Health Care Reform in Indian Country

Self-Governance Communication & Education

Self-Governance Tribes Striving Towards Excellence in Health Care

TSGAC – NPAIHB Webinar

Indian-Specific Cost-Sharing Protections:

Updates on Federal Policies and Implementation

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Agenda for Today's Webinar

- Introduction to Topic
- Structure of federal financial assistance for coverage through a Marketplace
- Overview of cost-sharing protections
- Review of Indian-specific cost-sharing protections
  - Different terms used to describe cost-sharing protections
  - Eligibility criteria
  - Eligibility determinations
- Comparison of Indian-specific cost-sharing variations
- Referrals for cost-sharing under "03" / "limited" cost-sharing variations
- Resolving problems and disputes regarding Indian-specific cost-sharing protections

Disclaimers

- *This training material is for informational purposes only and is not intended as tax or legal advice.*
- *Please talk with your accountant or attorney for specific tax or legal questions related to your Tribe, Tribal entity, or individual tribal members.*

Acronyms and Definitions

- ACA: Affordable Care Act
- HHS: Department of Health and Human Services
- CMS: Centers for Medicare and Medicaid Services, HHS
- CCIIO: Center for Consumer Information and Insurance Oversight, CMS
- QHP: Qualified Health Plan
- Issuer: Health insurance company that offers ("issues") QHPs on a Marketplace
- ECP: Essential community providers
- IHCPs (Indian health care providers) or I/T/Us (Indian Health Service, Indian Tribes, tribal organizations, and urban Indian organizations)
- FFM: Federally-facilitated Marketplace
- SBM: State-based Marketplace
- Plan management states: FFM states in which state is performing plan management functions (*e.g.*, network adequacy review)
- FPL: Federal poverty level
- PTC: Premium Tax Credit; APTC: Advanced Payment of PTC
- CSV: Cost-sharing Variation; CSR: Cost-sharing Reductions
- ISDEAA: Indian Self-Determination and Education Assistance Act
- IHCIA: Indian Health Care Improvement Act

Accessing ACA and Federal Regulations and Guidance

- Affordable Care Act (ACA)
  http://housedocs.house.gov/energycommerce/ppacacon.pdf

- Code of Federal Regulations (CFR)
  http://www.ecfr.gov/cgi-bin/ECFR?SID=7f8540b42be198e365873efe5f15dcb8&page=browse

- Guidance document: CCIIO 2015 Issuer Letter
  http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf

Structure of federal financial assistance for coverage through a Marketplace

Structure of Federal Assistance for Coverage through a Marketplace

Source and Distribution of Funding for Marketplace Coverage, 2015
- American Indian or Alaska Native Family -
Three-person household; annual income of $69,265 (350% FPL)
(bronze-level coverage; three Marketplace enrollees)

$14,000
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$0

$0
$5,701
$4,435
$2,961

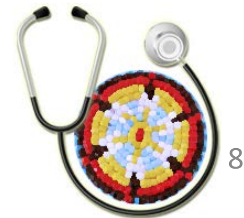
Cost-sharing: 40% of total
Premiums: 60% of total

Enrollee cost-sharing
Federal Cost-sharing reductions
Enrollee premium contribution
Federal Premium Tax Credit

Total Funding: $13,097

SOURCE: Analysis of Kaiser Family Foundation, "Analysis of 2015 Premium Changes in the ACA's Health Insurance Marketplaces", September 2014, Issue Brief.

Cost-sharing protections



Cost-Sharing / Reductions

1. Cost-sharing [45 C.F.R. 155.20]
   - "*Cost sharing* means any expenditure required by or on behalf of an enrollee with respect to essential health benefits (EHBs),
     - Including deductibles, coinsurance, copayments, or similar charges,
     - But excluding premiums, balance billing amounts for non-network providers, and spending for non-covered services."
2. Cost-Sharing Reductions [45 C.F.R. 155.20]
   - *Cost-sharing reductions* (CSR) means reductions in cost sharing (deductibles, coinsurance, copayments) for an eligible individual enrolled
     - In a silver level plan in the Exchange or
     - For an individual who is an Indian enrolled in a QHP in the Exchange.

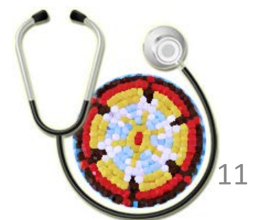
Cost-Sharing Reductions

- Exceptions to Cost-Sharing Reductions
  - Catastrophic plans: CSR apply only to "metal level" plans (bronze, silver, gold or platinum) – Don't enroll in a "catastrophic" plan.
  - Stand-Alone Dental Plans (SADPs): CSR do not apply to SADPs. When a pediatric dental benefit is provided by the QHP, the CSR applies to the pediatric coverage. [45 CFR § 155.1065]
  - Family plan considerations: The CSR available to each member enrolled in a family plan is the least comprehensive CSR that any individual in the family is eligible. [45 CFR § 155.305(g)]
  - Balance billing: *"Balance billing"* is when a provider bills a patient for the difference between the provider's charge and the allowed amount the health plan will pay.
- Example of Balance Billing
  - QHP sets a payment rate of $100 for a specific service for non-network providers. The standard arrangement is the QHP pays the provider $80 and the patient has a co-payment of $20.
  - The provider charges $130. The AI/AN patient has comprehensive cost-sharing protections and does not owe the co-payment. The QHP pays the provider $80 plus the $20 waived co-payment. But, the patient owes the provider a $30 balance billing amount.

Cost-Sharing Variations

3. Cost-Sharing Variations
   - QHP issuers are required to offer each QHP with a range of CSR packages, referred to as cost-sharing variations (CSVs).
     - Two of the CSVs are Indian-specific.
   - Under the Federally-facilitated Marketplace (FFM), the following CSV codes (Variant Component ID) are used:
     - 00 - Non-Exchange variant
     - 01 - Exchange variant (no CSV)
     - **02 - Open to Indians below 300% FPL ("zero" CSV)**
     - **03 - Open to Indians above 300% FPL ("limited" CSV)**
     - 04 - 73% AV Level Silver Plan CSV
     - 05 - 87% AV Level Silver Plan CSV
     - 06 - 94% AV Level Silver Plan CSV
   - Marketplace eligibility determination letters might—or might not—contain these CSV codes indicating which CSV applies to each Marketplace applicants.

http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/companion-guide-for-ffe-enrollment-transaction-v15.pdf (Page 36)



Requirement on QHP Issuers to Offer "Zero" and "Limited" CSVs

- A QHP issuer is required to offer a "zero" and "limited" version ("variation") of each QHP.

Cost-Sharing Plan Variations			
Metal Level	**QHP Issuer (*e.g.* , Cigna Health) Offerings**		
	QHP #1 Cigna Tracker**	**QHP #2** Cigna Moonshot**	**QHP #3** Cigna Signpost**
Platinum Gold* Silver* Bronze	- Same provider networks - Same benefits - Different cost-sharing	- Same provider networks - Same benefits - Different cost-sharing	- Same provider networks - Same benefits - Different cost-sharing

* QHP Issuers required to offer QHPs at silver and gold metal levels.

** 45 CFR §156.420(d) *Benefit and network equivalence in zero and limited cost-sharing plan variations.* A QHP and each zero cost-sharing plan variation or limited cost-sharing plan variation thereof must cover the same benefits and providers.

New!

Requirement for QHP Issuers to Provide "Summary of Benefits and Coverage" for Each "Zero" and "Limited" CSV

- Prior to 2016 open enrollment (*i.e.*, October 2015), QHP issuers are to make available a Summary of Benefits and Coverage (SBC) document for each QHP variation.
  - An SBC is to be prepared and made available for each "zero" cost-sharing plan variation and each "limited" cost-sharing plan variation, as well as for the CSVs available to the general population.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.modahealth.com	Value drugs	$0 copay	$0 copay	Covers up to a 90-day supply retail and mail order drugs. Copay per 30 day supply. Covers up to a 30-day supply specialty drugs. Prior authorization may be required.
	Select tier drugs	$0 copay	$0 copay	
	Preferred brand drugs	0% coinsurance	0% coinsurance	
	Non-preferred brand drugs	0% coinsurance	0% coinsurance	
	Specialty drugs	0% coinsurance	0% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	Prior authorization required to avoid a penalty of 50% up to a maximum deduction of $2,500.
	Physician/surgeon fees	0% coinsurance	0% coinsurance	
	Emergency room services	0% coinsurance	0% coinsurance	-----------none-----------

Labels for Indian-specific cost-sharing protections

ACA's Section 1402(d): Indian-specific cost-sharing protections

ACA Section 1402(d) SPECIAL RULES FOR INDIANS.—

"02" CSV

(1) INDIANS UNDER 300 PERCENT OF POVERTY.—If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))) whose household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section—

(A) such individual shall be treated as an eligible insured; and

(B) the issuer of the plan shall eliminate any cost-sharing under the plan.

"03" CSV

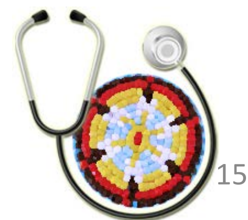
(2) ITEMS OR SERVICES FURNISHED THROUGH INDIAN HEALTH PROVIDERS.—If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services—

(A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and

(B) the issuer of the plan shall 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 subparagraph (A).

(3) PAYMENT.—The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection.

https://www.healthcare.gov/where-can-i-read-the-affordable-care-act/



Different Terms Used for Indian-Specific Cost-Sharing Protections

- In addition to the references cited above, in the federal regulations [at 45 CFR § 156.420] the terms "zero" cost-sharing plan variation and "limited" cost-sharing plan variations are used to describe the Indian-specific protections.
- In addition, under 45 CFR § 155.350 (b), the "03" protections are described as "*Special cost-sharing rule for Indians regardless of income".*

Description of Indian-Specific Cost-Sharing Protections				
Statutory Reference (Affordable Care Act)	**Regulatory Reference**	**Variant Component ID ("Code")**	**Title of Plan Variation (45 CFR §156.420)**	**Shorthand Reference**
ACA § 1402(d)(1)	45 CFR §155.350(a)	"02"	Zero cost-sharing plan variation	"100-300% FPL" or "under 300%"
ACA § 1402(d)(2)	45 CFR §155.350(b)	"03"	Limited cost-sharing plan variation	"Any income"

Eligibility criteria and determinations for Indian-specific cost-sharing protections

Definition of Indian Applicable to Indian-Specific Cost-Sharing Protections

In federal regulations [at 45 C.F.R. 155.300(a)], the definition of Indian applicable to the ACA's Indian-specific cost-sharing protections is:

- *"Indian* means any individual as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (Pub. L. 93-638)."
    - Member of an Indian Tribe
    - Shareholder in an Alaskan regional or village corporation
- Does not include all IHS beneficiaries
- Efforts continue by Tribal leadership to secure a regulatory change, or a change in law, that extends the definition of Indian that applies to the Indian-specific benefits and protections under Medicaid [42 CFR § 447.51] to the ACA's Indian-specific benefits.

Eligibility Criteria for Indian-specific cost-sharing protections

- To be eligible to enroll in Marketplace coverage, an individual must:
  - Live in the service area of the Marketplace (*i.e.*, the state),
  - Be in the U.S. legally, and
  - Not be incarcerated.
- And for "Zero cost-sharing variation" ("02"):
  - Meet the ACA's definition of Indian
  - Have household income between 100 and 300 percent FPL
  - Qualify for premium tax credits
- And for "Limited cost-sharing variation" ("03"):
  - Meet the ACA's definition of Indian
  - Have household income of any level
  - <u>Do or do not</u> qualify for premium tax credits
- To receive the "02" or "03" protections, an individual cannot be enrolled in a family plan with individuals who are not eligible for the "02" or "03" protections. [45 CFR § 155.305(g)]

Errors in Describing Indian-Specific Cost-Sharing Protections

Excerpt from CMS "Tribal Specific Fact Sheet: Special Protections for AI ANs" –

02 / Zero CSV:

"Tribal members and ANCSA shareholders with income at or below 300% of FPL:

- May be able to enroll in a **zero cost sharing plan**, which means no copays, deductibles, or coinsurance when receiving care from Indian health care providers or when receiving Essential Health Benefits (EHBs) through a QHP.
- There is no need for a referral from an Indian health care provider when receiving EHBs through the QHP."

03 / Limited CSV:

"Tribal members and ANCSA shareholders with incomes above 300% FPL:

- Can enroll in a **limited cost sharing plan**, which means no copays, deductibles, or coinsurance when receiving care from Indian health care providers.
- Will need a referral from an Indian health care provider to avoid cost sharing when receiving EHBs through a provider outside the Indian health system."

- http://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Outreach-and-Education-Resources.html#Tribal Specific Brochures
- http://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/AIANs-SpecialProtections-Fact-Sheet.pdf

Eligibility Criteria for Indian-Specific Cost-Sharing Protections

Eligibility for Indian-Specific Cost-Sharing Protections:
(1) Eligibility determinations for "insurance affordability programs"
and (2) non-income based eligibility determinations

If HH income is: (1)*

Household Income as a Percentage of Federal Poverty Level

Household Income as a Percentage of Federal Poverty Level	
500%+	Limited Cost-Sharing Variation
400%	Limited Cost-Sharing Variation
300%	Zero Cost-Sharing Variation
200%	Zero Cost-Sharing Variation
100%	Limited Cost-Sharing Variation
0	

Eligibility determination for insurance affordability programs*

HH income of any income level: (2)**

Household Income as a Percentage of Federal Poverty Level

Household Income as a Percentage of Federal Poverty Level	
500%+	Limited Cost-Sharing Variation
400%	Limited Cost-Sharing Variation
300%	Limited Cost-Sharing Variation
200%	Limited Cost-Sharing Variation
100%	Limited Cost-Sharing Variation
0%	

Non-income based eligibility determination**

45 CFR § 155.350(a) Special eligibility standards and process for Indians.

* 45 CFR § 155.350(a) Eligibility for cost-sharing reductions.

** 45 CFR § 155.350(b) Special cost-sharing rule for Indians regardless of income.

2015 FFM Enrollment #'s for Individuals Meeting Definition of Indian under ACA

Indian Enrollment in FFM, 2015 (as of February 2, 2015)			
	Meet ACA's Definition of Indian	**% of Indian Applicants**	**% of Indian Enrollees**
Applications Submitted to the Marketplace (at least one individual on application meets "Indian" criteria)			
Number of applications submitted	34,153		
Number of Indian individuals on applications submitted	125,822		
Average number of Indian individuals on each application submitted	3.7		
Determinations Made by Marketplace			
Individuals determined QHP eligible without CSR	42,028	50%	50%
Individuals determined QHP eligible with CSR	41,626	49%	49%
Individuals determined Medicaid Eligible	799	1%	1%
Individuals determined not eligible for QHP	335	0%	0.4%
Total determinations	84,788	67%	100%
Qualified Health Plan Selections (by cost-sharing reduction (CSR) type)			
01: No CSR	3,713	3%	14%
02: Income based (AI/AN only)	18,030	14%	69%
03: Non-income based (AI/AN only)	3,916	3%	15%
04 - 06: Standard income based CSR	597	0.5%	2%
Total Indians enrolled in coverage through FFM	**26,256**	**21%**	**100%**

Full CCIIO report is available on TribalSelfGov.org Website at http://tribalselfgov.org/wp/wp-content/uploads/2015/06/CCIIO-FFM-AI-AN-Enrollee-Counts-2015-REVISED-data-as-of-02-22-20.pdf

Concerns Over Eligibility Determinations Made for Indian-Specific CSVs

- Despite errors in describing the "03" / "limited" CSVs, persons with household income under 100% FPL should be receiving the "limited" CSV.
- Tribal leaders are working to clarify with HHS/CMS/CCIIO:
  - Correct eligibility criteria
  - Accurate eligibility determination process
  - Sufficient eligibility determination notifications
    - Eligibility determination letters provided to enrollees
    - Communications with QHP issuers
- Errors in eligibility determinations might be leading to problems with correct payment amounts being paid to IHCPs and other providers.

Comparison of Indian-specific cost-sharing protections

Comparison of Indian-specific CSVs

<u>Benefit of Indian-specific CSVs</u>

- 100 percent cost-sharing protections under both CSVs, with important caveats.

<u>Caveats for both Indian-specific CSVs</u>

- Cost-sharing protections apply only to essential health benefits (EHBs)
- Prior authorization
  - A QHP's prior authorization requirements still apply under "02" and "03" CSVs.
  - If the QHP's prior authorization requirements are not met by the enrollee, the plan can deny making any payment—or make only partial payment—for the service.
- With closed panel QHPs, no CSR for out-of-network providers.

<u>Caveats for "03" / "limited" CSV</u>

- "Referral for cost-sharing"
  - To secure CSR under "limited" CSV when a service is provided by a non-IHCP, a patient must receive a referral from an IHCP / THO (either before or after the service is provided).
- Risk of balance billing
  - Non-network providers may charge a patient an amount above the QHP's agreed upon payment rates.
    - When this occurs, the cost-sharing amounts are waived, but the patient is billed a "balance billing" amount by the provider.

Referrals for cost-sharing under “03” / “limited” CSV

“Referral for Cost-Sharing” under “03” / “limited” CSVs

- Under the “03” / “limited” CSV, a referral for cost-sharing is required to secure the comprehensive cost-sharing reductions when seeing a non-IHCP.
- A May 9, 2014, Q&A document from CCIIO indicates:
  - “To document eligibility for reimbursement for cost-sharing reductions provided to an enrollee on an EHB provided through referral under contract health services... the issuer must retain documentation that includes ... [a] copy of the referral.” [5/9/2014 CMS Guidance]
    - The CMS guidance from 5/9/2014 is linked here:
      https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CSRs_and_Contract_Health_Services_QA.pdf
- The Q&A guidance was issued by CCIIO to QHP issuers.
- The Q&A guidance was for the purpose of assisting a QHP issuer in submitting sufficient documentation to secure reimbursement for waived cost-sharing amounts.

Form and Process for “Referrals for Cost-Sharing”

- THOs have authority to issue a referral for cost-sharing in the form the THO chooses, within the guidelines issued by CCIIO.
  - Some THOs are issuing referrals for cost-sharing as (1) forms, (2) emails, and/or (3) cards.
  - THOs distinguish between “authorizations” for payment by a P/RC program and a “referral” for cost-sharing purposes.
- THOs are encouraged to work with QHP issuer on an agreed upon *process* for documenting a “referral for cost-sharing”.
  - Requirements placed on a THO by QHP issuer should be no more restrictive (or burdensome) than is provided for in the CMS May 9, 2014, guidance document.

CCIIO-Issued Guidance on "Referrals for Cost-Sharing"

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: **May 9, 2014**

Subject: **Cost-Sharing Reductions for Contract Health Services**

Q: What documentation standards, under the maintenance of records requirements in 45 CFR 156.480, apply for cost-sharing reductions for an item or service that has been furnished through referral from an Indian health program, including an urban Indian program, under contract health services?

A: 45 CFR 156.420(b)(2) specifies that issuers must provide cost-sharing reductions to eligible enrollees under 45 CFR 155.350(b) on any "item or service that is an EHB furnished . . . through referral under contract health services." 45 CFR 156.430 provides for payments to issuers for cost-sharing reductions. To document eligibility for reimbursement for cost-sharing reductions provided to an enrollee on an EHB provided through referral under contract health services, as defined in 25 U.S.C. 1603(5) and any implementing guidance, and to meet the standards set forth at 45 CFR 156.480, the issuer must retain documentation that includes the following information:

- Identification of the patient receiving the item or service (e.g. name and date of birth);
- The name and address of the provider delivering the item or service;
- A description of the item or service furnished through referral under contract health services, including the date(s) the item or service was provided; and
- The name of the Indian health program issuing the referral under contract health services, contact information for the program, and the date of the referral.
- A copy of the referral. (We note that many of the required elements above may be contained in the referral itself, and recognize that often the referral will be obtained after the service has been provided.)

Potential Source of Required Information for Documentation of Referrals for Cost-Sharing

- ***THO-supplied*** information
  - Identification information for patient receiving an item or service through referral (name of patient; date of birth of patient)
  - Name of the Indian health program (aka THO) issuing the referral under contract health services
  - Contact information for the THO issuing the referral
  - Date of the referral
- ***QHP-supplied*** service-specific information
  - Name and address of the provider delivering the item or service
  - Description of the item or service furnished through referral under contract health services
  - Date(s) the item or service was provided
- "We note that many of the required elements above may be contained in the referral itself, and recognize that often the referral will be obtained after the service has been provided."
  - Referrals can be issued retroactively, after service is provided.

Example of Form Used for Referral for Cost-Sharing

[Insert letterhead of Tribal Health Organization (THO) / Indian Health Program] *SAMPLE*

REFERRAL FOR COST-SHARING PROTECTIONS[1]

For individuals enrolled in a health insurance plan through the Health Insurance Marketplace with comprehensive cost-sharing protections under 45 CFR § 156.420(b)(3) ("limited cost-sharing variation").

1. This referral is being provided by [insert name of THO] Indian health program under the Purchased/Referred Care (aka contract health services) program for the following individual:

   Patient Name: ______________________

   Patient Date of Birth: ______________________

   Date of Referral: ______________________

2. This referral is for the following covered items and services (**check one**):

   ☐ All covered items and services: ______________________

   ☐ All covered items and services pertaining to the following treatment / episode of care:

   ____

   ____

   ☐ Specific items and services (list):

   (1) ______________________

   (2) ______________________

   (3) ______________________

For information on this referral, please contact [INSERT NAME OF THO / INDIAN HEALTH PROGRAM] at [INSERT PHONE NUMBER, FAX NUMBER, AND / OR EMAIL ADDRESS OF THO].

NOTES TO PATIENT:

- **This referral does not serve as an authorization for payment by the Purchased/Referred Care Program (aka contract health services).**
- **A "plan referral" (*e.g.*, prior authorization) may be required by the [health plan] prior to receiving an item or service. For questions on whether prior authorization is needed for a particular service, contact the [health plan] at: [INSERT PHONE NUMBER OF HEALTH PLAN].**

[1] This referral meets the requirements under the Patient Protection and Affordable Care Act as specified in the FAQ document released by the Centers for Medicare and Medicaid Services on May 9, 2014.

- TSGAC Resources
  - TribalSelfGov.org website Q&A on referrals [See question #19.]
    http://tribalselfgov.org/health-reform/health-q-a/section-a-marketplace-enrollment-and-sponsorship/
  - Sample 1: Single item or service referral
    http://tribalselfgov.org/wp/wp-content/uploads/2015/05/Referral_letter_Sample_1_generic_2015-04-14.pdf
  - Sample 2: Combined single / comprehensive referral
    http://tribalselfgov.org/wp/wp-content/uploads/2015/05/Sample-Referral-Indian-specific-Cost-sharing-Protections-2015-03-19b.pdf

Specifying Services on a Referral for Cost-Sharing: Example

[Insert letterhead of Tribal Health Organization (THO) / Indian Health Program] ***SAMPLE***

REFERRAL FOR COST-SHARING PROTECTIONS[1]

For individuals enrolled in a health insurance plan through the Health Insurance Marketplace with comprehensive cost-sharing protections under 45 CFR § 156.420(b)(3) ("limited cost-sharing variation").

1. This referral is being provided by [insert name of THO] Indian health program under the Purchased/Referred Care (aka contract health services) program for the following individual:

   Patient Name: ____________________

   Patient Date of Birth: ____________________

   Date of Referral: ____________________

2. This referral is for the following covered items and services (**check one**):

   □ All covered items and services: ____________________

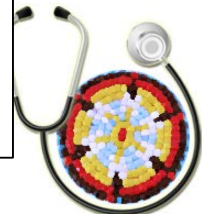
   □ All covered items and services pertaining to the following treatment / episode of care:

   ____

   ____

   □ Specific items and services (list):

   (1) ____________________



Notes to Enrollees on Limitations of Referral for Cost-Sharing: Example

- To ensure QHP enrollees / HIS beneficiaries understand the limitations of a "referral for cost-sharing:
  - THOs often distinguish between "authorizations" for payment by a P/RC program and a "referral" for cost-sharing purposes.
  - THOs often clarify that QHP prior authorization requirements still apply.

NOTES TO PATIENT:

- **This referral does not serve as an authorization for payment by the Purchased/Referred Care Program (aka contract health services).**
- **A "plan referral" (*e.g.*, prior authorization) may be required by the [health plan] prior to receiving an item or service. For questions on whether prior authorization is needed for a particular service, contact the [health plan] at: [INSERT PHONE NUMBER OF HEALTH PLAN].**

[1] This referral meets the requirements under the Patient Protection and Affordable Care Act as specified in the FAQ document released by the Centers for Medicare and Medicaid Services on May 9, 2014.

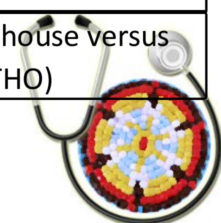
Comparison of CMS Referral Requirements under American Recovery and Reinvestment Act of 2009 (ARRA) and ACA

CMS Regulatory Approach to Indian-Specific Cost-Sharing Protections Under ARRA vs. ACA			
Statute	Statutory Language on Cost-Sharing Protections	Regulatory Language Implementing Eligibility Determination for Cost-Sharing Protections	Rationale Provided by CMS
ARRA section 5006(a)	"No enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by [an I/T/U] or through referral under contract health services for which payment may be made under [Medicaid]." **[ARRA §5006(a)]**	▪ "Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services are exempt from all cost sharing." **[42 CFR § 447.56(a)(1)(x)]**	"Because no formal paper trail may occur for the Medicaid agency to establish that a service has been delivered based on a referral under contract health services, ... [w]e propose that those Indians who are currently receiving or have ever received an item or service furnished by [an I/T/U] or through referral under contract health services are exempt from all cost sharing." **[CMS-2334-P]**
ACA section 1402(d)(2)	"If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by [an I/T/U] 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 ..." **[ACA §1402(d)(2)]**	▪ "The Exchange must determine an applicant eligible for the special cost-sharing rule described in section 1402(d)(2) ... if he or she is an Indian, without requiring the applicant to request an eligibility determination for insurance affordability programs ...." **[45 CFR § 155.350(b)]** ▪ "For individuals eligible for cost-sharing reductions under §155.350(b) ..., [the issuer must provide] a variation of the health plan with no cost sharing on any item or service that is an EHB furnished directly by [an I/T/U] or through referral under contract health services." **[45 CFR § 156.420(b)(2)]** ▪ "To document eligibility for reimbursement for cost-sharing reductions provided to an enrollee on an EHB provided through referral under contract health services... the issuer must retain documentation that includes ... [a] copy of the referral." **[5/9/2014 CMS Guidance]**	"Interpretation of section 1402(d)(2) of the Affordable Care Act: In the proposed rule, we discussed in detail our interpretation of sections 1402(d)(1), 1402(d)(2), and 1402(f)(2) of the Affordable Care Act. The implication of these interpretations is that cost-sharing reductions under sections 1402(a) and 1402(d)(1) of the Affordable Care Act are only available to individuals who are eligible for premium tax credits. However, we stated that under our interpretation, cost-sharing reductions under section 1402(d)(2) of the Affordable Care Act would be available to Indians regardless of their eligibility for premium tax credits." **[CMS-9964-F]**[1], [2]

Resolving problems and disputes regarding Indian-specific cost-sharing protections

Common Issues Experienced by THOs

Common Impediments to Maximizing Revenues through Tribal Sponsorship		
	Issue	**Considerations**
1.	Reimbursement rates / Discount on charges	Rates subject to negotiation with health plan; consider use of Section 206 authority
2.	Application of deductibles	Not permitted
3.	Application of cost-sharing - general	Not permitted
4.	Application of cost-sharing - pharmacy	Not permitted
5.	Denied claims - prior authorization required	Process improvement needed; possibly over-restrictive formulary in chosen health plan
6.	Denied claims - non-covered services	Bariatric surgery; Hepatitis C medications; compare health plan coverage policies
7.	Plan payment to patient, not provider	Potential problem when I/T/U is out-of-network; process improvement needed, if occurring
8.	Billing cycle delays	Opportunities to reduce length of time to submit bills to health plans and to respond to health plan inquiries
9.	Length of time to identify and enroll individuals in Marketplace coverage	Unlike Medicaid, Marketplace coverage is not retroactive; need for proactive enrollment
10.	Scope of services at I/T/U	Consider which services are best provided in-house versus outside providers (other THO; non-THO)



Importance of Documenting Issues with QHP Issuers: QHPs have 45-days to correct CSR-related payment issues

- Under the Indian-specific CSVS, no cost-sharing should be imposed for services provided to enrollees (assuming other requirements are met).
- A QHP issuer is not to reduce the payment to IHCPs (or non-IHCPs when service is delivered pursuant to a referral for cost-sharing) for any item or service by the amount of any waived cost-sharing. [*See* 45 CFR 156.430(g).]
- 45 CFR 156.410(c)(1)(i) dictates the **QHP issuer must refund the excess cost-sharing "paid by the provider" (*i.e.*, deducted from the payment to the provider)** **<u>within 45 calendar days</u>** of discovery of the improper application of these rules.
  - If patient was required to pay cost-sharing erroneously, there are repayment protections for the patient that apply as well.
    - http://www.ecfr.gov/cgi-bin/text-idx?SID=cee4ecb024fdffb42dfbc9e2d9ed6ad3&mc=true&node=se45.1.156_1410&rgn=div8

Filing Complaints with Marketplace

- CCIIO encourages all enrollees and providers to work with QHP issuers directly to resolve disputes.
- If problems and disputes are not resolved with QHP, complaints are to be filed with FFM through Health Insurance Casework System (HICS) [45 C.F.R. § 156. 1010]
  - Examples of potential complaints that are appropriate to file with the FFM include: the wrong cost-sharing amounts being charged an enrollee; the QHP not offering contracts to IHCPs; or the QHP charging the wrong insurance premium amount.
  - "Appeals" of an "alternative benefit determination" by a QHP are to be filed with the QHP.
- **Call FFM Contact Center (1-800-318-2596) to register a complaint.**
  - The complaint may be filed by enrollee or someone authorized to interact with the Marketplace on enrollee's behalf. At this time, there does not appear to be an ability to file a complaint through the HealthCare.gov Web site.
  - State-based Marketplaces to establish similar process.
    - An individual may also wish to contact the state's insurance regulator to file a complaint.

Importance of Filing Complaints

- There are timeframes established for QHPs to resolve complaints (14 days general standard; 72 hours "urgent" cases)
- CMS to track complaints and use aggregated complaint information as a tool for directing oversight activities in FFMs.
  - For example, if cost-sharing protections are applied incorrectly and not corrected timely, file complaint through HICS.
- In contrast to complaints, "appeals" of coverage decisions (also referred to as "alternative benefit determinations") are to be filed directly with QHP using internal and external review processes.

Resolution of Complaints Filed through HICS

- When calling the Contact Center, the Contact Center will enter your information into HICS, and the complaint will be provided to the QHP for resolution.
- There are timeframes established for QHPs to resolve complaints –
  - Urgent issue: Complaints regarding “urgent” issues are to be resolved by the QHP within 72 hours of receiving the complaint from the FFM. Urgent cases are those in which there is an immediate need for health services and, if the non-urgent standard were used, could seriously jeopardize the enrollee's or potential enrollee’s life, health or ability to attain, maintain, or regain maximum function, or one in which the process for non-urgent cases would jeopardize a potential enrollee's ability enroll in a QHP through FFMs.
  - Other issues: Non-urgent issues are to be resolved within 15 calendar days of receiving the complaint from the FFM.
- The QHP is to communicate resolution of the complaint to the enrollee within three days of resolving the issue. This may be done in writing or verbally. If verbally, the QHP is to provide a written statement to the enrollee “in a timely manner.”
  - The QHP is also to enter – within 7 days of resolving the issue – a description of the resolution into HICS, so the FFM staff will have information on how the QHP represents it responded to the complaint.
  - More information on the HICS can be accessed at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/casework-guidance-03132014.pdf