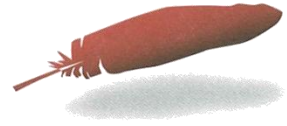


National Indian Health Board



Submitted via electronically

September 6, 2012

Mr. Gary Cohen, Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight (CCIIO)
Ms. Cindy Mann, Deputy Administrator and Director
Center for Medicaid and CHIP Services (CMCS)
Center for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-08010

RE: Issues from HHS Tribal Consultation on Federally-facilitated Exchanges (FFE)

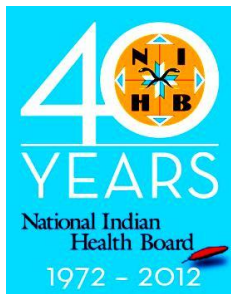
Dear Mr. Cohen and Ms. Mann,

On behalf of the National Indian Health Board (NIHB)¹, we are writing to provide a follow up written summary of the most important issues that surfaced in the recent Tribal Consultation sessions on federally-facilitated Exchanges (FFE) held on July 26, August 7 and August 9, 2012. We have written to Mr. Cohen separately about our concerns regarding Tribal Consultation at the State level in the planning for Exchanges. The following summarizes our main issues from the consultation sessions.

Data Elements and Applications

When CCIIO issued a request for input on data elements to be included in the single application form being developed by CMS for use by Exchanges, they included an "Indian placeholder". Tribes have requested more information about the overall process in which this information will be used to put the American Indian/Alaska Native (AI/AN) questions in context. The CMS Tribal Technical Advisory Group (TTAG), the National Indian Health Board (NIHB), and a number of tribes and tribal organizations submitted comments by the deadline. We appreciate that CMS will be hosting an All Tribes teleconference on September 7, 2012, where CCIIO will provide additional information about this and other data elements and enrollment questions

¹ Established 40 years ago, NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives. NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service ("IHS") Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act ("ISDEAA"), or continue to also rely on IHS for delivery of some, or even most, of their health care, NIHB is their advocate



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related to AI/AN. However, it seems as if previous information provided by the NIHB and the TTAG has not been used or referenced by CCIIO.²

In regard to advanced payment of tax credits and cost sharing reductions (APTC/CSR), Tribes were told at the consultation sessions that a waiver of cost sharing will only happen if applicant declares that he or she wants to be considered for an “Insurance Accessibility Program”. Subsequently, the ACA Policy Subcommittee for TTAG was reassured that cost sharing waivers for AI/ANs would be processed without considering eligibility for one of the Insurance Accessibility Programs (Medicaid, CHIP, Advanced Tax Credits). We would like to stress the importance of implementing the single streamlined application process in accordance with the statement made by CMS in the final rule on Exchange establishment:

In addition, in § 155.350(b) we provided that the Exchange must determine an applicant eligible for the special Indian cost-sharing rule in accordance with section 1402(d)(2) of the Affordable Care Act if he or she is an Indian, without requiring the applicant to request an eligibility determination that provides for collection or verification of income.³

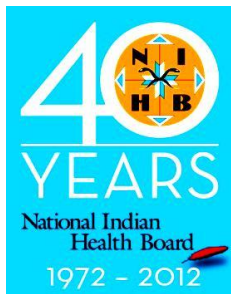
For AI/ANs, the single streamlined application process continues to be confounded by the definition of Indian issue. We remain concerned that the gap in how Medicaid determines who is an AI/AN for the purposes of that program and the somewhat narrower implementation that CCIIO seems to contemplate based on the definitions of “Indian” under the Affordable Care Act⁴ will put some AI/ANs in a worse situation than they are today. Unless, as we have strongly recommended, CCIIO and IRS interpret “Indian” to have the same meaning as it does for Medicaid, the single application for Medicaid and a HIE plan will not be nearly so “streamlined” as we had hoped since multiple questions will be required to ensure that the correct rule is applied to each of the programs and that AI/ANs are recognized as eligible for benefits to which they are entitled.

In response to questions at the HHS tribal consultation, the IHS Director and CMS staff acknowledged that some IHS beneficiaries who choose not to purchase health insurance coverage and who do not meet the definition of Indian under the Internal Revenue Code definition could be liable for the tax penalty administered by the Internal Revenue Service for not having “minimum essential coverage,” even though they are eligible for IHS services. We

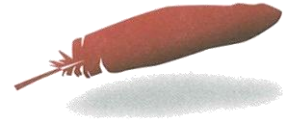
² See Letter to CMS Tribal Affairs Group from the Tribal Technical Advisory Group to CMS, Questions for Application for Medicaid and Exchange, December 19, 2011.

³ See *Federal Register*, March 27, 2012, CMS, “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans,” (CMS-9989-F), Vol. 77, No. 59, page 18382. (“Final Rule”)

⁴ We are pleased that finally there appears to be an acknowledgement that the two Exchange-related statutory definitions referenced in the ACA have the same meaning. See *Federal Register*, March 27, 2012, CMS, “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans,” (CMS-9989-F), Vol. 77, No. 59, page 18346.



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have been engaged with CMS on this matter for some time, and we would like to continue to work with CMS (and IRS, as needed) until a remedy is fashioned that meets the goals of the Affordable Care Act for a single, efficient, accurate and streamlined eligibility determination process for Exchange and Medicaid coverage and that works for all AI/ANs.

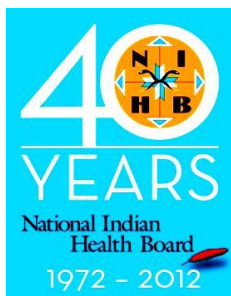
In response to the question “How will AI/AN prove that they don’t have to have insurance”, CMS staff responded, “Exchange will have to issue a letter or other document to an AI/AN so they have proof.” If this were the only approach allowed, or the primary approach used, it would be very difficult to implement as most AI/AN who are IHS beneficiaries will not have any reason to interact with the Exchange. To provide documentation to 1.5 million AI/AN would require a massive investment in employees to assist in the process at both the Exchange and in the communities. Furthermore, in meetings with the Medicaid and Medicare Policy Committee (MMPC) of the National Indian Health Board (NIHB), IRS representatives stated that the determination of tax penalties will likely be done by self-attestation of Indian status, which is the usual approach taken in federal income tax forms.

It appears that CCIIO may be overstating the Exchange role with regard to determining eligibility for Indian provisions related to IRS. We understand that, pursuant to the Affordable Care Act, self-attestation is not sufficient for purposes of a limited set of items (namely, proof of citizenship/legal residency and status as an Indian for purposes of Exchange eligibility and cost-sharing protections, respectively.) We are *not* aware of a heightened standard of verification under the ACA pertaining to any of the exemptions from the tax penalty for not securing minimum essential coverage, including the exemption for AI/ANs. We highlight this issue to ensure that a new standard is not inadvertently established when it is not required by the ACA. This issue, as all triggered by the fact that the Administration has not decided to rely on the Medicaid definition of “Indian” for all ACA provisions that use the term, continues to require very thoughtful implementation.

A follow-up question was asked: “What documentation is required by an AI/AN to provide to the Exchange to prove being an AI/AN?” CMS staff responded: “CMS needs more input from Tribes.” Tribes have given input to CMS on the broader issue of definition of Indian in response to NPRMs, including the attached letter on definition of Indian. We are available to discuss the development of operational guidance that would assist FFE and state-based Exchanges in verifying Indian status in a way that does not place an unnecessary burden on AI/AN applicants nor on Tribes.

Enrollment Assistance for AI/ANs - Navigators, In-Person Assistance and Medicaid Administrative Match (MAM)

We were informed that there will be competition for Navigator grants at the federal level with no set aside for Tribes. We are concerned about how this process, as well as the funding for “in-person assistance,” will be handled. In addition, we are convinced that Medicaid Administrative Match (MAM) and Out-stationed Eligibility Workers at Tribal sites should provide an option for



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States to be reimbursed by CMS for the costs of Tribes performing enrollment assistance regarding applications under the new streamlined consolidated process, whether the applicant turns out to be eligible for Medicaid or only an Exchange plan. A limited number of State Medicaid programs offer MAM agreements to tribal health programs. We believe CMS should affirmatively provide guidance to States that MAM agreements can reimburse tribal health programs for any assistance they provide to an individual to determine eligibility for any Federally-funded or subsidized health program, including both Medicaid and Exchange plans. We also believe those States that do not currently offer MAM agreements should be encouraged to do so. And, finally, we believe CMS should work with the TTAG to ensure that Indian health care providers have the resources they need from Medicaid and Exchange navigator and in-person assistance programs to assure that they can assist all AI/ANs who may qualify to fully participate in the new opportunities under the ACA.

AI/AN Alternatives for Medicaid Expansion

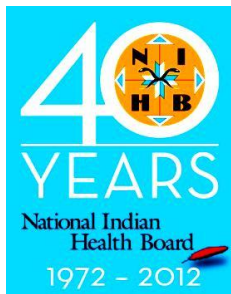
For non-expansion States, in response to questions raised in the Anchorage, AK, and Denver, CO, consultation sessions, CMS commented “We would be very interested in waiver proposals” from States/Tribes designed to expand Medicaid coverage solely to AI/AN through the Indian health, Tribal, Urban Indian health systems (I/T/U’s), possibly structured similar to the approved approach for AI/AN-specific benefits in Arizona. We hope CMS is developing a template for States to use in requesting such a waiver to extend Medicaid coverage provided by Indian health care providers even beyond that available through other providers. It is only through mechanisms like this that the United States can ensure that Medicaid will be fully available to AI/ANs. We were very encouraged to hear this and stand ready to assist CMS is developing the template.

CMS Responsiveness to Tribal Issues with States

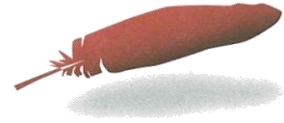
Medicaid representatives emphasized that Tribes in a State have the ability to request Tribal consultation directly with CMS if they are not satisfied with the Tribal consultation process or decisions by States with regard to State Plan Amendments or waiver requests presented by the State to CMS. We are pleased to hear this and hope that the same offer applies to allowing Tribes to request direct consultation with CCIIO if they are not satisfied with the Tribal consultation process and outcomes taken by State Exchanges or State Partners under the Federally-facilitated Exchanges.

Summary

We think these Tribal Consultation sessions were helpful to both inform Tribes and their health care providers, and to inform CMS about Tribal concerns. We recognize that both CMCS and CCIIO are under a great deal of pressure to design programs and promulgate regulations and to do so within the schedule set forth by the ACA. We heard CCIIO representatives say they are taking the approach that “where we start is not where we finish.” In other words, they want to stand up the FFE as quickly as possible and, at a later date, go back and develop additional capabilities or correct things that aren’t working.



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The National Indian Health Board understands that it is inevitable that course corrections and improvements will be needed after implementation, however Tribes also know from experience with CMS that it is better to get things right the first time rather than going back and trying to fix things that are in writing later. We are willing to devote our very limited resources to assisting you in the process, and we are asking you to devote the resources necessary to do the very best that you can do to get it right the first time around.

We appreciate your serious considerations of these comments and concerns. If you have any questions, please contact Jennifer Cooper at jcooper@nihb.org. Thank you.

Sincerely Yours,

A handwritten signature in black ink that reads 'Cathy Abramson'.

Cathy Abramson
Chairman, National Indian Health Board

Cc: Kathleen Sebelius, Secretary HHS
Valerie Davidson, Chair, TTAG
Dr. Yvette Roubideaux, Director, IHS
Stacy Bohlen, Executive Director, NIHB
Jennifer Cooper, Legislative Director, NIHB
H. Sally Smith, Chairwomen, MMPC
Marilyn Tavenner, Acting Administrator, CMS
Kitty Marx, Director of Tribal Affairs, CMS