

## ACA Questions, Scenarios and Comments

### **Eligibility**

#### Medicaid Eligibility Determination

We need clarification of the demarcation between Exchange and Medicaid/CHIP responsibility for screening applications, processing eligibility determination for Medicaid/CHIP, and enrollment in those programs, given it is the Medicaid agency's legal responsibility to make those determinations. While the Exchange must provide a single integrated eligibility process we recommend that it not be required to make final Medicaid or CHIP eligibility determinations and enrollment. While the intent of centralized Exchange eligibility determination is laudable, operational impacts are potentially huge. Because the single state agency is responsible for eligibility, the need to provide oversight of eligibility functions managed through the Exchange creates new complexities related to training, personnel, and program integrity. (These are magnified if the Exchange is not administered by a public agency, as currently envisioned in Washington state.) For example, Medicaid and CHIP eligibility determinations are made by staff covered by a collective bargaining agreement (CBA). In essence, this staff "owns" the eligibility work. If eligibility work is conducted outside the CBA through the Exchange, the risk of a demand to bargain and work stoppage that could compromise the state's ability to meet the 1/1/2014 implementation date is raised. Instead – if applicant screening through the Exchange identifies a potential Medicaid or CHIP applicant, that application could be (electronically) transferred to the Medicaid agency for "official" processing. In this way program integrity would be maintained consistent with CBA and organizational expectations, and determination of Medicaid eligibility for individuals under age 65 and 65 and older, using MAGI and/or traditional income/functional determinations, would remain in the single state agency.

- What standards of promptness apply to eligibility processing from the point when the Exchange screening determines potential Medicaid/CHIP eligibility until the individual is enrolled?

#### Household composition - Sneeve v. Kizer households:

In Washington, a child with income that makes a parent ineligible for Medicaid can be a separate medical assistance unit. This results from a ninth circuit court decision, called Sneeve v. Kizer. For excluded MAGI income, such as child support, would states no longer establish separate medical assistance units?

*Scenario:* An application for medical assistance consists of an unmarried mother (parent A), her child, unmarried father (parent B), his child, and their common child. Mother has earnings at 301%FPL. Father has earnings at 125%FPL. Currently, unmarried parents of a common child are not financially responsible for each other or the other parent's child, but both are financially responsible for the common child.

- Will this household be considered together, as one family unit?
- If not, to which household does the common child belong?
- If the common child is in parent A's tax unit and not parent B's, how is parent B's income counted, or is it?
- If one of the children had countable income, that when added to the parent's income, put the household in a different FPL range- how would the rules from the Sneeve v. Kizer lawsuit be applied?

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### American Indian/Alaska Natives (AI/AN)

1. Given the federal and state financial implications of cost-sharing exemptions for AI/ANs, we assume that self-attestation will no longer be an acceptable approach to verifying AI/AN status. Is this correct?
2. Through Washington State's Transitional Bridge 1115 Demonstration Waiver, a workgroup facilitated by the American Indian Health Commission developed an agreed approach to:
  - clarify the federal definition of an American Indian/Alaska Native (AI/AN), and
  - identify the array of official documents that support an individual's claim to be an AI/AN. Preliminary documentation requirements have been forwarded to CMS and we are awaiting guidance before they can be adopted. Details are included as an appendix to this document.
3. If we are not able to verify AI/AN status must we accept self-attestation or would an individual be considered not AI/AN?

### MAGI methodology

1. How will point-in-time income be converted to MAGI income? Does IRS have an online calculator for this?
2. Are there data on Washington state individuals who are below 133% of the FPL and have filed an income tax return (e.g., the percentage?)
3. If a Medicaid client does not report a new job and their MAGI is above the Medicaid standard, is a recoupment process required for Medicaid payments made on their behalf?
  - For example, a client received Medicaid in 2014, when they file taxes in 2015; they are above the Medicaid income standard. Is there a recoupment or overpayment?
4. If a MAGI household applies for Medicaid can we use the last year's MAGI tax income (rather than point in time) if the household attests that their MAGI income and tax filing unit represents current household unit and income?  
If the state had the option to use MAGI in this circumstance, it would streamline the application process for families as well as reduce the workload impact for states.

### Point-in-Time income methodology:

*Scenario:* Single person files an application through the Exchange. MAGI is 140%FPL. Client is just over income eligibility for Medicaid based on MAGI.

1. Because there is an expectation that states ensure no "harm" occurs to an individual's eligibility status, it appears necessary to look at point-in-time income for this client in addition to the initial MAGI determination. Is this correct?
  - If the client's income is 350%FPL based on MAGI:
    - Could this client be enrolled in the Exchange without reviewing point-in-time income?
    - Could a premium tax credit be applied to the client without conducting a Medicaid determination?
  - If the client's income is 125%FPL based on MAGI:

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- Can this client be moved directly to the Medicaid program without looking at point-in-time income?
- Can we skip the point-in-time calculation?
- Is there an FPL range in which a client can be considered for a premium tax credit without the need for a Medicaid determination?

*If an alternative is not available, we have concerns on how we would be able to do point-in-time determinations for all clients coming through the Exchange.*

2. When using income verification from another source (other than MAGI), do we convert the point-in-time income to MAGI? And if so, how?

### MAGI Scenario PPT/Questions handed out on 10/6/11

1. Scenario #5 and question#15: If the child is not eligible for Medicaid with the custodial parent, it was stated on the conference call that they would need to apply for the tax subsidy through the non-custodial parent. We are concerned that this additional “hand off” places a barrier to children receiving medical coverage. The child’s request for medical would need to be denied and the non-custodial parent would need to apply for the tax subsidy in the state in which they live. We would like to have CMS consider applying non-filer rules in this circumstance.
2. Question #2: Follow-up question – For point in time income must the same deductions (lines 23-36) on the tax form that MAGI uses be deducted? If not, it appears that MAGI would allow the 5% disregard and the disregards on lines 23-36, but point in time income would only allow the 5% disregard. Is this correct?

### Income disregards

For many years, Washington State has allowed “income disregards” in determining Medicaid eligibility for the following groups:

- (1) Children – income up to 200% of FPL disregarded;
- (2) Pregnant women – income up to 185% FPL disregarded;
- (3) Medically Needy – income up to the CNIL disregarded.

CMS approved Washington’s income disregards under Section 1902(r)(2) of the Social Security Act.

Under the new Section 1902(e)(14) and the proposed rules, it appears that the income disregards described above may no longer be applicable. The new law and rules require income to be calculated using MAGI (except for exempted groups), and prohibit income or expense disregards other than those specified in subparagraph (I). Is this a correct interpretation? If so, the previously approved disregards would seem no longer allowable for our Medically Needy Children and Pregnancy programs; or would this apply only to individuals up to 133% FPL? We need clarification on whether the 1902(r)(2) disregard can be allowed for all Medicaid groups that are excluded from the MAGI calculation.

### Medicare

1. If an individual does not have free Part A:
  - Is Medicare still considered affordable minimum essential coverage?

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- Do we look at entitled to (or enrolled in) Medicare?
  - For example, if an individual was entitled to (but not enrolled in) Medicare, are they still considered to have minimum essential coverage?
- 2. If an individual missed the open enrollment period for Medicare and is waiting for the special enrollment period, are they considered to have minimum essential coverage?

### Scenario:

*A single, 48 year old woman recently applied for Social Security. Her FPL is below 133%. She is enrolled in Medicaid in January 2014. In June, she is awarded Social Security benefits retroactively to January, 2014 in the amount of \$1000 per month. Her Medicare will begin in January 2016.*

- *Is the \$25,000 SSDI disregarded for a MAGI calculation?*
- 3. If Washington State elects to continue a Medically Needy (MN) program after 2014, could she choose MN Spend down instead of the subsidy to continue to receive the additional services covered under MN?
- 4. If a client under age 65 is eligible for Medicare and has income under 133%, can they receive benefits under the newly eligible program? Current rule states that if a person is being evaluated for the Medicare Savings Program they are excluded from the MAGI methodology. We are unclear on what this means. If a person under age 65 has Medicare and is under 133%, can they receive Medicaid under the newly eligible program?

### General

1. Can a state develop a new application for medical and no longer use a combined application (for Basic Food, public assistance, medical)?
2. We are concerned about timeframes for state workers and agencies listed on in the Medicaid document beginning on page 122. Are these examples, or will states be limited to the administrative times estimated in the document? These seem low, considering HCA is currently working with SSA to complete the required Security Design Plan and has spent over 100 hours on that one data-share alone.

### Retro Medicaid:

1. How will retroactive Medicaid eligibility be changed to accommodate efficient administrative links between the Exchange and Medicaid (and a Basic Health (BH) option if a state were to choose that option?)

### Scenario:

*A person files an application through the Exchange. Their MAGI calculation does not reflect their current financial circumstance. The Medicaid application is pending for more information.*

- Is it the intent of this rule that when a client is pending for Medicaid, for whatever reason, that they will be enrolled for a premium tax credit?

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- The individual is enrolled in a premium payment plan and receiving a subsidy while waiting for the Medicaid decision. We understand that the individual is not liable for any premium tax credit, but do they get any relief or refund for any premiums they paid during the waiting time?
- An individual applies through the Exchange on April 1, 2014, and is not eligible for Medicaid, CHIP or BH. If they have unpaid bills for January 2014, can a retroactive premium tax credit determination be completed for that period?

### Federal HUB & IRS:

We understand that the IRS has concerns about sharing “confidential” information, but access to these data is critical for Washington state since we do not have a state income tax through which tax households can be established. For program integrity, administration efficiency, and good beneficiary service, it is really essential that the IRS make the tax filing household data available through the federal HUB.

### Program Integrity:

#### Recommendations:

- *Addressed under the Eligibility (AI/AN) change section above* - Affirm the approach to establishing AI/AN status or provide guidance to ensure that cost sharing exemptions for the AI/AN population can be applied consistently, accurately, and without confusion when individuals income changes push them over the exemption threshold. This process will also require adherence to the 1902(a)(73) policy to seek advice from AI/AN representatives.
- Eliminate MEQC and have only one review through PERM.
- Align all eligibility rules to avoid administrative confusion and error.
- Assign (repurpose) PERM and MEQC staff to assist with ACA implementation rather than perform MEQC and/or PERM audits through 2014.
- Eliminate Medically Needy and Spenddown programs– if the goal is to simplify program categories and provide for a simple and streamlined eligibility, then eligibility should remain income based at the new FPL without accommodation for Spend down and a waiting period. Individuals above the Medicaid level could be provided subsidized coverage through the Exchange or BH option.
- *Addressed under the Exchange section above* - Do not insist that Exchanges make final Medicaid/CHIP official eligibility determinations in addition to preliminary screening. The Single State Agency for Medicaid should have clearly designated responsibility for all Medicaid and CHIP eligibility, not simply an oversight responsibility for the Exchange completion of eligibility determination.
- Hold states harmless through 2014 for all quality control/audit errors. We are concerned that an annual IRS reconciliation may uncover inconsistencies that the state had no way of knowing and that were not reported by the client. We recognize the critical nature of good documentation for all eligibility actions, but we have no control over what client report despite ongoing education and reminders. This is uncharted territory and without experience to identify opportunities to eliminate reconciliation challenges, states may find it essential to err on the side of more verification action as protection from unwanted audit errors. This is clearly counter to the ACA intent and the states’ desire for administrative simplification.

### Hearings/Appeals:

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### Recommendations:

- At the point of reconciliation, if a penalty is identified, states should be held harmless when an audit trail proves due diligence was followed and documentation can confirm this.
- Reconciliation penalty requests for hearings/appeals should be managed by the IRS and not the state Medicaid agency since the penalties are determined by the IRS. So many changes can occur between the time initial eligibility is determined and the date of reconciliation that penalties may end up being assessed through no fault of the state agency. Regardless of the ongoing education and expectation for clients to report changes, the likelihood is that some will not be immediately known to the state agency (employer wage reporting is usually between 3 – 6 months old before data matching details are available). When this happens the state may be vulnerable for audit error findings and a barrage of requests for hearings/appeals as clients receive a penalty determination from the IRS.

### ***Tax Credits***

#### Incarcerations

- How long does an individual have to be incarcerated to be considered ineligible for premium tax assistance? (e.g., a day, a week, a month?)
- Will the individual's medical eligibility be required to be suspended during any incarceration period, rather than benefits closed and reopened once the individual is released?

### ***FMAP for Newly Eligible Individuals and for Expansion States***

#### General Comments – (Methodology description Sec 433.206(a) and Sec. 433.206(b))

- Although the new MAGI rules are used for purposes of determining eligibility, only newly eligible members of the adult group will be eligible for the enhanced FMAP. Is this a correct interpretation? (i.e., we would not expect any children to be “newly” eligible for Medicaid in Washington State but that may not be the case in other states.)
- We concur with the concept of identifying an alternative approach for determining appropriate FMAP rates for individuals covered under Medicaid beginning in 2014. However at this time we simply do not have enough detailed information to settle on one of the 3 approaches offered or to make an informed comment on an alternative process. We would hope to have further opportunity to comment as additional details become available and as other states' comments are shared.
  - We agree that the four principles of accuracy, administrative simplification, transparency and pragmatism are reasonable criteria for measuring the feasibility of approaches proposed.
  - The fifth principle, “*sufficient data to identify, associate and reconcile expenditures with the related eligibility group to which the FMAPs apply*” is potentially problematic. During the first 3 years of implementation, state and federal governments will be gathering data on

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- new Medicaid beneficiaries, both those who are “newly eligible” and those in the “welcome mat” population who would be eligible under current Medicaid rules. While we expect to partner with the federal government to build a reasonable FMAP model that covers this initial period, states will need to be held harmless in any reconciliation if subsequently determined FMAP discrepancies are within a reasonable range. We suggest that FMAP adjustments be made on a prospective basis as the capacity for experience reporting becomes stable. The concept of a retrospective adjustment after a full reconciliation, even with the benefit of experience, poses an enormous administrative challenge at the state and federal levels. Given the current focus of states on fiscal challenges the specter of cash flow concerns magnifies concerns over decision-making absent a sound base of experience data.
- We would appreciate consideration of flexibility around the requirement, “*For the initial year (2014), States would give notice to CMS no later than one year prior to the beginning of the calendar year, January 1, 2013*”. Does this mean January 1, 2013 or one year prior, January 1, 2012? We suggest that a letter of intent from the state with a pledge of technical assistance from CMS would ensure that a formal methodology could be selected no later than the beginning of open enrollment for the 1st plan year of the Exchange.
  - Furthermore, any restriction that leaves states subject to a FMAP methodology requires sufficient enough experience for the state and federal governments to make an informed decision and commitment toward a single methodology (or explicit set of methodologies if that makes more sense for population groups). We suspect that a standardized methodology will not meet the needs of every state. And, it seems doubtful that 1 year of experience (2014) will be sufficient to lock-in a 3-year methodology to be used beginning in 2017. However, we would expect that by January 1, 2017 the 3 years of experience we would have gained would be sufficient to make an informed decision about a future 3-year lock-in period.
  - Washington is engaged with CMS in discussions to determine details and pilot the MAGI calculation. That effort will provide considerable insight to construction of an informative FMAP model. In addition, we would offer the state as a testing site for FMAP approaches. As our comments suggest, the issues we face concerning data availability are not unique; we have made inroads in developing a model that would inform the effort (alternative #3); and our fiscal situation emphasizes the need for diligence and engagement as interim and longer term payment methodologies are considered.

### Alternative 1: 2009 Eligibility Standard Threshold

From a superficial review, the determination of upper-income thresholds, as well as proxies for other eligibility criteria across categorical eligibility groups, appears to have the most appeal to Washington State as an approach to determining newly eligible vs. traditionally eligible FMAP status for individuals. However, we have the following comments/questions:

- We expect that many individuals who have been determined to be disabled would be considered “newly eligible” in 2014 because they would not have qualified for Medicaid under the state’s eligibility rules as of December 1, 2009 as a result of their disability income. However, under a MAGI calculation they would seem to qualify. (This question of applicability of SSDI to MAGI was raised above in the Eligibility-Medicare section.) It seems reasonable to use actual disability determinations only to ascertain the appropriate FMAP given that adequate

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incentives exist today for individuals to seek a disability determination and be enrolled in Medicaid if they're eligible.

- Determination of appropriate upper-income thresholds hinges on our ability to gather enough information to compare individual applicant income/asset proxies against December 2009 eligibility criteria.
  - As described above in Eligibility – Federal HUB & IRS, Washington State does not have an income tax and would therefore require technical assistance from the federal government to obtain information necessary to support the MAGI calculation and assessment of the potential impact of assets on the traditional eligible proxy calculation. We hope to avoid adding questions related to asset determination to the “streamlined” application since assets are not required for a MAGI calculation. We expect that applicants would find such questions intrusive and we would have no ability to enforce capturing information that is no longer relevant to eligibility determination. The ability to access IRS data is essential, with the caveat that we recognize the need to be diligent in addressing confidentiality concerns.
  - While it seems like a reasonable option, we understand that few states have completed their Asset Verification Systems (AVS). Washington is one of those states, hampered by an ongoing fiscal crisis and the inability to fund the AVS development.
  - We believe we may have data available to look at individuals who failed eligibility for a traditional Medicaid group based on their assets. Until we complete an analysis we cannot comment on the reliability of the data to assess a proportion of individuals who could be assumed to be “newly eligible” as a result of their likelihood to fail the “traditional eligibility” asset test. We suspect that differences in the types of income that will qualify for the MAGI eligibility determination effective January 1, 2014 could change this proportion of individuals significantly – specifically we are concerned about the implications of SSDI processing as noted earlier. We are continuing analysis in this area and encourage early CMS technical assistance related to outstanding MAGI questions that would influence the analysis.

### Alternative 2: Statistically Valid Sampling Methodology (Sec 433.210)

Our primary concerns regarding the development of a statistically valid sampling methodology are the limitation of data to determine actual expenditures for the sample and the tight timeline CMS would require to obtain sufficient data to build a model. It will take several years for Washington (and other states) to collect adequate medical services' financial data for people who weren't eligible under the benefits listed in the State Plan as of December 1, 2009; enough to support correct allocation of expenditures for these newly eligibles. This exercise would be complicated, if not compromised, by delivery system reforms being designed and implemented over the next few years to bend the cost curve and improve the quality of efficiency of services being provided. In addition, the state is pursuing the expansion of managed care for additional populations. And, expenditures reflect a benefit design in which optional services continue to erode. It may not be the case, but without a detailed conversation with CMS experts, this FMAP alternative appears to be an apples-to-oranges comparison in Washington state.

Similar data issues apply in the near term for a statistical methodology in which a per capita expenditure applied proportionately to determine appropriate FMAP claiming.



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Over the longer term, as the state data systems provide more robust medical services' financial experience, and the fiscal climate and delivery systems stabilize, it may be possible to reconsider the application of a statistical sample methodology for FMAP determination.

Washington would be interested in working with CMS to build and pilot variations of methodologies, in the near term and over time, to compare results from differing approaches and better understand the implications of data lag on establishing a realistic timeline for implementing robust model(s).

### **Alternative 3: HHS developed estimate of the proportion of newly eligibles and per capita expenditures for the projected newly eligibles (Section 433.212)**

As part of an analytic effort to describe the demographics and health status (including potential expenditures) of newly eligible populations, Washington state has built a model similar to the one described as alternative 3. With the help of Urban Institute analysts a data base was constructed using MEPS data reweighted to reflect the Washington population surveyed through the 2010 Washington State Population Survey. Details will be available in the very near future. While this model provides an interesting and representative perspective of Washington State in general, we would not consider any model of this nature to be accurate enough to support FMAP claims for the state at an individual level. However – we would expect to use it to assess the “reasonableness” of other approaches.

- There does seem to be considerable latitude for major errors in assumptions based on the imprecise nature of the data. However, we are hyper-sensitive at this time to the potential for cash flow issues for the state, and any retroactive claims adjustment implications once actual data are available. Even minor miscalculations could have drastic fiscal ramifications to the current (and near future) economic forecast.
- The proposal to verify actual claims beginning in CY 2016 to adjust and correct the model going forward is premature as noted earlier – data lag for services provided under fee-for-service arrangements can result in incomplete data for up to 12 months or more from the date of service. That would mean that in CY 2016 we would have fairly complete data for only 1 year of the Medicaid expansion – CY 2014. One year of data, assuming that it will take time for the bulk of Medicaid eligibles to actually enroll, would not provide a robust enough base for a 3-year commitment to a FMAP estimation model going forward.

### ***Exchanges***

Will the Exchange need to be able to track the five-year bar and switch lawfully present aliens from the premium tax credit to Medicaid once the five-year bar is reached?

- How would a family's premium be determined if children are on Medicaid and their parents are enrolled in separate QHP(s)? In the Exchange, can family members enroll in different QHPs?
- If someone is identified as an American Indian/Alaska Native (AI/AN):
  - If enrolled in a silver plan, are they exempt from all premium payments regardless of income?
  - Does the limited cost sharing called out in CMS 9974-P apply to AI/ANs and non-AI/ANs?

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Since individuals age 65 and older are not eligible for the Exchange, does this mean that if they are legally residing individuals serving their 5 year bar they cannot access the premium tax subsidy? Can legally residing individuals under age 65 access the tax subsidy if they have not met their 5 year bar?

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### Appendices:

#### American Indian Health Commission Workgroup to Operationalize a Definition of AI/AN

##### SUMMARY OF CURRENT DISCUSSION – AWAITING CMS REVIEW AND GUIDANCE

### Introduction

Special Terms and Conditions (STCs) for Washington State’s Transitional Bridge 1115 Demonstration Waiver require that individuals enrolled in the Basic Health program “*who have been determined to be American Indians/Alaska Natives*” be exempt from cost sharing. This is consistent with requirements of the Patient Protection and Affordable Care Act (ACA).

The American Indian Health Commission (AIHC) facilitated a work group to support efforts to implement this requirement. Initial discussions focused on operationalizing the definition of American Indian/Alaska Native (AI/AN) so that individuals to whom the cost sharing exemption applies can be clearly identified and tracked. The following summarizes the workgroup’s consensus approach to:

- a. clarify the federal definition of an American Indian/Alaska Native (AI/AN), and
- b. identify the array of official documents that support an individual’s claim to be an AI/AN.

Implementation of the work group’s findings requires approval of the Centers for Medicaid and Medicare Services (CMS) consistent with the STCs and as the approach to AI/AN determination for future publically subsidized programs that exempt or limit cost sharing for the AI/AN population.

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#### a. Definition of American Indian/Alaska Native Indian

STCs (i.e., page 12 footnote) use a definition of “Indian” consistent with Section 5006 of the American Recovery and Reinvestment Act (ARRA) and with the ACA. This definition is presented in the following box, with references to current law bolded and relevant excerpts shaded in grey in the text that follows for 42 CFR 136.12, and 25 USC 1603(c), 1603(f), 1679(b).

Indian means any individual defined at **25 USC 1603(c), 1603(f), or 1679(b)**, or who has been determined eligible as an Indian, pursuant to **42 CFR 136.12**. This means the individual:

- (1) Is a member of a Federally recognized Indian tribe;
- (2) resides in an urban center and meets one or more of the four criteria:
  - (a) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
  - (b) is an Eskimo or Aleut or other Alaska Native;
  - (c) is considered by the Secretary of the Interior to be an Indian for any purpose; or
  - (d) is determined to be an Indian under regulations promulgated by the Secretary;
- (3) is considered by the Secretary of the Interior to be an Indian for any purpose; or
- (4) is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

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### **42 CFR 136.12 - Persons to whom services will be provided.**

(a) *In general.* Services will be made available, as medically indicated, to persons of Indian descent belonging to the Indian community served by the local facilities and program. Services will also be made available, as medically indicated, to a non-Indian woman pregnant with an eligible Indian's child but only during the period of her pregnancy through postpartum (generally about 6 weeks after delivery). In cases where the woman is not married to the eligible Indian under applicable state or tribal law, paternity must be acknowledged in writing by the Indian or determined by order of a court of competent jurisdiction. The Service will also provide medically indicated services to non-Indian members of an eligible Indian's household if the medical officer in charge determines that this is necessary to control acute infectious disease or a public health hazard.

(2) Generally, an individual may be regarded as within the scope of the Indian health and medical service program if he/she is regarded as an Indian by the community in which he/she lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction.

(b) *Doubtful cases.* (1) In case of doubt as to whether an individual applying for care is within the scope of the program, the medical officer in charge shall obtain from the appropriate BIA officials in the jurisdiction information that is pertinent to his/her determination of the individual's continuing relationship to the Indian population group served by the local program.

(2) If the applicant's condition is such that immediate care and treatment are necessary, services shall be provided pending identification as an Indian beneficiary.

(c) *Priorities when funds, facilities, or personnel are insufficient to provide the indicated volume of services.* Priorities for care and treatment, as among individuals who are within the scope of the program, will be determined on the basis of relative medical need and access to other arrangements for obtaining the necessary care.

### **Sec. 1603. Definitions**

For purposes of this chapter--

(a) "Secretary", unless otherwise designated, means the Secretary of Health and Human Services.

(b) "Service" means the Indian Health Service.

(c) "Indians" or "Indian", unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) of this section, except that, for the purpose of sections 1612 and 1613 of this title, such terms shall mean any individual who (1), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (3) is considered by the Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the Secretary.

(d) "Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or

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established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(e) "Tribal organization" means the elected governing body of any Indian tribe or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities.

(f) "Urban Indian" means any individual who resides in an urban center, as defined in subsection (g) of this section, and who meets one or more of the four criteria in subsection (c)(1) through (4) of this section.

(g) "Urban center" means any community which has a sufficient urban Indian population with unmet health needs to warrant assistance under subchapter IV of this chapter, as determined by the Secretary.

(h) "Urban Indian organization" means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 1653(a) of this title.

(i) "Area office" means an administrative entity including a program office, within the Indian Health Service through which services and funds are provided to the service units within a defined geographic area.

(j) "Service unit" means--

(1) an administrative entity within the Indian Health Service,

or

(2) a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination Act [25 U.S.C. 450f et seq.], through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.

(k) "Health promotion" includes--

- (1) cessation of tobacco smoking,
- (2) reduction in the misuse of alcohol and drugs,
- (3) improvement of nutrition,
- (4) improvement in physical fitness,
- (5) family planning,
- (6) control of stress, and
- (7) pregnancy and infant care (including prevention of fetal alcohol syndrome).

(l) "Disease prevention" includes--

- (1) immunizations,
- (2) control of high blood pressure,
- (3) control of sexually transmittable diseases,

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- (4) prevention and control of diabetes,
- (5) control of toxic agents,
- (6) occupational safety and health,
- (7) accident prevention,
- (8) fluoridation of water, and
- (9) control of infectious agents.

(m) "Service area" means the geographical area served by each area office.

(n) "Health profession" means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, an allied health profession, or any other health profession.

(o) "Substance abuse" includes inhalant abuse.

(p) "FAE" means fetal alcohol effect.

(q) "FAS" means fetal alcohol syndrome.

### **Sec. 1679. Eligibility of California Indians**

#### **(a) Report to Congress**

(1) In order to provide the Congress with sufficient data to determine which Indians in the State of California should be eligible for health services provided by the Service, the Secretary shall, by no later than the date that is 3 years after November 23, 1988, prepare and submit to the Congress a report which sets forth--

(A) a determination by the Secretary of the number of Indians described in subsection (b)(2) of this section, and the number of Indians described in subsection (b)(3) of this section, who are not members of an Indian tribe recognized by the Federal Government,

(B) the geographic location of such Indians,

(C) the Indian tribes of which such Indians are members,

(D) an assessment of the current health status, and health care needs, of such Indians, and

(E) an assessment of the actual availability and accessibility of alternative resources for the health care of such Indians that such Indians would have to rely on if the Service did not provide for the health care of such Indians.

(2) The report required under paragraph (1) shall be prepared by the Secretary--

(A) in consultation with the Secretary of the Interior, and

(B) with the assistance of the tribal health programs providing services to the Indians described in paragraph (2) or (3) of subsection (b) of this section who are not members of any Indian tribe recognized by the Federal Government.

#### **(b) Eligible Indians**

## ACA Questions, Scenarios and Comments

Until such time as any subsequent law may otherwise provide, the following California Indians shall be eligible for health services provided by the Service:

(1) Any member of a federally recognized Indian tribe.

(2) Any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant--

(A) is living in California,

(B) is a member of the Indian community served by a local program of the Service, and

(C) is regarded as an Indian by the community in which such descendant lives.

(3) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.

(4) Any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

(c) Scope of eligibility

Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

### **b. Options for Documenting American Indian/Alaska Native *Indian* Status**

To support an application for coverage as an *Indian*, for which an exemption from cost sharing will apply, an applicant must have documentation to confirm Tribal:

- a. Membership,
- b. Descendancy, or
- c. Affiliation.

The following table provides 3 tiers of documents, with tiers representing increasing complexity of documentation requirements. Tier I documents are likely to be the most readily available; tier III may require the assistance of Tribal organizations to locate details.

## ACA Questions, Scenarios and Comments

DOCUMENTS THAT CONFIRM INDIAN STATUS		
TIER I	TIER II	TIER III
<p>1. Tribal Membership Card with picture from a federally recognized tribe. state recognized tribe or the Bureau of Indian Affairs (BIA)</p> <p>2. Tribal Sponsorship Agreement with the Health Care Authority for participation in the Basic Health program*</p>	<p>1. Current state driver's license with individual's picture, or a state identity card with individual's picture; AND</p> <p>a. A US American Indian/Alaska Native tribal membership card or tribal enrollment letter, without picture OR</p> <p>b. A certificate of tribal membership / affiliation, OR</p> <p>c. A document issued by the Bureau of Indian Affairs, such as Certificate of Indian Blood, OR</p> <p>d. A document issued by the Indian Health Service (IHS), a Tribal health program or an Urban Indian Program, attesting to an individual's eligibility (as an AI/AN) to receive health services at the IHS or Tribal health facility. **</p> <p>2. Indian and Northern Affairs Canada (INAC) Card; AND Documentation of 50% Native blood, such as:</p> <p>a. A Certificate of Indian blood issued by the Bureau of Indian Affairs OR</p> <p>b. A document issued by a federal or state recognized tribe verifying 50% Native blood***</p>	<p>1. Current state driver's license with individual's picture, or a state identity card with individual's picture; AND</p> <p>a. Documentation showing native descent, such as a birth certificate or relative tribal ID cards; OR</p> <p>b. A document issued by the Bureau of Indian Affairs, such as Certificate of Indian Blood.</p> <p>2. Current state driver's license or state identity card for a non-native mother carrying the child of an eligible native****; AND</p> <p>a. Proof of marriage to an eligible native father who must also provide tier I,II, or III documentation that confirms his AI/AN status; OR</p> <p>b. In cases where the mother is not married to the eligible native father - proof of paternity (in writing), from the father or by order of a court, including a tribal court. The father must also provide tier I, II, or III documentation that confirms his AI/AN status (unless there is a tribal court order).</p>

\* Tribal Sponsors are expected to obtain and maintain complete documentation of eligible native status as part of their sponsorship agreement with the Health Care Authority.

\*\* In the state of Washington there are currently 2 Urban Indian Health Centers, 3 Indian Health Service Clinics, and 34 Tribal Health Programs.

\*\*\* May be Canadian citizens but remain eligible for Basic Health and zero cost sharing if 50% native blood. The right of American Indians to freely cross the Canadian Border is based on the Jay Treaty signed by the US and Great Britain in 1794. In 1952, the Immigration and Naturalization Act limited the rights of Indians born in Canada to those with at least 50% native blood.

\*\*\*\*Non-Native women pregnant with the child of an eligible Native remain eligible for zero cost sharing only during pregnancy and up to six weeks post-partum.