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2121 SW Broadway
Suite 300
Portland, OR 97201
Phone: (503) 228-4185
Fax: (503) 228-8182
www.npaihb.org

SENT BY TELEFAX: (301) 443-4794 – Hardcopy via Federal Express

July 1, 2010

Yvette Roubideaux, M.D., M.P.H
Director
Indian Health Service
801 Thompson Avenue, Suite 440
Rockville, MD 20852

Re: Comments regarding P.L. 11-148 PPACA and IHCIA

Dear Dr. Roubideaux:

Established in 1972, the Northwest Portland Area Indian Health Board (NPAIHB) is a P.L. 93-638 tribal organization that represents forty-three federally recognized Tribes in the states of Idaho, Oregon, and Washington on health care issues. We are writing to provide our comments and recommendations to your May 12, 2010, "Dear Tribal Leader" letter, in which you and Paul Dioguardi, Director HHS-IGA, invited input to implement various provisions of the Patient Protection and Affordable Care Act (P.L. 111-148) and the reauthorization of the Indian Health Care Improvement Act (IHCIA).

As you may be aware, the NPAIHB played in critical role in the development of the IHCIA legislation and many of the provisions that were included in the Affordable Care Act. Northwest Tribes understand that the Affordable Care Act and amendments to the IHCIA will have lasting implications in developing the Indian health system. Because of this it is imperative that Indian Health Service (IHS) and other federal agencies carefully evaluate the impact that implementing health reform will have on providing services to American Indian and Alaska Native (AI/AN) beneficiaries and the Indian health system. It is the IHS' responsibility along with the Department's to ensure that the Indian health system is protected from any unintended consequences and promote the highest level of health care for Indian people.

Because of the reasons articulated above, Portland Area Tribes expect the IHS and Department to actively involve Tribes in the implementation efforts of the Affordable Care Act and the IHCIA amendments. In this regard, we are pleased to provide our comments and recommendations to your May 12th letter, which are organized around as follows: (1) Preamble to NPAIHB Comments; (2) IHCIA priorities and how to implement; (3) Affordable Care Act priorities and recommendations on how to implement, and; (4) How to consult with Tribes on an on-going basis as provisions are implemented.

I. Preamble to NPAIHB Comments

As a preliminary matter, Northwest Tribes urge the HHS Secretary and IHS Director to formally acknowledge that the IHCIA amendments are effective on the date of enactment of the Affordable Care Act, March 23, 2010. Northwest Tribes further recommend that the request for input to identify "priorities for implementation" shall not delay the immediate implementation of any new authorities allowed by law. While some new IHCIA provisions expressly require the Secretary to issue regulations, no provision contains language which delays its effectiveness until regulations are promulgated. Thus, issuance of regulations or agency guidance may be undertaken to help make utilization of new authorities more effective and efficient, but this activity should not delay their immediate applicability.

II. IHCIA priorities and how to implement

Provisions for which regulations, guidance or administrative action is required or needed

1. Establish a Negotiated Rulemaking Committee. For any rules that may need to be promulgated, the most efficient and effective way to develop regulations or other administrative guidance is to establish a Negotiated Rulemaking Committee comprised of tribal and IHS representatives. While the new law does not require the Secretary to use negotiated rulemaking, this procedure is available through the Negotiated Rulemaking Act, 5 U.S.C. 561, et seq. This procedure has been successfully used for development of recommended regulations for many Indian laws since it was first employed after enactment of the Indian Self-Determination and Education Assistance Act (P.L. 93-638, ISDEAA) amendments of 1994. It is an effective manner to obtain expertise from tribal representatives, while working together with IHS personnel, to produce regulations, guidance, and procedures that both the agency and tribes can support.

2. Section 409: Access to Federal Insurance. This is a ***"high priority"*** item for Portland Area Tribes. Sec. 409 allows a tribe/tribal organization operating any ISDEAA program to enroll its employees in the Federal Employee Health Benefit Program, provided it pays the premiums. This is a significant new opportunity for tribes to acquire more economical coverage. While the law does not *expressly* require regulations, it is clear that some form of guidance, procedures or regulations from the Office of Personnel Management will be needed to enable tribes to access the FEHBP. OPM has asked IHS to take the lead in implementing this provision, and tribes should be involved. Please see attached NPAIHB letter sent to OPM Director, John Berry, dated May 10, 2010.

3. Section 405: Sharing Arrangements with Federal Agencies. Sec 405(c) requires the Departments of Veterans Affairs and Defense to reimburse IHS and tribal health programs when they provide services to beneficiaries eligible for DVA and DoD services. IHS should take the lead in arranging with DVA and DoD an efficient billing/payment system. This should be a high priority for implementation attention.

4. Section 301: Health Care Facility Priority System. Requires IHS, in consultation with tribes/tribal organizations, to develop a health care facilities construction priority system which allows IHS and tribes/tribal organizations to nominate projects at least every 3 years. While *regulations* are not expressly required, the priority system developed will be applied throughout the IHS system.

5. Section 311: Other -Funding, Equipment and Supplies for Facilities. Requires IHS to "establish, by regulation, standards for the planning, design, construction, and operation of health care or sanitation facilities serving Indians under this Act."

6. Section 202: Catastrophic Health Emergency Fund (CHEF). This section requires issuance of CHEF regulations. The predecessor Sec. 202 did likewise, but IHS has never issued CHEF regulations. Unless there are issues about whether CHEF program operations comply with the law, regulations at this point are probably not needed.

7. Section 309: Tribal Management of Federally Owned Quarters. No regulations are required to implement this provision (Sec. 309); it should be considered in effect now. But IHS should update its personnel manuals to assure that IHS employees know of and comply with this new statutory authority for tribes.

Existing regulations that should be reviewed as a result of revisions to the IHCIA

8. Contract Health Services definition. Sec. 3(5) of the new law sets out a revised definition of contract health services. The existing regulation at 42 CFR 136.21(e) should be revised to conform.

9. Section 405: Sharing Arrangements with Other Federal Agencies (Payer of Last Resort). New Sec. 405(c) requires DoD and DVA to reimburse IHS and tribal programs for services provided to Indians eligible for DoD or DVA services. The POLR regulation at 42 CFR 136.61 should be updated to reflect this requirement. In addition, Sec. 2901(b) of the PPACA codifies in law the POLR status of IHS, tribal and urban Indian organizations. The IHS regulation should reference this statutory directive.

New Provisions for which tribes may want to be involved in development of regulations, guidance, eligibility criteria or other administrative action

10. Section 119: Community Health Aide Program (CHAP) expansion. Authorizes establishment of a CHAP program for tribes in the Lower 48 states, subject to the appropriation of new funds for this purpose. Tribes may want to be involved in deciding whether to use the Alaska CHAP criteria or to develop different criteria for the Lower 48 program.

11. Section 221: Licensing of Health Care Professionals. This provision would exempt Tribal Health Professionals from being licensed in the state of which they are practicing as long as they are licensed in another state. This is a priority to Portland Area Tribes as it would aid in the recruitment and retention of health professionals in rural areas and gives Tribes parity with IHS professionals. NPAIHB requests that the Center for Medicaid and Medicare services (CMS) issue a letter to State Medicaid Directors informing States they can no longer deny Medicaid provider status to a Tribal health care professional who is not licensed in the State, but does hold a license in another State.

12. Section 226: Contract Health Services Administration. The Secretary is authorized (but not required) to use Negotiated Rulemaking to develop a CHS distribution formula if, after receiving an ordered GAO report on the CHS program, she finds inequities in the current formula or problems with CHS administration.

13. Section 407: Eligible Indian Veteran's Services. This section authorizes the use of certain IHS-appropriated funds to pay expenses incurred by eligible Indian veterans who receive services from the Department of Veterans Affairs providers in IHS or tribal facilities. The Secretary is required to "establish such guidelines as the Secretary determines to be appropriate regarding the method of payments" to DVA. To the extent these guidelines would also apply to tribes, a tribal role in development may be desirable.

14. New Demonstration Programs. Several new demonstration programs are authorized in the new law. In some cases, funding will be needed before these authorities can be utilized. Criteria will be needed for selection of recipients and tribes may want to have input in their development.

15. New/revised Grant Programs. Tribes may want to have an integral role in developing eligibility criteria for new/revised grant programs, especially if new statutory language impacts existing similar programs. Title VII in particular will require some careful thought, as that Title's focus on substance abuse programs has been expanded to encompass wider behavioral health needs; it also creates new activities such as an Indian Youth Suicide Prevention program.

III. Affordable Care Act priorities and recommendations on how to implement

The sheer size and extent of the PPACA make it challenging for us to identify every provision that will impact our Northwest Tribes. An enormous number of new regulations will be required to implement the PPACA, as that law establishes a host of new programs and adds major new provisions to existing laws such as the Social Security Act and the Internal Revenue Code. HHS has already begun issuing regulations for provisions which become effective later this year and next year. In many cases, the law itself dictates implementation "priorities" by establishing specific timelines.

The National Indian Health Board's met in Denver last week to begin discussion of desired PPACA outcomes for Indian health, and to identify provisions in whose implementation it is important to assure that tribal leader input is obtained at the earliest stages of development. NPAIHB and its member Tribes has been an active participant in this process and endorse and support the recommendations submitted by the NIHB in follow up to your May 12th letter.

Desired Outcomes. For PPACA to fulfill the Administration's promise to American Indians and Alaska Natives, its implementation must:

- Significantly increase the rate of health coverage for American Indians and Alaska Natives, both on and off reservations.
- Financially strengthen Indian health providers so programs can expand service capacity and access to health care.
- Significantly reduce the glaring health disparities that plague American Indians and Alaska Natives.
- Ensure that Tribal leaders and Indian health program staff receive training in order to understand how PPACA works and are supplied with adequate resources to educate and enroll community members in new or expanded health programs.

- Ensure that all Indian communities directly benefit from new funding opportunities, grants and initiatives in a way that compliments the cultural context of their existing health programs.
- Implement Indian specific provisions as effectively and efficiently as possible.
- Recognize that the Indian health system is very different from the mainstream health delivery system and, therefore, assure that it is protected from any adverse consequences not intended by the statute, and receives express mention in regulations in order to achieve this outcome.
- Require all Department of Health and Human Services agencies with implementation responsibilities to engage in meaningful Tribal Consultation that respects the federal trust responsibility and Government-to-Government relationship with Tribes.

In order to accomplish these outcomes, PPACA must begin by implementing policies and actions in the following areas. The comprehensive and coordinated nature of PPACA will require an ongoing dialogue with Tribes and Indian communities in order to understand and accommodate the unique aspects of Indian health programs across the country. The following is not comprehensive list of PPACA items affecting Indian Tribes nationally, however represent the immediate issues from the perspective of Northwest Tribes, which should be addressed by the IHS and HHS:

A. <u>Indian exemption from individual mandate penalty – PPACA Sec. 1501(b) creates a new Sec. 5000A in the Internal Revenue Code which exempts members of Indian Tribes from the tax penalty for failing to obtain acceptable insurance coverage.</u>

The Secretary is charged with issuing certification attesting that the individual is entitled to the exemption. This process must be designed in a way that makes it easy for American Indians and Alaska Natives to obtain the certification in an expeditious and user-friendly manner.

B. <u>Exchanges and subsidies, especially Indian provisions.</u> Special Exchange rules for Indians: Sec. 1402(d) and Sec. 2901(a); Monthly enrollment window for Indians: Sec. 1311(c)(6)(D)

Regulations developed to implement the Exchanges must carefully set out the special treatment the law provides for IA/AN access to insurance products listed on the Exchanges. These includes: eligibility of AI/ANs to insurance products in the individual market; special enrollment period for AI/ANs; and cost-sharing protections for AI/ANs at/below 300% of the FPL and for all Indians served by an IHS, tribal or urban Indian organization health program. If HHS regulations implementing these provisions are not sufficiently explicit, AI/ANs could be denied the special considerations Congress intended.

C. <u>Premium and cost sharing payment on behalf of eligible Indian people</u>

Premium payment is a significant barrier to Indian enrollment in Exchange plans or high risk pools. To overcome this barrier, the regulations should establish an administratively simple mechanism which allows IHS, Tribes, Tribal organizations and Urban Indian programs to group-pay premiums on behalf of individual beneficiaries. Such group payment mechanisms are now used for enrolling individual beneficiaries in Medicare Part D plans. Since Exchanges will likely be operated by the states, the HHS regulations must expressly require the availability of such group pay options in order to assure the state systems will include them.

D. Use of high risk pools

Sec. 1101. For American Indians and Alaska Natives with pre-existing conditions, whether or not they use an Indian health program, purchasing insurance through a temporary high risk pool may be the only way to get affordable health coverage. In order to qualify, HHS should clarify with entities providing high risk pool coverage that IHS eligibility does not constitute "acceptable coverage" as defined in the PPACA, and, therefore, AI/ANs without other insurance coverage are eligible to acquire coverage from the high risk pools. Furthermore, ITU programs need a simple way to provide document that AI/AN beneficiaries have a pre-existing condition that would qualify them for coverage.

E. Modified Adjusted Gross Income – treatment of Indian income

Sec. 2002 of PPACA and Sec. 1004 of Health Care and Education Reconciliation Act. MAGI will be used as the basis for means tested eligibility for (among others) Medicaid and for Exchange plan premium subsidies. Regulations implementing the MAGI must expressly recognize Indian income exemptions provided by other Federal laws and assure that those exemptions also apply to MAGI calculations. HHS also has the responsibility to provide comprehensive outreach and education to Indian beneficiaries so they are informed about the types of Indian-specific income that are excluded in making MAGI calculations.

F. Exchange plan and high risk pool reimbursement for Indian health programs

PPACA Sec. 1311(c)(1)(C) requires the Secretary to include within Exchange health insurance plan provider networks "essential community providers" that serve predominately low-income, medically-underserved individuals. The HHS regulations should expressly include IHS, tribal and urban Indian organization programs in the definition of "essential community providers". Experience has demonstrated that private insurers often do not admit I/T/U providers to their provider networks. Thus, Exchange regulations should set out participation and payment requirements for I/T/U providers (as "essential community providers") modeled on the recent amendment to Sec. 1932 of the Social Security Act regarding participation of I/T/U providers in Medicaid and CHIP managed care entities.

Such express payment requirements are also needed to fully implement the revised IHCIA Sec. 206. This revised section gives IHS, tribal and urban Indian organizations providers a right of recovery from all third parties "the reasonable charges billed" by such providers, "or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities".

G. Medicaid expansion

The PPACA expands Medicaid to all individuals at/below 133% of FPL, effective in 2014, unless sooner expanded by a State Medicaid plan. Medicaid reimbursement is critically important to Indian health programs. PPACA Medicaid provisions will have a profound impact on access to health services for Indian people. CMS will have primary responsibility for most federal implementation. Priorities include how the HHS website and Exchange portals will convey information specific to

Indian provisions. The Coordinated Health Care Office must begin working with TTAG to make sure policies work to improve access for dually eligible Indian people. Indian specific directives to States will also be essential to implement.

H. Identifying and verifying Indian individuals eligible for special provisions

HHS regulations should include specific definitions as to individuals who are eligible for the special treatment the PPACA grants to Indians. These regulations should use the comprehensive definition of "Indian" set out in the final rule issued by CMS regarding Medicaid program premiums and cost-sharing. *See* 42 CFR 447.50(b)(1), as printed in 75 Federal Register 30261 (May 28, 2010).

I. Express Lane Agency status

PPACA Sec. 2901(c) adds IHS, tribal, and urban Indian organizations to the list of entities that have "express lane agency" status on whose determinations of eligibility a state may rely for purposes of Medicaid and CHIP eligibility. HHS must insure that states are aware that I/T/Us now have express lane agency status, and require them to provide I/T/Us with information on eligibility requirements, document processing and any necessary personnel training to enable them to perform their express lane agency functions.

J. "TrOOP" fix for I/T/U pharmacies

Effective January 1, 2011, PPACA Sec. 3314 requires Medicare Part D plans to count the cost of drugs dispensed by I/T/U pharmacies toward the true out of pocket expenses incurred by an individual Indian enrolled in a Medicare Part D plan. CMS must inform I/T/U pharmacies and Part D plans of this change so that all mechanisms are in place in advance of the January 1, 2011 effective date to implement this provision. In addition, IHS and the TTAG should revise the Indian Health Addendum which CMS requires to be included in Part D plan pharmacy provider agreements to reflect this revision to the "TrOOP" rules.

K. Tax exemption for tribally-provided benefits

Rapid implementation and education of PPACA Sec. 9021 is important to be sure American Indians and Alaska Natives understand that effective March 23, 2010, health benefits (including premiums) provided by IHS or tribes are not taxable income to individual AI/ANs.

L. Maternal, Child Home Visitation Program (HRSA and ACF)

PPACA Sec. 2951 establishes a new Maternal and Child Home Visitation Program for families at risk of poor maternal and child health. Tribes, tribal organizations and urban Indian organizations are eligible for competitive grants funded through a 3% set-aside at Sec. 2951(j)(2)(A).

While Indian Country is grateful for this express set-aside, the funds provided will not be sufficient to enable all at risk AI/AN communities. Thus, HHS must assure that States are required to include Indian communities in the needs assessments they must perform and services they must provide under the State grants made available under this Section.

M. Data collection for Federally-supported health programs

PPACA Sec. 4302 requires the Secretary to collect data for all federally-supported health programs according to race, ethnicity, sex, primary language and disability status of participants and to analyze these data to monitor trends in health disparities. It is vital that the data collection system includes categories for AI/ANs generally, and disaggregates data for AI/ANs served by I/T/U programs. It is well-known that AI/ANs suffer from the greater health disparities than other components of the American population. The data collection system should also be constructed to enable HHS to track the number of AI/ANs enrolled in Medicare, Medicaid and CHIP.

To successfully implement this provision, the Agency for Healthcare Research and Quality should be required to work with knowledgeable I/T/U and Indian researchers and Tribal Epidemiology Centers.

N. Workforce Development grant programs

Titles IV and V of Act: Many different HHS agencies will be involved and ITU access to these resources is important for successful implementation of PPACA and capacity building. Although some provisions explicitly list ITU or Tribes as eligible applicants, there should be a way to insure all programs are available in Indian Country and that application information is available at the earliest date possible.

O. Negotiated Rulemaking for Medically Underserved Populations and Health Professions Shortage Areas

Sec. 5602 requires the Secretary to utilize Negotiate Rulemaking for re-defining the terms medically underserved populations and health professions shortage areas. Indian Country is grateful that Indian organizations have been identified as entities to be represented on the Negotiated Rulemaking Committee.

P. Behavioral Health

In addition to Behavioral Health provisions in the IHCIA, PPACA includes: Sec. 1302; Sec. 2703; Sec. 2707; Sec. 2952; Sec. 3012; Sec. 3107; Sec. 3205; Sec. 3502; Sec. 4001; Sec. 4004; Sec. 4101; Sec. 4103; Sec. 4106; Sec. 4201; Sec. 4202; Sec. 5101; Sec. 5203; Sec. 5301; Sec. 5306; Sec. 5315; Sec. 5403; Sec. 5405; Sec. 5507; Sec. 5604; Sec. 10306; Sec. 10408; Sec. 10410.

The underlined Sections have specific references for Indian Country. The behavioral health features of the PPACA are numerous and complex. The Act offers significant opportunities to begin to ameliorate the impact of mental illness, drug abuse, and other behavioral issues commonly referred as "Behavioral Health" in Indian Country (consistent with Title VII of the IHCIA). Behavioral health issues have been profoundly underestimated and culturally undefined in the AI/AN population.

There are a variety of different opportunities in the Section above, that can impact or begin to ameliorate the profound needs in Indian Country, but only if ITUs can successfully find ways to tap into the various programs. Accessing new behavioral health programs under PPACA is complicated

by the fact that they will be administered by numerous federal agencies making an integrated strategy difficult to accomplish.

IV. How to consult with Tribes on an on-going basis as provisions are implemented

Portland Area Tribes want to be proactive – not just reactive. We understand that there are many internal implementation teams and some policy decisions are moving forward quickly. The provisions in PPACA are complexly intertwined and will impact Tribes in their roles as employers, health care providers and governments responsible for the health and wellbeing of their members. For these reasons, we strongly advise that Tribal representation be integrated into this process so that the critical voice of Tribes is reflected in all policy making processes which will impact them.

We also recommend that the Department convene a series of "All Tribes" calls to ensure that all of Indian Country has a chance to weigh in throughout this process. Because the role of IHS is limited, HHS and the Administration must effectively engage Tribes in both formal and informal consultation on a variety of PPACA policies which are beyond the expertise of IHS.

It seems that two consultation mechanisms are needed—one for the IHCIA, and one for the PPACA (described below). Whatever the process, it is imperative that Tribal leaders have a seat at the table with HHS and IHS as implementation of PPACA and IHCIA occur. Tribes as major stakeholders in the health reform process, we want to ensure that Tribal leaders are included in any major workgroup, advisory committee or consultation process that is used by HHS and IHS. We advise that the Department work with the NIHB and TTAG when it needs technical assistance on policies and implementation strategies that effect Indian people or Tribal and Urban Indian providers.

1. IHCIA tribal consultation. The implementation task facing IHS is three-fold: (i) identifying the new IHCIA provisions that do and do not require regulations; and (ii) identifying the few existing IHCIA regulations which must be updated as a result of the recent amendments; and (iii) preparing the new or up-dated regulations. Tribal leaders should be involved in all of these activities.

   As explained above, we believe the most efficient way to proceed is for the Secretary and the Director to establish a Negotiated Rulemaking Committee comprised of tribal representatives and IHS officials, and assign it to perform these three activities. While the Secretary retains final regulatory decision-making authority, the Negotiated Rulemaking Committee process can be greatly strengthened if the Secretary commits in advance to seriously consider the recommendations of the Committee. Negotiated Rulemaking has proved to be the most efficient and effective method for expeditiously producing regulations that can be supported by both the IHS and tribes.

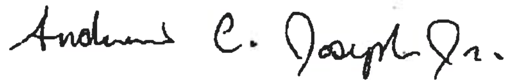
2. PPACA tribal consultation. While several PPACA provisions are Indian-specific, far more of them have no express Indian language but will impact the Indian health care delivery system. Thus, as advised above, HHS implementation teams must accept first-line responsibility for evaluating the impact of each regulatory policy on the Indian health system, and assuring that mechanisms are put in place to protect and enhance that system. The process must provide an opportunity for early and on-going interaction between tribal leaders and their technical representatives and the HHS

implementation teams. Perhaps a channel of communication can be established by Mr. Dioguardi through the HHS Office of Intergovernmental Affairs.

In closing, we want to thank you and Mr. Dioguardi for reaching out to Indian Country for input on important PPACA and IHCIA priorities and recommendations to consult with Tribes over these important items. Your continued effort to engage and consult with Tribes over important health care issues is to be commended. To this end, Northwest Tribes stand ready to assist you and Secretary Sebelius to work on the implementation of the Affordable Care Act and the reauthorization of the IHCIA.

If you should have any questions concerning our recommendations, feel free to contact Jim Roberts, NPAIHB Policy Analyst, at (503) 228-4185 or by email at jroberts@npaihb.org.

Sincerely,



Andy Joseph, Jr.,
NPAIHB Chairperson,
Colville Tribal Council Member

Joe Finkbonner, RPh, MHA
Executive Director

cc: Paul Dioguardi, Director, HHS-IGA
Stacy Ecoffey, Tribal Affairs, HHS-IGA
Doni Wilder, Area Director, IHS Portland Area Office

Enclosure: NPAIHB Letter to John Berry, OPM Director, May 10, 2010