National Indian Health Board

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Sent Via Email: consultation@ihs.gov

July 1, 2010

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

Attn:

Yvette Roubideaux, M.D., M.P.H., Director
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Paul Dioguardi, Director
Department of Health and Human Services
Intergovernmental Affairs
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Comments on Tribal Consultation and Priorities on Implementation of the Patient Protection And Affordable Care Act, P.L. 111-148, (PPACA) and Indian Health Care Improvement Act (IHCIA)

Dear Secretary Sebelius:

On behalf of the National Indian Health (NIHB) and the Centers for Medicare and Medicaid Tribal Technical Advisory Group (TTAG) and the Medicare and Medicaid Policy Committee (MMPC) which is a standing Committee of the National Indian Health Board, we write in response to the joint Health and Human Services/Indian Health Services May 12, 2010 "Dear Tribal Letter" requesting recommendations for consultation methodologies and priorities for implementation of the Indian-specific provisions of the PPACA and the amendments to the IHCIA. As a preliminary matter, we would like to state that we are appreciative of your outreach in working with Tribes as HHS/IHS proceeds in moving forward in implementing this historic act. We believe that the PPACA and IHCIA will greatly enhance our ability to provide increased and better health care services to American Indians and Alaska Natives.

Established in 1972, The National Indian Health Board advocates on behalf of all Tribal Governments, American Indians and Alaska Natives in their efforts to provide quality health care for ALL Indian People. Our Board Members represent each of the twelve Areas of Indian Health Service Areas; they are elected at-large by the respective Tribal Governmental Officials within their Area. Whether Tribes operate their own health care delivery systems through contracting and compacting or receive health care directly from the Indian Health Services (IHS), NIHB is their advocate. The NIHB serves as conduit to open opportunities for the advancement of American Indian and Alaska Native health care with other national and international organizations, foundations corporations and others in its quest to build support for, and advance, Indian care issues.

The PPACA and the recent amendments to IHCIA will have far-reaching implications for the health care of American Indians and Alaska Natives. Thus, it is imperative that all HHS and other federal agencies developing policies to implement the law clearly evaluate the impact on American Indians and Alaska Natives as well as the unique Indian health care delivery system. It is the Department's responsibility to protect the Indian health system from unintended consequences and to assure PPACA policies and implementation activities act in concert to promote the highest level of health possible for Indian people. Carrying out this responsibility requires HHS to analyze and communicate impacts and to involve Tribal leaders at all stages of the process.

In response to your May 12th letter, our comments are organized in three parts: (1) Process for Consultation; (2) IHCIA priorities; and, (3) PPACA priorities.

1. **Process for Consultation**

Indian Tribes, tribal organizations and Urban Indian programs want to be proactive – not just reactive. We understand that there are many internal implementation teams and some policy decisions are moving forward quickly. 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.

The TTAG and MMPC are two of the advisory committees currently engaged in working with both HHS and IHS. In addition, we recognize that the IHCIA Re-authorization Steering Committee, the IHS Budget Formulation Team, the IHS Tribal Self-Governance Advisory Committee, Center for Disease Control and Prevention and other Tribal advisory entities within HHS have been or will be involved in various elements of the PPACA and IHCIA implementation. We are working with Tribal representatives from these other workgroups/committees to exchange information and to assist in communicating our issues and concerns. In preparing our comments in this letter, we have tried to interact with several of these groups to prepare a consistent message regarding the processes for consultation on the PPACA and IHCIA.

The most important message that we would like to convey regarding consultation is that **Tribal leaders must have a seat at the table with HHS/IHS as we move forward in the implementation of PPACA and IHCIA**. As major stakeholders in the process, we want to ensure that Tribal leaders are included as a member in any workgroup, advisory committee or formal consultation process that is convened by HHS/IHS to assist in identifying and advancing Tribal priorities. **We suggest that the Department work with the NIHB and the TTAG when it needs technical input about policy and regulatory impacts on Indian people or Tribal and Urban Indian providers. To pursue its obligation to consult with Indian Tribes, we further suggest that the Department sponsor a series of "All Tribes" conference calls to ensure that Indian Country has a chance to weigh in throughout the implementation process.**

The provisions in PPACA will impact Tribes in their roles as employers, health care providers and governments responsible for the health and wellbeing of their members. 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 that are beyond the expertise of IHS.

A. <u>IHCIA Tribal consultation</u>. The implementation task facing IHS is three-fold: (i) identifying the new IHCIA provisions that **do** and **do not** require regulations; (ii) identifying the few existing IHCIA regulations that 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.

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.

B. PPACA Tribal consultation. While several PPACA provisions are Indian-specific, far more of them have no express Indian language but, nonetheless, impact the Indian health care delivery system. Thus, as we 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 his Office of Intergovernmental Affairs, and that Office could sponsor the "All Tribes" conference calls we recommended above.

2. **IHCIA Amendments - Priorities**

We urge you to officially acknowledge that all new authorities in the IHCIA are in effect as of the date the bill was signed by President Obama -- March 23, 2010 – and are available to Tribes and Tribal organizations that elect to utilize these authoritities. Certainly, many of these provisions are "self-implementing" and require no regulations. While some provisions will require procedures or regulations, the law did not indicate that their applicability would be delayed until regulations are promulgated. As noted, we think that HHS/IHS and Tribal leaders should work in partnership to identify which provisions will require new or revised regulations throughout this process.

The NIHB and TTAG identified two important provisions that should command IHS's immediate implementation attention because they require coordination with other Federal agencies in order for Tribes to utilize the authorities provided by the provisions. They are:

- <u>Section 409 (new) – Access to Federal Insurance</u>. This section allows a Tribe or Tribal organization that operates any program under an Indian Self-Determination and Education Assistance Act contract or funding agreement to purchase health and life insurance for their employees through programs established for federal employees. This provision will require establishment of procedures by the Office of Personnel Management in order for electing Tribes/Tribal organizations to enroll their employees in these programs. Because the provision offers ISDEAA contractors/compactors the chance to offer more economical fringe benefits packages to their employees, IHS and OPM should give it high priority for implementation.

- Section 405(c) – DVA and DoD reimbursements. This subsection requires the Department of Veterans Affairs and the Department of Defense to reimburse IHS and Tribal health programs when those Indian programs provide health services to DVA and DoD beneficiaries. IHS should immediately set up billing and payment procedures with DVA and DoD, as this reimbursement requirement is intended to provide additional revenue to both IHS-operated and Tribally-operated programs. Putting a billing/payment procedure in effect very soon will reduce the number of retroactive claims that must be processed beginning on March 23, 2010, when the provision became effective.

Another important provision that requires IHS to act – in consultation with Tribes and Tribal organizations – is Sec. 301, which calls for development of a new priority system for ranking health care facility construction projects. In our view, performing this requirement through a workgroup process noted above would be an efficient and effective way to put this new system in place expeditiously.

3. PPACA - Priorities

The sheer size and extent of the PPACA make it challenging for us to identify every provision that will impact our Tribal citizens and programs. The MMPC 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.

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 oppress American Indians and Alaska Natives.
- Ensure that Tribal leaders and Indian health program staff receive training 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 that have 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 objectives, HHS must begin by implementing policies and actions in the following areas. This list is not comprehensive nor is it in a priority order. 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.

A. 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.

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. Exchanges and subsidies, especially Indian provisions - 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 to assure AI/AN have full 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. Premium and cost sharing payment on behalf of eligible Indian people

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 documentation that AI/AN beneficiaries have a pre-existing condition that would qualify them for coverage.

E. Modified Adjusted Gross Income (MAGI) - 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 that informs them about the types of Indian-specific income that are excluded in making MAGI calculations.

F. <u>Exchange plan and high risk pool reimbursement for Indian health programs</u> - PPACA Sec. 1311(c)(1)(C)

This section 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. <u>Medicaid expansion</u>

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 implementation.

H. <u>Identifying and verifying Indian individuals eligible for special provisions</u>

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. <u>Express Lane Agency status</u> - PPACA Sec. 2901(c)

This section 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 enrollment. 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. "<u>TrOOP" fix for I/T/U pharmacies</u> - PPACA Sec. 3314

Effective January 1, 2011, this section 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. <u>Tax exemption for Tribally-provided benefits</u> - PPACA Sec. 9021

Rapid implementation and education of this section 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. <u>Maternal, Child Home Visitation Program (HRSA and ACF)</u> - PPACA Sec. 2951

This section 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. <u>Data collection for Federally-supported health programs</u> - PPACA Sec. 4302

This section 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.

N. <u>Workforce Development grant programs</u> - Titles IV and V of Act

Many different HHS agencies will be involved and I/T/U access to these resources is important for successful implementation of PPACA and capacity building. Although some provisions explicitly list I/T/U 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. <u>Negotiated Rulemaking for Medically Underserved Populations and Health Professions Shortage Areas</u> - Sec. 5602

This section requires the Secretary to utilize Negotiate Rulemaking to establish a methodology and criteria for designating medically underserved populations and health professions shortage areas. Indian Country is grateful that Indian organizations were identified as entities to be represented on the Negotiated Rulemaking Committee and urge the Secretary to ensure that the Committee contains several representatives from the Indian health community.

P. Behavioral Health

We are pleased to see the emphasis on behavioral health in numerous provisions of the PPACA.[1] These present new opportunities that can begin to address the impact of mental illness, drug abuse, and other behavioral issues in Indian Country. Behavioral health issues have been profoundly underestimated and culturally undefined in the AI/AN population. Much of the personal and societal burden of behavioral health conditions could be prevented or alleviated if individuals at risk for experiencing these conditions had access to appropriate prevention and treatment services.

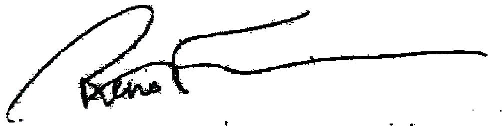
Some, but not all, behavioral health-related PPACA provisions specifically reference Indian Country eligibility. The various HHS agencies responsible for implementation should assure that the Indian health system and Indian people have a fair opportunity to benefit from ALL behavioral health provisions in the new law.

CONCLUSION

As we noted above, the NIHB, TTAG and MMPC groups have been actively involved in reviewing these provisions and working on recommendations and next steps. The MMPC met last week in Denver to begin preparing recommendations to present to the TTAG at its meeting scheduled for July 28 and 29, 2010. We invite you, Dr. Roubideaux, Mr. Dioguardi and other HHS officials to join us for the TTAG meetings, which will be held at the National Museum of the American Indian. We also invite HHS officials and implementation teams to communicate early and often with NIHB and TTAG about Indian health system impact issues as the Department proceeds to implement the PPACA. Departmental officials must be our partners in evaluating the impact of the new mechanisms on the Indian health system.

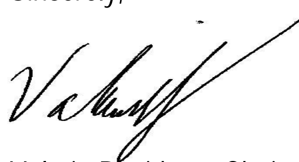
In closing, we greatly appreciate your outreach to Tribal governments in this process and your commitment to work with Tribes to improve our relationship and build healthier communities throughout Indian Country. Please feel free to contact Stacy A. Bohlen at Sbohlen@NIHB.org if you have any questions or need further information. Thank you.

Sincerely,



Reno Franklin, Chair, NIHB

Sincerely,



Valerie Davidson, Chair, TTAG

cc: NIHB Board of Directors
TTAG Members
MMPC Members
Tribal Self Governance Advisory Committee
Direct Service Tribal Advisory Committee

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[1] For example, see 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.