

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board 926 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Attention: CMS-2349-P
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: TTAG Comments on CMS-2349-IF: Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010

I write on behalf of the Tribal Technical Advisory Group (TTAG) to the Centers for Medicare and Medicaid Services (CMS) regarding the attached analysis and recommendations (Comments) to the Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services (HHS) in response to the request for comments published March 23, 2012 in the *Federal Register* titled “Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010 (CMS-2349-IF or Proposed Rule). We appreciate the opportunity to comment on this Proposed Rule.

Analysis and Recommendations

Timely determination of eligibility (§ 435.912)

TTAG appreciates that interim 42 C.F.R. § 435.912 recognize the importance of timely, efficient, and accurate determinations of eligibility for Medicaid and other insurance affordability programs. This is particularly relevant in the context of American Indians and Alaska Natives (“AI/ANs”), who are entitled to favorable treatment under the Medicaid program in order to encourage AI/AN enrollment and expand access to health services. For example, no Medicaid premiums or cost sharing may be imposed on an AI/AN applicant or an AI/AN receiving services from an Indian Tribe, Tribal organization, or urban Indian organization (I/T/U) directly or through referral under Contract Health Services.¹ In addition, AI/ANs will continue to be exempt from mandatory managed care enrollment², and, as added by section 5006(d) of the Recovery Act, AI/ANs enrolled in Medicaid managed care plans have the option of choosing an Indian health care provider as the AI/AN’s primary care provider.³

TTAG therefore strongly supports the proposed determination deadlines in 42 C.F.R. § 912(c)(3) of 90 days for individuals applying based on disability and 45 days for all others. We believe that these deadlines strike an appropriate balance between ensuring that States accurately and thoroughly make their

¹ Section 5006(a) of the American Recovery and Reinvestment Act (Public Law 111-5, enacted February 17, 2009; Recovery Act) amended sections 1916 and 1916A of the Social Security Act.

² Provisions relating to managed care 42 U.S.C. § 1396u-2(a)(2)(C).

³ Section 5006(d) of the Recovery Act amended section 1932(h)(1) of the Social Security Act (42 U.S.C. 1396u-2).



administrative determinations while simultaneously ensuring that applicants are enrolled in a timely manner. TTAG also supports the requirement in § 912(d) that State Medicaid agencies inform applicants of the timeliness standards so that applicants can organize their affairs accordingly.

TTAG does wish to comment on the proposed timeliness and performance standards that must be included in the State rule pursuant to 42 C.F.R. § 912(c)(2). Specifically, we appreciate the fact that under § 912(c)(2)(iv), State Medicaid agencies must develop standards that take into account:

The needs of applicants, including applicant preferences for mode of application (such as through an internet Web site, telephone, mail, in person, or other commonly available electronic means), as well as the relative complexity of adjudicating the eligibility determination based on household, income or other relevant information.

For a number of reasons, this provision will be particularly important in the AI/AN context. First, AI/ANs generally have far less access to computers or internet services than the general population;⁴ the FCC estimates that broadband deployment rate on Tribal lands is less than 10 percent, and anecdotal evidence suggests that actual usage rates may be as low as 5 to 8 percent, compared to 65 percent nationwide.⁵ As a result, AI/ANS will be far less likely to apply for Medicaid electronically, as opposed to in person or through the mail. This will be administratively more difficult to process and could lead to applications getting physically lost or misplaced.

Second, as TTAG has previously noted in comments, 42 C.F.R. § 435.603(e) codifies a number of income exemptions specific to AI/ANs for the determination of MAGI-based income. This may complicate the processing of AI/AN applications, as State Medicaid workers may be unfamiliar with these special protections for AI/ANs, particularly in States that do not have a sizeable AI/AN population. Finally, AI/AN family units often include extended family and may not necessarily reflect the traditional units with which State Medicaid workers are accustomed. Taken as a whole, there are numerous factors indicating that processing AI/AN applications will be a more cumbersome and error-prone process than processing those of the general populace.

While it is perhaps unnecessary to specify particular treatment for AI/AN applicants in these regulations, we urge CMS to continue to consult with Tribes and Tribal organizations about the specific needs of their service populations with regard to Medicaid enrollment. This consultation is necessary to ensure that CMS truly understands and appreciates the challenges with AI/AN enrollment in Medicaid, as well as the critical importance of such enrollment in light of the drastic underfunding of Tribal health programs and the need for third party reimbursement for services. This consultation should ultimately be geared towards developing proposed program standards and processes for AI/AN Medicaid enrollment that can be distributed to States as part of a greater effort to coordinate Tribal, State, and Federal resources and maximize AI/AN enrollment.

Medicaid Agency Responsibilities (§ 435.1200)

In light of the evolving eligibility standards for Medicaid, CHIP, and other insurance programs, TTAG supports the proposal in § 435.1200(f) that State Medicaid agencies make a website available to current and prospective Medicaid applicants and beneficiaries that includes information on application and enrollment for all State insurance affordability programs. In particular, we appreciate the fact that such

⁴ A recent article highlights the challenges that this lack of internet access raises to the ability of AI/ANs to complete educational programs and maintain employment. See http://www.huffingtonpost.com/2012/04/20/digital-divide-tribal-lands_n_1403046.html

⁵ See <http://transition.fcc.gov/indians/>.

websites and related information distribution systems must be in plain language and accessible to individuals with disabilities and persons with limited English proficiency (like many AI/ANs). We urge CMS to work with Tribes and State Medicaid agencies to ensure that Medicaid information is translated into Tribal languages like Yup'ik and Navajo.

However, as described above, AI/AN access to the internet is extraordinarily limited, and overreliance on websites as the main clearinghouse of enrollment information will lead to a disproportionately lower level of access for AI/ANs. Further, AI/AN often live in villages and reservations that are very remote and nowhere near the State Medicaid offices where they could otherwise access hard copy materials or interact with Medicaid agency employees. It is therefore important that State Medicaid agencies distribute any relevant hard copy materials in a wide variety of locations in Indian country, such as elder centers, schools, and Tribal health programs (and in the proper languages). In addition, the materials distributed at I/T/U facilities should be tailored to the I/T/U. This means they should eliminate information that is not relevant to AI/AN, identify the specific protections and provisions for AI/AN, and reflect the I/T/U programs in the state. Tribes should be involved in developing these materials to assure their accuracy and usefulness.

We therefore propose the following addition to the final rule as new section 42 C.F.R. § 435.1200(g):

(g) Distribution of Medicaid information and enrollment materials.

(1) Any information that the State Medicaid agencies make available on the Internet Web site established under § 435.1200(f) of this subpart shall be made available in hard copy at locations throughout the State to ensure distribution to populations with limited Internet access. The State Medicaid agencies shall offer these materials to, at minimum, the following classes of health care facility:

- (i) Federally qualified health centers;
- (ii) Rural health clinics;
- (iii) Disproportionate share hospitals;
- (iv) Critical access hospitals;
- (v) Health care facilities operated by the Indian Health Service, or by an Indian Tribe, Tribal organization, or urban Indian organization pursuant to the Indian Self-Determination and Education Assistance Act.

(2) State Medicaid agencies shall also ensure that such materials are distributed in rural areas at senior or elder centers, schools, and other locations with high concentration of individuals who may be eligible for Medicaid or CHIP.

TTAG believes that these additional provisions will help ensure that remote, medically underserved populations, such as AI/AN communities, receive proper access to critical information concerning Medicaid enrollment and application.

Eligibility screening and enrollment in other insurance affordability programs (§ 457.350)

TTAG generally supports the proposed requirements in interim 42 C.F.R. § 457.350 that State Medicaid, CHIP, and other insurance affordability programs coordinate the transmission of information indicating eligibility for one another's programs. However, a number of the proposed provisions in the interim rule require agencies to suspend an applicant's application for CHIP or disenroll an applicant from CHIP upon

a finding of eligibility for Medicaid (§ 457.350(f)(2), (j)(3)). However, the provisions do not require that such individuals be notified that their applications for CHIP have been suspended or that they have been disenrolled in CHIP.

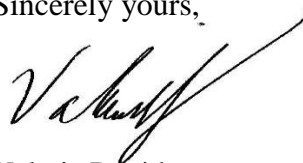
It will be very confusing, particularly in the context of populations like AI/ANs with low health literacy and limited English proficiency, to suddenly be transferred from one program to another without warning, or to apply for CHIP and receive back information about an application for Medicaid that they did not know had been filed on their behalf. This could act as a well-intentioned impediment to the enrollment of AI/ANs in the health programs that are critical to increasing access to care.

We therefore recommend that CMS include a requirement that in circumstances where agencies suspend an individual's CHIP application, or terminate an individual from the CHIP program, based on the individual's eligibility for Medicaid, that the Medicaid agency contact the individual both electronically and via physical mail and explain the transfer or terminations. We encourage CMS and State Medicaid agencies to consult with Tribes and Tribal health programs about this process so as to ensure that such explanations are readily comprehended and culturally appropriate for the AI/AN population.

Conclusion

Thank you in advance for consideration of these recommendations as we jointly work to advance the health status of American Indian and Alaska Native individuals and communities across the United States.

Sincerely yours,



Valerie Davidson
Chair, CMS Tribal Technical Advisory Group

Cc: Cathy Abramson, Chair, Tribal Technical Advisory Group to CMS
Dr. Yvette Roubideaux, Director, Indian Health Service
Kitty Marx, Director, CMS Tribal Affairs Group
Stacy Bohlen, Executive Director, NIHB
Jennifer Cooper, Legislative Director, NIHB