National Indian Health Board

Submitted via email: jeff.wu@cms.hhs.gov

September 30, 2015

Mr. Jeff Wu
Deputy Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Response to Request for Tribal Consultation on Referrals for Limited Cost-Sharing Variation Plans

Dear Mr. Wu:

On behalf of the National Indian Health Board[1], this letter is in response to your request for Tribal consultation on the issue of the minimum content of referrals for cost-sharing protections issued pursuant to ACA section 1402(d)(2)[2] issued by Indian health care providers (IHCPs) [3], NIHB recommends that the Center for Consumer Information and Insurance Oversight (CCIIO)—

- Clarify with Qualified Health Plan (QHP) issuers that the documentation requirements pertaining to the 03/L-CSV (Limited Cost-Sharing) that are imposed by QHP issuers on IHPCs can be no more rigorous than those outlined in current or subsequent CCIIO guidance documents.

[1] Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of 567 federally recognized Tribes 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 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 their health care, NIHB is their advocate.

[2] The Indian-specific cost-sharing protections are comprised of (1) the ACA section 1402(d)(1) protections, sometimes referred to as the "02" or "zero cost-sharing variation" (02/Z-CSV), and (2) the section 1402(d)(2) protections, sometimes referred to as the "03" or "limited cost-sharing variation" (03/L-CSV). AI/ANs who meet the definition of Indian under the Affordable Care Act and are enrolled in Marketplace coverage qualify for at least one of the two Indian-specific cost-sharing variations. Under the limited CSV, a referral from an Indian health care provider (IHCP) is required for AI/AN enrollees to secure cost-sharing protections at non-IHCPs. Under the 02/Z-CSV, no such referral is needed to secure comprehensive cost-sharing protections at any provider

[3] Indian health care providers (IHCPs) include Indian Health Service, Indian Tribe, Tribal health organization, and urban Indian organization providers and are sometimes referred to as "I/T/Us."

- Refrain from issuing requirements on IHCP Purchase and Referred Care (PRC) programs (except for the recommended requirements below on minimum data elements to be contained in a referral for cost-sharing) that infringe on the ability and flexibility of IHCPs to continue to manage their PRC programs.
- Continue to permit IHCPs to issue a range of referral types and forms, such as a single item or service referral, a referral based on an episode of care, and a comprehensive referral.
- If determined necessary, issue revised guidance indicating the following minimum data elements to be contained in a referral for cost-sharing from an IHCP—
    - Identification of the patient for whom the referral is being issued;
    - Name of the IHCP issuing the referral;
    - Contact information for the IHCP; and
    - Date of the referral (which may be past the date services were received).

For some PRC referrals for cost-sharing, the information above will appear on the referral itself. For other referrals for cost-sharing, some of the information (such as the date of referral) is accessed by the QHP issuer contacting the IHCP at the telephone number or e-mail address included on the referral.

A. Background and History of Current Issue

On June 30, 2015, the Alaska Native Tribal Health Consortium (ANTHC or Consortium) sent a letter to the Center for Consumer Information and Insurance Oversight (CCIIO) of the Centers for Medicare and Medicaid Services (CMS) in the federal Department of Health and Human Services (HHS) requesting the intervention of CCIIO in order to ensure that American Indians and Alaska Natives (AI/ANs)[4] in Alaska are not blocked from accessing the comprehensive Indian-specific cost-sharing protections provided to them under section 1402 of the Affordable Care Act. The Consortium explained that the policies and operational approaches being imposed by Moda Health were impeding access to needed health care services for AI/ANs enrolled through the Marketplace in plans operated by this issuer. These policies and approaches continue to threaten access to care for hundreds of Marketplace enrollees.

Specifically, the Consortium requested the following—

> We seek the intervention of [CCIIO] to prevent Moda Health from imposing on tribal health organizations (THOs) in Alaska—and by this, imposing on Marketplace enrollees—referral requirements that go far

[4] For purposes of this letter, references to Alaska Natives and American Indians are to persons meeting the definition of Indian under the Patient Protection and Affordable Care Act.

> beyond the CCIIO guidance addressing this issue.[5] Specifically, we are asking CCIIO to halt implementation of Moda Health's stated plan to reject, as of June 30, 2015, any THO-issued referrals for cost-sharing that do not include Moda Health-authored requirements.

We believe Moda Health was and continues to be in violation of 45 CFR §156.410(a). Subsection (a) of §156.410, "Cost-sharing reductions for enrollees," reads as follows—

> (a) *General requirement.* A QHP issuer must ensure that an individual eligible for cost-sharing reductions, as demonstrated by assignment to a particular plan variation, pays only the cost-sharing required of an eligible individual for the applicable covered service under the plan variation. **The cost-sharing reduction for which an individual is eligible must be applied when the cost-sharing is collected.** (Emphasis added.)

Moda Health is failing to comply with the requirements of 45 CFR §156.410(a) in two ways. First, the QHP issuer is not applying the cost-sharing reductions to 03/L-CSV plan enrollees at the time an 03/L-CSV enrollee receives a service that is otherwise subject to cost-sharing, resulting in L-CSV plan enrollees being subject to a $4,500 - $5,250 deductible and $4,650 – 13,200 in maximum out-of-pocket costs (depending on which Moda Health plan an enrollee is enrolled and whether under single or family coverage). As clearly indicated in the regulations at §156.410(a), an enrollee is "eligible" for the cost-sharing protections at the point of enrollment and assignment in an 03/L-CSV, not at some later date, such as when a referral is issued on behalf of the enrollee. Second, Moda Health is not honoring many of the referrals issued by Tribal Health Organizations (THOs)[6] in Alaska and, as a result, is charging patients cost-sharing amounts that are to be eliminated under the 03/L-CSV protections. [7] [8]

In addition to not recognizing some THO referrals for cost-sharing, and in addition to attempting to impose a referral form on THOs that requires unnecessary and redundant information, in recent incidents Moda Health—after receiving a referral that contains the information initially demanded by Moda Health—contacted THOs for additional information beyond what was indicated previously by Moda Health as sufficient. Meeting the constantly changing demands of this one QHP issuer—which are far beyond that required in CCIIO guidance—much less the potential demands of multiple QHP issuers, makes this process unworkable.

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[5] From the CCIIO Q&A document titled "Cost-Sharing Reductions for Contract Health Services" and dated May 9, 2014. *See* Attachment A.

[6] For example, two referrals were rejected by Moda Health early in 2015. Then, on March 30, 2015, Moda Health said they would not accept any additional comprehensive referrals. Since then, two additional comprehensive referrals were issued by THOs, and both were denied. Moda Health has not accepted a comprehensive referral since March 12th.

[7] In this letter, the term THOs is used interchangeably with the term Indian Health Care Providers (IHCPs).

[8] For instance, a Moda Health L-CSV bronze plan enrollee was recently subject to Moda Health applying a deductible in the amount of $5,774.57 when the enrollee attempted to have a prescription filled.

In addition, Moda Health appears to be in violation of 45 CFR §156.430(g). This section of the federal regulations reads—

> (g) *Prohibition on reduction in payments to Indian health providers.* If an Indian is enrolled in a QHP in the individual market through an Exchange and 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,** the QHP issuer may 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 the prohibitions on cost-sharing set forth in §156.410(b)(2) and (3). (Emphasis added.)

In not applying the cost-sharing protections at the time of application of cost-sharing amounts when an AI/AN enrollee receives services at a non-IHCP, Moda Health is effectively reducing the amounts paid to providers to whom the enrollee was referred by the amount of the imposed cost-sharing. This is resulting in denials of services to enrollees (if the enrollees fail to pay the cost-sharing amounts to the provider) or withdrawals of the request for services by enrollees for fear of being liable for the cost-sharing amounts.

The violation of these two provisions of federal regulations by Moda Health is impeding access to needed health care services for AI/AN plan enrollees.

In summary, Moda Health is violating federal regulations pertaining to the application of Indian-specific cost-sharing protections and by so doing is impeding access to needed health care services for AI/ANs enrolled in coverage through the Federally-Facilitated Marketplace. At the core of this issue (and the justification cited by Moda Health) is the imposition of Moda Health-generated requirements on THOs. These requirements infringe on the operation of the PRC programs operated by THOs in Alaska. Neither the failure to apply the statutory protections to AI/ANs fully nor the imposition of requirements on THO-operated PRC programs is acceptable. We ask CCIIO to direct Moda Health to refrain from imposing requirements on THOs that infringe on the operation of PRC programs by THOs, particularly as these requirements are not necessary for the implementation of the Indian-specific cost-sharing protections.

B. Request for Tribal Consultation on Content of Referrals for 03/L-CSV

In a July 9, 2015, notice, CMS issued a request for Tribal consultation "on the minimum information that must be included in a Purchased/Referred Care (PRC) referral made on behalf of American Indians and Alaska Natives enrolled in a Marketplace plan."

We appreciate the opportunity to enter into Tribal consultation with CMS on this issue. We understand CCIIO must ensure that requests for payment made by QHP issuers for reimbursement for cost-sharing reductions advanced on behalf of AI/AN plan enrollees are documented and confirmed. It is in the interests of CCIIO, as well as AI/AN enrollees, that QHP

issuers be reimbursed only when cost-sharing reductions were actually advanced on behalf of enrollees. Nonetheless, it is important to note that PRC programs are operated by IHCPs pursuant to policies established by the IHCPs. ACA section 1402 did not alter the authority of IHCPs to operate their PRC programs, and in implementing ACA section 1402, CCIIO and—in particular—QHPs should not infringe on IHCPs' discretion in operating their PRC programs.

It is also important to state that, except for the instance mentioned above regarding one QHP operating in Alaska, IHCPs across the United States generally have not experienced problems with QHP issuers accepting the referrals issued by IHCPs for purposes of accessing the 03/L-CSV protections. We continue to believe that the document issued by CCIIO on May 9, 2014, provides sufficient guidance to QHP issuers on the documentation requirements a QHP issuer must meet to receive reimbursement for cost-sharing reductions advanced on behalf of plan enrollees.

Recommendations on Minimum Content of Referrals

If clarification on the minimum information to be included in an IHCP referral is deemed useful, using the May 9, 2014, guidance for reference, we provide recommendations below on the information to be provided by IHCPs. The remaining data elements identified in the May 9, 2014, guidance would be supplied by the QHP issuer.

It is useful to understand that PRC referrals issued by IHCPs take many forms. Some are paper form referrals similar in appearance to "prior authorization referrals." Other referrals issued under PRC programs are in the form of cards, similar in appearance to health plan enrollment cards. Still other referrals under PRC programs are issued via e-mail correspondence. For some referrals under PRC programs, the information appears on the referral itself. For other referrals, some of the information (such as the date of referral) is accessed by the QHP issuer by contacting the IHCP at the telephone number or e-mail address included on the referral. And, as confirmed in the May 9, 2014 CCIIO guidance document, it is sometimes necessary for an IHCP to issue a referral after services have been received, providing a retroactive authorization.

Under our recommendations, an IHCP-issued referral would provide the following minimum information—

- Identification of the patient for whom the referral is being issued;
- Name of the IHCP issuing the referral;
- Contact information for the IHCP; and
- Date of the referral (which may be past the date services were received).

These four items are contained in the May 9, 2014, guidance from CMS/CCIIO to QHP issuers. Along with this information, IHCPs have the discretion to add additional information, such as whether the referral is for a particular set of items or services or for all essential health benefits. The remaining information identified in the May 9, 2014, guidance would be supplied by the QHP issuer. This information includes—

- The name and address of the provider(s) delivering the item(s) or service(s); and
- A description of the item(s) or service(s) furnished through referral, including the date(s) the item(s) or service(s) were provided.

As occurs under the 02/Z-CSV plans, under the 03/L-CSV plans, QHP issuers have the ability to access within their own records detailed information on the providers and services rendered, including provider name(s) and address(es), a listing and description of the item(s) and service(s) provided, and the date(s) the item(s) and service(s) were provided. None of this detailed information is secured from a PRC program when a QHP issuer seeks reimbursement for cost-sharing protections advanced under 02/Z-CSV. Likewise, none of this detailed information needs to be supplied by IHCPs for 03/L-CSV plan enrollees, as QHP issuers are already in possession of this information. For the IHCP to provide this information to the QHP issuer, the IHCP would either have to secure the Explanation of Benefits (EOBs) issued by the QHP issuer or gather the information from the records of plan enrollees.

Components of a PRC Program

A PRC program is comprised of two components. The first component is the function of referring Tribal members to outside providers for health care services. This is the "referred" component of the "Purchased and Referred Care" program. The second component is the function of authorizing payment for referred services when care is provided by outside providers. This is the "purchased" component of the "Purchased and Referred Care" program. Authorizations for payment made by a PRC program are constrained by the resources available to the PRC program. Referrals issued by PRC programs are not subject to the funding constraints of a PRC program and do not authorize payment for services from a PRC program.

Because IHCPs are obligated to operate their overall PRC programs within available funding, IHCPs oftentimes—but not always—impose a priority ranking when authorizing payments for medically necessary services. For instance, severely financially constrained PRC programs might solely authorize payment for "priority one" services, defined as health services addressing issues that threaten the life or a limb of a Tribal member. Other services that are typically covered by QHPs, such as proven preventive services, are ranked as a lower priority and would not be authorized for payment.

Interaction of PRC Programs with 03/L-CSV Referrals

The primary goal of PRC programs is to facilitate access to health services, whether through issuing an authorization for payment (the "purchased" component of "Purchased and Referred

Care") when care has been or will be received at an outside provider and/or through issuing a referral to an outside provider without committing the referring IHCP's PRC program to making a payment for the service (the "referred" component of "Purchased and Referred Care").

Approaches employed by IHCPs in operating their PRC programs vary greatly. This is a result, in part, of IHCPs seeking to balance sometimes competing goals, such as minimizing barriers to accessing care at outside providers and coordinating all health care services received by IHS beneficiaries. Another goal that is considered by IHCPs is maximizing third-party revenues to the IHCPs in order to have adequate resources to expand health services capacity within the Indian health system. The approaches employed by IHCPs to balance the various goals results in IHCPs implementing greatly varying policies and procedures. For instance, one IHCP might issue a comprehensive referral to one beneficiary for all health services while issuing a referral for only one specific service for another beneficiary.

The range of approaches outlined here (as well as others) under IHCP-operated PRC programs fit comfortably with implementation of ACA section 1402(d)(2). This point is evident in the fact that IHCPs already have submitted a range of referral formats to QHP issuers and that AI/AN enrollees in the 03/L-CSV plans have secured comprehensive cost-sharing protections, with the exception of those enrolled in plans offered by one QHP issuer in Alaska.[9]

It is important to note that the law only states that a referral removes cost-sharing, it does not impose qualifications for what constitutes a referral. ACA § 1402(d)(2) reads—

> "If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by [an IHCP] 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 ..."

The flexibility available to and applied by IHCPs is key to IHCPs' continued ability to meet the health care needs of Tribal members and must not—and need not—be infringed upon in the implementation of the 03/L-CSV established under ACA section 1402(d)(2).[10]

[9] It is important to note that many QHP issuers were initially unaware of the details of the 03/L-CSV and the 02/Z-CSV protections. IHCPs often engaged the QHP issuers to educate them on the Indian-specific provisions.

[10] In regulations, at 45 CFR § 155.350(b), CMS refers to the section 1402(d)(2) Indian-specific cost-sharing protections as the "Special cost-sharing rule for Indians regardless of income."

Addressing Comments Made by Federal Government Representatives During Tribal Consultation Sessions

Two teleconferences and one in-person meeting have been held as part of the Tribal consultation process. At these sessions, a number of questions were raised and comments made regarding broader issues involving implementation of the 03/L-CSV. We would like to address several of these issues, questions, and comments.

1. **Comment:** Congress established two variations of the Indian-specific cost-sharing protections. Implementation of the two variations must be sufficiently different to be true to the congressional intent.

   Response: The difference between the 02/Z-CSV and the 03/L-CSV is that, under the 02 / Z-CSV, "the issuer of the plan must eliminate all cost-sharing under the plan" without regard to whether the health care provider is an IHCP or not.[11] Under the 03/L-CSV, "no cost-sharing under the plan shall be imposed under the plan for such item or service," but a distinction is made between items and services provided by IHCPs and those provided by non-IHCPs. The comprehensive cost-sharing protections under 03/L-CSV apply at non-IHCPs only when the item or service is "furnished … through referral under contract health services."[12]

   The "through referral" requirement establishes a link between the availability of the comprehensive cost-sharing protections for an enrollee and the actions of the IHCP. This distinction is a significant one for IHCPs, as the IHCP is able to use the referral to influence the course of treatment for a beneficiary if the IHCP chooses to do so, for services provided by the IHCP and those provided by non-IHCPs. Although an IHCP is required to act by providing a referral if an AI/AN enrollee in a 03/L-CSV is to receive comprehensive cost-sharing protections at non-IHCPs, how an IHCP chooses to apply the PRC referral authority (*e.g.*, providing a service-specific referral, a comprehensive referral, or no referral at all) does not diminish the distinction between the two cost-sharing variations whereby the IHCP is able to decide whether and in what form to issue a referral.

2. **Comment:** A comprehensive referral is the same thing as a 02/Z-CSV and as such cannot meet congressional intent.

   Response: A comprehensive referral does not have the result of converting a 03/L-CSV into a 02/Z-CSV. Access to cost-sharing protections under the 02/Z-CSV never requires a referral for cost-sharing. Access to cost-sharing protections at non-IHCPs under the 03/L-CSV always requires a referral. A plan-year or comprehensive referral satisfies this

[11] ACA section 1402(d)(1)(B).

[12] The term "contract health services" was renamed "Purchased/Referred Care" in the Consolidated Appropriations Act of 2014.

referral requirement. Imposing additional requirements beyond what was established by Congress, though, could frustrate congressional intent.

In addition, in states that have not yet implemented an ACA section 2001 Medicaid expansion, the comprehensive referral aligns the cost-sharing protections for AI/ANs who would otherwise be eligible for Medicaid with applicable American Recovery and Reinvestment Act (ARRA) Indian-specific cost-sharing protections under Medicaid.

3. **Comment:** A "comprehensive referral" is too costly to the federal government and to the QHP issuer compared to providing a series of more limited referrals.

   Response: The costs to the QHP issuer and to the federal government should not be significantly different under a single comprehensive referral for cost-sharing and a series of more limited referrals for cost-sharing. And to the extent there is a difference in the cost, the cost under multiple narrow referrals might be higher.

   Under both scenarios, the QHP issuer will make payments to providers for items and services rendered. Under both scenarios, the QHP issuer will advance cost-sharing protections on behalf of AI/AN enrollees. And under both scenarios, the federal government will reimburse the QHP issuer for cost-sharing advanced on behalf of AI/AN enrollees. *But under no scenario should a referral for cost-sharing be viewed as, or converted in practice to, a mechanism to require and secure prior authorization for a service.*

   Unless there are unwarranted barriers to accessing essential health benefits, the volume of services should be assumed to be the same under both scenarios. (It is important to note that under neither scenario will a referral for cost-sharing override a prior authorization requirement that a QHP might impose on enrollees.) If there are unwarranted barriers to needed health care services, this is an unacceptable approach to calculating costs, or achieving savings, under one or the other scenarios.

   Costs might be slightly higher, if at all, under a scenario whereby a greater percentage of services are provided through IHCPs, rather than non-IHCPs, to the extent that payment rates to IHCPs are higher than otherwise due to IHCPs leveraging section 206 of the Indian Health Care Improvement Act. In addition, costs might be slightly higher under a series of narrower referrals as a result of increased administrative costs to issue and track the referrals.

4. **Comment:** A QHP issuer is burdened by additional costs if a comprehensive referral is issued versus a series of narrower referrals.

   Response: Similar to the response above, QHP issuers will not assume greater costs under a comprehensive referral than under a series of narrower referrals. Either way, essential health benefits would be provided to the plan enrollee. If a QHP issuer is

counting on the paperwork involved with IHCPs issuing service-specific referrals to result in reductions in access to essential health benefits, this should not be an acceptable rationale or approach to cost-containment. Referrals for cost-sharing should facilitate, not retard, timely access to essential health benefits.

In addition, the QHP issuer retains the ability to impose prior authorization requirements or other cost-containment mechanisms without regard to the type of referral for cost-sharing issued by an IHCP. This permits QHP issuers to continue to apply a permissible cost containment mechanism.

Finally, if IHCPs are blocked from continuing to issue comprehensive referrals for purposes of securing cost-sharing protections under the 03/L-CSV, the QHP issuers (as well as the IHCPs) will experience increased administrative costs. Handling and processing paper referrals for each item or service received outside of IHCPs will generate significant costs and consume a portion of the ACA-limited administrative funds. QHP issuers, along with non-ICHPs, also are likely to have to resubmit and re-process numerous claims, as AI/AN QHP enrollees secure referrals for specific items and services retroactively.

5. **Comment:** Referrals should be provided by an IHCP only after a determination is made that an item, service, or treatment is not reasonably available or accessible from an IHCP.

   Response: Congress did not include any such limitation in the plain language of Section 1402 of the ACA, and it would be inappropriate to invent such restrictions. In addition, given the limited budgets and provider shortages at many IHCPs, the very fact that an individual is referred out of the I/T/U system might itself free up a provider to offer other services necessary to avoid making such treatments unavailable or not accessible. This should be a determination for the IHCP to make, not a dictate from CCIIO.

   Furthermore, the QHPs and the federal government should not create unnecessary limitations on where AI/ANs seek care. This could be construed as discrimination against AI/ANs who have paid their premiums for health insurance and should be entitled to the same networks of providers and same services as non-AI/ANs.

   Additionally, it would be difficult or impossible for the QHPs or the federal government to enforce the language in this statement. Exactly how would they determine that the item, service or treatment is "not reasonably available or accessible"? It may be available, but not on a timely basis which would make it inaccessible. It might be accessible in some outdated version that offers lower quality, such an inferior equipment for tests, which would make it not available. If it is left to the Tribe to make this determination, there is no need for this "test" to be included in the referral.

6. **Comment:** PRC programs that issue comprehensive referrals today, and would expect to do so for enrollees under Marketplace coverage, are not permitted to do so under IHS policies.

   Response: IHS policies do not prevent the issuance of comprehensive referrals. In addition, IHS rules are not binding on tribal health programs operating ISDEAA programs. The law allows for cost-sharing exemption referrals to be made by IHS, Tribes and urban Indian programs. Each have different approaches to managing PRC programs, and urban Indian programs generally do not even have PRC programs. IHS direct service programs use a referral form and process that is not replicated in many of the self-governance Tribes that operate their own programs. It is not appropriate for CMS to restrict referrals to the IHS direct service model, and CMS should not impose any model used by IHS on to Tribes.

7. **Comment:** IHS issues either PRC referrals for specific items or services or referrals for episodes of care. IHS does not issue open-ended comprehensive referrals. Because IHS does not issue comprehensive referrals under its PRC programs, other IHCPs are not permitted to issue comprehensive referrals under PRC programs.

   Response: IHS policies are not binding on tribal health programs operating ISDEAA programs.

8. **Comment:** IHCPs are expected to apply the priority system operated under a PRC program to referrals under Marketplace coverage.

   Response: Under a PRC program, the priority system applies to "authorizations" for payment for services. The priority system does not apply to "referrals" for services. Imposing the funding constraints on authorizations for payment under an IHCP's PRC program to the issuance of referrals for cost-sharing protections would defeat the purpose of enrolling in comprehensive health insurance coverage. The goal of Tribes enrolling Tribal members in the Marketplace is to facilitate access to all essential health benefits without imposition of arbitrary funding caps, and to receive the services without requiring enrollees (or Tribes on their behalf) to incur out-of-pocket costs, as was intended by Congress in enacting the provisions.

9. **Comment:** Referrals must be limited to residents of Contract Health Service Delivery Areas (CHSDAs).

   Response: Referrals for cost-sharing are not limited to residence in a CHSDA, or to PRC priority levels. The ACA is designed to increase access to care, so the limitations of PRC authorizations are not relevant for AI/ANs with insurance purchased through a Marketplace, or previously for AI/ANs with Medicaid or other types of health insurance coverage. CHSDAs were established to ration care based on the limited resources of IHS, and for budgeting purposes to distribute the funding provided by Congress for PRC

to different service units. The Affordable Care Act and Marketplaces expand the available resources for AI/AN patients regardless of their place of residence. In addition, Self-Governance Tribes can design their programs differently from IHS, including covering different people than IHS-operated PRC programs.

10. **Comment:** Requiring a referral for each item or service, and for each episode of care, would not disrupt access to care or increase costs to IHCPs.

    Response: IHCPs operate their PRC programs in a manner that balances numerous program goals. Restraining the flexibility of IHCPs in issuing referrals would disrupt current practices, including the practice for many PRC programs of issuing comprehensive referrals for individuals enrolled in comprehensive health insurance coverage. Dictating the form of referrals also would limit the flexibility of IHCPs in how referrals are physically issued, likely resulting in greater administrative costs to PRC programs and additional time and travel costs imposed on plan enrollees to the extent the plan enrollee is required to travel to obtain a referral.

11. **Comment:** If implemented according to Tribal recommendations, the 03/L-CSV would be far more generous than other non-Indian-specific cost-sharing protections and would be far more costly than that intended by Congress.

    Response: At the present time, very few people across the country are enrolled in 03/L-CSV plans, and the cost for their care is insignificant to the federal budget, particularly when the marginal cost of coverage to the federal government for AI/ANs is compared to the cost for such coverage if the coverage were provided under the generally-applicable PTC and CSV rules. As Medicaid Expansion is adopted by additional states, the number of people in 03/L-CSV will likely decline as those under 100 percent of the federal poverty level will be enrolled in Medicaid with no premiums, co-pays or deductibles.

    Z-CSV plans and L-CSV plans (with absence of deductibles and copayments) assist the Federal government in meeting its trust responsibility to people who are members of federally recognized Tribes and shareholders in Alaska Native corporations. The Affordable Care Act is intended to cover uninsured Americans, including AI/ANs who have the lowest rates of insurance and highest rates of health disparities and to whom the federal government has promised health care at no cost.

    The actuarial value of both the 02/Z-CSV and the 03/L-CSV plans are 100 percent, according to CMS, as a result of the comprehensive cost-sharing protections provided for under each plan variation. This compares to an actuarial value ranging from 87 percent to 94 percent for modest income individuals enrolled in silver level coverage. Although the Indian-specific cost-sharing protections are greater, this is only slightly so when compared with other categories of Marketplace enrollees.

<u>Additional Recommendations</u>

In addition to the above comments and recommendations regarding referral forms, the Tribes across the country support the recommendations made by ANTHC to address the Moda Health requirements that are frustrating access to comprehensive cost-sharing protections in Alaska, and to ensure such impediments are not repeated elsewhere. We recommend that CCIIO—

- Indicate in guidance to all QHP issuers that Purchased/Referred Care (PRC) programs are operated by Indian health care providers (IHCPs)[13] and that efforts to impose requirements on an IHCP's PRC program are not permissible.
- Reiterate to all QHP issuers that, pursuant to 45 CFR §156.410(a), persons enrolled in 03/L-CSV plans are in fact eligible for cost-sharing protections and that the cost-sharing protections under the 03/L-CSV plans are to be applied when the cost sharing is collected, without regard to whether a referral for cost sharing has been issued. (Any overpayments or underpayments would be reconciled using the procedures described under 45 CFR §156.410(c).)
- Reiterate to all QHP issuers that, pursuant to 45 CFR §156.40(g), a QHP issuer is prohibited from reducing payments to IHCPs, and to non-IHCPs when the service is being provided pursuant to a referral from an IHCP, by the amount of the cost sharing that otherwise would have been due except for the cost-sharing protections.
- Indicate to Moda Health and other QHP issuers not to seek to impose requirements on IHCPs that exceed the parameters outlined in the CMS guidance document issued on May 9, 2014 and any subsequent guidance issued by CCIIO, unless agreed to by the IHCP.

Conclusion

According to data released by HHS, as of June 1, 2015, only 3,916 AI/ANs were enrolled in a 03/L-CSV plan through a Federally-Facilitated Marketplace. This figure represents a tiny fraction of all AI/ANs and an infinitesimally small number when compared with the total U.S. population.

Hopefully, the comprehensive cost-sharing protections under each of the two Indian-specific cost-sharing variations will prove attractive to a sizable number of AI/ANs in order for the Marketplace to serve as an additional vehicle for meeting the federal government's trust responsibility, as envisioned by Congress. To date, though, ACA implementation in Indian Country is a work in progress. Most of the AI/ANs enrolled in plans with limited cost-sharing have a portion of their premiums paid by Tribal Sponsorship programs. We believe IHCPs in general—and those Tribes who are helping to pay the premiums in particular—are in the position to determine the most workable policies and protocols for issuing referrals. We believe CCIIO's

[13] Indian health care providers include Indian Health Service, Indian Tribe, Tribal health organization, and urban Indian organization providers and are sometimes referred to as "I/T/Us."

focus is best aimed at assuring that QHPs are reimbursed for cost-sharing reductions for those who are eligible and to avoid fraud on the part of QHPs. To this end, we continue to offer our support to CCIIO and cooperation with QHP issuers in order to facilitate reasonable reporting requirements. We believe the May 9, 2014, CCIIO guidance to QHP issuers has served to meet these objectives and to facilitate the effective implementation of the 03/L-CSV. This is achieved through the guidance by imposing modest reporting requirements on QHP issuers and recognizing the authority of IHCPs to issue referrals pursuant to their PRC programs.

We appreciate your attention to implementation of the Indian-specific provisions in the Affordable Care Act. We hope that CCIIO will give full consideration to the recommendations made here. Doing so, we believe, will increase the likelihood that AI/ANs enroll in Marketplace coverage and ultimately experience greater access to critically needed health care services as a result of the elimination of cost-sharing.

Sincerely,

Lester Secatero, Chairman
The National Indian Health Board

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