National Indian Health Board

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October 31, 2011

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: NIHB Comments on CMS-2349-P: Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010

The National Indian Health Board[1] (NIHB) is submitting 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 August 17, 2011 in the *Federal Register* titled "Patient Protection and Affordable Care Act; Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010 (CMS-2349-P or Proposed Rule). We appreciate the opportunity to comment on this Proposed Rule.

Summary of Analysis and Recommendations

NIHB supports the overall approach and intent of the Proposed Rule in implementing portions of the Affordable Care Act,[2] particularly § 2001. "Medicaid coverage

[1] Established nearly 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.

[2] Refers collectively to the Patient Protection and Affordable Care Act (Pub. L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), and referred to herein as the Affordable Care Act or ACA. The ACA was subsequently amended by the Medicare and Medicaid Extenders Act of 2010 (Pub. L. 111-309), the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 (Pub. L. 112-9), and the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (Pub. L. 112-10).

for the lowest-income populations." We believe the Medicaid eligibility changes will make a major contribution to improving the health status of American Indians and Alaska Natives (AN/ANs). Although NIHB has not indicated our support on every section of the Proposed Rule that we do support, where we have not commented, NIHB is supportive of retaining the proposed language.

In the Comments, NIHB is offering recommendations in the following areas—

- Modified Adjusted Gross Income (§ 435.603, § 457.315): Clarify the exemptions allowed for AI/AN income. NIHB provides specific suggestions on how to present examples of exempt income for administrators unfamiliar with Indian- specific income protections.

- Extend Medicaid Coverage through End of Month (§ 155.410, §435.916, §457.343): Ensure that Medicaid coverage is not discontinued prior to end of the month to help prevent gaps in coverage.

- Residency for Medicaid Eligibility (§ 435.403): Modify language to address the special challenges in determining residency for AI/AN youth in out-of-state placements.

- Continued Applicability of 100% FMAP for Services to AI/AN by I/T[3] (§433.10): Clarify that the 100% FMAP that States receive for payments made to IHS and tribal providers for services they provide to AI/ANs will continue even when the enhanced rate for new services is reduced.

- Benchmark Benefits Package under Expansion (ACA § 2001(a), Social Security Act § 1902(k)(2)): When defining the section 1937 benchmark benefits package under the Medicaid expansion, consider and address the difficulties of low-income AI/AN in accessing medical services from remote locations.

Analysis and Recommendations

Modified Adjusted Gross Income (§ 435.603, § 457.315)

NIHB was pleased to see that proposed 42 C.F.R. § 435.603(e) codifies a number of income exemptions specific to AI/ANs for the determination of MAGI-based income. In particular, NIHB appreciates that CMS maintained the current Medicaid and CHIP treatment of distributions and payments from AI/AN resources in accordance with the directives found

[3] The term "I/T/U" means the Indian Health Service (IHS), an Indian Tribe, tribal organization or urban Indian organization, and is sometimes referred to as Indian Health Care Programs. 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 (IHCIA), 25 USC §1661. The term "Indian tribe" has the meaning given that term in Sec. 4 of the IHCIA, 25 USC §1603. The term "tribal organization" has the meaning given that term in Sec. 4 of the IHCIA, 25 USC §1603. The term "urban Indian organization" has the meaning given that term in Sec. 4 of the "IHCIA", 25 USC §1603.

in §5006 of the American Recovery and Reinvestment Act of 2009 ("ARRA"). Furthermore, we commend CMS for comparing Medicaid and IRS treatment of AI/AN income and selecting the most expansive interpretation of comparable exemptions, honoring the United States' trust responsibility to provide health care to AI/ANs.

However, in light of the importance of ensuring expansive access to Medicaid for AI/ANs, and considering the fact that the majority of State Medicaid employees have little experience with Indian-specific income considerations, NIHB believes that the proposed regulations require certain clarifications. Any ambiguities or generalities in the regulatory provisions could make it difficult for state Medicaid agencies to determine whether a certain type of AI/AN income is actually exempted under the new regulations. This could result in unwarranted delays in or denials of AI/AN Medicaid applications.

First, NIHB is concerned that the proposed rule might have inadvertently narrowed the scope of the AI/AN exemptions as established in ARRA. In proposed 42 C.F.R. § 435.603(e)(3)(iii)(A), CMS excludes "[d]istributions resulting from real property ownership interests related to natural resources and improvements located on or near a reservation or within the most recent boundaries of a prior Federal Reservation." This requirement is presumably based on ARRA § 5006(b)(1), which added the following provision to 42 U.S.C. § 1396a:

> (ff) Notwithstanding any other requirement of this title or any other provision of Federal or State law, a State shall disregard the following property from resources for purposes of determining the eligibility of an individual who is an Indian for medical assistance under this title:
>
> > (1) Property, including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior.
> >
> > (2) For any federally recognized Tribe not described in paragraph (1), property located within the most recent boundaries of a prior Federal reservation.
> >
> > (3) Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights.

> (4) Ownership interests in or usage rights to items not covered by paragraphs (1) through (3) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

It therefore appears that the language pertaining to "prior Federal reservations" is included in § 5006(b) of ARRA as a broadening clause (1) for tribes that may lack a present reservation and trust land base due to historical circumstances. It was not meant to limit the scope of clause (3) concerning natural resources.

However, in proposed 42 C.F.R. § 435.603(e)(3)(iii)(A), CMS has tied the "prior Federal reservation" clause to "[d]istributions resulting from real property ownership interests *related to natural resources and improvements*" (emphasis added). Instead of broadening the scope of lands from which excluded income can be derived consistent with the intent of ARRA, we believe that 42 C.F.R. § 435.603(e)(3)(iii)(A) actually narrows the natural resource exclusion described in clause (3) of the ARRA § 5006(b)(1).

In addition, the ARRA reference to usage rights in clause (3), concerning the exercise of federally protected rights, appears to contemplate off-reservation hunting, fishing, gathering, harvesting, and usage rights not tied to real property ownership. As a result, the use of the term "real property ownership interests" in proposed 42 C.F.R. § 435.603(e)(3)(iii)(A) is also unduly limiting. While we agree that income from the exercise of those off-reservation rights needs to be excluded, we believe that proposed 42 C.F.R. § 435.603(e)(3) requires clarification on this point.

Furthermore, with regard to the exemptions listed in proposed 42 C.F.R. § 435.603(e)(3)(ii)-(iv),[4] the language, as drafted, refers only to "distributions" or "payments." In the context of tax-exempt AI/AN income, such terms usually refer to per capita payments from tribes to their members. As such, they could be interpreted to be limited to such per capita payments, rather than also referring to direct earnings.

NIHB suggests replacing the words "distributions" or "payments" with the phrase "income derived" in each instance so as to broaden the scope and ensure that both tribal distributions and members' direct earned profits are exempted. In the alternative, we suggest noting (either in the exemption list or in the examples that follow) that the term "distribution" includes income received by an AI/AN as an owner of an interest in such lands, as a sole proprietor of a business operating thereon, or in the form of a distribution from a corporation, limited liability company, partnership, or other business entity located or operating thereon in which an AI/AN holds an ownership interest. CMS should clarify that this exclusion applies to both individually allotted trust and restricted lands, and to

[4] The "distributions" language is acceptable in subparagraph (i) given that it literally does refer to payments directly from an ANC or trust, rather than other types of income.

assignments, leases, or other rights of possession and use of tribal trust and restricted lands.

Along these lines, NIHB suggests adding clarifying language to ensure that the natural resources exemption applies to income earned by AI/AN from such sources as well as per capita distributions of such non-gaming sourced income from a tribe to its members. This clarifies the fact that although per capita distributions may be considered taxable income under the tax code, they must not be considered income for the purposes of Medicaid.

Finally, NIHB recommends explicitly adding exclusions for Judgment Fund distributions in light of their exclusion from taxable income under the Judgment Funds Use and Distribution Act, 25 U.S.C. § 1401, *et seq.*

To implement the suggestions listed above, we recommend the following edits to the proposed regulations:

> (3) *American Indian/Alaska Native exceptions.* The following are excluded from income:
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> > (i) Distributions from Alaska Native Corporations and Settlement Trusts;
> >
> > (ii) ~~Distributions~~ Income derived from any property held in trust, or that is subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, or property located within the most recent boundaries of a prior Federal reservation. This exclusion applies to income earned by an AI/AN from the use of such lands, or the grant of use rights to third parties, or from business operations and activities thereon, as well as per capita distributions of such non-gaming sources of income from a tribe to its members.
> >
> > (iii) Income derived from rents, leases, rights of way over, and royalties, usage rights, and natural resource extraction and harvesting, from:
> >
> > > (A) rights of ownership or possession in any lands described in subsection (ii) above, or any mineral or other interests therein, or
> > >
> > > (B) federally protected rights regarding off-reservation hunting, fishing, gathering, and usage of natural resources. ~~from real property ownership interests related to natural resources and improvements—~~

~~(A) Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or~~

~~(B) Resulting from the exercise of Federally-protected rights relating to such real property ownership interests;~~

(iv) ~~Payments resulting~~ Income derived from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom;

(v) Student financial assistance provided under the Bureau of Indian Affairs education programs.

(vi) Any funds distributed per capita or held in trust in satisfaction of a judgment of the Indian Claims Commission or the United States Court of Federal Claims in favor of any Indian tribe, band, group, pueblo, or community, together with any interest or investment income accrued thereon.

NIHB believes that the language proposed above will ensure that income exemptions associated with former reservations are not limited to income involving natural resources and improvements. It is imperative that the full extent of AI/AN-specific income taxation exemptions are reflected in MAGI determinations, and that the enumerated exemptions are not construed narrowly.

Specific Examples of AI/AN Medicaid Property Exemptions

NIHB understands that CMS is soliciting suggestions for specific examples of AI/AN Medicaid property exemptions so as to better guide State Medicaid agencies in their eligibility determinations.

Before offering suggestions, it is important to contrast the treatment of numerous types of income under the tax code with CMS's stated goals in proposed 42 C.F.R. § 435.603. For example, on page 51,157, in the preamble, CMS states that "there are several instances in which the IRC treats as taxable income distributions from AI/AN trust properties, which are excluded from income for the purposes of Medicaid and CHIP eligibility under the Recovery Act and other current law." We agree with CMS that the proposed regulations should be broader than those from the IRC in order to ensure expanded AI/AN Medicaid eligibility. As such, we believe that any specific examples listed in the regulation should reflect the comparatively broad scope of exemptions for Medicaid, not the narrower interpretations under the IRC.

For example, as currently drafted, proposed 42 C.F.R. § 435.603(e)(3)(ii) would exempt "distributions from any property held in trust, or that is subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior." This exemption, reflecting 42 U.S.C. § 1396a(ff)(1) (as added by ARRA § 5006(b)), generally reflects the income tax exemption for income directly derived from trust allotments under the U.S. Supreme Court's construction of the General Allotment Act in *Squire v. Capoeman*.[5]

However, for income tax purposes, courts have drawn a distinction under *Squire* between income from extractive or agricultural uses of the land, such as mining, oil and gas production, timber harvesting, farming and ranching, which is recognized as exempt, and income derived from rental and commercial operations conducted on a tribal member's allotment (or tribal assignment) which is not exempt.[6] As noted, though, the preamble states that CMS's purpose is to broadly interpret the MAGI exceptions, and that the exemptions in proposed 42 C.F.R. § 435.603(e)(3) specifically apply "notwithstanding the[ir] treatment . . . under the [Tax] Code." Pursuant to this authority, NIHB therefore suggests that CMS use the specific examples to draw a broader scope of exemptions than would be allowed under the Tax Code.

Similarly, per 42 U.S.C. § 1396a(ff)(4), proposed 42 C.F.R. § 435.603(e)(3)(iv) would exempt "payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom." This can be read either narrowly or expansively, depending on the context. We believe that guidance on this issue should clarify that items falling under this category might include, but are not limited to, property sold for use in healing or spiritual ceremonies, such as sage or sweetgrass, or may include artwork, pottery or jewelry with cultural or religious significance."

NIHB commends this broad interpretation, and urges CMS to list examples that will include sales of these and other types of Indian crafts and artwork that might not be treated as exempt under the Tax Code. NIHB believes that in light of the ARRA protections' clear impetus toward expanding AI/AN Medicaid enrollment, reflected in the preamble and the proposed regulations at issue, the "culturally significant property" clause should be given as wide a scope as is permissible.

NIHB proposes the following list of examples associated with each of the listed exemptions from the proposed regulation. The following exemptions include our suggested

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[5] 351 U.S. 1 (1956).

[6] *See*, *e.g.*, *Dillon v. United States*, 792 F.2d 849, 852-854 (9th Cir. 1986), *cert. denied*, *sub nom Cross v. United States*, 480 U.S. 930 (1987) (income from smokeshop operations not exempt); *Critzer v. United States*, 220 Ct. Cl. 43, 597 F.2d 708 (Ct. Cl. 1979), *cert. denied*, 444 U.S. 920 (1979) (income from operation of motel, restaurant, and gift shop, and from building rentals were not exempt).

edits from the previous section of this comment, as well as our additional proposed exemptions noted above.

- Distributions from Alaska Native Corporations and Settlement Trusts;
    - Cash (including cash dividends on stock received from a Native Corporation and on bonds received from a Native Corporation) to the extent that it does not, in the aggregate, exceed $2,000 per individual per year;
    - Stock (including stock issued or distributed by a Native Corporation as a dividend or distribution on stock) or bonds issued by a Native Corporation
    - A partnership interest distributed by a Native Corporation and partnership distributions with respect thereto;
    - Land or an interest in land (including land or an interest in land received from a Native Corporation as a dividend or distribution on stock); and
    - Payments from a settlement trust.
- Income derived from any property held in trust, or that is subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, or property located within the most recent boundaries of a prior Federal reservation.
    - Rents from any such lands or any improvements constructed thereon, e.g., housing, retail facilities, etc.;
    - Royalties or other compensation received from oil and gas production, mineral extraction, timber harvesting, and similar activities;
    - Profits or revenues derived from economic activity on the land, operation of motels, retail outlets, etc.
- Income derived from rents, leases, rights of way over, and royalties, usage rights, and natural resource extraction and harvesting, from (A) rights of ownership or possession in any lands described in subsection (ii) above, or any mineral or other interests therein, or (B) federally protected rights regarding off-reservation hunting, fishing, gathering, and usage of natural resources.
    - Profits from the sale, lease, or harvest of mineral, timber, and other such resources.

- Income derived from hunting, fishing, gathering, and harvesting fish, wildlife, and plant resources pursuant to Federally-protected rights, including off-reservation rights.

- Income directly derived from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom.

    - Property sold for use in healing or spiritual ceremonies, such as sage or sweetgrass.
    - Sales of artwork, pottery or jewelry with cultural or religious significance, such as traditional American Indian and Alaska Native crafts.
    - Handicrafts made by Alaska Natives from fish and wildlife resources taken for personal or family consumption.

    - Proceeds of sales of subsistence fish and game.

- Student financial assistance provided under the Bureau of Indian Affairs education programs.

    - Any student financial assistance provided under programs in title IV of the Higher Education At of 1965, as amended, or under the Bureau of Indian Affairs education programs

- Any funds distributed per capita or held in trust in satisfaction of a judgment of the Indian Claims Commission or the United States Court of Federal Claims in favor of any Indian tribe, band, group, pueblo, or community, together with any interest or investment income accrued thereon.

    - Per capita shares distributed to Tribal Members pursuant to the Indian Tribal Judgment Funds Use or Distribution Act (25 U.S.C. § 1401, *et seq.*), including interest and investment income earned on Judgment Funds while under administration.

Extend Medicaid Coverage through End of Month (§ 155.410, § 435.916, § 457.343)

In the preamble to the Proposed Rule, the drafters request comments on the termination of coverage policy under Medicaid and CHIP. This issue is covered in § 155.410 of Proposed Rule (Establishment of Exchanges and Qualified Health Plans, published in the Federal Register July 15, 2011) and touched upon in § 435.916 and § 457.343 of the current Proposed Rule. The currently proposed policy allows a state to terminate an individual's Medicaid coverage before that individual can obtain alternative coverage through an Exchange, making a gap in coverage possible. The Proposed Rule states that an alternative is being considered that would add a provision to the regulations that would extend

Medicaid coverage until the end of the month (the month that the termination notice period ends.) The drafters state that certain exceptions would apply.

NIHB supports the alternative proposal under which Medicaid coverage would be extended to the end of the month. First and foremost, this measure will help protect individuals from gaps in coverage. This proposal gives an individual a modest grace period under the Medicaid and CHIP programs. This grace period assures a measure of fairness given the timing restrictions of the Exchange enrollment and coverage periods. In total, this modest measure will promote the goal of helping people maintain continuous coverage.

This proposal also promotes one of the overall goals of the proposed Exchange regulations – to establish a streamlined, coordinated, and consumer-oriented system. This measure will greatly improve coordination between Medicaid/CHIP and the Exchanges.

Although some may argue that States will lose flexibility under the new proposal, NIHB points out that under the new proposal, States will make substantial gains in administrative efficiency. Furthermore, this approach is already the current practice in many States.

Residency for Medicaid Eligibility (§ 435.403)

The Proposed Rule proposes to simplify Medicaid's residency rules by striking the clause ``permanently and for an indefinite period'' from the definition for adults in § 435.403(h)(1) and (h)(4), and replacing the term ``remain'' with ``reside.'' For children under 21 not emancipated or married, the Proposed Rule proposes language that would align with the proposed definition for adults, albeit without the ``intent'' component (at § 435.403(i)(1) striking ``permanently and for an indefinite period'' and replacing ``remain'' with ``reside”). The drafters state that these changes will help to facilitate coordination of eligibility determinations across and between programs. These changes also make clear that States may not exclude individuals from coverage based solely on the fact that they do not maintain a permanent residence or fixed address. The change also makes clear that States may not determine residency of a child based solely on the residency of the parent.

NIHB supports this change and appreciates the drafters’ desire for flexibility especially in the case of children residing apart from their parents. NIHB notes that there are many AI/AN children who attend boarding schools operated by the Bureau of Indian Affairs. In many of these cases, children live in different states from their parents. These students often receive their medical care at IHS/tribally-operated health programs located near the boarding school. Where a student is eligible for Medicaid, the Indian health care program would like to bill the home state Medicaid plan, or enroll out-of-state AI/AN students in the local state's Medicaid program. Enrolling out-of-state students in the local State’s Medicaid program can work well and address important logistical challenges. For example, Oregon Medicaid has facilitated enrollment of AI/AN children from other States who attend the Chemawa Indian Boarding School. Allowing such children to claim

residency in the State where they attend school and live a large portion of the time makes practical sense for the individual and facilitates better coordination between programs.

NIHB also appreciates the flexibility shown in the Proposed Rule regarding residency for adults. Many AI/ANs must migrate from their reservation[7] to avail themselves of employment or higher education opportunities. Additionally, many families have ties to more than one reservation and may move periodically to respond to family or community needs.

Although NIHB supports this change, we believe that the drafters need to go further in regards to AI/ANs. The Proposed Rule preamble specifically states that the changes do not include "children who are visitors . . . for purposes of obtaining medical care." The same exclusion applies for adults. Because the Federal government has a special trust responsibility to AI/AN, and because AI/ANs must often seek care where it is offered through IHS or other culturally competent providers (often out of State), NIHB recommends that the drafters consider some additional situations the rules might address.

To begin with, NIHB notes that it is not uncommon or unreasonable for AI/AN who are Medicaid beneficiaries to cross State borders to receive care from IHS providers in other states. This situation occurs routinely where Indian reservations are located in more than one State. Navajo, Shoshone-Pauite Tribes of Duck Valley, Ute Mountain Ute, Colorado River, and Standing Rock illustrate this geographic reality. Unless the provider—the IHS or tribally-operated program—has a provider agreement with the patient's home State, the patient may not have access to health care, or the Indian health program may not be able to bill any Medicaid program for the patient's care.

Even when an individual's reservation lies completely within a State's borders, that individual may be compelled to obtain care outside the State. For instance, consider the case where an AI/AN individual, living in one State but affiliated with a Tribe in another, returns to his/her home reservation to receive care, so that he/she can be near family and community during a period of illness. Sometimes obtaining culturally-appropriate care drives the decision. Often, AI/AN people who are not affiliated with a program on a particular reservation will cross a nearby State border to receive no-cost care from an IHS-supported program. Sometimes providers refer patients in need of specialty care to out-of-state IHS or tribal programs – including residential programs -- where fellow patients are also AI/ANs and the care provided is designed specifically for an AI/AN population. Key examples of this kind of program are youth residential treatment centers (YRTCs) behavioral health programs for Indian youth (discussed in depth below) and IHS or tribally-operated programs for adults with substance abuse problems. There are comparatively few such

[7] For simplicity, we refer only to "reservations," however the issue is present when AI/ANs leave whatever their home community is, whether an Alaska Native village, a rancheria in California or former reservation lands in Oklahoma.

programs in Indian Country;[8] therefore, it is often the case that AI/AN patients must cross State borders to receive culturally competent – and thus more effective – care at these facilities.

As mentioned above, YRTCs are a specific example that the drafters should consider. IHS operates YRTCs that provide drug and alcohol treatment for adolescent age children who are enrolled members of Indian Tribes. Nationwide, there are eleven YRTCs, with five operated by the IHS and six operated by Tribes. These programs are not detention centers; they are health centers that provide quality, holistic, behavioral health care for Indian adolescents and their families in a substance-free residential environment that integrates traditional healing, spiritual values, and culturally-appropriate care.

If they are to receive care from IHS or tribal facilities, these individuals and their parents often will not have a choice in where they obtain care. Rather, they must seek care in whatever State it is available.[9] Furthermore, these families have very compelling reasons to seek care from IHS or tribal facilities. To mention a few of these reasons: IHS and tribal facilities have personnel that better understand the needs of AI/AN patients; the facilities provide culturally-appropriate care; and, most importantly, patients have better outcomes. These factors are present in other types of IHS and tribal specialty care, but are especially compelling reasons to seek care at YRTCs when substance abuse is the challenge.

Although these facilities may be able to enroll children in Medicaid in their home State and enroll themselves as providers, there are tremendous administrative burdens and barriers to doing so. One program may have children from a huge range of States. There are different requirements for compliance with each State's provider, licensure or certification that are administratively challenging to manage. Documentation requirements and obtaining these instruments from parents is also a tremendous challenge to getting the children enrolled in Medicaid. Because of the Medicaid program provides 100 percent Federal Medical Assistance Percentage (FMAP) to States in instances where services are rendered to AI/AN by IHS or tribal providers, enrolling AI/AN in the Medicaid program of the State housing these facilities does not place a financial burden on the hosting State. (*See* additional discussion below.)

NIHB urges the drafters to address AI/AN-specific challenges to access to care by further modifications to the residency definitions. NIHB is especially concerned with the residency definitions as they impact youth seeking treatment at YRTCs. The drafters have the opportunity to make YRTCs more accessible to AI/AN youth and in so doing, address a critically important issue to Indian communities across the country. It is the position of NIHB that the application of the Proposed Rule change to AI/AN youth placed in YRTC would

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[8] In fact, under the IHCIA, IHS is required only to provide at least one youth residential treatment program in each of the 12 areas, with one additional one in California. 25 U.S.C. § 1665g.

[9] The challenges associated with children's access to behavioral health care and reimbursement issues are documented in the CMS Tribal Technical Advisory Group report, "Six Recommendations to Address Across-State Border Issues for American Indian/Alaska Native Medicaid and CHIP Beneficiaries."

be consistent with the treatment of other youth in the Medicaid program receiving services out-of -state when they do not have control to decide where they will receive treatment.

Continued Applicability of 100% FMAP for Services to AI/AN by I/T (§433.10)

NIHB notes that the FMAP rates established for newly Medicaid eligible individuals pursuant to ACA § 2001 will be 100 percent, but will gradually decline to 90 percent. However, the FMAP for "amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 1603 of title 25)" is always 100 percent and should not be affected, whether the services were part of the expansion or not.[10] The drafters may want to consider making this explicit in revisions to the Proposed Rule or in a comment in the preamble.

AI/AN-Specific Protections from Cost-Sharing (generally)

NIHB notes that all the existing Medicaid protections for AI/ANs and I/T/Us apply under the new Medicaid expansion authorized under ACA § 2001, including rules relating to cost sharing.[11] For example, no Medicaid premiums or cost sharing may be imposed on an AI/AN applicant or an AI/AN receiving services from an I/T/U directly or through referral under Contract Health Services.[12] In addition, AI/AN will continue to be exempt from mandatory managed care enrollment. Additionally, as added by section 5006(d) of the Recovery Act, AI/AN enrolled in Medicaid managed care plans have the option of choosing an Indian health care provider as the AI/AN's primary care provider.[13] We encourage CMS to revise the Proposed Rule to indicate that these AI/AN-specific protections are applicable under the § 2001 expansions.

Benchmark Benefits Package under Expansion (ACA § 2001(a), SSA § 1902(k)(2))

Although NIHB supports the ACA goal of increasing the overall number of people eligible for Medicaid, we are concerned that the benefit coverage for newly-eligible individuals may be inadequate, especially since some benefits covered under traditional Medicaid may not be covered under the new Medicaid category. These individuals will receive "benchmark" or "benchmark-equivalent" coverage consistent with the requirements of section 1937 of the Social Security Act.[14] The coverage is to provide at least the "essential benefits" as required for Exchange-offered plans, including prescription

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[10] 42 U.S.C. § 1396d(b).

[11] Centers for Medicare and Medicaid Services, Dear State Medicaid Director Letter, SMDL #10-005, April 9, 2010, page 3. https://www.cms.gov/smdl/downloads/SMD10005.pdf.

[12] 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.

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

[14] ACA Section 2001(a)(2). The benchmark coverage will provide "essential health benefits", which, by law, will be modeled after what a typical employer currently provides today in the private sector.

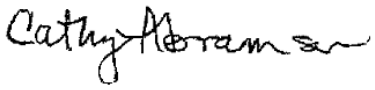
drugs and mental health services. But, services not included in typical employer-provided insurance, such as transportation services, may be excluded by a State from the Medicaid benchmark coverage.

We mention transportation in particular because the newly-eligible individuals are likely to have the same need for the benefits at issue as those currently served by Medicaid (or possibly a greater need, because of pent up demand), and AI/ANs often experience terrible, and well-documented difficulties accessing Medicaid-covered services from remote locations. NIHB urges CMS, in modifications to the Proposed Rule to address this specific issue.

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,



Cathy Abramson
Chairman, National Indian Health Board

C: Dr. Donald Berwick, Administrator, CMS
Dr. Yvette Roubideaux, Director, Indian Health Service
Valerie Davidson, Chair, Tribal Technical Advisory Group to CMS
Kitty Marx, Director, CMS Tribal Affairs Group
H. Sally Smith, Chair, NIHB Medicare, Medicaid and Health Reform Policy Committee (MMPC)
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Jennifer Cooper, Legislative Director, NIHB