National Indian Health Board

Delivered via electronic transmission

Submitted via *regulations.gov*

September 4, 2012

Martique Jones
Director, Regulations Development Group, Division B,
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Centers for Medicare & Medicaid Services
Room C-4-26-05
7500 Security Boulevard
Baltimore, Maryland, 212244-1850

RE: 1. Data Collection to Support Qualified Health Plan Certification and Other Financial Management and Exchange Operations (CMS-10433)

2. Data Collection to Support Eligibility Determinations and Enrollment for Employees in the Small Business Health Options Program (CMS-10438)

4. Data Collection to Support the Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Affordable Insurance Exchanges, Medicaid and Children's Health Insurance Program Agencies (CMS-10440)

Dear Ms. Jones,

On behalf of the National Indian Health Board (NIHB)[1], I am writing to provide recommendations in response to the request for comments from the Centers of Medicare and Medicare Services (CMS), Department of Health and Human Services (HHS) published on July 6, 2012 in the Federal Register notice *Agency Information Collection Activities; Proposed*

[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

Collection; Comment Request; Webinars. Specifically, we are addressing the data elements proposed for collection in

1. The *Data Collection to Support Qualified Health Plan (QHP) Certification and Other Financial Management and Exchange Operations (Document CMS-10433)*;
2. The *Data Collection to Support Eligibility Determinations and Enrollment for Employees in the Small Business Health Options Program (SHOP) (Document CMS-10438*); and
4. the *Data Collection to Support the Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Affordable Insurance Exchanges, Medicaid and Children's Health Insurance Program Agencies (Document CMS-10440*).

HHS and CMS Tribal Consultation Policies require that Tribes be consulted in the development of regulations and other guidance that have substantial direct effects on Tribes. The consultation, both formally and informally, that has occurred on these issues has been appreciated. Last December, the Tribal Technical Advisory Committee (TTAG) to CMS submitted recommendations on questions to ask in the single streamlined application to determine eligibility for the special provisions and protections for AI/AN. A copy of the TTAG letter is attached. In addition, we appreciate the August 20, 2012 webinar provided by CMS for Tribes about the Single Streamlined Application Data Elements on August 20, 2012.

To assure culturally appropriate services are readily available to enrollees in any Qualified Health Plan (QHP) offered, we have a strong interest in ensuring that the data collection forms provide sufficient data regarding American Indian and Alaska Native (AI/AN) participation and access to Indian Health Service (IHS), Tribal, and urban Indian health providers (collectively referred to as I/T/U). The proposed data collection effort must accommodate the identification of persons eligible for Indian-specific benefits, the unique attributes of the Indian health system, and the technical standards needed to support full implementation of the special provisions applicable to AI/ANs. For example, the Affordable Care Act (ACA) stipulates that cost-sharing (including both deductibles and co-pays) is waived for AI/ANs who receive their health care services at an I/T/U health facility or through referral by the I/T/U facility. In addition, AI/ANs who are enrolled in the individual market through an Exchange and have incomes under 300 percent of the poverty level pay no cost-sharing at any provider.[2] People who qualify for the benefits and protections as AI/ANs need to be identified in the enrollment process[3], 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.

[2] The QHP is to make-up the lost revenues to an Indian health care provider, and HHS is to make payments to QHP that enroll AI/AN to compensate for the additional costs associated with the cost-sharing protections.

[3] Pursuant to section 1311(c)(6)(D), AI/AN are eligible for special monthly enrollment periods in the individual market through an Exchange.

Thus, the information collected regarding the QHPs is important, as is the information that will be collected on the individual enrollment form.

For the many AI/ANs who receive their health care services through the IHS, a Tribally-operated health program (i.e. one operated by a Tribe or Tribal organization), or an urban Indian health clinic, it is important to assure that the QHPs an AI/AN may choose has an adequate provider network to meet their needs. Federal law allows an I/T/U to bill plans for services provided to AI/AN enrollees even when I/T/U programs are not part of the plan's network of providers. But for purposes of better coordination of care across all providers, ease and timeliness of billing, reduced likeliness of duplication of services, and other reasons, it is preferred that I/T/U be part of the QHP's provider network. As such, we are making recommendations here regarding data elements for the QHP application, as well as for an individual's enrollment.

With regard to individual enrollment, 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 information regarding where the applicant obtains primary care if such an enrollee uses an Indian health system provider. If an AI/AN is able to identify an I/T/U provider as their primary care provider, this may facilitate the I/T/U primary care provider to provide referrals within the network of the QHP that the AI/AN is enrolled, potentially leading to greater care coordination and more cost-effective care, even if the I/T/U is outside that network. Otherwise, there could be additional costs to the QHP to require an AI/AN enrollee to see one of its preferred providers when it has already reimbursed an Indian health provider for the same service.

In addition, 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 (APTC). 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 Outstationed Eligibility Workers and 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.

We understand that the single data element for identifying American Indians and Alaska Natives - "name of Indian tribe"- is considered a placeholder by CMS, meaning further refinement or expansion on this term is expected. We also understand 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 related to AI/AN. As these comments are due today before more information will be made available on AI/AN data on September 7, it is difficult for us to provide a full comprehensive comments here. We trust that the comments, which may be offered on September 7, or in subsequent written communications based on the information shared during the consultation, will be given the same weight as the comments we

provide below regarding the ways to enhance the quality of the information collected from the other data elements.

Given our current understanding of the data elements proposed to be included, as well as the rational for including those data elements, we offer the following additional comments.

A. QHP Network Adequacy: Document CMS-10433

To assure that AI/ANs enrollees in QHPs are not discouraged from continuing to use their I/T/U primary care provider, it is important that QHPs at least offer to enroll I/T/U providers in their networks. To evaluate network adequacy, we propose that the form provided to plans to apply for QHP status include a list of names and addresses of Indian health programs within the QHP service area. This would be the first column in a table with additional columns in which the QHP would supply the following information: (1) date the QHP sent a provider contract with Indian Addendum to the I/T/U program, if any; (2) date the I/T/U signed a provider agreement, if any; (3) I/T/U program rejected agreement (check mark, if applicable); and (4) no response from I/T/U program (check mark, if applicable). This table would allow the Exchange to make a determination of whether the QHP made a good faith effort to include I/T/U programs in its provider network. In the first year, a QHP would be deemed compliant with network adequacy standards regarding providers of Indian health services within the State if it is offered a contract with the Indian addendum to each of the I/T/U facilities listed, regardless of outcomes.

B. Placement of the Indian Questions in the Application: Document CMS-10440

The statement on data collection to support individual determination for insurance affordability has two appendices that identify data elements. Appendix A identifies data elements for the applications for Medicaid, CHIP and Advanced Payment of Tax Credits (APTC). Appendix B identifies data elements for enrollment in QHPs through Exchanges (not applying for insurance affordability programs). We presume that the data elements in Appendix B will be in the first part of the application, while the data elements in Appendix A will be in the last half of the application for those who want to be considered for the insurance affordability programs. If that is a correct assumption, then we believe the Indian question is located in the proper place for the application.

We are highlighting the issue of the order questions are asked / information is identified on an application because of the potential impact on access to Indian-specific benefits and protections that may result. We would like to stress the importance of implementing these provisions to have the effect of being 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.[4]

C. Tobacco Use: Documents CMS-10438 & CMS-10440

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 known as smudging. Asking an AI/AN 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 he or she uses 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 to indicate the use of commercial tobacco products versus ceremonial purposes.

D. Amount of Tribal Sponsorship applied Toward Premium: Document CMS-10440

The application process should include data (or at least a cell to enter data) on the amount of tribal sponsorship, if any, as well as other types of sponsorship applied toward the premium. This should be coordinated with the policies that set forth the terms and conditions of sponsorship.

E. Race and Ethnicity: Documents CMS-10438 & CMS-10440

Under "F" below, recommendations are offered on appropriate questions for determining if an individual meets the political and legal definition of AI/AN. The issue under this paragraph, though, pertains to one's self-identification as an AI/AN.

To better capture information regarding individuals who self-identify under a racial or ethnic category as AI/AN, the CMS TTAG recommended in its December 2011 letter to CMS that recommended the question be stated as "are you an American Indian, California Indian, Eskimo, Aleut, or other Alaska Native?"

[4] *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")

F. American Indian or Alaska Native Status: Document CMS-10438.

In addition and separate from the issue of racial or ethnic identification discussed above, there needs to be a clearly defined step in the application process that allows an individual to provide information that will demonstrate that he or she qualifies as an AI/AN for AI/AN-specific Medicaid benefits and protections and for AI/AN-specific Exchange-related benefits and protections.[5] If one eligibility standard is applied to AI/ANs for Medicaid purposes and a different eligibility standard is applied for Exchange purposes, then the enrollment process needs to enable an individual to determine eligibility as an AI/AN for each. In the December 2011 letter, TTAG also provided a list of suggested questions to help identify AI/ANs who qualify for the special benefits and protections.

We look forward to continuing this discussion on the AI/AN data element on the upcoming CMS All Tribes Call and future tribal consultations.

Conclusion

We fully appreciate the complexity and the tight period in which this enrollment structure is being developed. By addressing the issues pertaining to the I/T/Us and AI/ANs proactively, we hope that it will save time and work downstream as the Exchanges is implemented. We stand ready to assist you including answering any questions you may have.

Sincerely Yours,

Cathy Abramson

Cathy Abramson
Chairman, National Indian Health Board

Cc: Yvette Roubideaux, Director, Indian Health Service
Kitty Marx, Director, CMS Tribal Affairs Group
Stacy Bohlen, Executive Director, NIHB
Jennifer Cooper, Legislative Director, NIHB

[5] The range of AI/AN-specific benefits and protections include the cost-sharing and monthly enrollment protections in the individual market through an Exchange, eligibility for Medicaid cost-sharing protections, and the exemption from tax penalties under the Internal Revenue Code for AI/AN not securing minimum essential coverage.