

# Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board 926 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

Submitted via [regulations.gov](http://regulations.gov)

November 6, 2012

Centers for Medicare and Medicaid Services  
Office of Strategic Operations and Regulatory Affairs  
Division of Regulation Development  
Department of Health and Human Services  
Attention CMS-10320/OCN 0938-1086  
Room C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**RE: Comments of CMS-10003 / ONC: 0938-0829; Notice of Denial of Medical Coverage (or Payment)**

I write on behalf of Tribal Technical Advisory Group (TTAG) to the Centers for Medicare and Medicaid Services (CMS) regarding the request for comments on CMS-10003 / OCN 0938-0829 pertaining to the Notice of Denial of Medical Coverage (or Payment) published in the *Federal Register* on September 7, 2012 (Request for Comments).<sup>1</sup> We appreciate the opportunity to comment on the proposed new form, along with the form instructions. We provide below recommended additions to the Notice of Denial of Medical Coverage (or Payment) (“NDMCP”) as well to the Form Instructions for the NDMCP.

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<sup>2</sup> 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,

---

<sup>1</sup> 77 Federal Register 55216, Comment Request, Notice of Denial of Medical Coverage (or Payment), CMS-10003, September 7, 2012

<sup>2</sup> Sec. 5006(e) of the American Recovery and Reinvestment Act codifies in statute, at sections 1902(a)(73) and 2107(e)(1)(C) of the Social Security Act, the requirement for the Secretary of Health and Human Services to maintain a Tribal Technical Advisory Group within CMS and the requirement that States seek advice from Tribes on a regular and ongoing basis where one or more Indian health program or urban Indian organization furnishes health care services.

including through providers operating under the health programs of the Indian Health Service, Indian Tribes, tribal organizations and urban Indian organizations (I/T/U).<sup>3</sup>

## Background

CMS-10003 / ONC: 0938-0829, a Paperwork Reduction Act notice, requests comments on a revised Centers for Medicare and Medicaid Services (CMS) form that combines two previous forms, the Notice of Denial of Medical Coverage and the Notice of Denial of Payment. The revised form is to be used by health plans operating under the Medicare and Medicaid programs.<sup>4</sup> By combining the two forms into a single document, health plans are likely to find use of the document less burdensome as well as patients and their providers are likely to find use of the document to be less confusing.

For Medicare beneficiaries, section 1852(g)(1)(B) of the Social Security Act requires Medicare health plans to provide enrollees with a written notice in understandable language that explains the plan's reasons for denying a request for a service or denying payment for a service the enrollee has already received. The notice is to include a description of the appeals process. (Regulatory authority for this notice is at 42 CFR 422.568, 422.572, 417.600(b), and 417.840.)

For Medicaid beneficiaries, section 1932 of the Social Security Act identifies requirements for Medicaid managed care plans to explain reasons for denying a request for a service or denying payment for a service already received, and is to include information on beneficiary protections related to appealing a denial of coverage or payment. (Rules on the content of the written denial notice are at 42 CFR 438.404.)

Three documents are included through a link in the CMS-10003 *Federal Register* notice: 1) The proposed form NDMCP; 2) Form Instructions for the Notice of Denial of Medical Coverage (or Payment), CMS-10003-NDMCP; and 3) Supporting Statement – Part A, Notice of Denial of Medical Coverage (or Payment) – NDMCP, CMS-1003 / OMB approval #0938-0829.<sup>5</sup> We recommend modest but important changes to the NDMCP as well as to the Form Instructions.

## Analysis

---

<sup>3</sup> The abbreviation "I/T/U" means the Indian Health Service (IHS), an Indian Tribe, tribal organization or urban Indian organization, and is sometimes referred to collectively as "Indian Health Care Providers". The term "Indian Health Service" means the agency of that name within the U.S. Department of Health and Human Services established by Sec. 601 of the Indian Health Care Improvement Act (IHCIA), 25 USC §1661. The term "Indian Tribe" has the meaning given that term in Sec. 4 of the IHCIA, 25 USC §1603. The term "tribal organization" has the meaning given that term in Sec. 4 of the IHCIA, 25 USC §1603. The term "urban Indian organization" has the meaning given that term in Sec. 4 of the "IHCIA", 25 USC §1603.

<sup>4</sup> The form also provides optional language to be used in cases where a Medicare health plan enrollee also receives full Medicaid benefits that are managed by the Medicare health plan.

<sup>5</sup> The *Federal Register* notice can be accessed at [http://www.regulations.gov/#!documentDetail;D=CMS\\_FRDOC\\_0001-1048](http://www.regulations.gov/#!documentDetail;D=CMS_FRDOC_0001-1048). The related documents can be accessed at <http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS1235051.html>.

Currently, the majority of claims filed by Indian Health Care Providers<sup>6</sup> under Medicare and Medicaid are for direct fee-for-service reimbursement from the Federal program, and not through private managed care plans. Nonetheless, private plan participation by enrollees, and by Indian Health Care Providers, is growing under Medicare and Medicaid, and the proposed Notice of Denial of Medical Coverage (or Payment) will have increasing importance for Indian Health Care Providers. In fact, in some states a majority of Medicaid claims are filed through private managed care plans. Also, the guidance provided by the Centers for Medicare and Medicaid Services (“CMS”) through CMS-10003 may also inform the guidance to be issued by the Secretary of the Department of Health and Human Services (“HHS”) with regard to denials of coverage or payment, and any corresponding appeals, issued by health plans operating in health insurance exchanges (“Exchanges”) established pursuant to the Patient Protection and Affordable Care Act (“Affordable Care Act” or “ACA”).

Indian Health Care Providers have experienced significantly higher coverage and payment denial rates than the average rates cited by CMS. A significant source of these denials is a lack of understanding on the part of private health plans of the applicability of IHCA § 206 . IHCA § 206 requires health plans to pay Indian Health Care Providers for health services rendered to enrolled individuals, whether the Indian Health Care Provider is or is not an in-network provider.<sup>7</sup>

In these comments, TTAG offers recommendations that, we believe, will result in reduced unwarranted denials of coverage and payment and a reduction in the corresponding need for appeals. In addition, recommendations are offered to reduce the burden on patients and their providers in filing an appeal, as well as improve compliance with filing required information.

### Discussion and Recommendations

Included below is a discussion of issues of concern to TTAG pertaining to CMS-10003 and recommendations that, we believe, would reduce unwarranted denials and reduce the need for appeal of the denials. In addition, recommendations are offered to reduce the burden on patients and their providers in responding to the NDMCP (*i.e.*, filing an appeal), as well as to improve compliance with submitting all required information when filing an appeal.

---

<sup>6</sup> The term “Indian Health Care Providers” has the meaning given that term at 42 C.F.R. § 447.50(b)(2) and means a health care program operated by the Indian Health Service (“IHS”) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (often referred to as an “I/T/U”) as those terms are defined in section 4 of the Indian Health Care Improvement Act, Pub. L. 94-437, as amended, (“IHCA”), 25 U.S.C. § 1603..

<sup>7</sup> Indian Health Care Providers have the right to recover from various third party payers the reasonable charges billed by the Indian Health Care Provider for services provided to enrolled individuals, or, if higher, the highest amount the payor would pay a non-governmental provider. *See, Blackford v. Alaska Native Tribal Health Consortium*, 645 F.3d 1089, 1092 (9<sup>th</sup> Cir. 2011); *Yukon-Kuskokwim Health Corporation v. Trust Ins. Plan for Southwest Alaska*, 884 F. Supp. 1360, 1366 (D. Alaska 1994), and *Alaska Native Tribal Health Consortium v. Settlement Funds Held For or to Be Paid on Behalf of E.R. ex rel Ridley*, 84 P.3d 418, 424 (Alaska 2004).

## **Applicability of, and Improved Compliance with, IHCIA § 206**

The proposed NDMCP is important to the ability of American Indians and Alaska Natives (AI/ANs) to access necessary services and to the financial viability of Indian Health Care Providers.

Private plan participation under Medicare and Medicaid varies across the country. For instance, Medicare Advantage Plans do not exist in Alaska.<sup>8</sup> In addition, the State of Alaska does not use managed care plans in providing health insurance coverage to Medicaid enrollees. In other states, managed care plans under public programs are broadly available. For instance, a majority of enrollees and claims in Arizona are made through private managed care plans. But even in States with a significant degree of managed care penetration, managed care plans are only beginning to focus attention on serving the rural areas where many AI/ANs reside. As a result, many managed care plans are just beginning to become familiar with Indian Health Care Providers and the Indian-specific laws that apply to Indian Health Care Providers.

In addition, the Secretary of HHS is required to provide guidance on payment and coverage denials and appeals for health plans offered through Exchanges.<sup>9,10</sup> We encourage the Secretary to draw upon the guidance issued under this regulation in fashioning the denial and appeal policies for the Exchanges. In particular, building on this guidance, along with the recommended modifications to the proposed form and instructions suggested here, will be important for the enrollees served by the Federally-facilitated Exchange (FFE) that is anticipated to operate in Alaska.

In the Supporting Statement, CMS indicated that health plans denied, in whole or part, between 2.3% to 2.6% of all claims processed. For Indian Health Care Providers, these figures represent a low-end of the denial rates experienced. Significantly higher denial rates are typically experienced by Indian Health Care Providers. For example, denial rates with Indian Health Care Providers that are two to four times the national average cited by CMS are not uncommon.

---

<sup>8</sup> The proposed form does not appear to apply to Medicare prescription drug plans.

<sup>9</sup> On page 15 of the “General Guidance on the Federally-facilitated Exchanges” issued by the Center for Consumer Information and Insurance Oversight (CCIIO), CMS on May 16, 2012, the following was included pertaining to the appeal of eligibility decisions: “Appeals: We are evaluating how the Exchange appeals process will coordinate with State Medicaid and CHIP agencies, and we intend to provide further guidance and proposed rulemaking on this topic in the future.”

<sup>10</sup> ACA § 1001 / PHSA § 2719, as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA) includes requirements for the Secretary of HHS regarding standards for internal claims appeals and external reviews. For instance, pertaining to internal claims appeals, the ACA states: “[A] health insurance issuer offering individual health coverage... shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures set forth under applicable law (as in existence on the date of enactment of this section), and shall update such process in accordance with any standards established by the Secretary of [HHS] for such issuers.” Pertaining to external reviews, issuers are to “implement an effective external review process that meets minimum standards established by the Secretary through guidance...”

A significant source of these often unwarranted denials is a lack of understanding on the part of managed care health plans of the applicability of section 206 of the Indian Health Care Improvement Act. IHCA § 206 requires health plans to pay Indian Health Care Providers for health services rendered to enrolled individuals, whether the Indian Health Care Provider is or is not an in-network provider. As provided for under IHCA § 206, Indian Health Care Providers have the right to recover from various third party payers the reasonable charges billed by the Indian Health Care Provider for services provided to AI/ANs, or, if higher, the highest amount the payor would pay a non-governmental provider. IHCA § 206 was strengthened and clarified as part of passage of the Affordable Care Act in 2010.<sup>11</sup>

For services rendered by an Indian Health Care Provider to an individual enrolled in a health plan, generally there should not be denials of payments for such services by the health plan, unless the service itself is simply not covered (for example, elective cosmetic surgery). Providing an explanation in the preamble to the final rule on CMS-10003 as well as in the proposed Notice of Denial of Medical Coverage (and Payment) creates opportunities to *proactively* inform health plans operating under Medicare and Medicaid of the obligations under IHCA § 206, potentially reducing instances of incorrect denials of coverage and payment. In addition, informing health plans *and patients* through the explanatory materials on the appeals process could also serve to help remedy incorrect payment and coverage denials in conflict with IHCA § 206 and to do so with a reduced burden on the Indian Health Care Providers, their providers, and the health plans.

We are also concerned about the information provided regarding how appeals must be accomplished. The NDMCP identifies the information that a patient is to provide when appealing a denial. It includes a requirement that if someone other than the patient is going to act for the patient, both that person (the representative) and the patient “must sign and date a statement confirming this is what [the patient] want[s]”. While this generally makes sense and is explained in easily understandable terms, it is not a correct statement of law regarding appeals made by an Indian Health Care Provider on behalf of an AI/AN. Under Section 206, the right to recover is made available to the Indian Health Care Provider without requiring the participation of the patient.

Because an AI/AN need not pay for health care services from eligible Indian Health Care Providers, the AI/AN may have a diminished incentive (if any incentive at all) to seek remuneration from third parties for the provider’s cost to deliver care. To address that situation, the statute allows the provider to recover its expenses against third-party tortfeasors, relevant

---

<sup>11</sup> Section 10221 of the ACA included the Indian Health Care Improvement Reauthorization and Extension Act of 2009 (IHCIREA). Section 125 of the IHCIREA amended section 206 of the IHCA.

insurers, or other third parties by joining in the individual's litigation against those third parties, to protect its interest, **or by filing its own action.**<sup>12</sup>

- Recommendation: In the preamble to the Final Rule on CMS-10003, include an explanation of the applicability of IHCA § 206 to health plans, such as:

Section 206 of the Indian Health Care Improvement Act (25 U.S.C. § 1621e) provides that Indian Health Care Providers (*i.e.*, the Indian Health Service, Tribes and Tribal Organizations, and Urban Indian Organizations as those terms are defined under 25 U.S.C. § 1603) have the right to recover from various third party payers, for services provided to enrolled individuals, the reasonable charges billed by the Indian Health Care Provider, or, if higher, the highest amount the payor would pay a non-governmental provider. This right of recovery applies whether the Indian Health Care Provider is or is not an in-network provider. This right includes the right to appeal denials of coverage or payment without the participation of the American Indian or Alaska Native patient.

- Recommendation: In the document "Form Instructions for the Notice of Denial of Medical Coverage (or Payment), CMS-10003-NDMCP", add the following sentence under "Section Titled: Why did we deny your request":

For denial of payment or coverage involving Indian Health Care Providers (as defined in 42 C.F.R. § 447.50(b)(2)) explain why Indian Health Care Improvement Act § 206 does not require approval of coverage and payment.

The proposed new NDMCP does not appear to apply to Medicare prescription drug plans.

- Recommendation: Confirm to what extent, if at all, the NDMCP applies to coverage and payment denials for Medicare prescription drug coverage under a Medicare Prescription Drug Plan.
- Recommendation: In the Form CMS-10003-NDMCP, add the following sentence under section titled: "If you want someone else to act for you":

---

<sup>12</sup> (Emphasis added.) *Blackford v. Alaska Native Tribal Health Consortium*, 645 F.3d 1089, 1092 (9<sup>th</sup> Cir. 2011); *see also id.* ("[S]ubsection (a) which defines the scope of the right of recovery, allows the provider to recover 'to the same extent **that [the Alaska Native or American Indian] individual . . . would be eligible to** receive reimbursement or indemnification for such expenses.") (emphasis in original); *Yukon-Kuskokwim Health Corporation v. Trust Ins. Plan for Southwest Alaska*, 884 F. Supp. 1360, 1366 (D. Alaska 1994), *Alaska Native Tribal Health Consortium v. Settlement Funds Held For or to Be Paid on Behalf of E.R. ex rel Ridley*, 84 P.3d 418, 424 (Alaska 2004).

Indian Health Care Providers may appeal denials of coverage or payment issued to American Indians or Alaska Natives without requiring the signature of the patient.

### **Estimate of Burden on Patients and Their Providers from Responding to NDMCP**

The CMS document “Supporting Statement – Part A; Notice of Denial of Medical Coverage (or Payment) – NDMCP, CMS-10003 / OMB approval #0938-0829” contains the justification prepared by CMS and submitted to OMB for approval of the release of the Paperwork Reduction Act (PRA) notice, and included a review mandated by the PRA of the burden to comply with the notice. Although the compliance burden is estimated for health plans, an estimated burden on individuals (i.e., patients and their providers) to respond to a NDMCP is not included in the PRA estimate. In our experience it takes about a significant amount of time to complete the paperwork associated with responding to an inappropriate NDMCP. Our concern with the paperwork burden is that if the changes we recommend in these comments are not made, we will have to respond to many more such notices that we would have to if the payers were put proactively notified of their obligations under Section 206.

We appreciate the opportunity to provide comment on CMS-10003. We are available to provide additional information as may be necessary to fully consider our recommendations.

Sincerely,

A handwritten signature in black ink, appearing to read 'Valerie Davidson', with a long, sweeping flourish extending upwards and to the right.

Valerie Davidson

Chair, TTAG