Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board | 50 F Street NW | Washington, DC 20001 | (202) 507-4070 | (202) 507-4071 fax

May 28, 2026

Chris Klomp
Deputy Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: The Need for a Medicare Part C Indian Health Addendum

Deputy Administrator Klomp:

On behalf of the Centers for Medicare and Medicaid (CMS) Tribal Technical Advisory Group (TTAG), I write to follow up on our discussion during the last TTAG meeting about the need for an Indian Health Addendum for Medicare Part C provider agreements. As discussed below, CMS already has an Indian Addendum for Part D plans, which paved the way for Indian health care providers to participate in Part D plan networks. The lack of an Indian Addendum for Part C plans makes it difficult for Indian health care providers to participate in the Part C program. As a result, we request that CMS adopt an Indian Addendum for Part C plans modeled on the Part D Indian Addendum. As requested, I am sharing with you a draft Medicare Part C Indian Health Addendum for your review and consideration.

Background and Justification for the Request

In 2005, CMS issued Part D regulations that adopted a long-standing Tribal recommendation that Part D Sponsors be required to contract with Indian Health Service, Tribal, and Urban Indian facilities (I/T/Us) in their service area using a model addendum developed by CMS in consultation with Tribal stakeholders.[1] In the preamble to the Final Rule, CMS stated:

> We agree with the commenters who believe that—in the absence of a contracting requirement—Part D plans may make assumptions regarding the administrative costs (whether real or perceived) of contracting with I/T/U pharmacies and may not actively solicit the inclusion of these pharmacies in their networks. The lack of I/T/U pharmacies in Part D plan networks would render enrollment in Part D of little use to AI/AN beneficiaries who rely primarily on I/T/U facilities for their health care. For this reason, we have added a provision to our final regulations, at § 423.120(a)(6), requiring that Part D plans offer contracts to all I/T/U pharmacies in their service areas. However, we recognize that contracting with I/T/U pharmacies is potentially more complex than contracting with retail pharmacies given that there are a number of provisions in the standard contracts of commercial health plans that would likely need to be modified or deleted

[1] 42 C.F.R. § 423.120(a)(6)

> given statutory or regulatory restrictions to which I/T/U pharmacies are subject, as well as the particular circumstances of I/T/U pharmacies… Thus, standard contracting terms and conditions will not be sufficient for Part D plans to obtain the participation of I/T/U pharmacies in their networks. We are therefore requiring Part D plans to include a special addendum to their standard contracting terms and conditions in order to account for these differences.[2]

The resulting Part D Indian Health Addendum has been used for more than twenty years, strengthened legal compliance, improved network continuity, and ensured equitable access to culturally appropriate care for AI/AN Medicare beneficiaries.

CMS should adopt a similar regulatory requirement and model addendum for Part C. Indian healthcare providers face contracting barriers with Part C Medicare Advantage Organizations (MAOs) that closely mirror the challenges that originally led CMS to require Part D Sponsors to contract with Indian health care providers using the model Indian Health Addendum. MAOs frequently decline to contract with Indian healthcare providers in their service areas, thereby restricting access to care for many American Indian/Alaska Native Medicare beneficiaries who live in geographically remote areas where Indian healthcare providers are often the sole providers. AI/AN beneficiaries accessing care through Urban Indian Organizations in urban areas face the same risk of losing access to their Indian health care provider when MAOs decline to contract.

Even if MAOs contract with Indian healthcare providers, the standard contracts used do not incorporate the unique federal protections and statutory limitations applicable to Indian healthcare providers. This forces Indian healthcare providers to either agree to boilerplate agreements that are inconsistent with their federal rights and obligations or decline to enter those, thereby limiting their ability to bill Part C plans for services they provide to enrollees. Many decline to enter into agreements with Part C plans as a result.

When the Part D program presented nearly identical challenges for Indian healthcare providers more than twenty years ago, CMS implemented a regulatory solution that has since proven effective and durable. Given that the same types of contracting barriers for Indian healthcare providers occur within the Medicare Advantage program, CMS should adopt a comparable regulatory fix for Part C.

Sincerely,

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

Cc: Rachel Ryan Pederse, Acting Director, CMS Division of Tribal Affairs

Enclosure: Draft Indian Health Addendum to Medicare Part C Plan Agreement

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[2] 70 Fed. Reg. 4194, 4252–53 (Jan. 28, 2005).