

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid

National Indian Health Board | 910 Pennsylvania Avenue SE, Washington, DC 20003 | (203) 507-4070 | (203) 507-4071 (fax)

July 13, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via regulations.gov

Re: Maximum Out-of-Pocket (MOOP) Limits and Service Category Cost Sharing Standards

Dear Dr. Brooks-LaSure:

On behalf of the CMS Tribal Technical Advisory Group (TTAG), I write to provide a response to the Centers for Medicare and Medicaid Services (CMS) final rule with comment period, “Maximum Out-of-Pocket (MOOP) Limits and Service Category Cost Sharing Standards” (CMS-4190-FC4). While we appreciate the cost sharing limitations in this final rule, we would like to take this opportunity to reiterate our ask that (1) CMS require all Medicare Advantage (MA) plans to ensure American Indian and Alaska Native (AI/AN) beneficiaries have fair and equal access to the MA program and have access to Indian health care providers (IHCPs); and (2) that all MA plans reimburse Indian Health Service (IHS) and Tribal hospitals at the IHS OMB all-inclusive encounter rate.

Medicare Advantage Network Contracting

IHS, Tribal, and Urban Indian programs, although essential community providers in AI/AN communities, are very small players in a vast landscape of MA Plans that include Coordinated Care Plans, Medical Saving Account Plans, Private Fee-for-Service Plans, and other Religious and Health Care Prepayment Plans. This MA landscape has shifting financial incentives and have distinctive differences that make it difficult for Tribal beneficiaries and the Indian health system to interface with the health plans that comprise the MA program.

AI/AN beneficiaries participating in the MA program should be guaranteed the right to receive services from any IHS, Tribal, or Urban IHCP at any time and without penalty. There may be AI/ANs that want to participate in the MA program, however they may be reluctant to or do not, because their IHS provider is not included in the MA network. This affects beneficiary participation in MA and results in reimbursement issues for IHCPs. The final rule should require MA plans to reimburse IHCPs for services provided to MA enrollees whether the IHCP has a written contract with the MA plan or not. In addition, any IHCP that wants to contract with an MA plan should be allowed to do so.

CMS TTAG Letter to CMS Administrator Brooks-LaSure

Re: CMS-4190-FC4

July 13, 2022

Page 2 of 3

To implement this contracting requirement, the final rule should adopt the contracting requirements for IHCPs in Part D. IHCPs encourage enrollment in Part D by sponsoring premiums for their members to participate in Part D, while also providing Part D services. The Part D program allows the payment/reimbursement of AI/AN premiums, copayments, or deductibles to count toward out-of-pocket expenses. The Part D program requires Part D plans to offer contracts to IHCPs using a Tribal Contracting Addendum. The MA plans should be required to do the same.

MA Reimbursement: Indian Health Care Providers

IHS and Tribal health programs are exempt from certain CMS payment policies¹ and are instead reimbursed using the IHS Office of Management and Budget (OMB) encounter rate. However, MA plans do not currently reimburse IHCPs at the IHS-OMB encounter rates. Moreover, many MA plans often refuse to reimburse any IHCPs entirely. To address this issue, we ask that CMS clarify and require in the final rule that all MA plans must reimburse IHCPs at the IHS-OMB encounter rates.

The TTAG has provided a white paper to CMS outlining the rationale for reimbursing IHCPs at the IHS OMB rates. We attach that white paper and incorporate it by reference in these comments. To summarize, Section 206 of the Indian Health Care Improvement Act (IHCIA) provides that the United States, an Indian Tribe, or Tribal health organization has the right to recover from an insurance company, health maintenance organization, employee benefit plan, or any third party the reasonable charges billed by the Secretary, an Indian Tribe, or Tribal Organization in providing health services to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification. This right of recovery extends MA plans, regardless of whether the IHCP is in-network or not.² As a cost-based rate, the IHS-OMB rate at the very least should be considered "reasonable costs" for the purposes of Section 206.

The MA regulations at 42 C.F.R. § 422.205(b)(2) may also provide MA contractors to use different reimbursement rates for different specialties or for different practitioners (in this case IHS, Tribal, and Urban Indian health providers) in the same specialty. Allowing MA plans to reimburse the IHS OMB encounter rate to IHCPs will help facilitate the development of contracts with MA plans and support equitable access of AI/AN beneficiaries, who often have high health needs, in the MA program. This request has been brought to CMS through the TTAG for a couple years now, and CMS has recently confirmed that it is working on reconciling this request with IHCIA and other provisions governing MA plans. We appreciate the agency's engagement with the TTAG and its commitment to finding a solution to this concern.

The aim here is to appropriately reimburse the Indian healthcare system for its delivery of care to our people. The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) recently reported that a central concern about the capitated payment model used by

¹CMS has excluded IHS hospitals from the outpatient perspective payment system in recognition of the "challenge of health care delivery to a population that is in critical need and believes that upholding the current exemption will facilitate access to essential patient care services for AI/AN population." 42 C.F.R. § 419(b)(4).

² 25 U.S.C. § 1621e(a).

CMS TTAG Letter to CMS Administrator Brooks-LaSure

Re: CMS-4190-FC4

July 13, 2022

Page 3 of 3

MA plans is the potential incentive for these plans to deny payments to providers in an attempt to increase profits.³ As MA enrollment continues to grow, MA plans play an increasingly critical role in ensuring that our Medicare enrollees have access to medically necessary care and that our providers are reimbursed appropriately.⁴ Therefore, we must get ahead of these concerns and establish this IHS-OMB all-inclusive rate in order to guarantee that our AI/AN communities receive care without concern that access may be limited due to MA profit concerns.

Again, we thank CMS for its engagement with the TTAG on this issue. We appreciate your consideration of the above comments and recommendations and look forward to engaging with the agency further.

Sincerely,

A handwritten signature in black ink that reads "W. Ron Allen". The signature is written in a cursive, flowing style.

W. Ron Allen, CMS/TTAG Chair
Jamestown S'Klallam Tribe, Chairman/CEO

³ “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care,” OIG Report in Brief. OEI-09-18-00260, April 2022.

⁴ *Id.*