

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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Submitted via FFecomments@cms.hhs.gov

June 13, 2012

Secretary Kathleen Sebelius
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Comments on the General Guidance on Federally-facilitated Exchanges

Dear Secretary Sebelius,

I write on behalf of the Tribal Technical Advisory Group (TTAG) to the Centers for Medicare and Medicaid Services (CMS) to submit these comments in response to comment on the *General Guidance on Federally-facilitated Exchanges* issued by the Center for Consumer Information and Insurance Oversight (CCIIO) at Centers for Medicare & Medicaid Services (CMS) on May 16, 2012.

The TTAG advises 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 CMS¹. 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.

Throughout the past year, the Department of Health and Human Services (HHS) and the Department of Treasury have issued a series of seven (7) notices of proposed rule-making (NPRMs) for Exchanges. In each case, the CMS Tribal Technical Advisory Group (TTAG) has reviewed the NPRMs in consultation

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 (IHCA), 25 USC §1661. The term "Indian Tribe" has the meaning given that term in Sec. 4 of the IHCA, 25 USC §1603. The term "tribal organization" has the meaning given that term in Sec. 4 of the IHCA, 25 USC §1603. The term "urban Indian organization" has the meaning given that term in Sec. 4 of the "IHCA", 25 USC §1603.

with Tribes and submitted extensive comments regarding ways to make Exchange plans accessible to American Indians and Alaska Natives (AI/AN) and thereby reduce the terrible health disparities experienced by this segment of the population.

In nearly every case, HHS and Treasury have issued final regulations that do not adopt the recommendations from Tribes, but instead defer to States Exchanges to make decisions about those important issues. On September 14, 2011, you sent a letter to State Governors stating that “Tribes should be considered full partners by States during the design and implementation of programs that are administered by States with HHS funding” and requiring States to consult with Tribes in the development of Exchanges. You used words like “proactive” and “partner” and we applauded this approach. In many cases, the States are not meeting this goal. However, some States have been doing an exemplary job of consulting with Tribes, including Oregon, Washington and Minnesota. Some Exchanges have provided funding to Tribal Organizations to create policy documents, serve on planning committees and provide useful input as the details of such things as computer software are being designed. Where Tribal representatives, employees or technical advisors are serving on committees, there have been substantive and beneficial outcomes in the Exchange planning process.

Tribes expect no less from the Federal government in States that will have Federally-facilitated Exchanges. This means more than holding regional “listening sessions” – it means workgroups and policy engagement with Tribes and the organizations that represent them. We understand that the law sets January 1, 2013, as the date that HHS will decide whether there will be a State-operated Exchange, a Federally-facilitated Exchange, or a partnership. However, it is clear right now that some States with large AI/AN populations, including Alaska and Oklahoma, will not be prepared to have a State-operated Exchange. It is not too early for the Federal government to begin working with Tribes and Tribal organizations in those States to resolve important policy issues.

Our comments on the Exchange rules were designed to remove significant barriers that will prevent AI/AN from accessing the Exchanges. As you know, AI/AN have a right to free care through the Indian health system, and as a result have little or no incentive to purchase insurance on the private market, particularly if doing so would mean they could no longer as a practical matter receive convenient and culturally appropriate care through their choice of Indian health provider. AI/AN are unlikely to purchase private insurance on their own if they have right to free care, and Tribes need the ability to group pay premiums on their behalf if AI/ANs are going to be able to take advantage of the premium tax credits offered only through the Exchanges. Similarly, if Indian health providers are not allowed to participate in the Qualified Health Plans offered through the Exchanges, either because the Plans do not offer to contract with them or because when they do they impose conditions for participation that are contrary to federal law (such as imposing state licensing requirements which Indian health providers are exempted from under the Indian Health Care Improvement Act), then AI/AN are unlikely to participate in the Exchanges. That is why our comments urged HHS to allow Tribes to group pay Exchange premiums for their members and require Qualified Health Plans (QHPs) to offer to contract with Indian health system providers using an Indian addendum to those contracts that sets out existing federal laws applicable to the Indian health system.

The premium tax credits offered through the Exchanges represent a significant federal resource designed to assist the most vulnerable populations purchase insurance coverage and improve their health care outcomes. Congress intended that AI/ANs be able to take advantage of this resource, and added additional cost-sharing protections for AI/ANs who participate in the Exchanges in Section 1402(d) of the Affordable Care Act. If barriers to access to the Exchanges are not removed, however, these resources

will likely be left on the table, and the AI/AN population, which suffers some of the greatest health disparities in the nation, will effectively be excluded from meaningful participation in this critically important program.

In some cases, the final rules for health insurance exchanges defer to States and also encourage them to implement recommendations from Tribes. We would sincerely hope that the Federal government would demonstrate leadership by implementing those Tribal recommendations in Federally-facilitated Exchanges. For example, the final rules encourage but do not require State Exchanges to use an Indian Addendum for QHP contracts with I/T/U providers, and we believe the appropriate approach for the Federal government is to require use of an Indian Addendum in the Federally-facilitated Exchanges. When the Federal government is responsible for Exchanges, we see no reason to defer, delay or deny the approaches suggested by Tribes to make the systems workable.

While the Federal government has outlined some of the policies it will use in Federally-facilitated Exchanges, it has not addressed AI/AN protections and supports in the law. Our recommendation is that the Federal government takes the following approach:

1. Create a document that acknowledges each of the recommendations from Tribes and Tribal organizations submitted as a response to NPRMs.
2. Indicate which of the recommendations from Tribes and Tribal organizations the Federal government is willing to implement in Federally-facilitated Exchanges.
3. Use the remaining recommendations as the agenda for engaging Tribes and Tribal organizations on a State level to discuss the best ways to assure access to care for AI/AN through Exchanges. Involve Tribes and Tribal Organizations in each State in setting agendas that may include additional items that arise in the planning process.
4. If this requires an extensive engagement process with Tribes and Tribal organizations, HHS should provide funding (using funds that would have otherwise been used for Establishment grants for States that have chosen not to apply for, not to accept or to turn back their funding for Establishment grants, or other funds that may be available) to Tribal organizations in each State to prepare policy documents, participate in planning activities, and organize Tribal consultation agendas and meetings in the State.
5. HHS and Treasury should designate a person with policy authority in each State where there will be a Federally-facilitated Exchange as a key point of contact for Tribes and Tribal organizations. That policy person should have a list of Tribes, elected Tribal Leaders, and their designated technical advisors to contact with information and schedules for the development of policies, project deadlines related to the development of Exchanges, and meeting schedules.
6. At minimum, in each State where there will be a Federally-facilitated Exchange, Tribes and Tribal Organizations should be engaged with the Federal government to resolve issues related to the following topics:
 - a. Network Adequacy – requiring all QHPs to offer contracts to all I/T/U providers with an Indian Addendum.

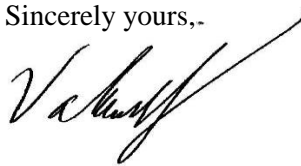
- b. Essential Health Benefits –reviewing the scope and duration of services and providers covered, and offering pediatric oral and vision services in the QHP versus a separate plan.
- c. Eligibility – identification of individuals who are eligible for special protections and provisions as AI/AN in the eligibility process and at the provider level to assure that deductibles and co-pays are waived. Utilization of existing databases or development of new databases to expedite eligibility determinations. Identifying how additional documentation will be requested and reviewed and eligibility determinations will be made when individuals are not included in approved data systems.
- d. Enrollment – enrollment processes must accommodate not only special provision for AI/AN in Exchanges (monthly enrollment, waiver of cost sharing, exclusion of certain sources of income), but also in Medicaid, Medicaid Expansion, Child Health Insurance Programs, and Basic Health Plans, if there are any in the State.
- e. Enrollment Assistance - carve outs for navigator contracts for the I/T/Us and other enrollment assistance funding, such as Medicaid Administrative Match (MAM).
- f. Tribal Sponsorship – allow aggregate payment of premiums and other policies to encourage Tribal sponsorship of individuals to enroll in Exchange plans.
- g. Outreach and Education – provide outreach and education that is culturally appropriate and assures that AI/AN know which QHPs have I/T/U providers in their networks and informs them of the special protections and provisions for AI/AN.
- h. Call Centers – decide whether it is most appropriate to have an Indian desk to handle questions and resolve problems regarding AI/AN and I/T/Us, or whether everyone who works at a call center should receive training about Tribes in the State, the Indian health care delivery system and special provisions in the law, regulations and systems for AI/AN.
- i. Website – ensure that the design of the website includes information specific to AI/AN and the I/T/U and is easy to access by consumers, as well as those assisting with enrollment.
- j. Waiver of Penalties for AI/AN without Insurance -- develop the system to assure that individuals are not penalized and to communicate who is covered by this provision in the law.
- k. Enforcement of Section 206 of the Indian Health Care Improvement Act (IHCIA) -- assure that the I/T/U is paid in a sufficient and timely way for services delivered to individuals who are enrolled in QHPs if the I/T/U is not a network provider.
- l. Reimbursements for Waived Cost Sharing --process to assure that the I/T/U receives payment for the co-pays and deductibles that are waived for AI/AN.
- m. Referrals through Contract Health Services (CHS) --rules and processes to assure that AI/AN who are enrolled in a QHP and referred through an I/T/U CHS program are not charged a co-pay or deductible for services they receive outside the I/T/U.

We believe that many of the issues listed above can be resolved on a nationwide basis by adopting policies for Federally-facilitated Exchanges. However, some issues will need solutions that are specific to the State in which the Federally-facilitated Exchange will operate. For example, a State with only one or two Tribes may require a very different scale of problem solving related to such things as enrollment assistance compared to a State with 30 or more Tribes.

TTAG has observed that this Administration has too often made decisions behind closed doors with only Federal agency representatives participating in the discussion and debate. We do not believe that the Indian Health Service or any other Federal agency speaks for Tribes. Tribal leaders and the individuals they designate need to be at the table to assure that that our Tribal citizens receive the benefits and protections which are specified in Federal law and that systems are developed that enhance the ability of our health care facilities and programs to meet the needs of our people.

Please consider this a request for enhanced Tribal Consultation on a federal and State-by-State basis for any issue that was included in Tribal comments on the NPRMs for Exchanges that the Federal government has not yet agreed to implement. TTAG appreciates the opportunity to provide input on this important government-to-government process. If you have any questions, you can email me at vdavidson@anthc.org. Thank you.

Sincerely yours,,-



Valerie Davidson
Chair, CMS Tribal Technical Advisory Group

cc: Dr. Yvette Roubideaux, Director, Indian Health Service (IHS)
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