Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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Sent electronically via regulations.gov

May 6, 2013

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore MD, 21244-1850
Attention: CMS-9955-P

RE: Comments regarding CMS 9955-P Standards for Navigators and Non-Navigator Assistance Personnel

I write on behalf of the Tribal Technical Advisory Group (TTAG) to the Centers for Medicare & Medicaid Services (CMS) regarding CMS-9955-P proposed rule Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel.[1] 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 . 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).

Navigators will serve a key role throughout Indian Country. Like CMS, our goal is to ensure that all American Indians/Alaska Natives (AI/ANs) are educated and knowledgeable of not only the marketplace basics, but also the key Indian specific provisions and protections. In general, we believe that the rules should encourage the availability of assistance with applications and provide applicants easy access to authorized representatives. Often Indian health providers serve these roles for AI/ANs to whom that they provide services and determine eligibility for funding for health care services. We believe it is critical that CMS not interpose barriers that would disrupt these longstanding relationships, which help individuals who typically have had limited access to overcome the barriers of language, geographic remoteness, discomfort, and distrust of government officials to achieve enrollment in health care programs for which they are eligible. While this does not mean that there should not be standards for accessing certain systems, the controls should not effectively eliminate the availability of meaningful assistance. With this perspective, we are providing the following comments.

[1] 78 Fed. Reg. 20,851 (Apr. 5, 2013) [Final Rule].

I. Provisions of the Proposed Rule

A. Standards Applicable to Navigators and Non-Navigator Assistance Personnel

1. Conflicts-of-Interests Standards - §155.215(a)

Section 1311(i)(4) of the Affordable Care Act states that Navigators must "avoid conflicts of interest," while § 1311(i)(5) requires the "Secretary, in collaboration with States, [to] develop standards to ensure that information made available by Navigators is fair, accurate, and impartial." In addition, 45 C.F.R. § 155.210(b) specifies that Exchanges establish a set of conflict-of interest standards applicable to Navigators in the Exchange.

Under the proposed regulation, the Navigator or Non-Navigator Assistance programs should not have a conflict of interest when presenting information or providing the range of coverage choices to individuals who receive the assistance, nor must they have a personal interest in the coverage choices made by individuals who receive the assistance. CMS reasons that the proposed amendments would help ensure that Navigators provide any small employers that request help from a Navigator with information and services in a fair, accurate, and impartial manner. However, CMS recognizes that these conflict of interest requirements technically only apply to Navigators, and not to non-Navigator assistance personnel; nevertheless, to ensure continuity and fairness, CMS seeks comment on its proposal to extend the conflict of interest regulations to non-Navigator personnel as well.[2]

CMS held a series of calls regarding this proposed rule and the funding opportunity regarding the Navigator program, and we understand based on these calls that the conflict of interest standard will not be strictly interpreted or otherwise applied heavy handedly. We appreciate this flexibility, as there are many instances a strict interpretation of the proposal would be unfavorable to Tribal Navigators. For example, we understand that a Federal facilitated exchange may not have an aggregated payment system where Tribal leadership may pay the premiums on behalf of their Tribal members. Absent this type of automatic enrollment, it is likely that individual AI/ANs who wish to participate in an Exchange will seek assistance from Tribally-based non-Navigator assistance personnel, or, if the Tribe is a Navigator, from the Tribe itself. Under a strict interpretation of the proposed regulations, however, the Tribe or its assistance personnel would be prohibited from directing interested AI/ANs to plans that include I/T/Us as a provider or to plans for which the Tribe will pay the unsubsidized portion of the premium. This will preclude the Tribe from guiding its members towards the qualified health plans (QHPs) that will best serve their needs and maximize benefits to the I/T/U system, ultimately frustrating the purpose of the ACA's Indian-specific protections, which are designed to encourage AI/AN participation in Exchanges.

We recommend that the final conflict of interest rules should explicitly exempt Tribes serving as Navigators as well as I/T/U staff or other Tribal members serving as non-Navigator assistance personnel from Navigator directing Tribal members to plans that include I/T/U as a provider or

[2] *Id.* at 20,586.

for which the Tribe pays the unsubsidized portion of the premium. As CMS recognizes, the purpose of the conflict of interest provisions is to prevent bias and reduce confusion.[3] Allowing Tribes and I/T/Us to guide AI/ANs towards the plans best suited to their medical, financial, and cultural needs will serve those goals: AI/ANs (many of whom have low health literacy and are unfamiliar with the private insurance marketplace due to their justifiable reliance on the Indian health system) will not have to make confusing and possibly uninformed choices of QHPs, and there is no bias in ensuring that AI/ANs are able to take advantage of benefits that are established in federal law and which reflect the federal government's trust duties towards Indian tribes.[4] At the very least, CMS should acknowledge that there is no conflict of interest in a Tribal Navigator informing an AI/AN that a Tribe has decided to sponsor premiums only for certain QHP plans. Any Navigator would have to do that to effectively inform an AI/AN trying to utilize his or her options within an Exchange.

As stated in §§ 115.215(a)(1)(i) and .215(a)(2) of the Proposed Rule, applicants for Navigator grants as well as Non-Navigator entities or individuals authorized to carry out consumer assistance functions must submit to the Exchange a written attestation that the Navigator and its staff do not have any of the prohibited conflicts of interest. Tribes or Tribal organizations that apply to become a Navigator, or any of their staff or members that are authorized as non-Navigator assistance personnel, could submit an attestation explaining how they will inform Tribal members about the importance of enrolling on the Exchange and informing them that certain plans allow their Tribes to sponsor premiums on their behalf. Such Tribes or individuals should thereafter be exempt from the conflict of interest provisions at least to the extent that they direct Tribal members towards QHPs that (1) include I/T/Us as a provider or (2) for which the Tribe pays the unsubsidized portion of the premium.

2. Training Standards - §155.215(b)

(a) Certification and Recertification

We appreciate the need for Exchanges to certify staff and volunteers to act as certified application counselors, particularly when such individuals will enter the homes of people they are assisting and have access to their personal and financial information. However, we urge CMS to recognize that flexibility is needed when drafting these policies in order to account for the unique nature of many AI/AN communities and to ensure that strict background checks do not eliminate many AI/ANs from these jobs.

For example, the U.S. Census Bureau has found it difficult to fill enumerator jobs on reservations when background checks are required: many AI/ANs who would otherwise be qualified for these

[3] *Id.*

[4] If, for whatever reason, CMS does not believe that it has the legal authority to implement such a waiver on behalf of Tribes as Navigators, it certainly should have the authority to do so on behalf of non-Navigator assistance personnel, for which CMS recognizes it has considerable more flexibility.

positions have struggled with drug or alcohol addiction that has led to a criminal record. But in many cases, such individuals have gone through treatment and earned the trust of the community, and are fully capable of providing the necessary services despite their potentially disqualifying past.

We understand that Census Bureau has approved these individuals upon receiving a Tribal recommendation as to their competency and qualification. Because Navigator grantees are expected to recruit and promote staff members who are representative of the communities they will serve, the Census model should also be adopted as part of any ultimate background check. CMS should not unnecessarily disqualify trusted and respected members of AI/AN communities through overly rigid adherence to background checks.

(b) Training model

We agree that Navigators should receive HHS-approved training before carrying out any consumer assistance functions in the Exchange. This rule proposes that a Navigator in the FFE will have up to thirty hours of initial training, plus continuing education and annual recertification. This is concerning as in comparison to the Maryland State Exchange, which will have 120 hours of training over three weeks. As training must be comprehensive, the description of the training module content standards are very broad; however, they do not appear to include information that would be crucial for assisting AI/AN enrollment. The training should include ACA-specific provisions pertaining to AI/AN including, but not limiting to, the following provisions:

- Special enrollment periods for AI/AN;
- Definition of Indian in Exchanges, Medicaid, and the Children Health Insurance Program (CHIP);
- AI/AN income that is included/excluded from MAGI in Exchange, Medicaid, and CHIP;
- How to submit documents for verification of Indian status and how to advise individuals if additional information will be needed to make that determination;
- Individual versus family plans – how they affect premiums, AI/AN benefits, and family out of pocket limits;
- Essential Health Benefits and how they apply to premiums and cost sharing for AI/AN;
- Exemptions from Individual Responsibility, including the Indian exemption, as well as others that could apply to Indians, such as hardship, incarceration, etc.;
- Multi-state plans offered by OPM ;
- How to find out if I/T/U is included in a QHP or MSP network;
- Tribal sponsorship; and
- Resources or contacts for Navigators and assistance personnel to obtain additional information and guidance with regard to the information listed above or about the Indian health system in general.

We believe that this type of training is absolutely essential to ensure that Navigators and other enrollment guidance personnel understand (or are at least aware of) the Indian health system and the application of the ACA in the context of AI/ANs, particularly in states with one or more federally-recognized Indian tribes or large populations of individual IHS beneficiaries. Absent

such guidance, it is almost certain that AI/ANs will experience delays in properly obtaining the benefits to which they are entitled, or may simply lose them altogether.

3. *Providing Culturally and Linguistically Appropriate Services (CLAS Standards) - §155.215(c)*

Proposed 45 C.F.R. § 155.210(e)(5) requires Navigators to provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange, including individuals with limited English. If a non-Tribe or non-Tribal organization Navigator provides the primary consumer assistance to communities with a large population of Tribes and/or Tribal members, then that Navigator should be required to know the specific protections for AI/ANs as set forth in the ACA and understand how they are applied in practice. Section 155.215(c)(6) of the proposed rule states that Navigator and non-Navigator personnel entities are required to implement strategies to recruit and promote a staff that is representative of the demographic characteristics of the communities in their service area. We commend CMS for recognizing the importance of ensuring that Navigator staff is culturally fluent in their communities.

To achieve these goals and to help convey assistance that is culturally appropriate to AI/ANs, Navigator programs should be encouraged to hire staff who are members of one or more Tribes in the areas that they serve. In order to maximize the cultural competence of Navigators serving high percentages of AI/ANs, Tribes or Tribal organizations that become Navigators should also be allowed to limit their services solely to their Indian community.[5] Finally, Navigators should be required to work with local Tribal communities to ensure that services and information are offered in Tribal languages to benefit those members of the community that might have limited English proficiency or who solely speak a Tribal language. In particular, FFEs will likely serve large numbers of Yup'ik speakers in Alaska and Navajo speakers in Arizona. It is extremely important that Navigators and non-Navigator assistance personnel be prepared to offer information in those languages.

II. Standards Apply to Certified Application Counselors

CMS is also seeking comment on whether all or some of the standards should be applied to certified application counselors. The objective is the same: assuring that counselors are knowledgeable and proficient in matters relating to the standards of eligibility and benefits and that they comply with various conduct standards, including applicable confidentiality, privacy, and security rules and avoidance of conflicts of interest and, in the case of Medicaid and CHIP, reassignment of claims. While we generally agree with such requirements, we believe that they

[5] Section 813 the Indian Health Care Improvement Act (IHCIA)[5] authorizes I/Ts to provide services to certain IHS-ineligible persons. Often, these I/T programs do not have enough space, staff, or resources to assist the non-Indian community, and serving them can take away valuable resources from the already strained and underfunded Indian health system. As long at the I/T/U Navigator directs the non-Indian to another consumer assistance program, such as a call center, then the I/T/U should meet the non-discrimination requirement.

must be carefully implemented for the purposes of Tribes and Tribal organizations in light of the unique nature of Indian health care.

There is a long history of low enrollment in Medicaid and CHIP among eligible AI/ANs. Experience has shown that the most effective approach to increasing this enrollment is to provide enrollment assistance at the point of service. For many AI/ANs, this means providing enrollment assistance in their home community or at the I/T/U clinic or hospital where they receive services. This is particularly important for AI/ANs for whom English may be a second language. Furthermore, applications ask very personal questions that are often confusing or need to be approached in a culturally appropriate and sensitive way, so it is helpful to have a trusted person assist in filling out the application. The Tribal or IHS clinic is also a convenient place for those who have limited transportation to access government offices. Further, State and Tribal relationships are fraught with longstanding issues and, under principles of tribal sovereignty, tribes and their employees should not be subjected to state authority in such matters as this. In recognition of the benefits of point-of-service enrollment, these Indian health organizations are increasingly providing enrollment assistance via employees who are funded through the IHS, Medicaid Administrative funding, direct Tribal funding, or through some combination of these sources.

Tribes support the idea that their staff should have access to training provided by Exchanges to develop proficiency in assisting individuals to enroll through the Exchange in Medicaid, CHIP, and plans offered on the Exchange, as well as premium assistance through tax credits, and to enroll in Medicaid or CHIP outside an Exchange portal. The rules require each assister to be individually certified. Especially during the implementation phase, we believe the training materials that the Federal Exchanges will make available to states should also be made available to Indian health providers so they can conduct training and attest to successful completion by their trainees.

We further recommend that CMS create an option under which I/T/Us can train staff and certify that individuals it sponsors meet all the relevant criteria. CMS should also require that State Medicaid/CHIP agencies and Exchanges accept all such certification. These provisions are particularly crucial for Indian health providers whose practices or service areas cross state borders, whose assisters might otherwise be subjected to a costly and burdensome process of obtaining multiple Exchange certifications. A separate rule that pertains to Tribes and Tribal employees would alleviate that likelihood.

Finally, we believe that CMS should provide clear direction about the circumstances in which certification is or is not required. For instance, if a health care provider has a bank of computers available and is willing to dedicate staff and volunteers to assist their clients to access information, and even help fill in the pages at the direction of the client, it is unclear as to whether those staff and volunteers must be certified (even though they have no access to information except that provided voluntarily by the client). If CMS implements these rules without any exception for these types of situations, it will significantly disrupt current systems of assistance and will likely to result in lower AI/AN participation in Medicaid, Medicaid Expansion, CHIP, QHPs, MSPs, and premium tax credits.

III. Competition for Navigator Grants

Provisions of the Exchange regulations at 45 C.F.R. § 155.210(c)(2) direct the Exchange to select *at least* two different types of entities as Navigators, one of which must be a community and consumer-focused non-profit group. Although Tribes and Tribal organizations are eligible to apply and become Navigators, they have to compete against many organizations within the Exchange. This will likely place many small Tribes or Tribal organizations at a serious disadvantage to be selected for Navigator funding due to their limited resources and inability to stand out among bigger, better established health programs. Requiring Exchanges to include Tribes and Tribal health programs as Navigators can bring in resources to their communities and ensure that Tribal members enroll in the Exchanges, many of whom otherwise might not enroll under a non-Tribal Navigator due to lack of proper outreach and education. While we understand that call centers will be made available for enrollment assistance, our experience is that consumers react better with face to face interaction and will be more likely to be persuaded to enroll in an Exchange if they have personal interaction with assistance staff instead of through the phone or internet.

This is particularly urgent given our concern that Tribal members will not enroll in the Exchanges when open enrollment begins on October 1, 2013 due to the lack of an aggressive outreach and education campaign in Indian country. The proposed rule states that Exchanges must have at least two Navigators; assuming that these two Navigators will most likely be located in large urban centers, this would force AI/ANs living in rural communities to drive several hours to visit the Navigator.[6] Tribal members may just forfeit enrolling in an Exchange simply because of the burden of traveling to seek assistance and additional information from Navigators does not seem to be worth the effort.

Therefore, we strongly encourage that FFEs require that at least one of the Navigators be a Tribal entity.[7] For a State partnership exchange where the State is performing the consumer operation, the Federal government should encourage the State to also hire a Tribe or Tribal organization to be a Navigator. For example, the following states will have an FFE and have large populations of American Indians and Alaska Natives who are between 133%-400% FPL and who would be eligible to enroll onto the Exchanges:

- Oklahoma – 50,473 AI/ANs;
- Montana – 15,303 AI/ANs;

[6] In the most remote communities in Alaska, AI/ANs might literally be forced to take an airplane or a boat to visit a Navigator on-site, and might have only periodic or virtually nonexistent access to internet bandwidth or telephone services in order to contact Navigators electronically.

[7] At the very least, this requirement should apply to any State containing one or more federally-recognized Indian Tribes.

- North Carolina – 15,599 AI/ANs[8]

As these numbers indicate, a large number of AI/ANs are eligible to enroll in the Exchanges. Tribal Navigators will help assure that they are offered the required level of outreach and education by providing this assistance in a culturally accepted manner to which Tribal members are accustomed.

Lastly, funding for Navigator program will also be critical to the success of the Navigator program, especially for Tribal Navigators. As announced in the Navigator Funding Opportunity Announcement posted on April 9, 2013, funding has been apportioned by state on the basis of the number of uninsured people in each state with an FFE, with a minimum of $600,000 per state. The amount of a final award available may be insufficient to fund the activities required, including possibly serving non-Natives, traveling to rural tribal communities and complying with the reporting requirements. We hope CMS would consider providing more resources for this program going forward.

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Thank you for your attention to these recommendations. We appreciate the opportunity to provide comment on CMS-9955-P. Please contact me for additional information as may be necessary to fully consider our recommendations.

Sincerely,

Valerie Davidson
Chair, Tribal Technical Advisory Group to CMS

cc: Yvette Roubideaux, Director, Indian Health Service
Kitty Marx, Director, CMS Tribal Affairs Group
Stacy Bohlen, Executive Director, NIHB

[8] Statistics from the American Community Survey of the U.S. Census Bureau, 2008.