



Tribal Technical Advisory Group

to the Centers for Medicare and Medicaid Services



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September 30, 2004

RE: Comments on the Treatment of American Indians and Alaska Natives and Reimbursement to Tribal, Indian Health Service and Urban Indian Programs Under August 3, 2004 Proposed Rules for 42 CFR Parts 417 and 422, The Medicare Advantage Program

File Code CMS-4069-P

Dear Administrator:

The Tribal Technical Advisory Group is concerned about the impact of the proposed regulations for Medicare Part C. The proposed regulations for the Medicare Advantage (MA) program published on August 3, 2004, do not mention American Indians, Alaska Natives, tribes, tribal organizations, tribal health services or the Indian Health Service.

The preamble to the regulations provides an analysis of the effects on small entities under the Regulatory Flexibility Act (RFA). The RFA analysis states: "We welcome comments on this approach and on whether we have missed some important category of effect or impact." We would like to state emphatically that you have missed an important category of effect and impact by omitting consideration of Tribal governments and Indian health care facilities.

The National Indian Health Board (NIHB) has submitted comments on the Part C regulations and the CMS Tribal Technical Advisory Group endorses those comments.

Furthermore, we urge you to consult with Tribes to identify issues and workable solutions when new programs are being designed by the Centers for Medicare and Medicaid Services.

Sincerely yours,

Valerie Davidson, Chair

RE: Comments on the Treatment of American Indians and Alaska Natives and Reimbursement to Tribal, Indian Health Service and Urban Indian Programs Under August 3, 2004 Proposed Rules for 42 CFR Parts 417 and 422, The Medicare Advantage Program

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The National Indian Health Board is deeply concerned about the impact of August 3, 2004, proposed Medicare Modernization Act (MMA) rules regarding the **Medicare Advantage** program on American Indians and Alaska Natives (AI/AN) as well as the Indian Health Service, Tribal and urban (I/T/U) health programs that serve them. These comments and recommendations are submitted to the Centers for Medicare and Medicaid Services (CMS) with the very serious concerns of Tribes across the nation.

INTRODUCTORY STATEMENT REGARDING INDIAN HEALTH SYSTEM

These comments address the implications of the proposed rules on the Indian health care delivery system and the changes that must be made to prevent Part C implementation from destabilizing the system responsible for providing health care to the approximately 1.3 million American Indians and Alaska Natives (AI/AN) served by the IHS system. In the form proposed by CMS, the rules will put in jeopardy significant revenues the Indian health system now collects from Medicaid for "dual eligibles". Since the loss of revenue to Indian health was **not** Congress's objective in enacting the Part C benefit, the rules must be revised in several respects to protect the Indian health system from what could be substantial harm. Furthermore, to enable voluntary enrollment by AI/AN in Part C requires substantial modifications to the proposed rules.

We ask that all CMS staff charged with reviewing comments and revising the proposed regulations be supplied with a copy of this introductory statement regarding the Indian health care system. Compliance with the dictates of notice and comment rulemaking requires that all relevant information supplied by commenters must be taken into account. Full consideration of the comments we offer on individual regulations can only be accomplished by a thorough understanding of the unique nature of the Indian health care system, and the responsibility of our steward, the Secretary of Health and Human Services, to assure that inauguration of Medicare Part C does not result in inadvertent and unintended harm to that system.

The regulations governing the Part C must be revised to achieve the following goals:

- Encourage MA enrollment by AI/AN by removing financial barriers and allowing AI/AN to voluntarily participate in Medicare Advantage plans, without financial penalty because of location of residence, selection of a plan that includes I/T/U, or use of I/T/U.
- Ensure that I/T/U, under all conditions, are held harmless financially and are fully reimbursed for covered services provided to AI/AN who enroll in a Medicare Advantage plan.
- Allow I/T/U the flexibility to sponsor AI/AN in Medicare Advantage plans, under a special group payer arrangement.
- Allow, in the future, the development of an AI/AN special Medicare Advantage plan that includes the active participation of Tribes in its design and implementation.
- Explicitly exempt AI/AN dual eligibles from mandatory participation in a State Title XIX MA or MA-PD Plan.

In order to fully comprehend the potential adverse impact Part C implementation will have on the Indian health care system -- particularly with regard to the dual eligibles it serves -- one must have an understanding of the way health care services are delivered to AI/ANs and the current state of Indian health. These considerations must be kept in mind as CMS reviews these comments in order to promulgate regulations that assure the inauguration of the Part C or Medicare Advantage (MA) program does not have negative consequences on the Indian health system by reducing the level of reimbursements from Medicaid or Medicare on which the system has come to rely.

Overview. The Indian health care system does not operate simply as an extension of the mainstream health system in the United States. To the contrary, the Federal government has built a system that is designed specifically to serve American Indian and Alaska Native people in the context in which they live -- remote, sparsely-populated and, in many cases, poverty-stricken areas where the Indian health system is the only source of health care. Integral to that system are considerations of tribal cultures and traditions, and the need for culturally competent and sensitive care.

U.S. Trust Responsibility for Indian Health. The United States has a trust responsibility to provide health care to AI/ANs pursuant to federal laws and treaties with Indian Tribes.¹ Pursuant to statutory directive,² this responsibility is carried out by the Secretary of Health and Human Services, primarily through the Indian Health Service (IHS) with annual appropriations supplied by Congress. The IHS-funded health system follows the public health model in that it addresses the need for both medical care and preventive care. In order to perform this broad mission, the IHS funds a wide variety of efforts including: direct medical care (through hospitals, clinics, and Alaska Native Village health stations); pharmacy operations; an extensive (but underfunded) Contract Health Services program through which specialty care IHS cannot supply directly is purchased from public and private providers; health education and disease prevention programs; dental, mental health, community health and substance abuse prevention and treatment; operation and maintenance of hospital and clinic facilities in more than 30 states; and construction and maintenance of sanitation facilities in Indian communities.

Health Disparities. AI/ANs have a higher rate of disease and illness than the general population and consequently require more medications and incur higher prescription drug costs than most Americans. A recent in-depth study of Indian health status performed by the staff of the U.S. Commission on Civil Rights³ reveals a number of alarming statistics such as:

- AI/ANs have the highest prevalence of Type II diabetes *in the world*, are 2.6 times more likely to be diagnosed with the disease than non-Hispanic whites, and are 420% more likely to die from the disease.
- The cardiovascular disease rate among AI/ANs is two times greater than the general population.
- AI/ANs are 770% more likely to die from alcoholism.
- Tuberculosis deaths are 650% higher among AI/ANs than the general population.
- AI/AN life expectancy is 71 years, five years less than the general U.S. population.
- The ratio of cancer deaths to new cancer cases is higher for Native Americans than the ratios for all other races, even though incidence rates are lower.
- The Indian suicide rate is 190 percent of the rate of the general population.

Composition of the Indian Health Care System. Operationally, health services to AI/ANs are delivered through the following entities:

- The Indian Health Service directly operates hospitals and clinics throughout Indian Country that are staffed by federal employees.
- Indian Tribes and tribal organizations may elect to assume management and control over IHS programs at the local tribal level through authority of the Indian Self-Determination and Education Assistance Act. At present, over one-half of the IHS budget is distributed to ISDEAA tribal programs.
- In 34 cities, urban Indian organizations operate limited health programs (largely referral services) for Indian people living in urban areas through grants authorized by the Indian Health Care Improvement Act.

Funding Sources. Indian health programs are supported primarily from annual federal appropriations to the Indian Health Service. Regardless of the operational form, all Indian health programs are severely underfunded. In a 2003 report⁴, the U.S. Commission on Civil Rights found that the per-capita amount spent by the Indian Health Service for medical care was nearly 50% lower than spending for federal prisoner medical care and only slightly more than one-third of the average spending for the U.S. population as a whole. The Veterans Administration spends nearly three times as much for its medical programs as the Indian Health Service.

¹ See, e.g., 25 U.S.C. § 1601.

² 42 U.S.C. § 2001.

³ U.S. Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System*, July 2, 2004 (staff draft).

⁴ U.S. Commission on Civil Rights, *A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country*, July 2003.

In an effort to improve the level of funding for Indian health programs, Congress, in 1976, made IHS/tribal hospitals eligible for Medicare Part A reimbursements, and enabled hospitals and clinics to collect Medicaid reimbursements, either as IHS facilities or as FQHCs. It was not until the 2000 BIPA that IHS facilities were authorized to collect for some Medicare Part B services. With enactment of the MMA, Congress authorized these facilities to collect for remaining Part B services for a five-year period.

Pursuant to Federal law, the cost of Medicaid-covered services, including pharmacy services, provided by I/T/Us to Indians enrolled in Medicaid are reimbursed to the States at 100% FMAP. Thus, the Federal government bears the full responsibility for these costs. If coverage for dual eligibles changes from Medicaid to Medicare, the Federal government must assure that the reimbursement of services for Indian dual eligibles continues without interruption and without reduction to I/T/U.

Indian health programs have become critically reliant on the third-party revenues, especially those supplied by Medicare and Medicaid. According to the IHS, Medicare, Medicaid and other third party collections can represent up to 50% of operating budgets at some facilities.

Scope of Services. The compliment of health services provided at a single site or by a Tribe varies from a single health station, common in Alaska, to comprehensive in and outpatient hospital services. Other health services provided directly by or through Indian health programs can include medical, dental, mental health, chemical dependency treatment, ambulance, pharmacy, home health, hospice, dialysis, public health and traditional healing.

The diversity of services provided through Indian health programs, and the generally limited size of the population they serve makes comprehensive contracting with private plans an expensive and challenging task.

Pharmacy Services for Dual Eligibles and Impact of Part D

Because most Indian health facilities are located in remote areas far distant from the mainstream health system, they must also operate pharmacies so their patients can access needed medications. IHS, Tribes, and urban Indian organizations operate 235 pharmacies throughout Indian Country. IHS and Tribes dispense pharmaceuticals to their Indian beneficiaries without charge, as is the case for all health services they offer.

A sizeable portion of the patient base for I/T/U pharmacies consists of dual eligibles. IHS estimates that there are between 25,963⁵ and 30,544⁶ individuals in the IHS patient database who are receiving both Medicare and Medicaid. Since this database does not include information from some tribally-operated facilities (those who do not use the IHS computerized data system) nor information about Indians served by urban Indian clinics, the number of dual eligibles system-wide is even greater than the IHS database reveals.

While there is no comprehensive data on the per-capita drug costs for dual eligibles in the Indian health system, we have been able to make some rough estimates by examining average state per-capita spending for this population. In 2002, the average per-capita spending for dual eligibles was \$918.⁷ We believe this is a very conservative figure for Indian Country, in view of the higher rates of illness that have expensive drugs associated with their treatment, including diabetes and mental illness. Furthermore, the IHS calculates that the cost of pharmaceuticals has increased by 17.6 percent per year between FY 2000 and FY 2003. This includes the cost of new drugs, increases in drug costs and population growth. Thus, if we trend the average out to the year 2006, the expected average per capita spending on drugs for dual eligibles would be \$1,756.

Using these population and per-capita spending data, we estimate that the Medicaid recovery for dual eligible drug costs in the Indian health system ranges between **\$23.8 million⁸ and \$53.6 million.⁹** It is vital that these revenues, so critical to the Indian health system, not be interrupted or reduced when dual eligibles are removed from the Medicaid for pharmacy services and placed into either an MA-PD or a Part D plan.

⁵ This number represents 85 percent of the three-year total of active users.

⁶ This is the number of active users, defined as at least one visit in the past three years.

⁷ From Table 2, "Full" Dual Eligible Enrollment and Prescription Drug Spending, by State, 2002, in "The 'Clawback:' State Financing of Medicare Drug Coverage" by Andy Schneider, published by the Kaiser Commission on Medicaid and the Uninsured, June 2004.

⁸ This low number was calculated using the 25,963 figure for dual eligibles in 2003 and the \$918 per capita spending in 2002. It is probably unrealistically low for 2006 given the increase in aging population in Indian Country and the increase in drug prices.

⁹ This higher number uses the 30,544 number of dual eligibles in 2003 and the \$1,756 estimated spending in 2006.

Part A and B Services for Dual Eligibles and the potential Impact of Medicare Advantage

As with Part D, the most serious concerns and most immediate reduction in Indian health program revenues are related to AI/AN who are dually eligible for Medicaid and Medicare. If States are allowed to mandate enrollment of these individuals in special MA or MA-PD plans, the result will be disastrous for affected Tribes. Although a financial analysis has not been conducted, potential revenue loss to I/T/U on a per patient basis would far exceed losses estimated for Part D alone.

The Secretary of Health and Human Services, as the principal steward of Indian health, has a responsibility to assure that the MMA, which was intended to benefit *all* Medicare beneficiaries, does not produce the opposite result for *Indian* Medicare beneficiaries who use the Indian health care system. He can guard against such an outcome by exercising the broad authority granted to the Secretary to assure access to Part C for AI/AN. We believe that Congress recognized that access for Indian beneficiaries means the ability to utilize Part C benefits through I/T/U and that AI/AN should be able to enjoy voluntary participation in Medicare Advantage plans on an equal basis with all other Medicare beneficiaries.

BACKGROUND FOR PART C ISSUES

There is a fundamental mismatch between the Indian health care system and the proposed rules to implement the MMA. The result of this flaw in the proposed regulations could result in a critical loss of revenue for the Indian health programs across the nation and will further contribute to an even greater disparity in health care between the AI/AN and the general population than already exists. In fact, the proposed rules for Part C make no mention of AI/AN or I/T/U at all. As written, it is unlikely that many AI/AN who receive health care through an I/T/U will be able to benefit from these important Medicare changes. If they do choose to participate in a Part C plan, it is unlikely that Indian health facilities will be able to obtain compensation for the services provided to those Medicare beneficiaries. Furthermore, to the extent that States require dual eligibles to enroll in Title XIX Medicare Advantage (MA) plans, I/T/U will experience significant reductions in revenue associated with these patients.

As sovereign nations and recognized governments, Tribes insist that HHS and CMS acknowledge the impact and financial burden MMA regulations have on Tribal governments and Indian people.

Appropriately including AI/AN and I/T/U in MMA proposed regulations for Medicare Advantage first requires the recognition of key elements of this fragile health system.

- AI/AN are a unique political group guaranteed health care through treaties.
- The federal government has failed to meet this obligation and currently funds Indian health programs at only about 50% of need.
- The Department of Health and Human Services has and continues to develop Tribal consultation policies which have not been used in the process of drafting or assessing the impact of the proposed MMA rules.
- AI/AN, especially those living on or near reservations, suffer from the highest levels of poverty and disease burden in the United States.
- I/T/U, as culturally appropriate providers, have achieved great success in promoting preventive services and improving the health of AI/AN but still face daunting challenges.
- The IHS and Tribally-operated facilities do not charge AI/AN individuals for the health services provided to them, but they do rely upon third party payments, including Medicare and Medicaid.
- Unlike other populations, AI/AN are often reluctant to enroll in Medicaid and Medicare because they understand health care to be a right, thus premiums, and other cost sharing significantly discourages their participation and acts as an insurmountable barrier to program enrollment.
- Unlike other health care providers, I/T/U cannot charge AI/AN patients and therefore beneficiary “cost sharing” merely results in significant and inappropriate reimbursement reductions.
- Many I/T/U facilities provide services in remote areas where the size of the population is insufficient to support a private health care delivery system and where the market forces key to the implementation of this legislation do not exist.
- Private health and prescription drug plans often do not want to contract with I/T/U for many reasons including the health status and small size of the AI/AN population, the special contracting requirements, and the high

administrative costs associated with developing and maintaining new contractual relationships with numerous small clinics.

- Resources spent by I/T/U to implement MMA by providing staff time for training, outreach, education, enrollment assistance, contract negotiation, and redesigning IT and administrative systems to accommodate new contracts with Medicare Advantage plans, further reduce funding for the health care of AI/AN.
- The number of AI/AN in the United States who are enrolled in Medicare and who use I/T/U is estimated to be 103,000. Approximately half of this group are thought to be dually eligible for Medicaid. Even if 20% of the remaining AI/AN Medicare population enrolls in a MA or MA-PD plan, the number of Indian enrollees in any MA plan will likely be very small and will have minimal impact on plans. However, because of the small and widely dispersed population, the per enrollee cost to plans (and I/T/U) to develop, negotiate, execute and implement contracts will be high.
- Although the impact of AI/AN enrollment in MA and MA-PD plans may seem insignificant to plans and CMS, the relative impact on individual Tribes could represent significant losses.

We hope CMS agrees that these regulations should minimize unintended consequences of MMA on I/T/U as well as promoting access to new Medicare options for AI/AN. There are two basic approaches to address Indian issues: 1) simple blanket policies requiring MA and MA-PD plans to pay I/T/U for covered services and limited exemptions for AI/AN; or, 2) numerous, extremely complex policies and exceptions to the proposed rules. **We challenge CMS to closely consider the issues presented here and assist in crafting language for the final rules that will “first do no harm” to Indian health programs and, second, step forward to actually improve access to Medicare for AI/AN and reimbursement for services provided to them by I/T/U.**

Options for AI/AN MMA Policy

Five policy decisions to alleviate well-documented problems I/T/U have experienced contracting with private plans would address a majority of concerns raised by the proposed rules:

1. Encourage MA enrollment by AI/AN by removing financial barriers and allowing AI/AN to voluntarily participate in Medicare Advantage plans, without financial penalty because of location of residence, selection of a plan that includes I/T/U, or use of I/T/U.
 - Waive AI/AN cost sharing for all plans.
 - If AI/AN dual eligibles are required to enroll in an MA or MA-PD plan, establish the default enrollment for AI/AN to an MA or MA-PD plan for which the network includes local I/T/U facilities, or pays fully for out of network services.
 - Allow unlimited plan switching to facilitate enrollment in plans with culturally sensitive I/T/U providers. Exempt AI/AN from “lock-in” or “lock-outs”.
 - Exempt AI/AN from cost differentials associated with selection of a plan that includes culturally appropriate I/T/U provider or more robust networks
2. Ensure that I/T/U, under all conditions, are held harmless financially and are fully reimbursed for covered services provided to AI/AN who enroll in a Medicare Advantage plan. We see three basic options to implement this policy:
 - a. Require all MA (and MA-PD) plans to recognize I/T/U as in-network providers and reimburse at IHS Medicaid rates (as paid under the original or traditional Medicare), even without contracts. We believe this would be the desired option of plans and CMS because the minimal administrative burden and simplicity of regulations would reduce the cost of implementation.¹⁰
 - b. Require MA (and MA-PD) plans to recognize I/T/U as in-network providers, even without contracts, and reimburse at Plan’s standard Medicare rates. CMS provides “wrap-around” reimbursement to hold I/T/U harmless for difference between plan reimbursement and IHS Medicaid rate.

¹⁰ Washington State Administrative Code provides a precedent and contains sample language for this provision. **WAC 284-43-200 Network adequacy.** (7) To provide adequate choice to covered persons who are American Indians, each health carrier shall maintain arrangements that ensure that American Indians who are covered persons have access to Indian health care services and facilities that are part of the Indian health system. Carriers shall ensure that such covered persons may obtain covered services from the Indian health system at no greater cost to the covered person than if the service were obtained from network providers and facilities. Carriers are not responsible for credentialing providers and facilities that are part of the Indian health system. Nothing in this subsection prohibits a carrier from limiting coverage to those health services that meet carrier standards for medical necessity, care management, and claims administration or from limiting payment to that amount payable if the health service were obtained from a network provider or facility.

- c. Require all MA (and MA-PD) plans to contract with all willing I/T/U under similar special contract provisions terms as those used for the special endorsed Prescription Drug Discount Card contracts and using IHS Medicare rates. Also exempt I/T/U from plan credentialing, risk sharing, and other contracting requirements that are conducted or prohibited by federal or tribal statute, rule or policy. These contract provisions are outlined under 422.112 and are similar to those recommended for Part D.
3. Allow I/T/U the flexibility to sponsor AI/AN in Medicare Advantage plans, under a special group payer arrangement.
 - Permit sponsorship of AI/AN with flexibility and adequate timelines to add and drop individuals
 - Require plans and CMS to send sponsors information normally sent to enrollees so sponsors can respond quickly
 - Add special plan disenrollment rule for sponsored AI/AN and require communication and problem resolution process between plan and sponsor prior to plan disenrollment of AI/AN
 4. Allow, in the future, the development of an AI/AN special Medicare Advantage plan that includes the active participation of Tribes in its design and implementation.
 5. Explicitly exempt AI/AN dual eligibles from mandatory participation in a State Title XIX MA or MA-PD Plan.
 - MMA should not reduce the funding currently going to support Indian health programs; however, the effect of mandatory AI/AN dual eligible enrollment would result in significant losses for effected I/T/U
 - Sec. 1932 [42 U.S.C. 1396u-2] exempts AI/AN from mandatory Medicaid managed care plan enrollment, in recognition of the many difficulties facing I/T/U in interfacing with private plans. For these same reasons, we believe AI/AN dual eligibles should not be required to enroll in MA or MA-PD plans.
 - Allow same options, or exemptions, for AI/AN as currently exists under state Medicaid plans.

Additional AI/AN policy issues that require changes in the proposed rules:

- Remedy potential reimbursement and Contract Health Services funding problems for I/T/U created by MSA without restricting as an option for AI/AN.
- Require consistency with Part D rules relative to AI/AN policy.

Recommended Revisions to August 3, 2004 Proposed Rules

Proposing specific section-by-section language changes to the proposed rules to accomplish the AI/AN policy objectives stated above would require time and resources beyond our current means. **We challenge CMS to come forward with comprehensive changes to the proposed rules that will appropriately allow access to MA for AI/AN and I/T/U as special populations and providers.** Listed here is a limited set of suggested revisions.

Subpart A – General Provisions

To enable an AI/AN specific MA or MA-PD plan in the future:

422.2 Definitions

Basic benefits add, “including covered services received through an Indian health service program.”

Special needs individuals add “American Indians and Alaska Natives (AI/AN) are exempt from mandatory enrollment in Title XIX plans but would qualify for optional enrollment in an AI/AN specialized MA plan.”

In establishing contracts with a national, statewide or regional MA or MAPD plans preference should be given to state licensed managed care organizations that are controlled by Indian Health Service funded Tribal and /or Urban Indian Health Programs which are funded to provide services in clients. This approach is the best means of assuring access to culturally competent and geographically proximal services to individual Indians.

To address the cost of implementation at the I/T/U level:

422.6 Cost Sharing in Enrollment Related Costs

We have commented to CMS on several occasions about the high cost to I/T/U for MMA implementation costs related to outreach, education and enrollment of AI/AN. We strongly encourage CMS to identify in this or another section the need for funding to support these activities be specifically directed to local I/T/U where the work is done and bearing the costs is most difficult. Unlike other Medicare populations, AI/AN are unlikely to enroll in MA plans without specific information from their I/T/U.

Subpart B – Eligibility, Election and Enrollment

To address potential intended loss of revenue to I/T/U:

422.52 Eligibility to elect MA plan for special needs individual

(b)(2) add, “except mandatory enrollment for AI/AN is prohibited.”

To discuss and address unique issues related to AI/AN Medicare MSA:

422.56 Enrollment in an MA MSA plan

(c) The enrollment of AI/AN in MSAs presents unique challenges. Tribes would like an opportunity to discuss this issue with CMS to ensure it is implemented in a way that will improve access to services.

To accommodate I/T/U group payer arrangements:

422.60 Election process

Require MA and MA-PD plans to accept AI/AN enrollment, even if CMS has allowed the plan to close due to capacity limits. Rationale: AI/AN could enroll in MA plans under a variety of circumstances, including a group sponsorship. Because the number of AI/AN is small and the number of culturally appropriate plans available will be very limited, CMS should require plans to enroll AI/AN at anytime.

422.62 Election coverage under an MA plan

We request that CMS add the following provisions in an appropriate place:

- AI/AN may switch MA or MA-PD plan at any time if local I/T/U is not reimbursed by plan as in-network provider at original (or traditional) Medicare rate
- AI/AN who are in a sponsorship program may, with the consent of the sponsor, switch plans at any time
- Sponsors may add AI/AN enrollees to an MA plan at anytime under the following conditions: relocation to sponsor service area; loss of alternative health insurance coverage; change in sponsorship policies.
- AI/AN sponsored in a group payer arrangement are exempted from “lock-ins” and “lock-outs”.

422.66 Coordination of enrollment and disenrollment through MA organizations

We request that CMS add the following provisions in an appropriate place:

- Establish a default enrollment process for AI/AN that uses a plan that reimburses local I/T/U at in-network rates
- Provide flexibility for switching plans under conditions AI/AN are likely to encounter
- Communicate directly with local I/T/U about patient enrollment/disenrollment

422.74 Disenrollment by the MA organizations

Add “Process for disenrolling an AI/AN under a sponsorship or group program must include direct communication with sponsor with adequate documentation of problem and steps taken to resolve as well as adequate timelines.”

422.80 *Approval of marketing materials and election forms*

This language lists as prohibited marketing activities for MA Plans to “*Engage in any discriminatory activity, including targeted marketing to Medicare beneficiaries. . .and (iii) solicit Medicare beneficiaries door-to-door.*” While the intent of this language is to prohibit aggressive enrollment practices that favor healthier individuals, the unintended consequence may be to limit the development of needed materials targeted to AI/AN. While MA Plan representative should be prohibited from soliciting business by going door-to-door, the outreach workers employed by tribal and IHS facilities should be encouraged to provide information about Medicare alternatives in the homes of AI/AN elderly. We ask that CMS clarify this issue.

Subpart C – Benefits and Beneficiary Protections

To address potential intended loss of revenue to I/T/U:

422.100 *General Requirements*

If not clearly addressed in another section, MA and MA-PD plans should be required to reimburse I/T/U at the original Medicare rate under all circumstances when the I/T/U provides a covered benefit.

To remove financial barriers for AI/AN enrollment:

422.101 (d) *Requirements relating to basic benefits special cost sharing rules*

Add (5) “Special rules for AI/AN. Covered services provided to AI/AN through I/T/U, including both direct care, contract health care and other payments, will be credited toward all AI/AN cost sharing including deductibles, copayments, coinsurance and catastrophic limits.”

To facilitate a special AI/AN MA or MA-PD plan and accommodate I/T/U group payer arrangements:

422.106 *Coordination of benefits with employer group health plans and Medicaid*

The discussion in the Federal Register states: “*Section 222(j)(2) of the MMA allows us to waive or modify requirements that hinder the design of, the offering of, or the enrollment in an MA plan offered by an employer, a labor organization. . .*” This type of waiver authority should also be used to create the flexibility to develop a national plan for AI/AN beneficiaries. We also ask CMS if this section could explicitly allow I/T/U or other entities to sponsor groups of AI/AN under a group plan. We assume this option to be exercised locally but could also envision a national AI/AN plan that would allow optional local sponsorship. We believe that few AI/AN who receive services through I/T/U will enroll in a MA plan on their own, therefore we ask CMS to develop an enabling option for I/T/U, or Tribes to enroll and pay for groups of AI/AN as sponsors.

As stressed above, we ask that dual eligible AI/AN be explicitly exempt from mandatory enrollment in MA or MA-PD plans.

To remove financial barriers for AI/AN enrollment:

422.111 *Disclosure requirements*

(e) *Changes to provider network* add “Changes to provider networks which affect AI/AN will provide cause for a AI/AN to switch to another plan at anytime without penalty.”

422.122 *Access to Services*

Access to services for AI/AN requires the inclusion of I/T/U. All MA and MA-PD plans, including private fee-for-service plans referenced under 422.114 (c), should be required to include Indian health facilities as in-network providers to achieve network adequacy (without requiring the I/T/U to serve individuals who are not IHS beneficiaries), and AI/AN beneficiaries should be exempted from higher cost sharing if they use I/T/U. There are several reasons for this recommendation including: 1) AI/AN should be able to seek care at I/T/U as culturally appropriate services; 2) AI/AN could not be charged any cost sharing by I/T/U thus differences in premium or copayments would only serve to further reduce revenue to tribal and Indian health facilities; 3) many I/T/U may be unable to contract with desirable MA or MA-PD plans for reasons already documented by CMS.

To enable I/T/U contracting with Part C plans:

Add “(a)(1)(i) *Access to IHS, tribal and urban Indian programs.* In order to meet access standards a Medicare Advantage plan or MA-PD plan must agree to contract with any I/T/U in its plan service areas.

- (i) Such contracts shall incorporate, within the text of the agreement or as an addendum, provisions:
 - A. Acknowledging the authority under which the I/T/U is providing services, the extent of available services and the limitation on charging co-pays or deductibles.
 - B. Stating that the terms of the contract may not change, reduce, expand, or alter the eligibility requirements for services at the I/T/U as determined by the MMA; Sec. 813 of the Indian Health Care Improvement Act, 25 U.S.C. §1680c; Part 136 of Title 42 of the Code of Federal Regulations; and the terms of the contract, compact or grant issued to Provider by the IHS for operation of a health program, including one or more pharmacies or dispensaries.
 - C. Referencing federal law and federal regulations applicable to Tribes and tribal organization, for example, the Indian Self-Determination and Education Assistance Act, 25 U.S.C. §450 *et seq.* and the Federal Tort Claims Act, 28 U.S.C. §2671-2680.
 - D. Recognizing that I/T/Us are non-taxable entities.
 - E. Clarifying that Tribes and tribal organizations are not required to carry private malpractice insurance in light of the Federal Tort Claims Act coverage afforded them.
 - F. Confirming that a MA plan may not impose state licensure requirements on IHS and tribal health programs that are not subject to such requirements.
 - G. Including confidentiality, dispute resolution, conflict of law, billing, and payment rate provisions.
 - H. Recognizing that an I/T/U formulary cannot be restricted to that of the MA-PD plan.
 - I. Declaring that the Agreement may not restrict access the I/T/U otherwise has to Federal Supply Schedule or 340b drugs.
 - J. Stating that the I/T/U shall not be required to impose co-payments or deductibles on its Indian beneficiaries.
 - K. Authorizing I/T/U to establish their own hours of service.
 - L. Eliminating risk sharing or other provisions that conflict with federal, IHS or tribal laws, rules or policies.”

We support the provision for payments to “*essential hospitals*” and request that I/T hospitals be explicitly identified by adding to (c)(6) All hospitals operated by Tribes or the Indian Health Service will be considered essential under this provision.”

Subpart F – Submission of Bids, Premiums, and Related Information and Plan Approval

To remove financial barriers for AI/AN enrollment and accommodate I/T/U group payer arrangements:

422.262 Beneficiary Premiums

AI/AN served by an I/T/U will most likely not elect to pay Part D premiums because these patients can access health care through the Indian Health Service (IHS) based on the Federal Government’s obligation to Federally recognized Tribes. It is our interpretation that the payment options cited to implement 422.262, Beneficiary Premiums, includes the IHS and Tribes. (Preamble, page 46651, “the IHS may wish to pay for premiums to eliminate any barriers to Part D benefits”). We specifically ask CMS to remove barriers Tribes have encountered in paying Part B premiums for AI/AN under current CMS group payer rules (size of group

and switching an individual from automatic deduction to group pay). Without these changes it is unlikely that AI/AN, who are entitled to health care without cost sharing, will enroll in MA plans.

Subpart G – Payments to Medicare Advantage Organizations

To discuss and address unique issues related to AI/AN Medicare MSA:

422.314 Special rules for beneficiaries enrolled in MA MSA plans

The enrollment of AI/AN in MSAs presents unique challenges. Tribes would like an opportunity to discuss this issue with CMS to ensure it is implemented in a way that will improve access to services.

To address potential intended loss of revenue to I/T/U:

422.316 Special rules for payments to federally qualified health centers

Add “Tribal FQHCs are not required to contract with MA or MA-PD plans as a condition for reimbursement. CMS will pay tribal FQHC at the same rate they would receive under original Medicare.”

Conclusion

We understand that some of the MMA proposed rules related to point of service options and coverage of areas without adequate networks are intended to encourage the availability of MA and MA-PD plans in rural areas. However, because I/T/U operate in a diverse range of environments, the patient populations tend to be small and the array of possible local options is unknown, proposing complex policies to shoehorn in AI/AN seems ill advised. Our assessment of the negative impact on AI/AN and their access to MA plans is based on years of experience under implementation of State Medicaid managed care waivers. While the experience of Tribes and AI/AN under these private health plans was frequently disastrous, a number of Indian policy models have emerged which can be adopted for MMA implementation. In fact, to acknowledge these problems, a July 17, 2001 “Dear State Medicaid Director” letter, was issued by CMS directing states to notify and communicate with Tribes during a waiver or renewal and inform Tribes of “the anticipated impact on Tribal members.” We encourage CMS to consult with Tribes in a similar manner, and although it has, by default, fallen on Tribes themselves to assess the impact of MMA proposed regulations, we expect CMS to seriously consider remedies for all of the issues raised in this letter.

Again we urge CMS to consider eliminating unnecessary administrative cost burdens to all involved (AI/AN, I/T/U, CMS, Tribes, Indian Health Service and MA plans) and adopt simple blanket policies for AI/AN and I/T/U that will promote access to these new benefits as well as guarantee Medicare reimbursements from the MA and MA-PD plans.