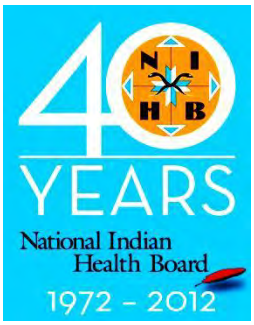

National Indian Health Board

April 9, 2012

Submitted via email to consultation@hhs.gov

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

Dear Secretary Sebelius:

The National Indian Health Board[1] ("NIHB") appreciates the opportunity to file comments in response to the 14th National Department of Health and Human Services (HHS) Tribal Budget Consultation on March 8-9, 2012. These written comments are to supplement the comments shared by the NIHB Board Members over the two days.

This Administration has made its commitment to Indian health and the fulfillment of the federal trust responsibility clear by ensuring that the Indian Health Service (IHS) consistently receives annual increases. The NIHB is truly grateful for the increases that have provided a long awaited opportunity to address health disparities in our American Indian and Alaska Native (AI/AN) communities.

However, we also must reassert the fact that trust responsibility and treaty obligations for the health of AI/AN people does not begin and end with the IHS. As you said yourself, Madam Secretary,

> "From my perspective, when it comes to the health and well-being of the American Indian and Alaska Native people, our responsibility at HHS extends beyond the Indian Health Service and our Office of Intergovernmental and External Affairs. It is a critical part of our work in every operating division and program office across the Department."

[1] Established nearly forty years ago, NIHB is an inter-tribal organization that advocates on behalf of Tribal governments, American Indians and Alaska Natives (AI/ANs) for the provision of quality health care to all AI/ANs. NIHB is governed by a Board of Directors consisting of representatives from each of the twelve IHS Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In Areas where there is no Area Health Board, Tribal governments choose a representative. Area representatives communicate policy information and the concerns of the Tribes in their Area to NIHB. Whether Tribes operate their own health care programs through contracts or compacts, or receive health care directly from the IHS, NIHB is their advocate.

We appreciate this commitment. It is with this in mind that the NIHB presents the following global comments, observations and requests on the HHS budget process and requests.

GENERAL COMMENTS

Protect Health Programs and Services for Indians from Across the Board Cuts and Sequestration. Following the passage of the *Budget Control Act* and failure of the Congressional "Supercommittee," the NIHB is particularly concerned with the prospect and potential effects of the sequestration process on HHS divisions providing services and programs to Indian people. The lack of adequate health care services to AI/ANs has resulted in our populations suffering from the worst health disparities in the Country. With the recent increases, Indian Country is just beginning to make progress. Across the board cuts to program funding that supports Tribal health puts critical patient care at severe risk. The Tribes' unique trust relationship with the Federal Government is vital to the health of Indian people, and this trust responsibility extends beyond the IHS to all Federal agencies. We ask the Administration's continued support in fulfilling this trust duty by protecting the funding for health programs and services delivered to AI/ANs from across the board cuts and sequestration.

Increase Direct HHS Funding Opportunities to Tribes and Tribal Organizations. Tribes and Tribal organizations receive a disproportionately low number of HHS grant awards. AI/ANs are approximately 1.5% of the U.S. population, but AI/AN entities serving them receive only 0.51% of total grant funds awarded by HHS agencies. The barriers associated with this disparity generally fall under statutory and regulatory issues, as well as limitations on the resources of Tribes and Tribal organizations. The NIHB strongly recommends the development of Indian "set-asides" or special grant initiatives within HHS grant programs, as well as increase the number of grants targeted specifically to Tribes and Tribal Organizations.

COMMENTS BY HHS OPERATING DIVISION

Agency for Health Research and Quality (AHRQ)

Develop AI/AN Specific Non-Competitive Grants on Utilizing Health IT to Improve Quality. In the President's Proposed Budget Fiscal Year (FY) 2013, AHRQ states, "[A] continued emphasis on new research grants is the portfolio's highest priority as the need for evidence on the use of health IT to deliver high-quality health care has grown dramatically with the widespread adoption of health IT." This is especially true for AI/AN communities, where improvements in quality are essential for a population suffering disproportionately from so many adverse health effects. The NIHB requests that AHRQ uphold its emphasis on new research grants and support AI/AN specific non-competitive grants on utilizing health IT to improve Quality with a "set-aside" for $1.0 million from the $6.6 million proposed in the President's FY 2013 request to support new research grants.

Protect AI/AN Health Services Research Grants. The FY 2013 request contains significant reductions in Health Services Research Grants. The NIHB urges AHRQ to protect AI/AN specific health services research from these budgetary cuts.

Establish a Tribal Healthcare Research and Quality Advisory Committee to AHRQ. One of AHRQ's stated goals is, **"**to advance excellence in health care for American Indian/Alaska Natives." However, as long as there is a lack of AI/AN specific data in almost all of AHRQ's data collection methods, this can never be fully realized. Establishing an AHRQ Tribal Advisory Committee to help better understand why there are such low levels of AI/AN data collection would significantly increase health services research in Indian Country.

Centers for Disease Control and Prevention (CDC)

Support Capacity Building for Tribes and Tribal Organizations. The NIHB asks that Tribes and Tribal health organizations be funded at the same amount as non-tribal organizations such as the National Association of County and City Health Officials, Association of State and Territorial Health Officials, and the National Association of Local Boards of Health. Additionally, the CDC should increase the number of positions and fill existing vacancies within the Office for State, Tribal, Local and Territorial Support and the Agency for Toxic Substances and Disease Registry Tribal programs.

CDC Leadership Should Actively Participate in Tribal Consultation and Develop Accountability Mechanisms. The NIHB insists upon the presence of CDC leadership during the Tribal consultation process. Tribal leaders make sacrifices to be present for the joint discussion and CDC leadership should affirm their respect for the Tribal consultation process. We also recommend the development of a tracking mechanism that identifies Tribal concerns, and assigns accountability for the purpose of taking action and reporting progress to Tribal leaders and/or their designated representatives at each consultation.

The Centers for Medicare & Medicaid Services (CMS)

CMS must provide additional support to Tribes during the formation and implementation of State Exchanges. In order to fully participate and benefit from State Health Insurance Exchanges, Tribes require additional assistance from CMS, both during the planning process and in the enrollment process. CMS should identify funding sources and mechanisms for Tribes to assist in the enrollment process for Exchanges. The agency should also develop culturally appropriate outreach and education materials about the Exchange and use effective channels of communication. Finally, states must be encouraged to designate an Indian health expert at the Exchange who is empowered to resolve problems, answer questions, keep a list of FAQs, and work with the Indian health system providers, Exchange Plans, call center and others.

Resolve Access Barriers Related to Interstate Medicaid Assistance for AI/ANs. This issue affects AI/AN children who attend out of State Boarding Schools, Indian youth and adults who need culturally appropriate behavioral health services and access to Medicaid reimbursements

for care provided in another state. Under current Federal law and regulations, states may enter interstate agreements to facilitate administration of their Medicaid and Children's Health Insurance Program (CHIP) program**s**. Increasing the number of interstate compacts can address the previously discussed potential portability issues that AI/ANs and their families face in seeking Medicaid or CHIP assistance. We ask that CMS do everything it can to facilitate additional interstate compacts for the purposes of ensuring all AI/ANs benefit from Medicaid expansion.

Exempt AI/ANs From Medicaid Cuts, Required Premiums, Deductibles, Copayments, or Other Cost Sharing and Reject any Waiver Application Without Proof of Tribal Consultation. Many states are and will continue to reduce their Medicaid and CHIP programs in ways that have negative impacts on health programs for AI/ANs. These include elimination of optional Medicaid benefits, cuts in eligibility and provider rates, and elimination of other health programs that rely on state dollars. The negative implications for access to services and available funding for Indian health programs are significant. It would be a breach of the special relationship between Tribes and the federal government, as well as the intent of the Affordable Care Act (ACA), to subject Tribes to the whims of their states.

Indian Health Service (IHS)

Adopt the National Tribal Budget Formulation Workgroup's funding recommendations for the IHS budget for FY 2014. The NIHB fully supports the Workgroup's requests for FY 2014. A total request of $5.3 billion will realistically fund IHS programs. This level acknowledges population growth, medical inflation, and the trust responsibility of the federal government. This includes $469.4 million to ensure current services continue uninterrupted and IHS' fiscal obligations are met. It also includes $502.8 million for IHS program expansion, which reflects modest increases over FY 2012 Enacted budget levels to provide additional support for national Tribal priorities.

Commit to a 10-year plan to fully fund the IHS total need of $26.1 billion. In spite of the significant increases for IHS that this Administration has advanced over the last three years, IHS remains funded on average at only about 56.5% of need. Tribes continue to urge the Administration and Congress to work to rectify this problem. Fully funding IHS is a major step toward ending the stark health disparities between AI/ANs and the U.S. general population.

Work to fully implement and fund the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA) and Indian-specific provisions of the Affordable Care Act (ACA). The IHCIA and the Indian-specific provisions of the ACA hold much promise for the improved health of Native people. The NIHB requests that this Administration expedite the implementation of provisions like IHCIA Sec. 405 (c): Department of Veteran Affairs and Defense reimbursement to IHS and Tribal facilitates for services provided to AI/AN veterans. Additionally, HHS and IHS must ensure that individual Indians currently receiving health benefits continue to receive all the benefits in the implementation of the ACA by seeking a uniform definition of Indian.

Support the Reauthorization of the Special Diabetes Program for Indians (SDPI) Beyond FY 2013. Since 1997, SDPI has been making major progress on the high incidence of type-2 diabetes and its related illnesses in Indian Country. Over the years, meticulously kept data has shown that a modest federal investment can have tangible, life-saving impact. As it begins to consider reauthorization beyond its expiration in FY 2013, Congress is still awaiting news of last year's progress. The NIHB respectfully requests that IHS release the 2011 SDPI Report to Congress as soon as possible, so that legislators may better understand the success and necessity of the program.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Strong support for the Behavioral Health – Tribal Prevention Grant (BHTPG). The NIHB was very pleased to learn that the BHTPG was again included in the President's budget request for FY 2013. Once appropriated, this grant will allow Tribes to address major behavioral health disparities in a culturally specific way and on a non-competitive basis. The NIHB is thankful for SAMHSA's efforts on this issue and will continue to support the BHTPG throughout the Congressional appropriations process.

Funds for Testing and Delivering Targeted Interventions Need to go Directly to Tribes, or Need Measures to Ensure that States Work With Tribes and Those Tribes Receive Services. In spite of SAMHSA's best efforts, access to behavioral health funding remains elusive for many Tribes and if the cuts in the FY 2013 request are implemented, access will become more difficult. For the funding that remains, it is critically important that Tribes receive their fair share. Many states use data from Tribes in their applications for grants, but after being awarded funding, states often choose to direct services to non-native communities. Tribes believe this common practice disregards the purpose of the grants. Funding should be awarded directly to Tribes, or should be monitored in a manner that ensures Tribes receive a fair portion of funds or services.

COMMENTS ON CROSSCUTTING ISSUES

The Affordable Care Act

The passage of the Affordable Care Act and the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA) in 2010 was the most significant advancement in Federal health policy for our country in decades. As implementation efforts have begun to show, together the ACA and the IHCIA create the potential to greatly advance health care delivery in Indian Country, and to more fully realize health care that is equitable and accessible to all American Indians and Alaska Natives, no matter how remote the location or how tattered the infrastructure currently may be.

As we continue with full implementation of the ACA and the IHCIA, and as set forth at the beginning of the legislative debates and enshrined in the new section 3 of the IHCIA, Declaration

of National Indian Health Policy, the fundamental principles for Indian Country's participation in achieving the goals of health reform must continue to be adhered to throughout implementation of the ACA.[2]

Two of these principals are:

- To ensure that health reform supports and protects the Indian health system through implementation of Indian-specific provisions, where needed, and;
- To ensure that all actions undertaken to implement the IHICA, and the ACA, are carried out with active and meaningful consultation with Indian Tribes and tribal organizations, and conference with urban Indian organizations.

Regulatory work

Through this and other tribal consultation opportunities, and through the formal regulation proposal and comment process, NIHB has worked to facilitate the collective input of Indian Tribes. In doing so, NIHB has prepared analyses of the proposed Federal regulations implementing the ACA and prepared and submitted comments on the most critical of the proposed rules.

In addition, NIHB is under contract with the IHS and the CMS to produce a twice monthly Regulation Review and Impact Analysis Report. The purpose of the NIHB Regulation Review and Impact Analysis Report (Regulation Report or RRIAR) is to identify, summarize and track key regulations issued by CMS pertaining to Medicare, Medicaid, CHIP, and health reform that affect (a) American Indians and Alaska Natives and/or (b) Indian Health Service, Indian Tribe and Tribal organization, and urban Indian organization providers. The now 160-plus page Regulation Report includes a summary of the regulatory analyses prepared by NIHB and/or the Tribal Technical Advisory Group to CMS (TTAG) and indicates the extent to which the recommendations made by NIHB and/or TTAG were incorporated into any subsequent CMS actions.

[2] SEC. 103. DECLARATION OF NATIONAL INDIAN HEALTH POLICY. Section 3 of the Indian Health Care Improvement 15 Act (25 U.S.C. 1602) is amended to read as follows: SEC. 3. DECLARATION OF NATIONAL INDIAN HEALTH POLICY. Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal 20 obligations to Indians— (1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy; (2) to raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives; (3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities; (4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population; (5) to require that all actions under this Act shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this Act and the national policy of Indian self-determination; (6) to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and (7) to provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

As indicated in the NIHB Regulation Report, numerous recommendations have been provided by NIHB and the Tribal Technical Advisory Group to CMS (TTAG) over the past 18-plus months. We understand that final rules have been issued and more final rules will be forthcoming. To the extent the final rules are not fully responsive to our recommendations, we would like to continue to engage with you on these recommendations in the development of the Federal Exchange. In instances where the NIHB and/or TTAG recommendations are adopted, we appreciate that and look forward to working closely with CMS and each State to successfully implement these provisions.

Implementation of the Affordable Care Act

Efficient and Accurate Identification of AI/AN: Enabling AI/AN individuals to access the benefits and added protections under the ACA and the IHCIA, and Medicaid provisions, requires the accurate identification of who is American Indian and Alaska Native. In the ACA, there are three references to the definition of "Indian," each with slightly different wording. It is critical that HHS give guidance to the States to facilitate application of a single operational definition of "Indian" that is consistent with the various provisions of the Affordable Care Act and captures the breadth of authorities under which individuals are identified as Indian. For example, there are slight wording differences between the definition that applies to the special monthly Exchange enrollment period for AI/AN (the definition cited in section 4 of the IHCIA) and the definition (cited in section 4(d) of the Indian Self-Determination and Education Assistance Act) that applies to eligibility for the comprehensive cost-sharing protections through the Exchange for certain AI/AN.

To have a more efficient – and more accurate – process for the identification and documentation of who is an Indian for these purposes, and to minimize potential confusion, we continue to recommend that a single operational definition should be adopted for use by Exchanges.[3]

Facilitate Enforcement of New Mandatory Contracting Provision: Under a new provision of the IHCIA (section 408(a)(1)), health plans participating in a Federal program – such as participating in an Exchange – are required to offer to include Indian Health Service, Tribes and Tribally-operated programs, and urban Indian programs (I/T/U)[4] as in-network providers in their health plans. This provision was included in the health reform legislation with the aim of removing barriers to care experienced by AI/ANs when receiving care from I/T/U and non-I/T/U providers alike and enabling I/T/U providers to be more consistently reimbursed and more fully be integrated into the networks of health insurance plans.

For example, there are instances today when an AI/AN with health insurance coverage receives a primary care service from a (non-network) I/T/U provider and then is referred to a non-I/T/U (but network) provider for certain specialty services. In order to be seen by the specialty

[3] One option is the application of the definition of Indian promulgated by CMS, as defined in section 447.50(b)(1) of title 42 of the Code of Federal 10 Regulations, as in effect on July 1, 2010.

[4] The term I/T/U or Indian health care provider shall have the meaning given that term in 42 C.F.R. § 447.50(b)(2), where that term is defined to mean a health care program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act, (25 U.S.C. 1603).

provider, a health plan requires the AI/AN to receive a referral from a network primary care provider. As a result, the AI/AN has to go back to a network (but non-I/T/U) provider for the sole purpose of getting a referral. This is costly to the system (there is an extra, and non-medically necessary visit to a primary care provider) and care to the AI/AN is delayed, and may be blocked if the AI/AN is not able to set-up and attend a second visit with an (in-network) primary care provider.

AI/ANs have the highest rate of many health conditions, and access to both primary care and specialty services is key to addressing these needs. About 1 in 5 (18%) AI/AN individuals have two or more chronic conditions.[5] This compares to a rate of 1 in 10 (10%) for non-Hispanic whites.

To streamline implementation of section 408(a), we recommend that HHS and States require health plans, as a condition of participation in an Exchange, to offer to include Indian Health Service, Tribes and Tribally-operated programs, and urban Indian programs (I/T/U) as in-network providers in their health plans. This will educate Exchange plans of the requirement and facilitate the successful implementation of this requirement of Federal law.

Indian Addendum: We appreciate the encouragement by HHS to facilitate use of an Indian Addendum to the contracts established between Exchange plans and plan providers.

The new section 408(a) of the IHCIA is but one of the numerous AI/AN-specific or I/T/U-specific provisions of Federal law that apply to Exchanges, health plans that participate in Exchanges, providers, and/or AI/AN. Among other things, these provisions involve State licensure, reimbursement, and cost-sharing protections. For example, under section 1402(d)(1) of the ACA health plans offered through an Exchange are not allowed to require AI/ANs with family income at or below 300 percent of the federal poverty level to pay any cost-sharing. In addition, under section 1402(d)(2), a health plan offered through an Exchange may not require an AI/AN with family income under 400 percent of the federal poverty level who is served by an I/T/U provider to pay a co-payment. In addition, under the latter section (d)(2) provision the health plan may not reduce payment to an I/T/U provider by the amount of any cost-sharing that would have been due from the AI/AN patient absent this provision (i.e., the health plan has to pay the I/T/U provider the cost-sharing amount.) To the extent there is an increase in costs to a health plan as a result of these AI/AN protections, the HHS Secretary is to make an "actuarially-equivalent" payment to health plans serving AI/AN.

Except for the cost-sharing protections offered AI/AN in the individual market in an Exchange, all of the other AI/AN-specific and I/T/U-specific provisions apply inside and outside of the Exchange.[6] Achieving compliance from health plans can be a time-consuming and arduous

[5] Kaiser Family Foundation, "Race, Ethnicity and Health Care, Issue Brief: A Profile of American Indians and Alaska Natives and Their Health Coverage", September 2009, page 1.

[6] Other Federal Indian-specific provisions include: Section 206 of the IHCIA provides I/T/U providers the right to receive reimbursement for services rendered to health plan enrollees; I/T/U providers have the right to limit their service population to select populations; a health plan cannot require an I/T/U that is a non-taxable entity to collect or remit taxes; an I/T/U that is covered by the Federal Tort Claims Act cannot be required to obtain or maintain professional liability insurance; section 221 of the IHCIA exempts a health care professional employed by an Indian tribe or tribal organization from the licensing requirements of the state in which such tribe or tribal

process for I/T/U providers and individual AI/ANs. Outside of the Exchange, Tribes and tribal organizations will have to work health plan by health plan to negotiate these Indian-specific provisions. Inside the Exchange, though, the Exchange structure provides an efficient mechanism to educate plans and enforce these provisions. A significant goal of health reform is to eliminate inefficiencies in the health system, and this is one instance, if the opportunity is acted upon, where efficiencies can be achieved.

Because these Indian-specific requirements are numerous, sometimes complex, and often-times unfamiliar to health plans, NIHB recommends that HHS and Exchanges require health plans offered through an Exchange to use an "Indian Addendum" with I/T/U providers in order to facilitate the identification and enforcement of Indian-specific provisions of Federal law. Such an approach is in place between health plans and I/T/U pharmacies participating under the Medicare Advantage (Medicare Part C) and Medicare Prescription Drug (Part D) programs. Under Medicare, the Part C and Part D plans are required to use an Indian Addendum (referred to as an I/T/U Addendum) when contracting with I/T/U pharmacy providers. Rather than create an added administrative burden, the use of the I/T/U Addendum has proven to simplify implementation of these provisions and increase compliance with Federal requirements.

Indian Sponsorship: The ACA, supported by provisions in the IHCIA, represents a significant transition from a provider-based to a combined provider-based and insurance-based system to serve AI/AN.

The premium and cost-sharing assistance to be available through an Exchange will be particularly beneficial to the AI/AN community. Eighty-two percent of AI/ANs are in families with family income at or below 400% of FPL, compared to 55% for non-Hispanic whites.[7] In addition, 89% of uninsured AI/AN are in families at or below 300 percent of the federal poverty level.[8]

Rather than rely predominantly on direct funding to I/T/U providers by way of Federal appropriated funds to IHS, as a result of the ACA I/T/U providers will be receiving a much greater share of resources from third-party reimbursement. It is hoped that this broadened revenue stream from the Medicaid expansion and the Exchange coverage will begin to close the funding gap experience today in the Indian health system.

To facilitate this transition to insurance coverage, Indian Tribes may wish to sponsor tribal members who enroll in Exchange plans, meaning the Tribe may choose to pay the portion of the health insurance premium that would be required of an AI/AN Exchange enrollee. Depending on their income, for some AI/AN considering enrolling in an Exchange plan their share of the

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organization performs services, provided the health care professional is licensed in a state; to the extent that an I/T/U is exempt from State licensing requirements, the I/T/U cannot be required by a health plan to hold a State license to receive payments; an I/T/U cannot be required to submit any disputes between the parties to binding arbitration; and a health plan may not deny a claim submitted by an I/T/U based on the claim format if the format used complies with Title XVIII of the Social Security Act.

[7] Kaiser Family Foundation, "Race, Ethnicity and Health Care, Issue Brief: A Profile of American Indians and Alaska Natives and Their Health Coverage", September 2009.

[8] American Consumer Survey, All AI/AN with Household Income Data; data analyzed by the California Rural Indian Health Board, August 17, 2011.

premium will be very modest, but so will their incomes. For other AI/ANs that may consider enrolling in an Exchange plan, their premium share can be substantial. To encourage and assist tribal members, Tribes may allocate tribal resources to pay the unsubsidized portion of the premium. For AI/AN individuals, this could result in expanded service options. For tribal providers, enrollment of AI/AN in Exchange plans may result in increased revenues. In addition, for States, increased Exchange enrollment further broadens the pool of Exchange enrollees and increases the total amount of Federal subsidies flowing to their State.

NIHB recommends that HHS and Exchanges facilitate Tribes and tribal organizations in becoming financial sponsors for AI/AN by requiring each Exchange to permit Indian Tribes, Tribal organizations and urban Indian organizations to pay the unsubsidized portion of the health plan premiums on behalf of Exchange enrollees they designate, using a collective payment process.

Increase Funding for ACA and IHCIA Implementation in Indian Country: Closely related to ensuring adequate tribal input is the need to ensure there is funding provided through the Exchange Establishment grants to fund policy development by Tribes and tribal organizations. Tribes are not merely one in a list of special interest groups. The Federal government has a unique and recognized government-to-government relationship with Tribes and is obligated to carry out their Federal trust responsibility. The Exchange Establishment grant funding is a ready-made mechanism for ensuring that adequate resources are in place to support the tribal input.

A more fully funded Indian health system will be, if implemented successfully, a by-product of ACA implementation. Educating Tribes, tribal organizations, and tribal members about the new options available under the ACA will be critical to this. In addition, it is critical that tribal voices are heard in the Exchange planning and implementation process.

Through Exchange Establishment grant funding, through HHS education and outreach grants, through Exchange funding for Navigators, and through the insurance coverage options to be available in an Exchange and under Medicaid, we believe that there are sufficient resources available within the already allocated health reform funding and the new funding mechanisms to advance the goals of health reform in Indian country. However, we need HHS to be proactive in ensuring that the provisions are implemented and the new coverage options are available to AI/ANs and to their Indian health care providers in ways that enable the funds to flow where and when needed.

State-Tribal Relations under ACA

We commend the Department for its recent efforts to foster positive State-Tribal relations in implementing health care reform. While Tribes recognize the need for the Department to grant States flexibility in implementing programs like the Health Insurance Exchanges and Medicaid expansion, Tribes need to have an equal seat at the table with States as these programs are implemented. Congress intended these programs be used as an additional means to help meet the United States' trust responsibility to provide health care to American Indians and Alaska Natives. If Tribes are not allowed to meaningfully participate in the development of these programs at

both the federal and State level, it is unlikely that American Indians and Alaska Natives will be able to reap the benefits they are designed to provide.

Many Tribes still do not have positive working relationships with their States. This poses a problem when States administer federal programs with federal funds that are intended, in part, to fulfill the United States' trust responsibility to provide health care to American Indians and Alaska Natives. In order to fulfill the Department's trust responsibility to Tribes, the Department has historically stressed the need for States that administer federal programs to consult with Tribes. As Secretary Sebelius recently stated:

States must consult with Tribes to ensure the programs that they administer with federal funding meet the needs of the Tribes in that state. Tribes should be considered full partners by states during the design and implementation of programs that are administered by states with HHS funding. The requirement of states to consult with Tribes in the development of the Affordable Insurance Exchanges is an example of how states can proactively include and collaborate with Tribes during the planning stages of a program that has the potential to benefit Tribal members greatly.9

Tribes commend the Department for continuing its commitment to require States to consult with Tribes in administering these federal programs, and are encouraged by the Department's recent efforts to do so in implementing Health Insurance Exchanges and in promoting transparency in State access to Section 1115 Waivers. As discussed below, however, we believe more needs to be done in order to ensure that Tribes can meaningfully participate in the development of these programs.

Health Insurance Exchanges

As indicated in the comments the NIHB and TTAG provided on the Department's proposed Exchange Establishment rule, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans" (CMS-9989-P), Tribes support the Department's decision to include Tribes in the list of stakeholders with which Exchanges must consult under Section 1311(d)(6) of the Affordable Care Act. Section 155.130 of the Proposed Rule directs that each Exchange that has one or more Federally-recognized Tribes located within its geographic region must engage in regular and meaningful consultation with such Tribes and their officials. Similarly, Tribes commend the Department's decision to condition the issuance of Exchange planning grants on meaningful consultation with Tribes.

In its comments on the proposed rule, the TTAG recommended that the Department include the following to ensure that States engage in meaningful consultation with Tribes:

(1) A requirement that the Department must approve a State's tribal consultation policy before an Exchange could be approved;
(2) Require States to demonstrate they have consulted with Tribes in developing the Exchanges and the conditions for participation as a Qualified Health Plan before an Exchange could be approved;

[9] Kathleen Sebelius, Secretary, Department of Health and Human Services, "Dear Governors" letter, September 14, 2011.

(3) Require States to demonstrate meaningful consultation with Tribes on an ongoing basis as they begin to administer the Exchange program in their states;
(4) Require contacts for Tribes within the Department and within each exchange.

Consultation with Tribes on the development of Exchanges has been inconsistent across the country. We understand that in a few States, Tribes have been brought on as meaningful participants in the development of exchanges. In many more States, however, Tribes do not have a seat at the table, and are not being consulted with. For example, we understand that in many States, rather than engage in meaningful government-to-government consultation, the State has simply asked Tribes to respond to a generic list of questions. Simply asking Tribal governments to answer a generic list of questions developed for all stakeholder groups falls far short of government-to-government consultation, and do little to ensure that an Exchange will be designed in a manner that ensures meaningful access to American Indians and Alaska Natives.

The federal government must not only ensure that States consult with Tribes, but it must also continue to consult with Tribes as it implements key aspects of the Exchanges at the federal level. Under Section 1321(c)(1) of the ACA, the Secretary must establish and operate a federally facilitated exchange in States that forgo establishing an exchange. In Sections 1324 and 1334 of the ACA, the Office of Personnel Management ("OPM") is required to select two multi-state plans that will operate across the Exchanges. Both of these programs will be critically important to Tribes.

We are concerned that the Department has yet to consult with Tribes on the development of a federally-facilitated Exchange. Recent reports indicate that the Department has made considerable progress on the federally-facilitated exchanges, but we are unaware of any consultation with Tribes on the federally-facilitated exchanges to date. For example, in a recent progress report on the development of the Exchanges, the Department announced that it is "continuing to make investments in the development of a Federally-Facilitated Exchange," and that "[i]n collaboration with contractors, other agencies, and States, HHS has completed work on key IT and operational business processes and business requirements for the Federally-facilitated Exchange."[10] To the extent that the Department is already consulting with States and other third parties on the development of a Federally-facilitated exchange, Tribes must be included as well. As NIHB indicated in the comments it submitted on the Exchange establishment proposed rule, there are significant barriers to AI/AN participation in the Exchanges that must be overcome. We look forward to working with the Department to assist it in the development of a Federally-facilitated Exchange that allows meaningful access to American Indians and Alaska Natives.

Additional State/Tribal Relations

Incentivize States To Fully Cooperate With And Include Tribes. Many federal programs cannot be carried out successfully, without the full participation and input of the Tribes. Relationships *must* be created and maintained at the federal, national, and local levels. HHS has the ability and the duty to create incentives for states to engage and work with Tribes (for

[10] 2012 Progress Report: States Are Implementing Health Reform.

example – requiring consultation with Tribes before certain actions can be taken; asking Tribes to give recommendations on federal approvals before approval is given; recognizing and rewarding states with exemplary records in working with Tribes). Consulting with the Tribes means actively listening to what Tribes have to say, and making every possible good faith effort to respond to Tribal concerns. Consulting does not mean "notification."

Form Partnerships To Achieve More Accurate AI/AN Data And Statistics. Lack of data and misclassification issues tends to result in weak data for AI/AN populations. Weak data, in turn, tends to preclude Native Americans from funding opportunities. There needs to be enhanced partnering between federal, state, and tribal entities to gather, analyze, and disseminate data. Furthermore, funding opportunities that include data collection need to be designed to take into consideration the fact that AI/AN data collection is in the beginning stages, yet urgently needed.

Enhance Cultural Competence At The State Level. States need cross-cultural training to improve their understanding of the Tribes with whom they must work, and AI/AN citizens they must serve.

Behavioral Health

Commit to enhanced collaboration between IHS and SAMHSA. NIHB supports collaboration and leveraging behavioral health resources among the IHS and the Substance Abuse and Mental Health Services Administration (SAMHSA) programs. Currently, behavioral health programs within these agencies operate with little communication or cooperation. A greater focus on partnership will yield a stronger focus on the issue of behavioral health disparities in Indian Country.

CONCLUSION

On behalf of NIHB, thank you for this opportunity to provide written comments. I believe we share a common goal: the enhancement of the quality of life and health for American Indians and Alaska Natives. Indian Country will continue to work diligently with the Administration to improve our Indian health care delivery system. NIHB appreciates the Administration's leadership and commitment to honoring the nation's Federal trust responsibilities by continuing to make the needed investments in the Indian health care delivery system.

Yours in Health,

Cathy Abramson
Chairperson
National Indian Health Board