



Tribal Technical Advisory Group

to the Centers for Medicare and Medicaid Services



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April 7, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Dr. McClellan:

On behalf of the Tribal Technical Advisory Group, I write to seek your assistance with three time-sensitive Medicare Part D implementation matters of enormous importance in Indian Country.

1. Special Enrollment Period

Our Request. The TTAG and its representatives have been seeking CMS designation of a special enrollment period (SEP) for non-dual eligible American Indians and Alaska Natives (AI/AN) in order for Tribes to have a chance to enroll these beneficiaries (at the Tribe's expense) in a Part D Plan after the Initial Enrollment Period ends on May 15, 2006. For the reasons stated below, we believe our request is warranted and is consistent with agency policies set out in the CMS "Eligibility, Enrollment and Disenrollment" PDP Guidance document. Unfortunately, that Guidance does not address the unique situation of AI/AN beneficiaries served by the IHS and Tribally-operated health programs, although we believe it should. CMS staff have told us that any Tribal program not in effect by May 15 would have to wait until January 1, 2007, to commence.

Justification for the Request. *We believe CMS should want to aid AI/AN beneficiaries to access the Part D program by providing an appropriate SEP for them.* There are several reasons why such an SEP should be recognized:

1. *Unique situation of the Indian health system.* Since AI/ANs are entitled to health care at no cost from an IHS or Tribal facility, there is little or no incentive for these beneficiaries to pay a premium to enroll in a PDP. Thus, in order for these beneficiaries to access the Medicare Part D benefit, the Tribe must establish a "group payer" program through which the Tribe assists members to enroll in a PDP and pays the fees on their behalf.

Tribes, unlike employers and unions, do not have in place programs for paying premiums on behalf of their members. Tribes must establish entirely new internal mechanisms to operate a "group payer" program and need the time to do so. The action requires approval by the Tribal Council, the identification of funds to be used to cover costs of participation, development of internal policies and accounting systems, counseling beneficiaries, and negotiations with a PDP. It will be difficult, if not impossible, for most Tribes to accomplish all needed activity by May 15, the end of the Initial Enrollment Period. Without an SEP, these AI/AN beneficiaries will be effectively denied the opportunity to participate in Part D for the remaining months of 2006.

2. CMS Guidance -- SEP for loss of Credible Coverage. Sec. 20.3.5 of the "Eligibility, Enrollment and Disenrollment" Guidance provides an SEP for a beneficiary who loses credible coverage. As you know, the drug coverage provided by IHS and Tribal programs qualifies as credible coverage. Enrollment in a PDP would provide an AI/AN beneficiary with an alternate resource for drug coverage that, under IHS eligibility rules, must be used to cover drug costs. Thus, such a beneficiary would effectively lose his/her IHS credible coverage as long as he/she is enrolled in a Part D plan. This circumstance should entitle the AI/AN to an SEP, as is the case for any beneficiary who loses credible coverage after May 15.

3. CMS Guidance -- SEP for Employer Group Health Plan. The legal authority to establish an SEP for "exceptional conditions," Sec. 20.3.8 of the Guidance, expressly provides a three-month SEP for individuals who disenroll from employer or union sponsored coverage to enroll in a Part D plan.

The EGHP member's circumstances are very much like those affecting AI/ANs whose costs to enroll in a PDP are covered by a Tribe. The Indian beneficiary, like the EGHP member, would leave his/her current coverage and acquire in its place coverage from a Part D Plan. Why, then, is an SEP beyond the May 15 deadline permitted for EGHP members but denied to members of Tribes whose fees would be paid on their behalf by their Tribe?

Conclusion. For these reasons, the TTAG urges you to establish a SEP for AI/AN beneficiaries so they can enroll in a PDP through a "group payer" program established by an Indian Tribe or Tribal organization. This action is vital for fair and appropriate access to Medicare Part D by this segment of the Medicare community.

2. Facilitated Enrollment and PDP Billing AI/AN for Subsidized Premiums

Our Request. Because of the unique situation facing Tribes and their AI/AN Medicare beneficiaries, we are asking for four actions:

1. That CMS prohibits PDPs from taking any punitive actions against AI/AN beneficiaries who are autoenrolled in a PDP and for whom premiums are not paid; and that PDP guidance on this prohibition be developed by CMS and reviewed by the TTAG as soon as possible.
2. As the TTAG has requested several times, that CMS only autoenroll AI/AN beneficiaries in plans that contract with the nearest I/T/U facility.

3. That CMS provide the I/T/U access to a database or list of names of individuals who have been autoenrolled in PDPs and the names of the plans into which they have been enrolled.
4. That CMS allow Tribes and IHS more time to resolve problems caused by facilitated enrollment in a responsible way.

Justification for the Request. When CMS moved up the timeline to facilitate the enrollment of people who qualified for a Low Income Subsidy, it created unique problems for I/T/U providers. We do understand that facilitated enrollment will benefit individuals who will have no premium to pay. However, some of our AI/AN patients will now start receiving bills from Part D Plans for premiums. It is extremely difficult to get many AI/AN to enroll in state and federal programs -- elders receiving bills will just compound this problem. During the Medicare Part D trainings last year, staff of CMS, IHS and SSA encouraged Tribal staff to help elders apply for the Low Income Subsidy (Extra Help). The slogan they used was, "When in doubt, fill it out," even though IHS could not pay premiums and no Tribal group payer programs had yet been established. Most AI/AN elders were encouraged to apply without knowing whether or not they would be eligible for a full subsidy.

Elders who now receive premium bills will be, rightfully, very upset. Currently IHS beneficiaries can receive their medicines without charge, so there is no incentive or reason for AI/AN to pay the premiums themselves. Premiums and co-pays represent an added expense, not a savings for AI/AN. If the Tribe does not have a group payer program, there is no way to pay the premium. When the premium is not paid for a plan into which a person has been enrolled (without their explicit consent), we fear that PDPs will hold the Indian beneficiary responsible. We are deeply concerned that PDPs will have the option to take the individual to collections as a business decision.

Another business decision that PDPs could make is to keep the individual enrolled so that the PDP could continue to receive federal subsidies without ever being billed for drugs that the I/T/U facility provides to the enrolled person - because the I/T/U facility doesn't know that the person is enrolled. This would be a terrible mismanagement of federal funds.

CMS has told us that the only way to resolve the problem is to actively cancel or disenroll the beneficiary through the PDP they have been assigned to. Many Tribes will not even know who these beneficiaries are or what PDP they have been enrolled in. We believe it is unwise for CMS to simply allow the PDP to take whatever action it wants to collect premiums as a "business decision" and certainly unfair for the PDP to take any action against these Indian elders.

Conclusion. For these reasons, we ask CMS to intervene by prohibiting PDPs from penalizing AI/AN elders, and developing a mechanism to convey this information to PDPs. We are also asking for CMS to find a way to allow Tribes to access information regarding their patients who are receiving premium bills. In the future, these problems can be prevented by simply enrolling AI/AN in PDPs that have contracts with I/T/U pharmacies.

3. Recouping erroneous expenditures for dual eligibles during transition

Our Request. We are asking for three actions:

1. CMS should extend the deadline for submission of bills for transitional expenditures by I/T/U programs to PDPs for a period of three months after we receive specific information about how to submit the bills.
2. CMS should provide Tribes with a memo to the PDP that can be included with these bills to explain that they must reimburse Tribes for expenditures submitted through the new deadline date.
3. CMS should provide Tribes with a list of CMS and PDP contacts to whom these expenditures should be submitted.

Justification for the Request. We believe that all Tribal expenditures paid for covering drugs needed by dual eligibles during the transition period should be reimbursed by the PDPs. The simple reason for this policy is that the federal government paid twice for these drugs – IHS money was used by Tribes to ensure their patients received needed drugs during the transition and CMS money was also paid to the PDP in their capitated payment. Therefore, the PDP was overpaid at the expense of underfunded Tribal health programs.

There are two situations where this is a problem:

- The first situation relates to Tribal pharmacies, especially those that use the Indian Health Services (IHS) information system called RPMS. The software modifications which allowed Tribes to correctly identify pharmacy claims information for Medicare Part D was not distributed to Tribes until March 24, 2006. For the “patch” to work properly, patient information must be loaded into the system. The delay in the software, the onsite time to install the patch and the time it will take to bill the claims will extend past the March 31st transition deadline. Therefore, Tribes simply need more time to be able to submit these claims.
- The second situation relates to Tribes that paid retail pharmacies through the Contract Health Services program. Again, this was federal (IHS) funding that was used to pay for drugs that the PDP was already paid to provide.

We first raised this issue with CMS and IHS in an e-mail on January 23rd and again with Leslie Norwalk on the White House teleconference on February 6th. Ms. Norwalk assured us that we would be reimbursed for those expenditures. We have subsequently asked repeatedly for guidance about how to bill for those expenditures and we have not received the necessary information.

We are still facing the following problems:

- Tribes without pharmacies cannot access the E1 reports and don’t always know which PDP the beneficiary was enrolled in at the time of service.

- Tribal CHS programs are just now receiving January invoices from some retail pharmacies with the billing details. Small rural retail pharmacies have been overwhelmed since January.
- Tribes that purchase drugs through the CHS program do not have contracts with PDPs. They do not know how or where to send the bills. Sorting through these “messed up” invoices, identifying the patients and covered drugs, preparing an invoice to each PDP will take some time for the already stressed staff.
- Despite our requests, there still has been no written guidance from CMS providing names of individuals at each PDP who are familiar with the Indian health situation and prepared to process the bills. Without this information, we would be sending bills into “black holes” with no accountability and no opportunity to follow up efficiently.

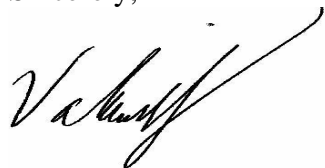
Conclusion. In order to prevent federal overpayment for prescription drugs, especially during the Medicare Part D transition period, Tribes must be able to recoup payments from PDPs. In order to do this, Tribes need the intervention of CMS to extend the deadline for submission of claims for reimbursement beyond March 31, direction from CMS on how to submit this information, and exactly which PDPs to submit the information to.

Summary

The implementation of Medicare Part D has been especially difficult for Tribes. Although it was known that I/T/Us would lose significant pharmacy revenue (now estimated at \$16,000,000 for 2006) the administrative and other costs have also been extremely high. As you can see from this letter, I/T/Us have not yet been able to “benefit” from the program as was predicted by CMS in the preamble of the final rules. We ask for your help in taking the above actions to help mitigate some of the problems we are facing right now.

Thank you.

Sincerely,



Valerie Davidson, Chair
Tribal Technical Advisory Group

Cc: TTAG members
Dorothy Dupree, CMS