IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

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

August 4, 2015

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-10561
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Comments on CMS-10561, ECP Data Collection to Support Qualified Health Plan (QHP) Certification for PY 2017

On behalf of the Tribal Self-Governance Advisory Committee (TSGAC), I write to provide our comments on the Centers for Medicare and Medicaid Services' (CMS') Paperwork Reduction Act Notice titled "Essential Community Provider Data Collection to Support QHP Certification for PY 2017" (Notice).[1] The purpose of the Notice is to indicate the process CMS is proposing to use to update and maintain the essential community provider (ECP) list established by the Department of Health and Human Services (HHS). The HHS ECP List is used by qualified health plans (QHPs) offered on a Health Insurance Marketplace to identify ECPs operating in their service areas. QHPs are required to include a certain percentage of ECPs in their provider networks and meet other requirements specifically pertaining to Indian health care providers (IHCPs).

Established in 1996, the TSGAC provides information, education advocacy and policy guidance for the implementation for Self-Governance within the Indian Health Service (IHS). We appreciate the opportunity to provide these comments. In addition, we understand CMS anticipates publishing a proposed rule on this topic shortly. We ask that CMS consider the following comments and recommendations from TSGAC when finalizing the data collection plan proposed in this Notice and when drafting and finalizing the upcoming proposed rule.

The TSGAC applauds CMS for taking a proactive approach to ensuring the provisions in the Patient Protection and Affordable Care Act (Affordable Care Act or ACA) pertaining to ECPs are fully implemented and adhered to by QHP issuers. And specifically, we applaud CMS' efforts to update the HHS ECP List and the procedures used by QHP issuers in identifying ECPs, particularly IHCPs, that are to be offered contracts and are to be included in the QHP provider networks. We are concerned, though, that the timeframe for updating the HHS ECP List is too short and that the sanction if an ECP does not provide all requested data (which appears to be exclusion from the HHS ECP List) is too severe and ultimately counterproductive.

The TSGAC offers recommendations on these points below:

[1] CMS-10561, published in the Federal Register on June 5, 2015(80 FR 32132-3).

Background

In the Notice, CMS indicated that providers must "submit an ECP petition to appear on the HHS ECP list or provide required missing data fields to remain on the list." The Instructions for the Essential Community Providers Provider Petition for the 2017 Benefit Year (Instructions) associated with this Notice further stated that "some of the provider listings received from our federal partners are missing data elements critical for issuers to identify such providers for contract offerings" and that "providers that appear on the HHS ECP list for the 2016 benefit year must complete any required missing data fields in order to remain on the HHS ECP list for the 2017 benefit year." At present, all providers on the 2016/Draft 2017 HHS ECP List, including IHCPs, are missing data for at least three required data fields.

According to a discussion with representatives of the Center for Consumer Information & Insurance Oversight (CCIIO) of CMS, between October 23, 2015, and November 23, 2015, CMS plans to open the Essential Community Providers Provider Petition for the 2017 Benefit Year (Petition).[2] All IHCPs, even those that already appear on the 2016/Draft 2017 HHS ECP List, will have to provide some currently missing information in order to remain on the list for benefit year 2017.

Previous CCIIO guidance indicates that IHCPs seeking to correct their information or be added to the HHS ECP List prior to October 23, 2015, can e-mail CMS at essentialcommunityproviders@cms.hhs.gov. According to the guidance, these IHCPs also should contact the federal agency responsible for initially supplying their information to CMS for inclusion on the HHS IHCP List (*i.e.*, the Indian Health Service) and request to update their information.

Comments and Recommendations

The TSGAC offers the following comments and recommendations for CMS' consideration:

1. Attestation to Imposition of Sliding Fee Scale

The Instructions linked to the Notice list a number of statements to which provider petitioners must attest to qualify as an ECP, including the following: "Provider accepts patients regardless of ability to pay and offers a sliding fee schedule." However, IHCPs do not impose a sliding fee scale on IHS beneficiaries.

The "Provider Petition" Excel spreadsheet includes several questions as to the type of ECP provider status, such as: "Are you either eligible for or participating in the 340B program or you are a rural health clinic?" Instructions and explanations are then provided to indicate what the ramifications are for particular answers. A question could be added to the document asking if a provider is an IHCP and, if so, could indicate that the IHCP is not required to certify as offering a sliding fee schedule.

[2] These dates are accurate as of August 4, 2015. CMS plans to issue regulations on ECP data collection later this year, and these dates might change.

We recommend that:

a) CMS indicate it will not impose the requirement to offer a sliding fee schedule on IHCPs as a condition for being included in the HHS ECP List.

b) CMS add a question as to whether a provider is an IHCP and if the answer is yes indicate that the IHCP is not subject to the requirement to offer a sliding fee schedule.

2. Window to Update HHS ECP List

As indicated by CCIIO representatives, between October 23, 2015, and November 23, 2015, CMS plans to open the Petition for providers to make corrections and updates to their entries on the HHS ECP List.

We are concerned that the one-month window will not allow sufficient time for the hundreds of non-IHS Indian health care providers to access and update their information through the Petition. Therefore, we recommend that CMS:

a) Consider extending the timeframe for making updates to the HHS ECP List.

b) Prior to excluding current IHCPs on the HHS ECP List, undertake proactive efforts to contact individual providers to inform them of the need to update their entry or entries on the HHS ECP List.

c) Prior to excluding current IHCPs on the HHS ECP List, provide a list of the IHCPs that have failed to update their entry or entries to the Tribal Self-Governance Advisory Committee to IHS, the TSGAC, and/or IHS to allow proactive outreach by these organizations.

d) Provide a six-month grace period after the November 23, 2015, deadline prior to removing any IHCPs from the HHS ECP List.

3. Required Inclusion of National Provider Identifier

According to the Instructions, the data fields for which providers on the HHS ECP List must provide correct information include "National Provider Identifier" (NPI), "Org County" (organization county that the issuer would use to contact the provider for purposes of contract negotiations), and "POC 1 Email" (primary Point of Contact e-mail that the issuer would use to contact the provider for purposes of contract negotiations for the provider facility). With regard to NPI, the Instructions explicitly state, "If you currently appear on the HHS ECP List, you must enter your NPI in order to remain on the HHS ECP List for the 2017 benefit year." A review of the Draft 2017 HHS ECP List shows that none of the providers currently on the list have information listed for NPI or either of the other two fields, indicating that all of these providers will have to complete the Petition to remain on the list for PY 2017.

We generally support the mandated inclusion of an e-mail address for the primary Point of Contact, as well as the other fields indicated in the Instructions. However, for IHCPs, as was done with the initial list of IHCPs, we believe it would be most efficient for CMS to request that IHS provide the data for the fields for which IHS has the relevant information. Specifically, IHS is in possession of the NPI numbers for each IHCP. Having IHS provide the list of NPI numbers for all IHCPs is likely to result in a more rapid updating of the IHCP entries, minimizing the chances that any IHCPs would be excluded from the HHS ECP List for non-compliance with the requirement to update individual data fields through the Petition.

The TSGAC recommends that at least with regard to the NPI numbers, CMS populate this field with data provided directly from IHS for each IHCP.

4. Required Data

In addition to the three data elements identified above, we understand that CMS may be considering identifying additional data elements as "mandatory" fields. Failure to populate the mandatory fields would result in a current entry on the HHS ECP List being dropped from the list.

The TSGAC suggests that certain data are necessary for CMS to maintain an accurate HHS ECP List and to enforce the ECP-related contracting requirements. We support CMS in its efforts to enforce the ECP provisions. However, other data elements, although potentially useful in better understanding ECP operations, might not be critical to the successful operation of the ECP program. Dropping an existing ECP entry for not supplying non-critical information seems to be a sanction out of proportion with the benefit of providing the information, and this practice might generate counterproductive results by unnecessarily excluding ECPs, particularly IHCP ECPs, which are desperately needed in the provider networks of QHPs in order to facilitate access to critical health care services.

The TSGAC recommends that CMS limit the identification of "required" or "mandatory" data elements that could result in ECPs being excluded from the HHS ECP list to only those data elements critical to the ability of CMS to operate the ECP program.

5. Maintenance of Requirement to Offer to Contract with IHCPs

CMS has indicated that ECPs not providing all the required data elements requested will be excluded from the HHS ECP List. Given that the ECP contracting requirements appear to be tied to the HHS ECP List, a failure to be included on the HHS ECP List might impede or eliminate an ECP's right to the ECP protections in the Affordable Care Act.

One critical protection provided to IHCPs is the requirement for QHP issuers to offer a contract that meets minimum standards to each IHCP operating in the QHP's service area. In order to maintain this protection, we encourage CMS to state clearly that an IHCP's right to be offered a contract that meets minimum standards (and to accept the contract offer if the IHCP chooses) is retained even if the IHCP is not listed on the HHS ECP List. Doing so would have

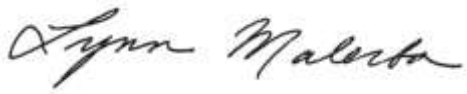
the practical effect of allowing an IHCP that learns they are not on the HHS ECP List sometime during a Marketplace coverage year to contact a QHP issuer and request a contract offer.

Although this would not impose a requirement on a QHP issuer to offer contracts proactively to IHCPs that are not on the HHS ECP List, it would retain the right of an IHCP to receive a contract offer from a QHP issuer if the IHCP notifies the QHP issuer of the IHCP's interest in a contract.

The TSGAC recommends that CMS clarify in the Petition, CCIIO Issuer Letter, and other appropriate documents that an IHCP's right to be offered a contract from a QHP issuer that meets minimum standards (and to accept the contract offer if the IHCP chooses) is retained even if the IHCP is not listed on the HHS ECP List.

In closing, we thank you again for the opportunity to comment on the Notice. The TSGAC looks forward to our continued, joint efforts to ensure the ACA's ECP provisions are fully implemented, adhered to, and enforced. Should you need additional information or have questions regarding these comments, please contact me at (860) 862-6192; or via email: lmalerba@moheganmail.com. Thank you.

Respectfully submitted,



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