

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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Submitted via <http://www.regulations.gov>.

June 10, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9942-NC
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Comments on CMS-9942-NC, Request for Information Regarding Provider Non Discrimination

I write on behalf of the Tribal Technical Advisory Group (TTAG) of the Centers for Medicare & Medicaid Services (CMS) to comment on the Notice of Proposed Rulemaking issued jointly by CMS and the Department of Labor (DOL, jointly the Agencies) on CMS-9942-NC, Request for Information Regarding Provider Non Discrimination (the Notice).¹

The TTAG advises 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 in 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/ANs) under these Federal health care programs, including through providers operating under the health programs of the Indian Health Service (IHS), Indian Tribes, tribal organizations and urban Indian organizations (referred to as Indian health programs or I/T/Us).

The Notice seeks comment on Section 2706(a) of the Public Health Service Act (PHSA),² which prohibits certain insurance issuers from "discriminat[ing] with respect to participation under [a health] plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law," with a limited exception for "establishing varying reimbursement rates based on quality or performance measures."³ Specifically, the Agencies are requesting comment "on all aspects

¹ 79 Fed. Reg. 14,051 (Mar. 12, 2014).

² Added by section 1201 of the Patient Protection and Affordable Care Act (ACA), codified as amended at 42 U.S.C. § 300gg-5.

³ In full, this provision states:

of the interpretation of Section 2706(a) of the PHS Act. This includes but is not limited to comments on access, costs, other federal and state laws, and feasibility.”⁴

Thank you for the opportunity to respond to the Notice. As discussed below, we believe that Section 2706(a) prohibits insurers from excluding mid-level provider types commonly used by I/T/Us from their networks. In addition, we believe that the Agencies erred by suggesting that covered insurers may discriminate in rate setting based on “marketplace factors.” The Agencies’ subsequent actions should reflect these points.⁵

I. Background.

On April 29, 2013, the Agencies issued a Frequently Asked Question (FAQ)⁶ stating that Section 2706 “does not require plans or issuers to accept all types of providers into a network and also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations.”

The Senate Committee on Appropriations subsequently expressed its concern that the FAQ:

advises insurers that this nondiscrimination provision allows them to exclude from participation whole categories of providers operating under a State license or certification. In addition, the FAQ advises insurers that section 2706 allows discrimination in the reimbursement rates based on broad

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures.

⁴ 79 Fed. Reg. at 14,052.

⁵ It is unclear whether the Agencies are soliciting comments for the purposes of future rulemaking or are simply seeking responses to the FAQ discussed below.

⁶ FAQs about Affordable Care Act Implementation Part XV, *available at* <http://www.dol.gov/ebsa/faqs/faq-aca15.html> and <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca—implementation—faqs15.html> (Apr. 29, 2013).

‘market considerations’ rather than the more limited exception cited in the law for performance and quality measures. Section 2706 was intended to prohibit exactly these types of discrimination.⁷

The Committee then “direct[ed] HHS to work DOL and the Department of Treasury to correct the FAQ to reflect the law and congressional intent.”⁸ The solicitation of comment in the Notice followed.

II. Discussion.

1. Section 2706(a) Prohibits Insurers from Excluding or Discriminating Against Entire Provider Types.

As noted by the Senate Committee, the goal of Section 2706(a) is “to ensure that patients have the right to access covered health services from the full range of providers licensed and certified in their State.”⁹ The FAQ’s statement that Section 2706(a) “does not require plans or issuers to accept all types of providers into a network” undercuts this important statutory protection and could disproportionately disadvantage Tribal providers.

The I/T/U system utilizes a community-based public health model with many approaches that are not found in other American medical delivery systems. Indian health programs have pioneered alternative providers such as community health aides and practitioners, behavioral health aides, and dental health aides (including dental health aide therapists), as well as new approaches to delivering services in rural areas (like telehealth).¹⁰ Given that funding issues and remote facility locations often make it difficult for I/T/Us to retain full-time physicians, Indian health programs rely heavily on these and other non-physician providers such as nurse practitioners and advance practice nurses, physician assistants, etc.: for example, in 2009, 46 percent of IHS employees were nurses or physician assistants,¹¹ and there are currently over 600 CHA/Ps providing care to more than 50,000 people in 180 Alaska Native communities.¹²

⁷ S. REP. NO. 113-71, at 126 (2013).

⁸ *Id.*

⁹ S. REP. NO. 113-71 at 126.

¹⁰ CENTERS FOR MEDICARE AND MEDICAID SERVICES’ TRIBAL TECHNICAL ADVISORY GROUP, AMERICAN INDIAN AND ALASKA NATIVE STRATEGIC PLAN 2013-2018 at 7 (Feb. 20, 2014).

¹¹ NATIONAL CONGRESS OF AMERICAN INDIANS, NON-PHYSICIAN PRACTITIONERS IN INDIAN HEALTH SERVICE at 6 (Aug. 13, 2009).

¹² COMMUNITY HEALTH AIDE SELECTION AND TRAINING, OVERVIEW OF THE ALASKA COMMUNITY HEALTH AIDE PROGRAM at 32.

In light of drastic IHS underfunding¹³ and the AI/AN population's high morbidity and low level of insurance,¹⁴ it is critically important that insurers do not discriminate in their networks against the mid-level and other provider types who are often the only health service providers in Tribal communities. But the Agencies' current FAQ suggests that it is permissible for insurance issuers to simply exclude such provider types from their networks altogether. We therefore recommend that the Agencies interpret Section 2706(a) as prohibiting group health plans and health insurance issuers offering group or individual health insurance coverage from:

- Systematically excluding “whole categories of providers operating under a State license or certification”¹⁵ from their networks; and
- Restricting provider reimbursement or network inclusion according to the type or location of the provider's facility or service site.

This interpretation is consistent with the language and purpose of Section 2706(a) and will help protect vital sources of health services for AI/ANs.

2. Section 2706(a) Prohibits Insurers Discriminating Based on Marketplace Factors.

As noted above, Section 2706(a) authorizes insurers to establish “varying reimbursement rates based on quality or performance measures.” But the FAQ additionally states that insurers can discriminate based on “market standards.” The Senate Committee correctly noted that the FAQ's inclusion of the “market standards” clause exceeds “the more limited exception cited in the law for performance and quality measures”¹⁶ and is prohibited by the plain language of the statute.

Even if the statute permitted a market-based rates exception, it could negatively impact providers by aggravating an existing problem wherein insurance companies limit or

¹³ IHS is only funded at approximately 50% of need. *See* NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP'S RECOMMENDATIONS ON THE INDIAN HEALTH SERVICE FISCAL YEAR 2015 BUDGET at 3 (May 2013).

¹⁴ *See generally* Samantha Artiga, Rachel Arguello & Philethea Duckett, “Health Coverage and Care for American Indians and Alaska Natives” (Oct. 7, 2013), *available at* <http://kff.org/report-section/health-coverage-and-care-for-american-indians-and-alaska-natives-executive-summary/>.

¹⁵ S. REP. NO. 113-71 at 126.

¹⁶ *Id.*

reduce payments for certain provider types who do not work in specific facilities. For example, some insurers will pay for nurse midwives, but only if the midwife works in a hospital; if they work in a free-standing birth center, the insurer may pay the midwife but not the facility cost, even though the birth centers charges are only a fraction of the hospital's. Insurers could potentially justify this practice by citing reduced or withheld reimbursement in disfavored facility types as a "market standard," when in reality there would not be any quality or performance-related reason for doing so. Section 2706(a) should not allow such practices.

Finally, the Agencies should recognize that issuers may not discriminate against I/T/Us that choose to recover under the terms of Section 206 of the Indian Health Care Improvement Act,¹⁷ and that, when Marketplace issuers offer network contracts to I/T/Us as required by the Center for Consumer Information and Insurance Oversight (CCIIO),¹⁸ the contract must include payment rates at least equal to the issuer's generally applicable rates for in-network providers. If not, the Agencies risk aggravating existing problems of issuers refusing to negotiate in good faith with Indian providers and implementing sharp practices designed to minimize payments to Indian health programs. In accordance with its previous comments to CCIIO on the Final 2015 Letter (dated February 25, 2014) and comments to CMS on CMS-9949-P (dated April 21, 2014), the TTAG urges the Agencies not to interpret Section 2706(a) in such a way as to invite insurers to systematically exclude Tribal providers from insurance networks or to inappropriately reduce their recovery.

III. Conclusion.

Section 2706(a) prohibits insurer discrimination against providers operating within the scope of their state licensure or certification, with a limited exception for rate setting based on quality or performance measures. However, the Agencies' posted FAQ suggests that insurers can exclude or otherwise discriminate against entire provider types, and may do so based on marketplace factors with regard to reimbursement rates. As noted by the Senate Committee on Appropriations, the statute's plain language forecloses both such interpretations. We therefore suggest that any subsequent amendments to the FAQ or

¹⁷ 25 U.S.C. § 1621e (authorizing I/T/Us to recover from third parties their reasonable charges billed or, if higher, the highest amount the third party would pay for care and services furnished by providers other than I/T/Us, to any individual to the same extent that such individual, or any non-I/T/U provider of such services, would be eligible to receive reimbursement if (1) such services had been provided by a non-I/T/U provider and (2) such individual had been required to pay such charges or expenses and did pay such charges or expenses).

¹⁸ See Final 2015 Letter to Issuers in the Federally-facilitated Marketplaces (March 14, 2014) (requiring that issuers offer network 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").

regulations published pursuant to the Notice reflect the Senate Committee's interpretation of the statute, as the Agencies' failure to do so could have serious consequences for Indian health programs.

The TTAG appreciates the opportunity to comment on the Notice and looks forward to a continued open dialogue with the Agencies on the issues discussed above.

Sincerely,

A handwritten signature in black ink, appearing to read "Valerie Davidson". The signature is fluid and cursive, with a long, sweeping flourish extending from the end.

Valerie Davidson
Chair, TTAG