

# Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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April 30, 2013

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9964-IFC  
Mail Stop C4-26-05  
7500 Social Security Boulevard  
Baltimore, MD 21244-1850

## **RE: Comments on CMS-9964-IFC, Patient Protection and Affordable Care Act; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014**

On behalf of Tribal Technical Advisory Group (TTAG), I am writing to provide comments on CMS-9964-IFC, the proposed rule entitled "Patient Protection and Affordable Care Act; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014." 78 Federal Register 15541 (March 11, 2013) ("Proposed Rule").

The TTAG advises Center of Medicare and Medicaid Services (CMS) on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program, and any other health care program funded (in whole or part) by CMS. In particular, the TTAG focuses on providing policy advice to CMS regarding improving the availability of health care services to American Indians and Alaska Natives (AI/AN) under these Federal health care programs, including through providers operating under the health programs of the Indian Health Service, Indian Tribes, tribal organizations and urban Indian organizations (I/T/U).

The TTAG offers the following comments to the Centers for Medicare and Medicaid Services (CMS) on the Proposed Rule:

### **I. Background on Indian-specific Cost-Sharing Plan Variations**

Section 1402(d) of the Patient Protection and Affordable Care Act provides critically important cost-sharing reductions for AI/ANs who purchase insurance through an Exchange. These special cost-sharing reductions for AI/ANs were included in the ACA to implement the federal trust responsibility and ensure that AI/ANs are able to participate in the Exchange plans at no cost to them. Section 1402(d) creates two cost-sharing reduction rules for AI/ANs. Under Section 1402(d)(1), all AI/ANs with incomes less than 300 percent of the federal poverty level (FPL) who purchase insurance through an Exchange are exempt from cost-sharing no matter where or how they receive their care. Under Section 1402(d)(2) of the ACA, all AI/ANs (no matter what their income level) are exempt from cost-sharing when they receive care through the IHS, a tribe or tribal organization or an urban Indian

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organization (referred to as I/T/U), or through a referral under Contract Health Services. Under Section 1402(d)(3) of the ACA, the Secretary of HHS is tasked with paying issuers the amount necessary to offset any increase in the actuarial value of the Qualified Health Plan (QHP) by reason of these Indian cost-sharing exemptions.

**II. Proposal for an Alternate Standard for the Administration and Payment to Issuers of the Value of Cost-sharing Reductions provided to Eligible Persons**

a. Background

Under the Proposed Rule, an alternative, optional methodology is allowed for calculating the value of cost-sharing reductions provided for the purpose of reconciliation of advance payments of cost sharing reductions. CMS is seeking comment on the proposed alternative as well as on the appropriate length of a transition period permitting the use of the simplified methodology.

We understand CMS is working to accommodate concerns expressed by plan issuers of the administrative burden of providing payments to providers that offset the amount of the cost-sharing protection provided eligible enrollees and then having to undertake a second process of submitting data to CMS to request reimbursement for the additional payments made in implementing the cost-sharing protections.

We would like to express a somewhat countervailing concern that, absent reimbursement to health plans in the amount of *actual* cost-sharing reductions provided by the issuers, and instead CMS may provide payments to issuers based on estimates, financial incentives may be created whereby plan issuers have a financial incentive to minimize the cost-sharing protections afforded to eligible AI/ANs.

In addition, we would like to raise a caution that any alternative or replacement payment approach that may be developed by CMS in the future, such as a prospective, capitated payment mechanism, account for the great variation in the degree to which specific AI/ANs will access the cost-sharing protections afforded under section 1402(d) of the ACA.

For instance, under the “limited cost-sharing plan variation” established pursuant to section 1402(d)(2) of the ACA, all AI/ANs (no matter what their income level) are exempt from cost-sharing when they receive care through an I/T/U or through a referral under Contract Health Services. If uniform capitated payments were to be paid to issuers for each AI/AN enrollee subject to these protections, but the amount of the capitated payment was made without regard to whether the individual AI/AN actually accessed services directly or through referral from an I/T/U, the capitated payments could greatly overstate the costs of the protections paid by some health plans and greatly understate the costs of the protections paid by other health plans. Health plans operating in and enrolling AI/ANs in one state or region of a state could be greatly overpaid. And, health plans operating in other states or in other regions of the same state could be greatly underpaid. Not only is

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this result a possible outcome, it is a likely outcome given the concentration of I/T/U facilities in certain regions and the absence of I/T/U facilities in other regions, such as in urban areas. The resulting effect of such a payment policy on the finances of issuers and on the interest of issuers to enroll AI/ANs in their plans would not likely be favorable to the interests of AI/ANs.

Similarly, if a uniform capitated payment amount were paid to health plans who enroll AI/ANs eligible for the zero cost-sharing plan variation, and the payments were not adjusted for the health status of the enrollee (as is done generally under the risk adjustment program), significant additional financial incentives – beyond the financial incentives that may already exist – could be created for health plans to avoid enrolling AI/ANs who have greater than average health care needs. Avoiding the creation of such unhelpful financial incentives, though, can be minimized, or eliminated, if payments from CMS to issuers for the cost-sharing protections afforded AI/ANs under the ACA reflect the issuer's actual expenditures on the cost-sharing protections for AI/ANs.

b. Recommendations

To address the concerns identified above, the TTAG recommends that CMS consider and incorporate the following recommendations.

1. With regard to the “appropriate length of a transition period permitting the use of the simplified methodology”, we recommend two years. This should provide adequate time for any issuer to establish systems to reconcile payments according to the standard methodology.

In addition, we recommend that issuers who elect the simplified methodology be required to use the underlying payment methodology for an equivalent length of time (i.e., two years) after the transition period, before moving to any new payment approach that CMS may propose. The intention of requiring an equivalent follow-on period using the standard methodology is to provide sufficient time to collect data on the actual value of payments made by these issuers. The data could then be compared to the estimated payment amounts made in earlier years, and the data could be added to the overall data set used in evaluating the extent of the cost-sharing protections and estimating the cost of the cost-sharing protections.

2. Overall, in order to evaluate the operation of the program, we request that CMS ensure there is a robust amount of data collected on the actual payments made by issuers under the Indian-specific cost-sharing variations, and ensure the data collected is representative of the experiences of all health plans, with consideration to factors such as the service areas of plans, the degree of I/T/U penetration in the service areas, the percentage of AI/ANs enrolled in a plan, plan size and market concentration, and whether the protections were provided under the limited or zero cost-sharing variations.

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3. Continue to use as the primary payment methodology a mechanism that is based on actual (and not estimated) payments made by issuers for the cost-sharing protections provided to AI/ANs under the limited and zero cost-sharing variations.

We further recommend that CMS propose to transition to an alternative payment mechanism only if it is demonstrated that counter-productive financial incentives will not be created by such an alternative payment mechanism.

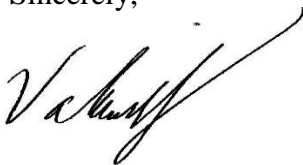
4. To the extent that administrative costs are a significant concern of issuers with regard to the effort involved in reconciling the initial, estimated payments received from CMS with the actual amounts expended on cost-sharing protections, we recommend that CMS provide an appropriate administrative fee to the issuers for this activity.

### **III. Tribal Consultation**

The TTAG greatly appreciates the opportunity to comment on this Proposed Rule. We hope the comments provided are useful, will be incorporated in subsequent CMS actions, and, if not, an explanation will be provided as to the reasons any recommendation may not have been incorporated. In addition, we note that the preamble to the Proposed Rule identified the need to engage in tribal consultation on the issues contained in the Proposed Rule. We look forward to engaging with CMS through the tribal consultation process.

Please feel free to contact Jennifer Cooper at [jcooper@nihb.org](mailto:jcooper@nihb.org) if you are in need of additional information that I may be able to provide. Thank you.

Sincerely,



Valerie Davidson  
Chair, TTAG

cc: Dr. Yvette Roubideaux, Director, IHS,  
Mr. P. Benjamin Smith, Director, Office of Tribal Self-Governance, IHS  
TTAG Members  
TTAG Technical Work Group Members