

# 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

July 14, 2004

Dr. Mark McClellan, Administrator  
Centers for Medicare and Medicaid Services  
200 Independence Avenue, S.W.  
Humphrey Building  
Washington, DC 20201

Re: Indian Principles for Medicare Part C

Dear Dr. McClellan:

A variety of provisions contained in the Medicare Modernization Act related to Medicare Part C could have negative impacts on American Indian/Alaska Native (AI/AN) health programs. Small tribal programs are especially vulnerable to changes related to managed care and shifts in local plan contracting arrangements. Consultation with tribes will help reduce the risk of jeopardizing the viability of these small programs. The wide variability of tribal health care capacity and the fact that tribes have multiple roles as providers, purchasers and beneficiary advocates gives many Medicare policy decisions the potential for wide impacts in Indian Country.

We were pleased to hear you acknowledge that all health care is local. At that local level it is very difficult for many tribes to effectively respond to or participate in external changes in community health provider arrangements. Indian Health Service, tribal and urban Indian programs (I/T/Us), although essential providers for AI/AN communities, are small players in a vast landscape of shifting financial incentives and have distinctive differences and difficulties interfacing with private health plans and HMOs.

With the unique circumstances of Indian health programs in mind, the CMS Tribal Technical Advisory Group (TTAG) offers the following recommendations for you to consider as regulations are drafted for Medicare Part C. The basic purpose of these recommendations is to improve access to Medicare Part C for AI/ANs and I/U/Ts that choose to participate, while preserving the fragile Indian health system for those who do not. We believe incorporating these concepts into draft regulations or administrative policies may help to accomplish both important goals.

## Beneficiary Issues

1. *Access to Indian health programs.* AI/AN beneficiaries should be guaranteed the right to receive services from I/T/Us at any time and without penalty, whether or

not they enroll in a Part C plan or HMO. Open access to Indian health programs that provide culturally competent services is a key component to improving AI/AN health status.

2. *Switching.* AI/AN beneficiaries who sign up for a Part C plan or HMO that does not contract with the I/T/U where they receive services should be allowed to switch back to fee-for-service or to a different plan at any time. Initial marketing materials sent to AI/AN beneficiaries may be confusing and until the changes in Part C are “mature” it’s important that AI/AN do not lose access to their I/T/U providers.
3. *Benchmark premiums.* AI/AN beneficiaries who sign up for any Part C plan or HMO should be charged premiums, copays and deductibles as if the plan were a benchmark plan. AI/AN access to Part C is dependant on whether or not their I/T/U providers participate in a particular plan. Annual changes in benchmarks and plans will cause confusion and often the provider network is not known until after enrollment periods end. Furthermore, it is possible that only the more “expensive” plans will contract with I/T/Us, creating an unfair situation by financially restricting access to care for AI/ANs. Furthermore, most plans do not have actuarial experience with AI/AN Medicare enrollees and as such are likely to avoid the potential risk of an unknown population with serious health status disparities.
4. *Waive late enrollment penalties.* To encourage AI/AN to participate in Part C, late enrollment penalties should be waived, including those for Part D. It will take time for MMA changes to be understood and responded to by AI/AN and I/T/Us. Waiving penalties may encourage participation after more is understood about MMA.

## **Outreach, Education and Enrollment**

5. *Funding.* To be successful in Indian Country, CMS must provide significant funding to the local level I/T/U for outreach, education and enrollment. I/T/Us must have flexibility to adapt materials and messages to reflect local situations. For an AI/AN to select a Part C plan or HMO, they must be able to understand and make informed choices to know if their I/T/U contracts with a plan and how it might benefit them or the community. This can only be assessed and communicated at the local level.

## **Provider Issues**

6. *Reimbursement to I/T/Us for all Part C enrollees.* Part C plans and HMO’s should be required to reimburse I/T/Us for services provided to enrollees as if the I/T/U were an in-network provider. The reimbursement rate should be the same as the I/T/U would receive if the service were delivered under the Medicare fee-for-service option. Because the plan or HMO will receive federal funding to provide all services, I/T/Us should not be required to subsidize care with additional federal dollars. In situations where Medicare is already paying a plan for Part C

coverage, plans should be required to reimburse I/T/Us for services they provide to plan enrollees, whether or not written contracts are in place.

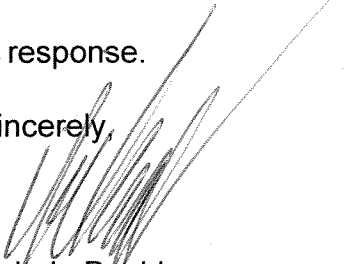
7. *Network adequacy and contracting.* Any I/T/U that wants to contract as a Part C provider should be allowed to do so. To enable this contracting, plans or HMOs should be required to include the following elements in their agreements with I/T/Us:
  - a. Acknowledge the authority under which the I/T/U is providing services, the extent of available services and the limitation on charging co-pays or deductibles.
  - b. State that the terms of the contract may not change, reduce, expand, or alter the eligibility requirements for services at the I/T/U as determined by the MMA; Sec. 813 of the Indian Health Care Improvement Act, 25 U.S.C. §1680c; Part 136 of Title 42 of the Code of Federal Regulations; and the terms of the contract, compact or grant issued to Provider by the IHS for operation of a health program.
  - c. Reference federal law and federal regulations applicable to tribes and tribal organization, for example, the Indian Self-Determination and Education Assistance Act, 25 U.S.C. §450 *et seq.* and the Federal Tort Claims Act, 28 U.S.C. §2671-2680.
  - d. Recognize that I/T/Us are non-taxable entities.
  - e. Clarify that tribes and tribal organizations are not required to carry private malpractice insurance in light of the Federal Tort Claims Act coverage afforded them.
  - f. Confirm that plans and HMOs may not impose state licensure requirements on IHS and tribal health programs that are not subject to such requirements.
  - g. Include confidentiality, grievance, dispute resolution, conflict of law, billing, and payment rate provisions.
  - h. Recognize that an I/T/U drug formulary cannot be restricted to that of the plan or HMO.
  - i. Declare that the Agreement may not restrict access the I/T/U otherwise has to Federal Supply Schedule or 340b drugs.
  - j. State that the I/T/U should not be required to impose co-payments or deductibles on its AI/AN beneficiaries.
  - k. Authorize I/T/U programs to establish their own operational policies including hours of business, after hours coverage and administrative functions.
  - l. Clarify that credentialing, accreditation, utilization review and quality improvement are functions covered within the Indian system and I/T/Us cannot be required, as a condition of contracting, to participate in the plan or HMO's systems.
  
8. *Consistency with Part D Indian policies.* Part C plans offering Part D and contracting with I/T/Us should be required to be consistent with Part D policies specific to AI/AN or I/T/Us. This consistency should include allowing I/T/U payment/reimbursement of AI/AN premiums, copayments or deductibles to count toward all enrollee out-of-pocket expense limits.

We sincerely appreciate the opportunity to provide these recommendations to you. As the Medicare Modernization Act continues to be implemented, other policy issues will certainly arise. It is our hope that decisions made by CMS will improve access to

Medicare for all American Indians and Alaska Natives as well as ensure the sustainability of the fragile Indian health programs that provide these essential health services.

Thank you and we look forward to your response.

Sincerely,



Valerie Davidson  
Chair, CMS TTAG  
Executive Vice-President,  
Yukon-Kuskokwim Health Corporation

cc: Dorothy Dupree  
TTAG Members