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Submitted electronically: public.comment@orhix.org

September 14, 2012

Howard "Rocky" King
Oregon Health Insurance Exchange
3414 Cherry Avenue, N.E.
Suite 190
Salem, OR 97303

Dear Mr. King:

The Northwest Portland Area Indian Health Board (NPAIHB) is a Public Law 93-638 Tribal organization that represents health care issues of Oregon's nine federally-recognized Tribes.¹ We are writing in response to the Oregon Health Insurance Exchange (ORHIX) proposed application requirements for certification of insurance companies and "Qualified Health Plans" to be offered on ORHIX.

The Patient Protection and Affordable Care Act (ACA) directs the U.S. Department of Health and Human Services (HHS) to issue certification criteria for Qualified Health Plans (QHPs) sold in American Health Benefit Exchanges. In March 2012, HHS issued final rules governing the Exchanges, including requirements for issuers and QHPs offered through the Exchange. State-based Exchanges must ensure their standards for QHPs and issuers meet federal requirements and may also choose to create additional certification standards.

We note that developing these requirements will have a direct effect on the participation of American Indian and Alaska Natives (AI/AN) participation in ORHIX. We also note that unless our recommendations around network adequacy and contracting with Tribes as essential community providers are implemented, than AI/ANs may not have a sufficient choice of health care providers. Before finalizing this pending RFA, we urge ORHIX to conduct a formal tribal consultation on its requirements pursuant to the ORHIX Tribal Consultation Policy.

Our comments and recommendations are organized by overall page number for the entire 81 page document, even though the attachments have their own page numbering system.

¹ A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.L. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

Page 2 – Carrier conference call

The Request for Application (RFA) states that there will be an opportunity to have carrier questions answered during a conference scheduled for Wednesday, October 1, 2012, from 9:00 a.m. – 11:00 a.m.. We recommend that ORHIX allow a Tribal representative to sit in on this meeting to hear questions and issues from the carriers. It will also provide an opportunity to respond to any carrier questions that might arise concerning Tribal issues.

Page 2 – Exchange customer groups – individuals

We recommend editing the following statement so it does not preclude individuals that may not be employed from having access to affordable health coverage offered through the ORHIX:

Individuals without access to affordable coverage ~~at work~~ will also be able to find out whether they are eligible for tax credits to help them pay for coverage.

Page 4 - Benefit Design Standards

We recommend the following grammatical correction:

Each plan will comply with the benefit design standards required by the ACA, including the cost sharing limits, actuarial value requirements, and federally approved Oregon-specific essential health benefits.

Page 4 – Plans

We recommend making the following clarification and grammatical correction:

Each Carrier will also be able to offer two additional, non-standard plans at each metal tier (bronze, silver, gold, with platinum plans optional), for a maximum total of three per service area. ~~Each~~

Page 4-5 -Cost-Sharing Reductions

This section does not fully capture the cost-sharing reductions for AI/ANs and will require some clarification. The ACA creates two different cost sharing regulations for Indians. The first relates to section 1402(d)(1) which states that an AI/AN enrolled in any QHP whose household income is less than 300 percent FPL must be treated as an eligible insured and eliminates all cost-sharing; and section 1402(d)(2) removes cost sharing obligations for AI/ANs if they receive care directly from the Indian Health Service, a Tribe or urban Indian health program, or through referral under contract health service program. Additionally, the issuer of the plan may not reduce the payment to any such entity for service or items. Thus, we recommend the following edits:

Carriers will reduce the enrollee cost-sharing levels in silver-level qualified health plans sold to individuals with household income below 250 percent of the federal poverty level(FPL). These reductions are to be achieved primarily by reducing maximum out-of-pocket limits. Carriers will also eliminate enrollee cost sharing (both deductions and co-pays) for American Indians and Alaskan Natives (AI/ANs) with income up to 300 percent of the FPL, as well as AI/ANs at any income level who receive services from a facility or program operated by the federal Indian Health Service, or a Tribe, or an urban Indian program (I/T/U). In addition, there will be no

deductible or co-pays for AI/AN who are referred by an I/T/U provider to other providers under the Plan. The federal government (IRS) will reimburse Carriers for costs associated with reduced or eliminated enrollee cost sharing. The Exchange will not participate in the Carrier's relationship with the IRS, but will provide information to the Carrier and IRS regarding an enrollee's eligibility for cost sharing reductions and federal premium tax credits.

Page 5 – Network Adequacy

The language contained in this section does not provide sufficient detail to determine how network adequacy requirements will be met by QHPs. Thus, it's important to underscore that Federal rules governing Exchanges include network adequacy standards requiring Exchanges to ensure that QHP provider networks are sufficient in number and types of providers, including mental health and substance abuse providers, to assure that all services are accessible without unreasonable delay. This includes IHS, Tribal and urban Indian health programs (I/T/U) in Exchange plan networks.

To ensure compliance with the Indian-specific provisions of law and simplify administration of QHPs we recommend that ORHIX adopt the following certification requirements of participations for QHPs:

- (1) Require compliance with IHCA Sections 206 and 408 as a condition of certification and recertification;
- (2) Require QHPs to offer to contract with all Indian Health Providers in the QHP's service area as in-network providers;
- (3) Require QHPs to use the CMS (or ORHIX) approved "Indian Addendum" when contracting with Indian Health Providers.

These proposed conditions are allowable under CMS rules. CMS has made it clear in its regulations regarding the establishment of Exchanges that ORHIX may direct specific requirements for QHPs, so long as those conditions are not inconsistent with federal requirements.² As discussed below, ORHIX has the authority to fulfill each of our recommendations and the concerns they address are commented on directly in CMS's implementing regulations regarding implementation of Exchanges.³

Section 408(a) of the Indian Health Care Improvement Act (IHCA) requires health care programs that receive Federal funding to accept I/T/U providers.⁴ It requires any:

Federal health care program to accept an entity that is operated by the Service, an Indian Tribe, tribal organization, or urban Indian organization as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity meets generally applicable

² 45 C.F.R. § 156.200(d) ("A QHP issuer certified by an Exchange must adhere to the requirements of this subpart and any provisions imposed by the Exchange, or a State in connection with its Exchange, that are conditions of participation or certification with respect to each of its QHPs"). *Also see*, 77 Fed. Reg. 18406.

³ *Federal Register*, March 27, 2012, CMS, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," (CMS-9989-F), 77 Fed. Reg. 18310 et seq. ("Final Rule").

⁴ Section 408 of the IHCA was added to the IHCA in 2010 with the passage of the Affordable Care Act.

State or other requirements for participation as a provider of health care services under the program.⁵

The term "Federal health care program" is defined elsewhere in Section 408 by reference to Section 1128B(f) of the Social Security Act, 42 U.S.C. 1320a-7b(f). The Social Security Act broadly defines "Federal health care program" to include:

any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code). 42 U.S.C. §1320a-7b(f).

This definition also includes "any State health care program, as defined in section [1320a-7\(h\)](#) of this title." *Id.* Under this broad definition, any "plan or program" that provides health benefits "through insurance or otherwise" that is funded directly "in whole or in part" by the United States must include I/T/U providers.

Section 206 of the iHCIA establishes a right of all Indian Health Providers to recover from an insurance company, health maintenance organization, employee benefit plan, third-party tortfeasor, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State).⁶ This requirement, which was amended in the ACA, was originally enacted in 1988, to assure that insurers and other responsible third-parties would not benefit unfairly from the fact that American Indians and Alaska Natives ("AI/ANs") have a right to receive services of the IHS without incurring any personal obligation to pay.⁷ This right arises from the special trust responsibilities and legal obligations of the United States to AI/ANs.⁸ These trust and legal obligations also require IHS and Tribal Health Programs to serve their members and other AI/ANs. Section 206 also prohibits States, other subdivisions of a State, or health plan from enacting laws or contract requirements that limit this right to payment.⁹

CMS has affirmed that IHCIA Section 206 and 408 requirements apply to federal and State operated Exchanges. In its rulemaking, CMS stated:

The primary purpose of section 408 of iHCIA is to deem Indian health providers as eligible to receive payment from Federal Health Care Programs for health care services provided to Indians if certain standards are met. Eligibility to receive payment under section 408 of iHCIA does not depend on in-network status with a QHP. Section 206 of iHCIA provides that all Indian providers have the right to recover from third party payers, including QHPs, up to the reasonable charges billed for providing health

⁵ We note that Section 408(a)(2) of the IHCIA makes it clear that any licensing requirement imposed by a state will be deemed to have been met by the I/T/U provider if it meets the standards required for licensing regardless of whether a license is obtained, and Section 221 of the IHCIA provides that licensed professionals at an I/T/U facility do not have to be licensed in the state in which they are located provided they are licensed in any state.

⁶ 25 U.S.C. § 1621e(a) (IHS and Tribal Health Programs) and (i) (application of all provisions of § 1621e to UIOs).

⁷ IHS is not permitted to impose any charges on AI/ANs, nor may it require any Tribal Health Program to do so. 25 U.S.C. §§ 458aaa-14, 1621e(f), 1681, and 1681r(b).

⁸ 25 U.S.C. § 1602.

⁹ 25 U.S.C. § 1621e(c).

services, or, if higher, the highest amount an insurer would pay to other providers to the extent that the patient or another provider would be eligible for such recoveries.¹⁰

Given that AI/ANs enrolled in Exchanges are not subject to in-network access limitations to health services of Indian Health Providers and that those Providers must be reimbursed for those services, it is in the best interests of States to require all QHPs to certify that they will comply with IHCA Sections 206 and 408 and to require them to offer network contracts to all Indian Health Providers in their service area(s).

In-network status will lead to greater coordination and timeliness of care to AI/AN patients, and more certainty and timeliness of payment to Indian Health Providers.¹¹ For QHPs as well, including Indian Health Providers as in-network providers offers significant advantages, including meeting network adequacy requirements for serving AI/ANs; reducing avoidable emergency department use; timely inpatient discharge and placement; and, potential reduction in the overall volume of billed services to the QHP. Requiring QHPs to offer Indian Health Providers network contracts would not create an undue burden on the QHP as the total number of Indian Health Providers facilities is not large.

It is also important for ORHIX to make this a requirement because it is highly unlikely that QHPs will offer contracts to Indian health providers due to their concern about compliance with non-discrimination, insurance and indemnification, licensure of health care professionals, and dispute resolution. Many of these issues are governed by federal statute and regulations that most often inhibit establishing network contract relationships with Indian providers.

Page 6 - Special Requirements for American Indian/Alaska Natives

Based on the discussion above, we recommend that this section be revised to add an additional bullet that as follows:

- Carriers will offer to contract with all Indian Health Providers in their service area as in-network providers and use the CMS (or ORHIX) approved "Indian Addendum" when contracting with Indian Health Providers.

We further recommend that the wording related to tribal sponsorship not limit tribes to sponsoring tribal members. Tribes may also want to sponsor descendants who qualify as IHS beneficiaries. This recommendation is consistent with the Exchange final rule which states:

"...we recognize that some Exchanges may wish to work with tribal governments to facilitate payment on behalf of enrollees, including aggregated payment. We encourage Exchanges to include this option as part of its consultation with tribal governments. This rule does not prohibit a QHP issuer from accepting third-party payments of premiums

¹⁰ Final Rule, 77 Fed. Reg. 18420.

¹¹ AI/AN enrollees may have needed health care services delayed or denied if they are required, after being served by an out-of-network Indian Health Care Provider, to meet with an in-network primary care provider in order to receive a referral to an in-network specialist.

from tribal governments, tribal organizations, or urban indian organizations for enrollees through the Exchange."¹²

Suggested edits:

- *Carriers will agree to the terms and conditions of Oregon's Tribal Premium Sponsorship Program that allows tribes to pay premiums on behalf of individuals ~~a tribal member~~.*

Page 12 – Plan offerings

The first description seems repetitive with regard to gold plan offerings. No recommendation here, just not that this section may require editing.

Page 12 – Cost sharing reductions

On this form there is no mention of Ai/AN cost sharing reductions. Recommend including language related to cost-sharing exemptions for Ai/ANs.

Page 12 – Enrollment management

There is no mention of special Ai/AN monthly enrollment periods, although there is reference to something that might include it. Recommend including language related to monthly enrollment option available for Ai/ANs.

Page 15 – Quality- ORS §741.001 (d): "Improve health care quality and public health, mitigate health disparities linked to race, ethnicity, primary language and similar factors . . ."

These are the only strategies listed for reducing health care disparities:

Implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

It may be that this is a direct quote from the law or it may be providing examples of ways to carry out the law. However, it should be amended to add: "where there are I/T/U providers every attempt will be made to include those providers in the Plan's network" (or something to this effect).

Page 15 – Access - 2. Do you include essential community providers in your health benefit plan networks?

This question should be asked differently to elicit a more useful response. With the current wording, an acceptable answer might be, "Yes." A better question would be: "Please list the types of essential community providers that are included in your health benefit plan network by type of provider and location."

We also note that Federal Exchange rules require a QHP to include within its network a sufficient number and geographic distribution of essential community providers, where available, that serve

¹² Final Rule, 77 Fed. Reg. 18338.

predominantly low income, medically underserved individuals. Providers meeting this definition deliver significant care to the uninsured and enrollees in public programs. A staff model health plan or integrated delivery system plan that contracts with a single medical group must have a sufficient distribution of providers to ensure reasonable and timely access for low-income, medically underserved individuals in its service area.

In order to meet network adequacy requirements and for the purpose of serving AI/ANs, we recommend ensuring a sufficient choice of providers requires that QHPs offer contracts to all I/T/U providers in the QHP's service area. We further recommend, consistent with ACA §§ 1311(c)(1)(B) and (c)(1)(C), that as a condition of participation in an Exchange, QHPs should be required to offer to include all available I/T/U providers in the plan's provider network.

If this recommendation were adopted and all I/T/U providers in Oregon decided to contract with a particular QHP, this would still not create an undue burden on the QHP as the total number of I/T/U facilities is minimal as there are only twelve I/T/U health care delivery sites in the entire State.

Page 15 – Access - 3. Are there communities within your geographic service area that rely heavily on essential community providers and would benefit from expanded contracts with such providers?
We note similar concerns as expressed in Question 2 above. Suggest the following edits:

3. ~~Are there~~ Which communities within your geographic service area ~~that~~ rely heavily on essential community providers and would benefit from expanded contracts with such providers?

Page 15 – Access - 4 . Please describe your referral process and prior authorization process when the IHS or Tribal 638 facility is not a participating panel provider.

We applaud ORHiX for including this question on the application form. We recommend adding "payment process" to this question.

Pages 23-24 – Tribal Sponsorship

Overall, this section looks good. However, it looks again here like only people certified by the Exchange as AI/AN can be sponsored by a tribe. Tribes should be free to sponsor individuals in Tribal communities who are outside the CClIO definition of AI/AN. This might include people who are moved off Medicaid as their incomes rise and qualified as AI/AN under Medicaid, but do not qualify under Exchange rules. Suggested edit:

a. The Carrier will accept ~~tribe~~ indicators from the Exchange, signifying an individual is ~~AI/AN and~~ participating in the TPSP. This signifies to the carrier that while there is an individual name on the policy, an AI/AN specific entity has agreed to pay the premium for that person.

The Tribe should be notified if there is any cost sharing charged, so that they can get involved to do problem-solving, if needed. Suggest the following:

g. In the unlikely event that there are cost sharing charges, the Carrier will send ~~all~~ cost-sharing charges to the tribal sponsor as well as to the individual ~~AI/AN person~~.

There are two items in this section on Tribal Sponsorship that seem unrelated to Tribal Sponsorship:

3. If the Carrier contracts with a Federally Recognized Tribe or Indian Health Care provider, Carrier will notify the Exchange.

4. Carriers will agree to use the Indian Addendum, which outlines federal law and regulations, when contracting with a specified Indian Health Care Provider.

It is not clear whether item 3 above refer to a contract with a Tribe with regard to direct Tribal Sponsorship payment arrangements, or it refers to becoming a part of the provider network under the plan. Is the purpose of reporting this to the Exchange to enable the Exchange to tell AI/AN potential individual enrollees whether or not their I/T/U provider is part of the plan network? If so, this might be explained in item #3. While we appreciate requiring the Indian Addendum, its placement in the Tribal Sponsorship section suggests that it is only required for contracting with the I/T/U if there is Tribal Sponsorship. We recommend that items 3 and 4 be placed under a different heading, such as "Indian Health Providers in Plan Networks."

Page 26 - VI. COMPLAINTS, GRIEVANCES AND APPEALS

This specifies that one category of complaints – " b. AI/AN eligibility status" – will be handled by ORHIX. However, there is another category that should be included here or elsewhere. This relates to billing issues as a result of AI/AN eligibility status, including charges for deductibles and co-pays, and payment to the I/T/U for off plan services. We recommend including requirements for these situations.

Page 26-27 - VII. MANAGEMENT OF ENROLLMENT

On-going enrollment for AI/AN is specified in A.5. in C.2.a. there is a mention of issuing enrollment cards. We recommend that enrollment cards clearly identify individuals who are exempt from cost sharing to ensure compliance with federal requirements.

Page 30 – I. 834 Enrollment and Disenrollment Data

NPAIHB, and its member Tribes, are party to comments submitted to CMS on the format for the 834 form and electronic records. For the purpose of issues discussed in the section, we have attached the CMS Tribal Technical Advisory Group's comments on this issue. We encourage adoption of the TTAG concerns and recommendations.

Pages 33-81 – Summary of Health Insurance Exchange Rules

The last half of the document is a summary of Health Insurance Exchange rules put together by the National Association of Health Commissioners. This looks like a useful document; however, we note the following concerns:

- The part on navigators (p. 40) includes language that is concerning for I/T/U participation in navigator grants. We note that I/T/U programs are eligible to serve as Navigators and that they are trusted providers of information to AI/ANs. They have the ability to communicate information through existing relationships in a manner that is culturally and linguistically

appropriate to the needs of their primary target population – all of which are requirements for Navigators to be able to perform.

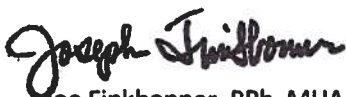
We note our concerns over the conflict-of-interest statements: The authorizing law (ACA § 1311(i)(4)(A)) and the promulgated regulations (45 U.S.C. § 155.210(d)) provide clear guidance to prevent conflicts of interest. The law and proposed regulations do *not* bar Navigators from also being health care providers that receive payment from QHPs for health care services provided to their enrollees. *Given the multiple roles performed by American Indian and Alaska Native Tribes and tribal organizations – such as elected representatives and advocates, employers and providers, and health insurance premium sponsors – the clarity in the Federal guidance on this will ensure that Tribes and tribal organizations will be able to serve as Navigators.* The specific listing of "Indian Tribes, tribal organizations [and] urban Indian organizations" as entities eligible to serve as Navigators (in 45 U.S.C. § 155.210(b)(2)(viii)) further clarifies that these multiple roles are recognized and permitted. The dual role of assisting with enrollment as well as providing direct health care services is similar to the work I/T/U do today to assist in enrolling eligible individuals in to Medicaid and CHIP.

- This document (p.48) misses one of the categories of cost sharing waivers for Ai/AN, which may explain why it is also missing in the ORHIX RFA. On page 58, it shows a lack of understanding of the indian health system by making reference to "referral under contract" rather than "referral under Contract Health Services." No change is required, only that we note the source information is not entirely correct.

We fully appreciate the complexity and tight timeline that ORHIX is under to develop these requirements. By addressing the AI/AN issues proactively, we hope make things more efficient and increase AI/AN participation in ORHIX, which ultimately serves to address our State's health disparities. To this end, we thank you in advance for consideration of these recommendations as we jointly work to advance the health status of American indian and Alaska Natives in Oregon.

if you have questions concerning our comments and recommendations, please contact Jim Roberts, Policy Analyst at (503) 416-3276, or email at jroberts@npaihb.org.

Sincerely,



Joe Finkbonner, RPh, MHA
Executive Director

cc: Amy Fauver, Deputy Director
Sonciray Bonnell, Tribal Community Program Analyst
Rachel Oh, Community Program Analyst
Lisa Morawski, ORHIX

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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Delivered via electronic transmission

Submitted via regulations.gov

August 30, 2012

Data Interchange Standards Association

7600 Leesburg Pike, Suite 430

Falls Church, VA 22043

Subject: Comments on 005010X307 - 834 Health Insurance Exchange: Enrollment

Attention: ASC X12 Administrator

Dear Administrator,

I write on behalf of the Tribal Technical Advisory Group (TTAG) of the Center of Medicare and Medicaid Services (CMS) regarding the attached analysis and recommendations to the Data Interchange Standards Association in response Comments on 005010X307 - 834 Health Insurance Exchange: Enrollment. We appreciate the opportunity to comment.

The TTAG advises Center of Medicare and Medicaid Services (CMS) on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program, and any other health care program funded (in whole or part) by CMS.¹ In particular, the TTAG focuses on providing policy advice to CMS regarding improving the availability of health care services to American Indians and Alaska Natives (AI/AN) under these Federal health care programs, including through providers operating under the health programs of the Indian Health Service, Indian Tribes, tribal organizations and urban Indian organizations (I/T/U).²

It has recently come to our attention that Form 834, which is being developed to create standards for electronic data interchange for Health Insurance Exchange Enrollment, is available for review. We have submitted comments through the electronic comment process; however, we would like to use this opportunity to explain some of our concerns and recommendations.

¹ Sec. 5006(e) of the American Recovery and Reinvestment Act codifies in statute, at sections 1902(a)(73) and 2107(e)(1)(C) of the Social Security Act, the requirement for the Secretary of Health and Human Services to maintain a Tribal Technical Advisory Group within CMS and the requirement that States seek advice from Tribes on a regular and ongoing basis where one or more Indian health program or urban Indian organization furnishes health care services.

The abbreviation "I/T/U" means the Indian Health Service (IHS), an Indian Tribe, tribal organization or urban Indian organization, and is sometimes referred to collectively as "Indian Health Care Providers". 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.

We understand that these standards are technical and intended to reflect implementation and policy decisions that have been made and communicated to the authors of this draft Technical Report. As we discuss below, we are aware that many decisions are not yet final. Our comments are made with the understanding that, as future decisions are made, changes in the technical Standards will occur to ensure full implementation of the policies. Thus, in some cases our comments highlight places where we believe changes are needed based on decisions and law that have already been made, and in other places we highlight changes that may be necessary as future decisions are made.

We also want to note that some of our comments provide for language that may not be consistent with the form of other language, because of our lack of familiarity with the embedded levels of this very technical report, or because we want to be precise in communicating our meaning. We understand that shorter versions may be needed in the final Standards and request that adequate documentation of the meaning of the shortened phrases be provided.

Background

There is very little content in the draft Form 834 that indicates an awareness of the Indian health care delivery system or the special provisions and protections for American Indians and Alaska Natives (AI/AN) in the Affordable Care Act and other legislation. The enrollment form used by Exchanges and Qualified Health Plans needs to accommodate some of the unique attributes of the Indian health system and the body of federal Indian law, and the technical standards need to support full implementation of the special provisions applicable to AI/ANs.

For example, the ACA stipulates that cost sharing (including both deductibles and co-pays) is waived for AI/ANs who receive their services at an Indian health facility or are referred through that facility to another provider in the plan. In addition, AI/AN enrolled through the individual market in an Exchange with income under 300 percent of the poverty level pay no cost-sharing at any provider. Furthermore, the plan is to make-up the lost revenues to the provider. People who qualify for the benefits and protections as AI/AN need to be identified in the enrollment process, in the identification cards that are issued by QHPs to their enrollees, and in the information that is accessed by QHP billing departments and others who provide services, such as pharmacies.

Many AI/ANs receive their health care services through the federal Indian Health Service (IHS), a Tribally-operated health program (i.e. one operated by a Tribe or Tribal organization), or an urban Indian health clinic. Taken together these are called the "I/T/U" or "the Indian health system." People who are eligible for Indian health services are also eligible to enroll in Health Insurance Exchange plans. Federal law allows the I/T/U to bill plans for services provided to AI/AN enrollees even when the I/T/U facility is not part of the plan's network of providers. We are not entirely clear whether the covered individual or the plan provides the underlying data to populate the form: however, in light of the payment requirements, we think the AI/AN enrollee should be able to provide this information if such an enrollee uses an Indian health system provider. This will also facilitate the opportunity to recognize that if AI/ANs choose an I/T/U provider as their primary care provider, it would be most cost effective if that primary care provider can provide referrals within the network for the plan in which the AI/AN is enrolled, even if the I/T/U is outside that network.

In addition, the tribes, tribal organizations, and urban Indian organizations may be sponsors of individuals who enroll in Exchange plans. The sponsors would pay the portion of the premium that is not subsidized through Advanced Premium Tax Credits. The I/T/U may also assist people to enroll in Exchange plans, as navigators, in-person assisters, or supported by other types of funding, such as Medicaid Administrative Match. The I/T/U may also assist people with paperwork, and therefore may be requested to receive EOBs, changes in enrollment status, and other types of notifications for some enrollees.

The Centers for Medicaid and Medicare Services (CMS) has not yet released all the regulations that apply to AI/AN and the I/T/U. Tribal Consultation Policies of the Department of Health and Human Services (HHS) and CMS require that Tribes be consulted in the development of those regulations and other guidance. As more policy decisions are made, there may be a need to accommodate additional information in the 834 enrollment process.

As you know, the electronic comment process is tied to specific elements in the document under review. For purposes of simplicity, the comments in this letter are organized sequentially by page number and topic.

Sponsor (pages 5 and 20)

The definition of sponsor lists the types of organizations that could be a sponsor, including employer, union, government agency, association, or insurance agency. However, this list is incomplete because it does not mention Tribe, Tribal Organization, or urban Indian health organization in the list of potential sponsors. If referencing all of these types of Indian sponsors individually is inconsistent with the other entries, the phrase "Indian entities" could be used, as long as it is defined somewhere.

Identification of AI/AN (pages 21, 80, 81, 86 and 174)

The only mention of AI/AN is under demographic information, specifically in relation to race and ethnicity (pages 21, 80, and 81). In addition to this identification, and independent of it, there needs to be a separate section of the standards document to capture that an individual is eligible to receive the benefits and protections as an AI/AN, such as waiver of cost sharing. Certain protections and benefits do not derive from the individual's self-identification with a race or ethnicity, but rather from a political and legal definition of AI/AN. When a person is enrolled in a health plan as an AI/AN who is qualified for those benefits and protections, then that information should be connected to other outcomes, such as waiver of cost sharing. There is element detail on co-insurance (page 86) that could be tied to the designation of AI/AN and show a zero amount for co-pays and deductibles. Also, the AI/AN designation should appear on enrollee identification cards issued by the QHP (page 174).

Navigator (pages 49, 50, and 52)

Form 834 has details related to navigators, including a navigator identification code (page 49) and navigator licensing information (page 50). The form envisions that States may control navigator licensing (page 52). However, it is a general principle of tribal sovereignty that States cannot license Tribes. ACA specifically lists Tribes as one of the types of organizations that could serve as navigators. While the rules on navigators have not yet been issued, we recommend that either there be a generic code that indicates that Tribal navigators are exempt for licensing, or another element/question could be used to establish that the navigator is working for a Tribe or Tribal

Organization. Alternatively, the document could identify navigators that have been selected by a state (or the Federal government) rather than the licensing status.

Primary Care Provider Information and Reasons for Status Change (pages 56, 57, 176 and 187)

As discussed above, AI/ANs should be able to designate the I/T/U as their primary care provider even when the I/T/U facility is not part of the provider network offered by the Plan. If Form 834 relies on the QHP provider codes to designate the primary care providers in their network (page 176), then there should also be a code that indicates an exemption whereby the AI/AN can have an out-of-network provider, or assign individual provider codes to each I/T/U in a state that would work across plans. Whether the I/T/U is an in-network or out-of-network provider, one reason that an AI/AN may want to change their primary care provider (pages 56, 57, 187) is that they prefer to receive services through the Indian health system.

Tobacco and other substance use (page 87)

If a person is a smoker or uses chewing tobacco, then the QHP can charge a higher premium due to the increased health risk. However, in many American Indian cultures tobacco is used for ceremonial and religious purposes, often as smudging. Asking an American Indian individual to answer a generic question about tobacco use may lead to an erroneous answer and conclusion. If a person self-identifies as AI/AN and indicates that they use tobacco, then a follow up question (and related technical standard) should provide clarification as to whether it is solely for ceremonial or religious purposes. Another way to handle this is to change the initial question.

Codes for Responsible Person (page 145)

It may be important for an I/T/U sponsor to receive copies of notifications from the QHP intended for the enrollee, particularly if it is a sponsor for that individual. The most likely place to list the I/T/U sponsor contact information (address, phone number, e-mail) is in the section that identifies a "responsible person." It would be helpful to broaden this category by changing or adding a code. For example, 9K could be "key person or organization." Alternatively, while the relationship code offers an "other" category, it might be helpful to the QHP to also have a category that is "Sponsoring Indian health entity."

Scenario (page 205)

The current document offers a single example that applies Form 834 to a sample situation. Given the unique attributes of AI/ANs and I/T/Us, it might be helpful to run a scenario of an AI/AN with tribal sponsorship and cost sharing waivers to see if the current structure of the form provides the necessary information.

Summary

We fully appreciate the complexity and the tight time frame in which this enrollment structure is being developed. By addressing the AI/AN issues proactively, we hope that it will save time and work downstream as the Exchanges are implemented. We stand ready to assist you or to answer any

questions you may have. Please contact Jennifer Cooper at jcooper@nihb.org , if you would like to discuss any of the items in this letter.

Sincerely yours,

Signature BLOCK

Valerie Davidson
Chair, CMS Tribal Technical Advisory Group

Cc: Gary Cohen, Acting Administrator, CCIIO
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