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

June 1, 2023

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

Re: Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

Dear Administrator Brooks-LaSure:

On behalf of the Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG), I write to you in response to the final rule, "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly" (CMS-4201-F). We encourage the agency to take a strong look at its policies and to be proactive in considering the impact on Tribal nations. As you know, the Indian healthcare system is unique, and therefore, to ensure that policies work for – and with – our system, there must be a unique approach to protect and promote the health and well-being of American Indian and Alaska Native (AI/AN) beneficiaries.

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 on the topic in August 2022, and the TTAG comments submitted on the proposed rule, the TTAG remains concerned that CMS has not taken the appropriate, necessary steps to ensure that the program works for AI/AN beneficiaries. While CMS acknowledges in this final rule the aggressive and inappropriate tactics taken by Medicare Advantage (MA) plans and third-party marketing organizations (TPMOs), we urge CMS to ensure that there are enforcement mechanisms in place to hold them accountable, and to consider the rest of our comments on the proposed rule that went unanswered. Those recommendations are included in the comments below.

The TTAG continues to work toward a Medicare program that works with the Tribal health care delivery system and improves the health of our people. In looking forward to the Contract Year 2025 process, we urge the agency to engage early and often with the TTAG to ensure Tribal priorities are considered so that needs can be met by CMS rulemaking.

Recommendations:

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

While this final rule addresses some of the concerns the TTAG and other commenters expressed around the marketing tactics of TPMOs, this rulemaking did not go far enough to address the specific and unique challenges and the inappropriate nature of the tactics deployed in Indian Country. We believe that any changes included in this final rule lack an effective enforcement mechanism that will hold these entities accountable for their actions and in turn change their behavior.

An enforcement scheme is necessary to hold TPMOs accountable. Education and outreach can only do so much. The mechanism 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). We expect there will be AI/ANs who will 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.

We urge CMS to 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, rulemaking 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 contracts 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 permit 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 the Indian Health Care Improvement Act (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 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 redirects 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

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. 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.

Sincerely,

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