Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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Delivered via electronic transmission

August 30, 2012

Data Interchange Standards Association
7600 Leesburg Pike, Suite 430
Falls Church, VA 22043
Subject: Comments on 005010X307 - 834 Health Insurance Exchange: Enrollment
Attention: ASC X12 Administrator

Dear Administrator,

I write on behalf of the Tribal Technical Advisory Group (TTAG) of the Center of Medicare and Medicaid Services (CMS) regarding the attached analysis and recommendations to the Data Interchange Standards Association in response to the 005010X307 - 834 Health Insurance Exchange: Enrollment .We appreciate the opportunity to comment.

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.[1] 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, including through providers operating under the health programs of the Indian Health Service, Indian Tribes, tribal organizations and urban Indian organizations (I/T/U).[2]

It has recently come to our attention that Form 834, which is being developed to create standards for electronic data interchange for Health Insurance Exchange Enrollment, is available for review. We have submitted comments through the electronic comment process; however, we would like to use this opportunity to explain some of our concerns and recommendations.

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1 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.

2 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.

We understand that these standards are technical and intended to reflect implementation and policy decisions that have been made and communicated to the authors of this draft Technical Report. As we discuss below, we are aware that many decisions are not yet final. Our comments are made with the understanding that, as future decisions are made, changes in the technical Standards will occur to ensure full implementation of the policies. Thus, in some cases our comments highlight places where we believe changes are needed based on decisions and law that have already been made, and in other places we highlight changes that may be necessary as future decisions are made.

We also want to note that some of our comments provide for language that may not be consistent with the form of other language, because of our lack of familiarity with the embedded levels of this
very technical report, or because we want to be precise in communicating our meaning. We understand that shorter versions may be needed in the final Standards and request that adequate documentation of the meaning of the shortened phrases be provided.

Background

There is very little content in the draft Form 834 that indicates an awareness of the Indian health care delivery system or the special provisions and protections for American Indians and Alaska Natives (AI/AN) in the Affordable Care Act and other legislation. The enrollment form used by Exchanges and Qualified Health Plans needs to accommodate some of the unique attributes of the Indian health system and the body of federal Indian law, and the technical standards need to support full implementation of the special provisions applicable to AI/ANs.

For example, the ACA stipulates that cost sharing (including both deductibles and co-pays) is waived for AI/ANs who receive their services at an Indian health facility or are referred through that facility to another provider in the plan. In addition, AI/AN enrolled through the individual market in an Exchange with income under 300 percent of the poverty level pay no cost-sharing at any provider. Furthermore, the plan is to make-up the lost revenues to the provider. People who qualify for the benefits and protections as AI/AN need to be identified in the enrollment process, in the identification cards that are issued by QHPs to their enrollees, and in the information that is accessed by QHP billing departments and others who provide services, such as pharmacies.

Many AI/ANs receive their health care services through the federal Indian Health Service (IHS), a Tribally-operated health program (i.e. one operated by a Tribe or Tribal organization), or an urban Indian health clinic. Taken together these are called the “I/T/U” or “the Indian health system.” People who are eligible for Indian health services are also eligible to enroll in Health Insurance Exchange plans. Federal law allows the I/T/U to bill plans for services provided to AI/AN enrollees even when the I/T/U facility is not part of the plan’s

network of providers. We are not entirely clear whether the covered individual or the plan provides the underlying data to populate the form: however, in light of the payment requirements, we think the AI/AN enrollee should be able to provide this information if such an enrollee uses an Indian health system provider. This will also facilitate the opportunity to recognize that if AI/ANs choose an I/T/U provider as their primary care provider, it would be most cost effective if that primary care provider can provide referrals within the network for the plan in which the AI/AN is enrolled, even if the I/T/U is outside that network.

In addition, the tribes, tribal organizations, and urban Indian organizations may be sponsors of individuals who enroll in Exchange plans. The sponsors would pay the portion of the premium that is not subsidized through Advanced Premium Tax Credits. The I/T/U may also assist people to enroll in Exchange plans, as navigators, in-person assisters, or supported by other types of funding, such as Medicaid Administrative Match. The I/T/U may also assist people with paperwork, and therefore may be requested to receive EOBs, changes in enrollment status, and other types of notifications for some enrollees.
The Centers for Medicaid and Medicare Services (CMS) has not yet released all the regulations that apply to AI/AN and the I/T/U. Tribal Consultation Policies of the Department of Health and Human Services (HHS) and CMS require that Tribes be consulted in the development of those regulations and other guidance. As more policy decisions are made, there may be a need to accommodate additional information in the 834 enrollment process.
As you know, the electronic comment process is tied to specific elements in the document under review. For purposes of simplicity, the comments in this letter are organized sequentially by page number and topic.

Sponsor (pages 5 and 20)

The definition of sponsor lists the types of organizations that could be a sponsor, including employer, union, government agency, association, or insurance agency. However, this list is incomplete because it does not mention Tribe, Tribal Organization, or urban Indian health organization in the list of potential sponsors. If referencing all of these types of Indian sponsors individually is inconsistent with the other entries, the phrase "Indian entities" could be used, as long as it is defined somewhere.

Identification of AI/AN (pages 21, 80, 81, 86 and 174)

The only mention of AI/AN is under demographic information, specifically in relation to race and ethnicity (pages 21, 80, and 81). In addition to this identification, and independent of it, there needs to be a separate section of the standards document to capture that an individual is eligible to receive the benefits and protections as an AI/AN, such as waiver of cost sharing. Certain protections and benefits do not derive from the individual's self-identification with a race or ethnicity, but rather from a political and legal definition of AI/AN. When a person is enrolled in a health plan as an AI/AN who is qualified for those benefits and protections, then

that information should be connected to other outcomes, such as waiver of cost sharing. There is element detail on co-insurance (page 86) that could be tied to the designation of AI/AN and show a zero amount for co-pays and deductibles. Also, the AI/AN designation should appear on enrollee identification cards issued by the QHP (page 174).

Navigator (pages 49, 50, and 52)

Form 834 has details related to navigators, including a navigator identification code (page 49) and navigator licensing information (page 50). The form envisions that States may control navigator licensing (page 52). However, it is a general principle of tribal sovereignty that States cannot license Tribes. ACA specifically lists Tribes as one of the types of organizations that could serve as navigators. While the rules on navigators have not yet been issued, we recommend that either there be a generic code that indicates that Tribal navigators are exempt for licensing, or another element/question could be used to establish that the navigator is working for a Tribe or Tribal Organization. Alternatively, the document could identify navigators that have been selected by a state (or the Federal government) rather than the licensing status.

Primary Care Provider Information and Reasons for Status Change (pages 56, 57, 176 and 187)

As discussed above, AI/ANs should be able to designate the I/T/U as their primary care provider even when the I/T/U facility is not part of the provider network offered by the Plan. If Form 834 relies on the QHP provider codes to designate the primary care providers in their network (page 176), then there should also be a code that indicates an exemption whereby the AI/AN can have an out-of-network provider, or assign individual provider codes to each I/T/U in a state that would work across plans. Whether the I/T/U is an in-network or out-of-network provider, one reason that an AI/AN may want to change their primary care provider (pages 56, 57, 187) is that they prefer to receive services through the Indian health system.

Tobacco and other substance use (page 87)

If a person is a smoker or uses chewing tobacco, then the QHP can charge a higher premium due to the increased health risk. However, in many American Indian cultures tobacco is used for ceremonial and religious purposes, often as smudging. Asking an American Indian individual to answer a generic question about tobacco use may lead to an erroneous answer and conclusion. If a person self-identifies as AI/AN and indicates that they use tobacco, then a follow up question (and related technical standard) should provide clarification as to whether it is solely for ceremonial or religious purposes. Another way to handle this is to change the initial question.

Codes for Responsible Person (page 145)

It may be important for an I/T/U sponsor to receive copies of notifications from the QHP intended for the enrollee, particularly if it is a sponsor for that individual. The most likely place to list the I/T/U sponsor contact information (address, phone number, e-mail) is in the section that identifies a "responsible person." It would be helpful to broaden this category by changing or adding a code. For example, 9K could be "key person or organization." Alternatively, while the relationship code offers an "other" category, it might be helpful to the QHP to also have a category that is "Sponsoring Indian health entity."

Scenario (page 205)

The current document offers a single example that applies Form 834 to a sample situation. Given the unique attributes of AI/ANs and I/T/Us, it might be helpful to run a scenario of an AI/AN with tribal sponsorship and cost sharing waivers to see if the current structure of the form provides the necessary information.

Summary

We fully appreciate the complexity and the tight time frame in which this enrollment structure is being developed. By addressing the AI/AN issues proactively, we hope that it will save time and work downstream as the Exchanges are implemented. We stand ready to assist you or to answer any questions you may have. Please contact Jennifer Cooper at jcooper@nihb.org, if you would like to discuss any of the items in this letter.

Sincerely yours,

Valerie Davidson
Chair, CMS Tribal Technical Advisory Group

Cc: Gary Cohen, Acting Administrator, CCIIO
Cindy Mann, Director, Centers for Medicaid and State Services
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