



Tribal Technical Advisory Group

to the Centers for Medicare and Medicaid Services

National Indian Health Board 101 Constitution Ave NW, #8B02 Washington, DC 20001 (202) 742-4262 (202) 742-4285 fax www.nihb.org



April 10, 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:

We are writing to you about the Centers for Medicare & Medicaid Services (CMS) decision to waive the Medicare Part B premium surcharge for members of tribes that were served under Interagency Agreements between CMS and Indian Health Service (IHS) from the time period July 1999 to 2002. While we support this decision, we believe it did not go far enough. The decision to waive the late enrollment fees will only apply to 62 tribes nationwide. The basis of CMS' decision is that IHS served as an agent of the federal government when providing advice to potential Medicare beneficiaries only during the time period of the interagency agreements.

The Tribal Technical Advisory Group (TTAG) has organized a subcommittee to address the issues associated with granting equitable relief and to assist in the development of operational guidelines to implement the waiver of late enrollment under Section 1837(h) of the Social Security Act (the Act). The Equitable Relief subcommittee has met to discuss the late enrollment issues and concluded that equitable relief should be extended more widely for American Indian and Alaska Native (AI/AN) Medicare beneficiaries and not be limited to only those tribal members covered in the CMS/IHS Interagency Agreements. The subcommittee's position is based on the same reason upon which CMS concluded that equitable relief be granted in the first place, that IHS functioned as an agent of the federal government when advising potential beneficiaries to enroll in the Part B program. It should not matter whether there were Interagency Agreements or not; in most instances the IHS was the only federal agency available for AI/AN beneficiaries when making enrollment decisions about Part B.

Under section 404 of the Indian Health Care Improvement Act (IHCIA), the Secretary, acting through the IHS was required to make grants to tribes and tribal organizations to assist individual Indians to enroll in both Medicare Part A and B. Under this same authority, the IHS fulfilled the Secretarial responsibility by providing advice and guidance to AI/ANs throughout the entire Indian health system for a significantly greater time than the term of the Interagency Agreements. This responsibility was not created or limited by the Interagency Agreements

between IHS and CMS. Since IHS was acting for the Secretary, its advice and direction should be attributable to all the agencies of the Department. This Secretarial responsibility was not created or limited by the Interagency Agreements between IHS and CMS.

When fulfilling the obligations under section 404, as while acting under the Interagency Agreement, IHS took into account the extent to which Medicare Part B would actually provide a benefit to IHS beneficiaries equal to or greater than the cost of the premiums. Since AI/ANs are entitled to receive free health care to do less would be an abrogation of Federal duties imposed under the IHCA.

IHS did not have authority to bill Medicare Part B until 2001 when limited authority to bill was first granted. It was not until the passage of the Medicare Modernization Act that full Part B participation was granted to IHS. *See* section 630. Based on its responsibility to AI/ANs and its conduct under the Interagency Agreements, it is certain that IHS advised its beneficiaries, whether directly served by IHS or served by Tribes, not to enroll in Medicare Part B since doing so did not change the services available to users served by the IHS system and the IHS could not bill for Part B services. Thus, IHS has been advising potential Medicare beneficiaries throughout the IHS system for a much longer time period than that covered by the Interagency Agreements. This advice and guidance resulted in potential AI/AN beneficiaries not enrolling in the Part B and now facing insurmountable penalties should they want to enroll (or should their Tribe want to pay premiums for them.)

Section 1837(h) of the Social Security Act reinforces the points made above and provide broad authority for remedying this problem.

(h) In any case where the Secretary finds that an individual's enrollment or nonenrollment in the insurance program established by this part of part A pursuant to section 1818 is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Federal Government, or its instrumentalities, the Secretary may take such action (including the designation for such individual of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums) as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.

This provision of the Social Security Act makes clear that the misinformation need not have come from CMS or even a Federal employee. Moreover, it includes express authorization for providing relief, including adjustment of premiums, In addition, CMS regulations permit relief if the error, misrepresentation, or inaction was by a federal employee or any other person "authorized by the Federal Government to act on its behalf." 42 C.F.R § 406.38(a). On most

reservations and regions in which Indians reside, there are no Social Security Administration (SSA) offices. Indian elders have virtually no access to the internet and very limited access to information about toll-free numbers for SSA or CMS. IHS¹ is the only meaningful Federal presence with regard to access to health care from any source. Potential Indian Medicare beneficiaries acted responsibly in relying on communications from IHS representatives, as the official representatives of the Federal Government.

Both section 1837(h) and the 42 C.F.R. § 406.38(b)(5) offer the potential for sweeping relief by authorizing the Secretary to take “other remedial action which may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.” 42 C.F.R. §406.38(b)(5). The Secretary should take that opportunity here and apply it across the board to all American Indians and Alaska Natives who did not enroll in Part B prior to the date on which IHS and Tribes acquired authority to bill for Part B services. This relief should be granted for all, not on an individual basis. If communication with any AI/ANs can be established in a Service Area, it should be imputed to all others in the same Service Area. Given the age of the individuals affected and turnover in IHS personnel, it will be extraordinarily difficult to establish individual communications. Nor should it be required.

There is no basis for believing that IHS would have communicated with only some Medicare eligible elders and not others or that it would have told representatives of one Tribe this information and not others. As recent experience with Medicare Part D has proven, AI/AN elders, who more than any other IHS beneficiaries cling to the promises of the United States that they be entitled to free health care, will not seek out other coverage unless advised and assisted to do so. Moreover, given the passage of time, the changes in staffing during that time, and the frailties and language and cultural barriers that affect elder AI/ANs, if proof is required at the individual AI/AN level, the even the limited equitable relief promised will be illusory.

Finally, CMS deliberated the equitable relief issue without the participation of tribal representatives. This issue was addressed by the IHS/CMS Steering Committee, which does not include any tribal representation. Although the IHS Headquarters’ officials who participate are very knowledgeable, they lack the tribal specific knowledge that TTAG members offer. It was precisely to overcome this kind of challenge that the TTAG was created. It is unfortunate that the letter to IHS on January 26, 2005, was sent before there was an opportunity for the TTAG to take up this issue with CMS, but that should not stop reconsideration now, especially since even the limited relief granted has not yet been implemented.

Such reconsideration should not be influenced by the fact that there are other groups of Medicare beneficiaries who may seek similar remedies. The duty the United States owns to AI/ANs is

¹ When we refer to IHS communications with individual AI/ANs, we believe this also includes communications by employees of tribal health programs acting as instrumentalities of the Federal government when carrying out programs of the IHS under the Indian Self-Determination and Education Assistance Act (ISDEAA). The tribal health programs retain strong ties to IHS and obtain direction and substantial information about matters related to Medicare through IHS.

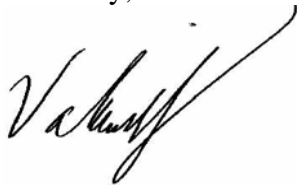
unique and justifies ensuring that every decision is made in a way that maximizes the opportunity for AI/ANs to obtain the health care promised them by treaty, executive order, and law.²

The TTAG respectfully requests that CMS reconsider its decision to limit waiving the Medicare Part B premium surcharge to just those tribes covered under the Interagency Agreements. We believe the most expeditious course would be to simply expand the relief to cover all tribes and to eliminate the requirements of individual knowledge. If that occurred the TTAG Equitable Relief Subcommittee is prepared to begin to meet immediately with CMS and IHS regarding implementation of the expanded relief. If further consideration of the requests in this letter is needed, we respectfully request that you direct your staff to meet with the subcommittee to further analyze this matter and report back to you.

We realize that for many CMS staff this issue seems as if it has been resolved and that the Tribal advocates should simply move on to implement the limited relief offered. Having not had the opportunity to be part of the decision, we cannot responsibly take that approach. The wellbeing of our elders is at stake. Medicare Part B offers them opportunities to address their health problems that we cannot let pass without pursuing this matter.

I thank you for your personal attention to this very important matter!

Sincerely,



Valerie Davidson
Chairman, Tribal Technical Advisory Group and
Executive Vice-President,
Yukon-Kuskokwim Health Corporation

² We know that some groups, such as Veterans military retirees received statutory relief under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Section 625. This should make the request of AI/ANs even more compelling. Elder Indians are so few in number that they do not have the clout to obtain special relief from Congress, nor should they need to ask, when the authority exists now in current law.