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AGENDA ITEM

[X] **For Possible Action**

[ ] **Information Only**

Date: July 31, 2023

Item Number: VI

Title: Proposed Final Language related to CFR 156.1250 for Aggregated Billing for Tribal Health Clinics, after conclusion of Public Comment period

PURPOSE

The purpose of this report is to provide information to the Board and public regarding the implementation of the Tribal Sponsorship Program and with the conclusion of the public comment period for stakeholders on proposed language that will be included in the annual Issuer Agreement and the Nevada Health Link Policy Manual.

SUMMARY OF CHANGES

SSHIX received a substantial amount of comments and questions during the public comment period, and this feedback has been included in the "For board consideration and approval" section of this document. The changes reflected below in our proposed language for the Plan Year 24 Issuer Agreement and Nevada Health Link Policy Manual were intended to address and resolve these comments and questions. In particular the feedback we received convinced SSHIX that an additional document, which was not included for review during the public comment period, would be necessary to cement the business relationship between Tribal Health Clinics and the participating issuer(s) of their choice and clearly delineate the roles and responsibilities for both parties. This forthcoming document, which we are referring to herein as the Addendum for the Aggregation of Monthly Premiums for Tribal Enrollees, is still under internal development, however a draft version of this document will be circulated to both issuers and Tribal Health Clinics during August, 2023, for review by their respective legal teams.

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EXISTING CFR:

§ 156.1250 Acceptance of certain third-party payments.

Issuers offering individual market QHPs, including stand-alone dental plans, and their downstream entities, must accept premium and cost-sharing payments for the QHPs from the following third-party entities from plan enrollees (in the case of a downstream entity, to the extent the entity routinely collects premiums or cost sharing):

(a) A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;

(b) An Indian tribe, tribal organization, or urban Indian organization; and

(c) A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.

PROPOSED LANGUAGE FOR PLAN YEAR 24 DRAFT ISSUER AGREEMENT:

4.6 Aggregated Billing for Tribal Health Clinics:

45 CFR 156.1250 requires QHP Issuers to accept premium and cost-sharing payments for tribal members directly from Indian tribes, tribal organizations, or urban Indian organizations. By default, the monthly premiums for these enrollments are managed on an individual-policy basis. The Exchange has therefore leveraged the authority granted by 45 CFR § 155.240(b) to establish terms and conditions which will standardize the aggregated payment of premiums for tribal enrollees by Nevada's Tribal Health Clinics.

Issuers who participate in the Aggregated Billing process can simplify the administration of these enrollments by receiving a single, aggregated monthly payment for all policies belonging to a Tribal Clinic. Before participation can begin, issuers must submit a completed copy of SSHIX's Intent to Participate in Aggregated Billing for Tribal Health Clinics form. A list of participating issuers, as well as their rating areas and supported payment methods, will be made available at https://www.nevadahealthlink.com/tribes/.

Tribal Health Clinics who wish to participate in the Aggregated Billing process must have a signed and executed network provider agreement in place with the participating issuer(s) of their choice, and they must also maintain a signed and executed copy of SSHIX's Addendum for the Aggregation of Monthly Premiums for Tribal Enrollees. This addendum, which details the roles and responsibilities for participating issuers and Tribal Health Clinics, serves as a binding agreement between one issuer and

one clinic for a single plan year, and must be renewed on an annual basis.

Participating clinics are also required to maintain a minimum of one (1) certified Tribal Enrollment Representative (TER) on staff at all times. TER's are individually certified by SSHIX to offer enrollment assistance to tribal consumers. Participating issuers are required to make educational resources regarding their plan offerings available to TER's in the same manner as these resources are made available to Navigators or In-Person Assisters.

Tribal enrollments leverage existing functionality within the Exchange platform, and no information can be provided via 834 to distinguish tribal enrollments from non-tribal enrollments. To facilitate aggregated billing SSHIX will provide a list of applicable enrollments, referred to as the Tribal Enrolled Consumers report, to participating Tribal Clinics by the fifth (5th) of each month. This report, which will be transmitted via email as a password-protected Excel spreadsheet, includes columns for Exchange Assigned Policy ID and Subscriber ID, and is derived from the invoices that SSHIX sends to issuers each month for their Carrier Premium Fee. This process ensures parity between the two sets of reports by guaranteeing that every enrollment listed on the Tribal Enrolled Consumers report will have a matching enrollment on SSHIX's monthly invoice, including any adjustments that might be required by retroactive corrective action.

After the clinics have verified the completeness and accuracy of each monthly report, they will forward the report via email to the applicable issuer by the tenth (10th) of each month for generation of a monthly Aggregated Invoice. The Aggregated Invoice, which must reference a unique invoice number and specify the name of the issuer (ideally on company letterhead), and which must include individual line-item detail for each enrollment, will then be sent back to the clinic via email by the fifteenth (15th) of each month for review.

Once the invoice is approved the clinic will remit a single, aggregated premium payment using a payment method supported by the issuer by the twentieth (20th) of each month, and the issuer will be responsible for ensuring that aggregated premium payments are appropriately applied to each of the individual policies listed on the Aggregated Invoice. After the aggregated payment is processed the issuer must complete the monthly cycle by sending an email confirmation back to the clinic confirming the application of the single, aggregated payment to each of the individual policies listed on the aggregated invoice. For a detailed illustration of the monthly process please refer to the SSHIX Tribal Aggregated Billing Workflow.

Tribal Clinics are responsible for keeping their enrollments up to date, and clinics will be financially responsible for all active enrollments as of the first (1st) of each month. Tribal enrollments will be subject to the same grace period rules as non-tribal enrollments with respect to termination for non-payment, i.e. 90 days for policies with APTC and 30 days for policies with no APTC.

In order to help ensure proper oversight and support from SSHIX, participating issuers and clinics shall cc: tribalenrollments@exchange.nv.gov on all aggregated billing-related correspondence.

PROPOSED LANGUAGE, NEVADA HEALTH LINK POLICY MANUAL:

6.20 Aggregated Billing for Tribal Health Clinics

45 CFR § 156.1250 requires Qualified Health Plan (QHP) Issuers to accept premium and cost-sharing payments for tribal members directly from Indian tribes, tribal organizations, or urban Indian organizations. By default, the monthly premiums for these enrollments are managed on an individual-policy basis. The Exchange has therefore leveraged the authority granted by 45 CFR § 155.240(b) to establish terms and conditions which standardize the aggregated payment of premiums for tribal enrollees by Nevada's Tribal Health Clinics.

The intent of this policy is to simplify the administration of tribal enrollments by allowing clinics to remit a single, aggregated monthly payment representing their entire enrolled population. Tribal Health Clinics who participate in the Aggregated Billing Process are subject to the terms and conditions of the Operator Agreement. Tribal Clinics are also responsible for keeping their enrollments up to date, and clinics will be financially responsible for all active enrollments as of the first (1st) of each month.

Issuers who participate in the Aggregated Billing Process are subject to the terms and conditions of SSHIX's annual Issuer Agreement. Issuers are responsible for generating a monthly Aggregated Invoice for participating clinics, and also for ensuring that aggregated premium payments are appropriately applied to each of the individual policies listed on the Aggregated Invoice.

Tribal Health Clinics who wish to participate in the Aggregated Billing process must have a signed and executed network provider agreement in place with the participating issuer(s) of their choice, and they must also maintain a signed and executed copy of SSHIX's Addendum for the Aggregation of Monthly Premiums for Tribal Enrollees. This addendum, which details the roles and responsibilities for participating issuers and Tribal Health Clinics, serves as a binding agreement between one issuer and one clinic for a single plan year, and must be renewed on an annual basis.

FOR BOARD CONSIDERATION AND APPROVAL:

The Exchange opened a two-week public comment period that was extended to July 21, 2023 for Exchange partnered Issuers and stakeholders to provide feedback on the additions made to the Annual Issuer Agreement, Section 4.6 and the Nevada Health Link Policy Manual, Section 6.20. The comment period was from June 22, 2023 to July 21, 2023. All feedback, comments, and questions were directed to Janel Davis, the Exchange's Chief Operations Manager, at j-davis@exchange.nv.gov.

Partnered Issuers have asked various questions about the tribal sponsorship and shared their questions with the Exchange by the requested deadline of July 21, 2023. These questions have been provided to the public and board for consideration.

The Exchange is requesting that the Board consider the following option for final language:

- Approve the draft proposed language as final language with revisions based on Issuer's feedback received by the Exchange.

The Exchange received questions from insurance carriers based on the language additions to the Issuer

Agreement and Nevada Health Link Policy Manual and the Tribal Sponsorship Program. The insurance carriers did not have any changes or edits to the proposed language in the Annual Issuer Agreement or the NVHL Policy Manual, however, the Exchange is sharing the inquiries and questions below from insurance carriers with the Board, in leu of public comment. These questions have been answered from the Exchange directly with the insurance carrier. These questions will also be included on the Tribes webs page on NevadaHealthLink.com for public consumption. The Exchange has also incorporated the issuer feedback/questions into the three supplemental documents mentioned within this report, so the concerns have been addressed.

Questions from Health Plan of Nevada (HPN):

- How many tribal health clinics are participating in the aggregate premium billing?
- Is it known how many HPN members, to date, have received direct enrollment assistance by Nevada tribal clinics?
- What is the proposed timing for issuers to receive the monthly enrollment consumers report?
    - Need to understand the data fields in the proposed monthly enrolled consumers report
        - QuestConfirm enrollment ID equals policy ID?
        - What is the "enrollee ID"?
        - Confirm that Subscriber ID equals exchange ID?
        - Can the Issuer member ID be included in the report?
        - Confirm that CMS Plan ID equals HIOS?
- How should issuers expect to receive the report, i.e. EFT, email, etc.?
- Are issuers expected to send an aggregate invoice directly to the clinics (per the workflow document)?
    - What is the expected delivery method?
    - What is the expected timing for issuers to provide invoices?
    - Will there be a required format for the aggregate invoice?
    - Should the consumer still receive a premium invoice for member responsibility?
- How will the aggregate payment be provided to the Issuer?
    - What is the expected timing of payment receipt by issuer?
- What is required for the aggregate payment confirmation?
    - What is the required issuer response format?
    - What is the required delivery method?
    - What is the required timing for the response?

Questions from Hometown Health:

- We'd like clarification on information presented in prior meetings, specifically will all tribal members be eligible for aggregated billing? Or is it only tribal members employed by tribal health clinics?
- How will members be identified?
    - Is it only through the Enrolled Consumers Report?
    - Could there be an identifier on the 834 file?
- How will terms for non-payments be handled if the tribe doesn't pay timely and there is a mix of members with APTC and without (for example: 90 days APTC versus 30 days Non-APTC)?
- Are there changes to any other existing terms and conditions that would be applicable to individual consumers because the billing is consolidated (for example: Will payments terms still be monthly in advance)?

- Are there specific requirements or changes for written communications to the individual members (invoices/notices) because of the consolidated billing?
- For new members payment is required for coverage to be effectuated. What is the workflow for collecting the first payment?
- What is the deadline for the issuers to complete the intent to participate form?

Letter from Anthem, now Elevance Health:

Interim Director Janel Davis & Members of the Nevada Silver State Health Insurance Exchange Board:

Anthem Blue Cross and Blue Shield of Nevada appreciates the opportunity to provide comments regarding the Board's desire to implement an aggregated billing workflow and tribal sponsorship program. As you may know, our plan has served the state for 50 years with over 686,000 commercial, Medicaid and Medicare members. While we fully endorse initiatives that improve healthcare access and options for Nevadans, we offer the following comments regarding the proposed tribal sponsorship program.

We understand the intent of the program is to simplify the administration of tribal enrollments by allowing clinics to remit a single, aggregated monthly payment representing their entire enrolled population, but remain concerned about the potential complexity of the billing structure and what that would entail. We also understand the intent is to provide coverage to new members and keep them covered and want to ensure that current SEP qualifying event requirements are still met for members enrolling outside of the OEP. We are concerned that this program might be used in a way where members can join when they need medical care and then drop coverage shortly after. This would negatively impact the ACA market in the state and have unintended consequences.

Anthem is committed to providing a positive customer experience and service to the community, and we believe a fully digital solution to support the tribal sponsorship program should be developed and implemented. We think this added administrative step could create a disjointed customer experience for the members and potentially undermine a consistent experience. Anthem would like to partner with Exchange leadership in developing a digital CX strategy and implementation plan for the tribal sponsorship program.

Additionally, since underlying policies still belong to the Individual member, we respectfully request that renewal notices, member information, and any other form of communication go directly to the member and not the clinic. We also request that a clear and concise policy be put into place on how to apply premiums if the payment does not match the bill. Because premiums are applied at the member level, if the aggregate payment does not match the bill, we will not know how to apply any of the premium without specific polices to address this.

We are also interested in reviewing the Operator Agreement referenced in the Letter to Issuers, as well as the Issuer Annual Agreement that references billing.

Thank you for your consideration and allowing us the opportunity to provide comments. Should you have any questions, please feel free to reach out to Ashley Jonkey, government relations director, or Collins Mathews, director of strategy and program sales. We look forward to further collaboration on this issue and others.

Sincerely,

Ashley Jonkey
Government Affairs Director, Nevada
Elevance Health

Question from Aetna/CVS:

- DuAne Young – Aetna: Good morning, CVS/Aetna does not have any concerns at this time but our vendor has the question I am sure if you team can answer. Do all of the tribal clinics have the ability to process EFT/Wire payments or are some of the smaller clinics still on a paper check system?

Comment from Molina Healthcare of Nevada, Inc.:

- Molina Healthcare of Nevada, Inc. confirms that we have reviewed the proposed language regarding the tribal sponsorship aggregated billing workflow to the Nevada Health Link Policy Manual and Annual Issuer Agreement. At this time there are no comments/feedback. We do have other members from our technical teams continuing to review the proposed language and could potential have some feedback that can be provided during the public comment period later this month.

Response from Imperial Health:

- Michael G. Polis, General Counsel, Imperial Health: Thank you, Ms. Davis – we will review the information provided.