**HHS Consultation Sessions on Federally-Facilitated Exchanges**

**Talking Points for Tribes**

**Dated: July 2012**

**A. Significance of Federally-Facilitated Exchanges for Tribes**

1. Premium tax credits offered through the Exchanges represent a significant new federal resource for health care.

a. The Exchanges are designed to assist the most vulnerable populations purchase insurance coverage, improve their health care outcomes, and reduce disparities.

b. Congress intended that AI/ANs be able to take advantage of this resource, and included special protections and benefits in the Affordable Care Act for Tribes.

2. Unique circumstances for AI/AN must be addressed for them to enroll in Exchange plans.

a. AI/AN are unlikely to purchase private insurance on their own when they have a historical, moral and legal right to free care from the federal government.

b. Tribal sponsorship of individuals by paying the unsubsidized portion of their premiums is needed for enrollment of AI/AN.

c. If Indian health providers are not allowed to participate in the networks of Qualified Health Plans (QHPs) offered through the Exchanges, then they are unlikely to sponsor premiums.

d. Indian health facilities are unlikely to be providers in QHPs unless there is a mandate for QHPs to offer them provider contracts with an Indian addendum.

e. AI/AN must be identified in electronic data systems so that providers know that cost sharing is waived for them, and providers must have a way to collect the amount that would otherwise be paid through cost sharing.

3. At least 12 states with Federally-recognized Tribes will have FFE.

a. Alaska, Oklahoma, Michigan, Montana, Wyoming, South Dakota, Florida, Louisiana, Alabama, Texas, Kansas, and North Carolina

b. This includes more than half the federally-recognized Tribes in the U.S.

**B. Process and Tribal Consultation**

1. HHS has issued 7 notices of proposed rule-making (NPRMs) for Exchanges.

a. TTAG reviewed the NPRMs in consultation with Tribes and submitted extensive comments.

b. HHS issued final regulations that defer to States Exchanges to make decisions about important AI/AN issues.

c. When States decide not to operate Exchanges, the federal government has no reason to accommodate their needs for flexibility.

d. The FFE must exercise the federal trust responsibility for Tribes and carry out the federal Tribal consultation policies as mandated in the President’s Executive Order.

2. Tribes expect a full partnership in FFE design and implementation.

a. On September 14, 2011, Sec. Sebelius sent a letter to State Governors stating:

“Tribes should be considered full partners by States during the design and implementation of programs that are administered by States with HHS funding” and requiring States to consult with Tribes in the development of Exchanges.

b. Some States have been doing an exemplary job of consulting with Tribes, including Oregon, Washington and Minnesota.

(1) Some Exchanges have provided funding to Tribal Organizations to create policy documents, serve on planning committees and provide useful input as the details of such things as computer software are being designed.

(2) Where Tribal representatives, employees or technical advisors are serving on committees and included in these discussions, there have been substantive and beneficial outcomes in the Exchange planning process.

c. Tribes expect no less from the Federal government in States that will have Federally-facilitated Exchanges.

d. If this cannot be done on a state-by-state basis, there should be workgroups with I/T/U and CCIIO participation (including Technical Advisors for the I/T/U and contractors for HHS who are designing systems) on a national level with Tribal representation from each state with an FFE.

3. What Tribes want as an outcome from this Consultation session:

a. Commitment from HHS to work proactively in a government-to-government relationship with Tribes as full partners during the design and implementation of federally-facilitated exchanges;

b. Agenda of items mutually agreed upon by HHS and the TTAG to be the subject of workgroup deliberations;

c. Plan for engagement Tribal representatives and their technical advisors in workgroups with those in HHS who are making decisions on the important issues.

(1) Tribal Organizations on the State, Area and National level should designate their representatives and technical advisors to serve on these workgroups.

(2) Federal participants must have decision authority.

(3) When appropriate, federal contractors who are designing computer systems should participate so that they have a full understanding of the goals and objectives related to Indian issues.

(4) There should be Tribal and Federal co-chairs for each workgroup who are responsible for decisions regarding agendas and the conduct of meetings.

d. Timetable for design and implementation activities with Tribal workgroups scheduled to meet proactively to resolve issues

(1) Workgroups should begin meeting now, not after January 1, 2013.

(2) Some workgroup meetings should be face-to-face over a period of 1-2 days so that there is adequate time to work through issues and develop recommendations.

4. Recommended approach for agenda setting for workgroups.

a. Create a document that acknowledges each of the recommendations from TTAG, Tribes and Tribal organizations submitted as a response to NPRMs.

b. Indicate which of these recommendations the Federal government is willing to implement in Federally-facilitated Exchanges (=consent agenda, needs no further discussion).

c. Use the remaining recommendations as the agenda for workgroups.

d. If this requires an extensive engagement process with Tribes and Tribal organizations, HHS should provide funding to Tribal organizations in each State to prepare policy documents, participate in planning activities, and organize Tribal consultation agendas and meetings in the State.

(1) Use funds that would have otherwise been used for Establishment grants for States that have chosen not to apply for, not to accept or to turn back their funding for Establishment grants

(2) Use other funds that may be available.

e. HHS and Treasury should designate a person with policy authority in each State where there will be a Federally-facilitated Exchange as a key point of contact for Tribes and Tribal organizations.

(1) That policy person should have a list of Tribes, elected Tribal Leaders, and their designated technical advisors to contact with information and schedules for the development of policies, project deadlines related to the development of Exchanges, and meeting schedules.

**C. Five (5) Workgroups Proposed and Issues for their Agendas**

1. Workgroup on Qualified Health Plan (QHP) Networks and Essential Health Benefits
   1. Require all QHPs to offer contracts to all I/T/U providers with an Indian Addendum
   2. Indian Addendum wording
   3. Develop rules and processes to assure that AI/AN who are enrolled in a QHP and referred through an I/T/U CHS program (and/or are below 300 percent FPL) are not charged a co-pay or deductible for services they receive outside the I/T/U.

d. Essential Health Benefits

(1) Review the scope and duration of services

(2) Providers covered

(3) Substitution of benefit categories from benchmark plan

(4) Offering pediatric oral and vision services in the QHP versus a separate plan

(5) Compliance with Mental Health Parity and Addiction Equity Act (MHPAEA)

2. Workgroup on Eligibility, Enrollment and Tribal Sponsorship

a. Eligibility

(1) Identification of individuals who are eligible for special protections and provisions as AI/AN in the eligibility process and at the provider level to assure that deductibles and co-pays are waived.

(2) Utilization of existing databases or development of new databases to expedite eligibility determinations.

(3) Deciding how additional documentation will be requested, submitted, reviewed, and stored and how eligibility determinations will be made when individuals are not included in approved data systems.

(4) Develop the system to assure waiver of penalties for AI/AN without Insurance and to communicate who is covered by this provision in the law.

b. Enrollment process

(1) Enrollment process must accommodate special provision for AI/AN in Exchanges (monthly enrollment, waiver of cost sharing, exclusion of certain sources of income).

(2) As single point of enrollment, Exchanges must be able to identify AI/AN for benefits and protections in Medicaid, Medicaid Expansion, Child Health Insurance Programs, and Basic Health Plans, if there are any in the State.

c. Tribal Sponsorship

(1) Allow tribes to decide which individuals they want to sponsor and provide opportunity for aggregate payment of premiums.

(2) Decide the terms and conditions of Tribal Sponsorship.

(3) Allow I/T/U clinic addresses to be used for QHP mailing to enrolled individuals.

d. Website

(1) Design the website to include information specific to AI/AN and the I/T/U.

(2) Test the website in Indian Country and in urban Indian clinics to make sure it is culturally appropriate, easy to navigate to Indian health information, and the information is presented in a way that is accurate and easy accessible to consumers, as well as those assisting with enrollment.

e. Enrollment Assistance

(1) Carve outs for navigator contracts for the I/T/Us, including an Indian Addendum.

(2) Provide other enrollment assistance funding, such as Medicaid Administrative Match (MAM).

f. Call Centers

(1) Decide whether it is most appropriate to have an Indian desk to handle questions and resolve problems regarding AI/AN and I/T/Us, or whether everyone who works at a call center should receive training about Tribes in the State, the Indian health care delivery system and special provisions in the law, regulations and systems for AI/AN.

(2) Review scripts that are used in call centers to assure their accuracy for AI/AN and I/T/Us.

(3) Provide appropriate back up for call center employees who are unable to answer questions about AI/AN and I/T/U and standards for timely response.

(4) Keep FAQs and review answers for accuracy.

3. Workgroup on Payment for Services Provided by I/T/U

a. Enforcement of Section 206 of the Indian Health Care Improvement Act (IHCIA)

(1) Assure that the I/T/U is paid in a sufficient and timely way for services delivered to individuals who are enrolled in QHPs if the I/T/U is not a network provider.

(2) Create single point of contact for I/T/U facilities that have problems collecting from QHPs, and a process for dealing with those issues.

b. Reimbursement for Waived Cost Sharing

a. Develop a process to assure that the I/T/U receives payment for the co-pays and deductibles that are waived for AI/AN.

b. Develop process to reimburse other QHP providers for waived cost sharing for AI/AN.

4. Workgroup on FFE Data

a. Enrollment data

b. Federal data hub

(1) IHS registration data

(2) Other AI/AN data sets

c. Identifying AI/AN in FFE data and reports

(1) For benefits and protections for AI/AN

(2) For reimbursing cost sharing

(3) Performance metrics

(4) Measuring effectiveness/barriers to enrollment of AI/AN

5. Workgroup on Outreach and Education (could be Federal Coordinating Workgroup for FFE O& E or assign to TTAG O&E Subcommittee)

a. Provide outreach and education that is culturally appropriate.

b. Assure that AI/AN know which QHPs have I/T/U providers in their networks.

c. Inform consumers and providers about the special protections and provisions for AI/AN.