulatory standard.

In a call with CCIIO staff, we learned that in 2014 only one QHP had to avail itself of the narrative justification to become certified as a QHP. Yet Indian Health Providers across the country – both IHS and tribal – have yet to be offered contracts from issuers in good faith using the Indian Addendum. Many, perhaps, are relying on old and out of date contracts that pre-existed enactment of the ACA and revisions to the Indian Health Care Improvement Act. Many more have simply failed to take action. The bottom line, however, is that Indian Health Providers across the country are continuing to face difficulties in obtaining good faith offers to be included in QHP networks using contracts that use the Indian Addendum.

For example, we understand in Washington that the issuers are simply offering the I/T/Us short addenda to existing contracts and are not using the Indian Addendum. Tribal healthcare providers in Alabama, Louisiana and North Caroline have reported receiving zero offers to contract with the QHPs operating in their states. In the state of Maine, only a single QHP offered contracts all five Tribes.

In order to address this continuing problem, the Final Rule should codify the requirements in the Final 2015 Issuer Letter, and in doing so clarify that in order to be offered "in good faith" to an Indian Health Provider, a contract must include payment rates at least equal to the generally applicable rates of the issuer for in-network providers. Simply stating that an offer will be considered in good faith if it includes terms that a willing, similarly situated non-ECP provider would or "has accepted" is insufficient. That standard would allow a QHP issuer to simply identify the lowest contract rate (and most issuer friendly terms) an issuer had ever been able to obtain and take the position that at least one "willing, similarly situated non-ECP provider" "has accepted" that rate or terms. That is not an offer in good faith, but a race to the bottom.

That race to the bottom is all-too familiar for Indian Health Providers, and is precisely what the revisions to Section 206 of the Indian Health Care Improvement Act were designed to prevent. The Final Rule and Final 2015 Issuer Letter should not be implemented in a manner that allows QHPs to interpret the requirement to make offers in good faith to mean they can simply match the lowest terms (and rates) they have been able to obtain from any provider.

While Section 206 provides Indian Health Providers with a right of recovery based on highest rates regardless of whether they are in-network or not, the lack of in-network status for Indian Health Providers will continue to pose a barrier to AI/AN participation in health reform.

LIMITED NON-DISCRIMINATION EXCEPTION FOR INDIAN HEALTH PROVIDERS THAT ARE CERTIFIED APPLICATION COUNSELORS

The Proposed Rule provides a limited exception to non-discrimination provisions for Indian health providers that are certified application counselors. The proposed rule states that "[u]nder this proposed exception, an organization receiving Federal funds to provide services to a defined population under the terms of Federal legal authorities (for example … an Indian health provider) that participates in the certified application counselor program … may limit its provision of certified application counselor services to the same defined population." The NIHB strongly supports this limited exception for Indian health providers, whose mission is defined by law to improve health outcomes for the native beneficiaries they serve.

As recognized in CMS's TTAG Strategic Plan, the United States has a unique trust responsibility towards Indian people regarding health care. In furtherance of that trust responsibility, Congress has enacted Indian-specific laws with regard to health care, as well as included Indian-specific provisions in general laws to address Indian participation in federal health care programs. The CMS Tribal Consultation Policy recognizes that this special treatment in furtherance of the trust responsibility "is derived from the political and legal relationship that Indian Tribes have with the Federal Government and is not based upon race." "As long as the special treatment [for Indians] can be tied rationally to the fulfillment of Congress' unique obligation toward the Indians, such legislative judgments will not be disturbed." *Morton v. Mancari,* 417 U.S. 535, 555 (1974). The Proposed Rule's limited exception to the non-discrimination provisions for Indian health providers falls comfortably within this rule in recognition of the political and legal relationship with Indian tribes and to further the federal trust responsibility to implement the law in a manner that recognizes that unique relationship and the unique status of the Indian health care system. The limited exception should be codified in the Final Rule.

REQUIREMENT TO PUBLISH ONLINE PROVIDER DIRECTORIES

The Final 2015 Letter to Issuers states that CMS, in accordance with 45 C.F.R. 156.230(b), will require QHPs to make provider directories available online and that a URL directory link should be provided as part of the QHP application. While we support this requirement, we believe that it, too, should be codified in the Final Rule, rather than simply stated in the Final 2015 Letter to Issuers.

The details regarding what information must be provided, and how it must be provided, could continue to be provided and updated as need be in each annual Letter to Issuers. We support the information that would be required in the 2015 Letter to Issuers, which provides:

> CMS, as administrator of the FFMs, will require QHPs to make their provider directories available to the Marketplace for publication online by providing the URL link to their network directory. CMS expects the URL link to direct

> consumers to an up-to-date provider directory where the consumer can view the provider network that is specific to a given QHP. The URL provided to the Marketplace as part of the QHP Application should link directly to the directory, such that consumers do not have to log on, enter a policy number, or otherwise navigate the issuer's website before locating the directory. If an issuer has multiple provider directories, it should be clear to consumers which directory applies to which QHP(s). Further, CMS expects the directory to include location, contact information, specialty, and medical group, any institutional affiliations for each provider, and whether the provider is accepting new patients. CMS encourages issuers to include languages spoken, provider credentials, and whether the provider is an Indian health provider. Directory information for Indian health providers should describe the service population served by each provider, as some Indian health providers may limit services to Indian beneficiaries, while others may choose to serve the general public.

This information will be of critical importance to AI/ANs who when selecting a QHP in which to enroll can be assured that the Indian Health Provider of their choice is included in the network. This information will also be critically important to Indian Health Providers. Posting an up-to-date provider directory that identifies Indian Health Providers will clarify what the understanding is of the issuer with regard to which Indian Health Providers are included in the network. Given the variety of issuer plan offerings, it is not unusual for there to be confusion as to which plan networks a provider is included. The up-to-date provider directories will also be useful to CMS as a tool to identify the extent to which QHPs have actually included Indian Health Providers in their provider networks. The NIHB strongly urges CMS to fully implement this requirement in 2015.

We request, though, that CMS clarify in the Final Rule for CMS-9949-P the intent of this section of the Final 2015 Letter to Issuers. In the citation shown above, with regard to Indian Health Provider-specific information, CMS provided somewhat conflicting directives to issuers. CMS stated, "CMS <u>encourages</u> issuers to include languages spoken, provider credentials, and whether the provider is an Indian health provider." (Emphasis added.) The next sentence in the paragraph states, "Directory information for Indian health providers <u>should</u> describe the service population served by each provider, as some Indian health providers may limit services to Indian beneficiaries, while others may choose to serve the general public." The paragraph seems to state that it is optional (i.e., "encourages") to indicate whether a provider is an Indian Health Provider, but is required (i.e., "should") to indicate what population is served by each Indian Health Provider.

We recommend that CMS clarify that the provider directory must indicate which providers are Indian Health Providers and, if the Indian Health Provider has provided the information, whether non-Indian Health Service eligible populations are also served by the Indian Health Provider.

CMPs for Providing False or Fraudulent Information

The Proposed Rule defines several circumstances in which HHS may impose Civil Monetary Penalties (CMPs) on individuals it determines have provided false or fraudulent information in violation of Section 1411 of the ACA. One of these circumstances includes for individuals who

apply for enrollment in a QHP for cost sharing reductions, or for an exemption from the Individual mandate because of their status as an Indian, or because they are eligible for a hardship exemption. While the NIHB fully supports the need for enforcement mechanisms to ensure that individuals are not falsely claiming status as Indians or IHS-eligible individuals to benefit from the Indian-specific benefits of the ACA and/or hardship exemption for IHS-eligible individuals, we are somewhat concerned with the mechanism for enforcement. The Proposed Rule states if any person "fails to provide correct information under section 1411(b) of the Affordable Care Act and such failure is attributable to negligence or disregard of any regulations of the Secretary, the person may be subject to a CMP." "Negligence" is defined to mean "any failure to make a reasonable attempt to provide accurate, complete, and comprehensive information."

A number of factors could lead AI/AN to fail to provide "accurate, complete, and comprehensive information" including low educational levels, low literacy levels, low levels of health insurance literacy, poverty, poor housing, high rates of alcohol and drug usage, poor health, lack of telephone and computer access, and confusing wording on applications. Miscommunications can result when people who work at the Call Centers do not understand the Indian health system, and do not have translators for AI/AN for whom English is a second language. Enrollment assisters may not be properly trained and may give misinformation or inaccurate guidance.

When people do not complete an application, they might assume that the application would not be processed, but they would never think of their inaction as negligence. Incomplete information should not be considered fraudulent unless there is intent to defraud the government or the insurance companies.

Negligence is defined so broadly that people might find themselves accused of fraud when they reasonably refuse to respond to phone calls initiated by strangers and asked to give their social security number, as has happened to a number of AI/AN hardship exemption applicants. The AI/AN applicants have refused to answer to protect themselves from what seemed like fraudulent behavior, and yet under the negligence standard they could be charged with fraud.

Given the issues we have been seeing across the country with regard to AI/AN demonstrating Indian status – either when enrolling in a QHP or when applying for an exemption from the Individual mandate – we are concerned that CMS may interpret the standard for negligence in a manner that penalizes individual AI/ANs acting in good faith for the failures of the FFE website, or the inexperience of the federal contractors tasked with making Indian status determinations. For example, we understand that some individuals were informed by the call centers to simply put "any tribe" in when applying for a QHP when the drop down menu was not yet working. Many others have been wrongly assigned a hardship exemption rather than the Indian exemption by the contractors reviewing those applications.

The negligence standard is going to be so difficult to explain to AI/AN communities that it could result in people refusing to apply for insurance through the Marketplaces because they are afraid that the information they give could lead to a financial punishment. Particularly when people's lives are complicated, they often cannot fit into categories on an application, for example listing

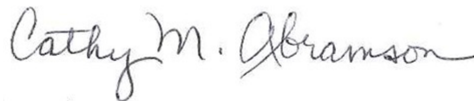
people in their household. Fear of giving wrong answers that could be interpreted by someone else as fraud could lead people to avoid the whole endeavor.

Given the potential for error by federal contractors wholly unfamiliar with Indian people and tribal documentation, we believe that the standard for negligence in the Proposed Rule should broadly define what is considered a "reasonable" attempt from the perspective of the Native individual seeking to provide such information. This will be critically important, at least in the initial years of the Exchanges, as these issues are worked out.

CONCLUSION

The NIHB appreciates the opportunity to comment on the Proposed Rule, and looks forward to a continued open dialogue with CMS and CCIIO through tribal consultation on the important issues discussed above.

Sincerely,



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