Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board | 910 Pennsylvania Avenue, SE | Washington, DC 20003 | (202) 507-4070 | (202) 507-4071 fax

February 13, 2023

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: Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications

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) proposed rule, "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications" (CMS -4201--P).

Aggressive and misleading marketing by MA plans has been a longstanding concern in Indian Country. While we appreciate the agency recognizing the concerns voiced in the TTAG response to the request for information (RFI) on the topic in August 2022, the TTAG also submitted comments that voiced its concern over these practices in response to CMS-4192-P. We urge CMS to ensure that there are enforcement mechanisms in place to hold Medicare Advantage (MA) plans and their third-party marketing organizations (TPMOs) accountable for inappropriate behavior that has continued to mislead our Elders to enroll in an MA plan that does not meet their needs.[1]

Included below, you will also find additional comments submitted by the TTAG in response to the RFI.[2] The TTAG continues to work toward a Medicare program that

[1] *See* additional attachment(s) for examples of aggressive, deceptive marketing practices that beneficiaries in Indian Country endure at the hands of these MA plans.
[2] *See* additional attachment(s) for full TTAG comment on the CMS RFI (CMS-4203-NC) and for additional comments the TTAG has submitted on Medicare Advantage.

works with the Tribal health care delivery system and improves the health of American Indian and Alaska Native (AI/AN) people across this nation.

Recommendations:

I. CMS must have an enforcement plan in place that will hold MA plans accountable for overstepping with aggressive marketing tactics

While this proposed rule addresses the concerns the TTAG has expressed with the marketing tactics of TPMOs in Indian Country, it does not go far enough. It appears that these changes lack an enforcement scheme that will hold these entities accountable for their actions.

An enforcement mechanism is necessary to hold TPMOs accountable for inappropriate or uninformed marketing tactics. Education and outreach can only do so much. It is also valuable that CMS have effective enforcement mechanisms in place to hold TPMOs accountable for inappropriate marketing tactics, and any measures that mislead beneficiaries to change their coverage. The enforcement mechanisms should be developed with Tribal consultation to account for the special circumstances in Indian Country and the detrimental impact that an inappropriate switch to an MA plan could have on the care that AI/AN beneficiaries receive, further exacerbating the health disparities that exist.

II. Require MA plans to reimburse IHCPs for services provided to MA enrollees regardless of whether the IHCP has a written contract with the MA plan

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 (including no prior authorization). 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. 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 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 contacts to IHCPs using a Tribal Contracting Addendum. The MA plans should be required to do the same.

III. Require MA plans to reimburse IHS and Tribal hospitals at the IHS OMB encounter rate

The TTAG has reiterated our ask that all MA plans reimburse Indian Health Service (IHS) and Tribal hospitals at the IHS OMB encounter rate. This 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. The MA regulations at 42 C.F.R. § 422.205(b)(2) may 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. 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.

IV. Ensure there are experts on hand to field Indian-specific questions and concerns from AI/AN beneficiaries

The TTAG recommends that CMS ensure that there are designated contacts available to respond to specific AI/AN concerns It has been reported that AI/AN beneficiaries often have a difficult time contacting Medicare with their questions and concerns. Beneficiaries have reported long call wait times, connectivity issues in rural areas that exacerbate the impact of remaining on call waiting, and concern over the lack of alternatives for reporting such concerns (e.g., an online portal reporting option).

In addition, the unique nature of the Indian healthcare system requires a special knowledge in those assisting callers with their coverage concerns. The TTAG suggests this could be addressed by creating a special contact number for AI/AN beneficiaries to utilize in order to contact Medicare with concerns over their MA plan or other coverage. This could be created by a special number, or, in the alternative, a redirect prompt at the beginning of a call to 1-800-MEDICARE that could redirect a caller to someone with the requisite knowledge of the intersection of IHS or Tribal health care delivery systems and the Medicare program and its Part C counterpart.

Conclusion

The TTAG looks forward to the continued partnership with CMS in developing policies and programs that work for and with the Tribal healthcare system, in accordance with the nation’s trust responsibility to provide for the health of Tribal nations.

We appreciate the acknowledgment that the marketing of these plans needs attention, and we look forward to working with CMS to develop an enforcement framework that holds these MA plans and TPMOs accountable. The Medicare program is vital to the

health of our Elders. We appreciate your consideration of the above comments and recommendations and look forward to engaging with the agency further.
Sincerely,

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