



# Tribal Technical Advisory Group



To the Centers for Medicare & Medicaid

National Indian Health Board | 910 Pennsylvania Avenue SE, Washington, DC 20003 | (203) 507-4070 | (203) 507-4071 (fax)

August 31, 2022

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; Request for Information on Medicare**

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) request for information, “Medicare Program; Request for Information on Medicare” (CMS-4203-NC).

**Preamble to Comments:**

Before commenting specifically on this request for information, we highlight the important context in which TTAG’s comments are offered, and which should inform CMS’s consideration of them: the deep inequities in this nation’s health care delivery system, and the Biden administration’s commitment and urgent effort to eliminate them. Over the last year the entire federal government, including CMS, has been working to respond to the President’s Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (EO 13985).

For the first time, the federal government is taking a systematic approach to address equity issues. CMS has responded by first issuing its CMS Strategic Plan, “Pillar: Health Equity” that laid out CMS’ definition of health equity and a broad strategy to advance equity through its programs. More recently, CMS has published its Framework for Health Equity 2022-2032, which is a more detailed ten-year plan intended to address equity and health disparity issues across Medicare, Medicaid, CHIP, and the Health Insurance Marketplaces.

Important to understand about health disparities is that American Indian and Alaska Native (AI/AN) people were once one of the healthiest people on this continent, before colonialism and the United States policies of termination, assimilation, and boarding schools caused an “intergenerational pattern of cultural and familial disruption”<sup>1</sup> that drive health disparities to this day. These drivers have manifested in some of the worst health disparities for AI/AN people,

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<sup>1</sup> [“Federal Indian Boarding School Initiative Investigative Report”](#), Department of Interior, Assistant Secretary Bryan Newland, May 2022.

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including extraordinarily high and disproportionate rates of infant and maternal mortality, cancer, cardiovascular disease, depression and other behavioral health conditions, among other ailments. The recent Department of Interior Boarding School Report explains that “Native Americans continue to rank near the bottom of all Americans in terms of health, education, and employment. Many AI/ANs face unique challenges and harsh living conditions resulting from the United States having removed their tribes to locations without access to adequate resources and basic infrastructure upon which their tribal governments can foster thriving communities.”<sup>2</sup>

It is important to acknowledge that efforts to address these disparities are often complicated by culturally inappropriate interventions and an inadequate understanding of the historical effects of United States policies and ongoing trauma of AI/AN people.<sup>3</sup> It is this history that is the root cause of the significant health disparities that affect AI/AN populations.

The TTAG is deeply appreciative that the President’s EO 13985 and the CMS Framework for Health Equity provide an opportunity to focus on these concerns, and that the CMS Framework provides an opportunity to design, implement, and operationalize policies and programs to address health equity issues. The TTAG has always taken the position that CMS has ample legal authority to undertake distinct policies and programs specifically focused on AI/AN beneficiaries and the IHS programs that provide their care, because of their unique legal status under the U.S. Constitution and the duties owed by the federal government under its treaty and trust responsibilities to AI/ANs.<sup>4</sup>

Under established principles of Indian law, programs and policies that are specifically established for Indigenous people and organizations do not constitute prohibited race-based classifications; rather, they are based on the unique political relationship between the federal government and Indian Tribes. This unique legal relationship, taken together with EO 13985 and CMS’ Framework for Health Equity, provides a sound basis for CMS to adopt the TTAG recommendations on the Proposed Rule. We trust you will agree that the TTAG recommendations are directly related to CMS’ Framework discussed in “Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps.” These TTAG’s recommendations fit clearly in the intended outcomes of this chapter of the Framework as well as other priority areas of the Framework.

### **Comments:**

The TTAG provides comments on the CMS RFI on the Medicare Advantage program included below. We look forward to continuing to engage with the agency on these important issues in an effort to improve the quality and efficiency of care provided to our people and to attain health equity that AI/AN communities are still severely lacking.

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<sup>2</sup> *Ibid.*

<sup>3</sup> “[Indigenous Health Equity](#).” Abigail Echo-Hawk, Director, Urban Indian Health Institute, August 7, 2019.

<sup>4</sup> See “Legal Basis for Special CMS Provisions for American Indian and Alaska Native,” Appendix A, CMS-TTAG Strategic Plan 2020-2025.

### ***Section A. Advance Health Equity***

#### **1. What steps should CMS take to better ensure that all MA enrollees receive the care they need?**

- Important to ensuring that all MA enrollees receive the care they need is to understand the different needs of the various communities that CMS serves. AI/ANs have traditional health care practices that are important for CMS to recognize the value and efficacy of integrating into CMS programs. There must be respect and recognition of traditional beliefs, ceremonies, and other practices of healing the mind, body, and spirit. We hope CMS takes into serious consideration the following responses to the RFI, below. We look forward to engaging with the agency further to improve the experience and the care provided by MA plans to our communities.

#### **3. What are effective approaches in MA for screening, documenting, and furnishing health care informed by social determinants of health (SDOH)? Where are there gaps in health outcomes, quality, or access to providers and health care services due partially or fully to SDOH, and how might they be addressed? How could CMS, within the scope of applicable law, drive innovation and accountability to enable health care that is informed by SDOH?**

- Important to understand about health disparities is that AI/AN people were once one of the healthiest people on this continent, before colonialism and the United States policies of termination, assimilation, and boarding schools caused an “intergenerational pattern of cultural and familial disruption”<sup>5</sup> that drive health disparities to this day. These drivers have manifested in some of the worst health disparities for AI/AN people, including extraordinarily high and disproportionate rates of infant and maternal mortality, cancer, cardiovascular disease, depression and other behavioral health conditions, among other ailments.
- The recent Department of Interior Boarding School Report explains that “Native Americans continue to rank near the bottom of all Americans in terms of health, education, and employment. Many AI/ANs face unique challenges and harsh living conditions resulting from the United States having removed their tribes to locations without access to adequate resources and basic infrastructure upon which their tribal governments can foster thriving communities.”<sup>6</sup>
- It is important to acknowledge that efforts to address these disparities are often complicated by culturally inappropriate interventions and an inadequate understanding of the historical effects of United States policies and ongoing trauma of AI/AN people.<sup>7</sup> It is this history that is the root cause of the significant health disparities that affect AI/AN populations.

#### **7. What food- or nutrition-related supplemental benefits do MA plans provide today? How and at what rate do enrollees use these benefits, for example, for food insecurity and managing chronic conditions? How do these benefits improve enrollees' health? How are**

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<sup>5</sup> [“Federal Indian Boarding School Initiative Investigative Report”](#), Department of Interior, Assistant Secretary Bryan Newland, May 2022.

<sup>6</sup> *Ibid.*

<sup>7</sup> [“Indigenous Health Equity.”](#) Abigail Echo-Hawk, Director, Urban Indian Health Institute, August 7, 2019.

**MA Special Needs Plans (SNPs) targeting enrollees who are in most need of these benefits? What food- or nutrition-related policy changes within the scope of applicable law could lead to improved health for MA enrollees? Please include information on clinical benefits, like nutrition counseling and medically tailored meals, and benefits informed by social needs, such as produce prescriptions and subsidized/free food boxes.**

- We understand that some MA plans offer nutrition benefits such as home meal delivery and healthy food options for beneficiaries. This benefit, if more widely offered, would surely improve the health of many AI/AN beneficiaries.
- Many Tribal nations exist in food deserts, which the USDA defines as parts of the country void of fresh fruit, vegetables, and other healthful whole foods, usually found in impoverished areas. This is largely due to a lack of grocery stores, farmers' markets, and healthy food providers. Food deserts continue to perpetuate the health inequities we see in underserved, rural communities, as one of the strongest social determinants of health (SDoH). Food insecurity has one of the most extensive impacts on the overall health of individuals: individuals who are food insecure are disproportionately affected by chronic diseases, including diabetes, high blood pressure, and obesity, which exacerbates adverse effects on overall health and well-being.<sup>8</sup>
- Addressing food insecurity – by way of recognizing and addressing the impact of food deserts – would go a long way in addressing health inequities in Indian Country, and we hope that CMS will prioritize this issue in evaluating potential food- or nutrition-related policy changes to improve health for MA enrollees.

**8. What physical activity-related supplemental benefits do MA plans provide today? At what rate do enrollees use these benefits? How do these benefits improve enrollees' health? What physical activity-related policy changes within the scope of applicable law could lead to improved health for MA enrollees?**

- We know some MA plans cover gym membership costs and other tools for improving physical fitness. However, part of this benefit should include the investment in the infrastructure necessary for partaking in these activities. For example, a gym membership benefit to an enrollee who lives in an area without a community gym to utilize is useless in improving an enrollee's health. There must be investment to ensure that facilities are available to them, within a reasonable distance and accessible to those who need it, in order for this benefit to realize and be utilized.

### ***Section B. Expand Access: Coverage and Care***

**1. What tools do beneficiaries generally, and beneficiaries within one or more underserved communities specifically, need to effectively choose between the different options for obtaining Medicare coverage, and among different choices for MA plans? How can CMS ensure access to such tools?**

- In order for AI/ANs to be fully informed on their options when it comes to MA plans and their various coverage options, any information provided to potential enrollees must

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<sup>8</sup> Feeding America, *Impact of Hunger and Health*. <https://www.feedingamerica.org/hunger-in-america/impact-of-hunger/hunger-and-nutrition>.

include an explanation of any and all impact that a switch from traditional Medicare coverage to an MA plan may have on their coverage and service options, including physician choice.

- The TTAG has reiterated our ask that CMS require all Medicare Advantage (MA) plans to ensure American Indian and Alaska Native (AI/AN) beneficiaries have fair and equal access to the MA program and have access to Indian health care providers (IHCPs).
- As you know, we are seeing more and more of our Tribal patients getting enrolled in the MA plans not only during open enrollment (OE), but outside of the OE period. We have seen some clinics assert that they do not believe that enrollees are being told all the information about the MA plans by the agents that call them. This can easily create confusion over enrollment, the benefits of enrolling in an MA plan, and the potential implications to their coverage and service options as an AI/AN enrollee.

**2. What additional information is or could be most helpful to beneficiaries who are choosing whether to enroll in an MA plan or Traditional Medicare and Medigap?**

- AI/AN beneficiaries need specific information on the effect of enrolling in any of the above programs. The AI/AN population has specific Medicare protections that they must be made aware of in order to make a fully informed decision regarding their insurance coverage.
- TTAG recommends that CMS require MA plans to clearly disclose, on all marketing materials, that they are private companies and not Medicare. In this rule, CMS proposed adding a new disclaimer that would be required when TPMOs market MA plans and Part D products, and the TTAG wholly supports this proposal. We urge CMS to ensure that this disclaimer is clear, unambiguous, and easily identified in all marketing products. This is essential in ensuring that beneficiaries are properly informed of their options and made appropriately aware of who they are dealing with. Some Tribal health advocates have communicated to us that it is not always made clear to beneficiaries that they are communicating with a private company, rather than a representative of the federal Medicare program. A clear disclaimer will help to ensure that beneficiaries are properly informed of their options for receiving care.
- TTAG recommends CMS provide additional outreach and education to TPMOs to ensure sufficient familiarity with the Indian health system. As you know, the Tribal healthcare system is unique, and TPMOs may not even be aware that they may be misleading in their marketing to Indian Country. TPMOs need to be aware of the intricacies CMS TTAG Letter to CMS Administrator Brooks-LaSure Re: CMS-4192-P March 7, 2022 Page 3 of 4 of the Indian healthcare system to ensure that they do not misrepresent coverage and other options for AI/AN beneficiaries. Because there are various nuances to health coverage for many AI/AN peoples, it is important that insurance agents be fully informed in order to properly serve beneficiaries receiving care through IHS or Tribal facilities. CMS should provide the resources and guidance necessary to ensure TPMOs are properly informed on the relevant nuances of the Indian healthcare system and how their MA plans will affect Tribal members' healthcare options.

**3. How well do MA plans' marketing efforts inform beneficiaries about the details of a given plan? Please provide examples of specific marketing elements or techniques that have**

**either been effective or ineffective at helping beneficiaries navigate their options. How can CMS and MA plans ensure that potential enrollees understand the benefits a plan offers?**

- We have heard from AI/AN beneficiaries that MA plans have been aggressive and invasive when marketing their plans to them.
- TTAG recommends that CMS create an enforcement mechanism that holds these TPMOs accountable for inappropriate marketing tactics. 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.
- 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. They 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 that 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. Not only would this provide AI/AN callers with correct guidance on their coverage, but it would also alleviate some of the wait-time concern that beneficiaries have reported.
- It is critical that Tribal citizens have access to sufficient information to make informed choices about their health plans. Beneficiaries have reported feeling pressured into believing they will receive the same or better care if they make the switch from their original Medicare coverage to an MA plan. This is not always true. In addition, it is critical to inform beneficiaries that not all MA plans are built the same. There is a lot of variation among plans, and MA plans in general are not always optimal for Tribal citizens if they receive care through an IHS facility.
- A dedicated Medicare AI/AN contact would be able to help Tribal beneficiaries understand these nuances, or to connect them with a patient benefit coordinator before making any changes to their coverage, to discuss how an MA plan may work – or not work – for them. If additional support is needed, the Tribal member can be directed to their Tribal enrollment assister or benefit coordinator at their IHS or Tribal facility. AI/AN beneficiaries need easy access to specialized Medicare support who can answer

their questions about MA plans and ensure beneficiaries are able to make fully informed decisions about their health care.

**5. What role does telehealth play in providing access to care in MA? How could CMS advance equitable access to telehealth in MA? What policies within CMS' statutory or administrative authority could address access issues related to limited broadband access? How do MA plans evaluate the quality of a given clinician or entity's telehealth services?**

- CMS can advance equitable access to telehealth in MA by allowing coverage and reimbursement for telehealth services furnished through audio-only communications, and to make this permanent.
- Much of Indian Country is rural. In fact, 46.1 percent of AI/ANs live in rural communities, a rate which is more than twice that of the overall U.S. population.<sup>9</sup> This brings its own complications with administering telehealth to AI/AN communities, and more must be done to invest in the infrastructure necessary to bringing telehealth to rural and underserved communities.

***Section C. Drive Innovation to Promote Person-Centered Care***

**1. What factors inform decisions by MA plans and providers to participate (or not participate) in value-based contracting within the MA program? How do MA plans work with providers to engage in value-based care? What data could be helpful for CMS to collect to better understand value-based contracting within MA? To what extent do MA plans align the features of their value-based arrangements with other MA plans, the Medicare Shared Savings Program, Center for Medicare and Medicaid Innovation (CMMI) models, commercial payers, or Medicaid, and why?**

- Allowing MA plans to reimburse the IHS OMB encounter rate to IHCPs 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 also 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 IHCA and other provisions governing MA plans.

**2. What are the experiences of providers and MA plans in value-based contracting in MA? Are there ways that CMS may better align policy between MA and value-based care programs in Traditional Medicare (for example, Medicare Shared Savings Program Accountable Care Organizations) to expand value-based arrangements?**

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<sup>9</sup> Janice C. Probst, Fozia Ajmal, *Social Determinants of Health among Rural American Indian and Alaska Native Populations*, Univ. of S.C. Rural and Minority Health Research Center, July 2019, [https://www.sc.edu/study/colleges\\_schools/public\\_health/research/research\\_centers/sc\\_rural\\_health\\_research\\_center/documents/socialdeterminantsofhealthamongruralamericanindianandalaskanativepopulations.pdf](https://www.sc.edu/study/colleges_schools/public_health/research/research_centers/sc_rural_health_research_center/documents/socialdeterminantsofhealthamongruralamericanindianandalaskanativepopulations.pdf).

- 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. 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 also 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.

**8. How do beneficiaries use the MA Star Ratings? Do the MA Star Ratings quality measures accurately reflect quality of care that enrollees receive? If not, how could CMS improve the MA Star Ratings measure set to accurately reflect care and outcomes?**

- The TTAG has commented in the past with concerns over Star Ratings systems – concerns over how the ratings may inaccurately portray I/T hospitals due to skewing of the reported measures due to a lower patient population, therefore increasing the impact that a negative outcome or incident could have on ratings. We encourage CMS to ensure that any Star Ratings calculation accurately report on the quality of care that enrollees receive. Engaging with the TTAG on this could help formulate measures that we see as designating “quality care” to a patient, which may vary from the general population’s consideration of “quality.”

***Section D. Support Affordability and Sustainability***

**1. What policies could CMS explore to ensure MA payment optimally promotes high quality care for enrollees?**

- The TTAG has reiterated our ask that all MA plans reimburse Indian Health Service (IHS) and Tribal hospitals at the IHS OMB all-inclusive encounter rate.
- 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. 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, CMS 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 also 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 must be required to do the same.

**3. As MA enrollment approaches half of the Medicare beneficiary population, how does that impact MA and Medicare writ large and where should CMS direct its focus?**

- This is an important opportunity for CMS to get ahead of the concerns listed within these responses from the TTAG and to focus on the sub-populations – like AI/ANs – that have specific needs and particular barriers to care. These communities face unique challenges, and it is valuable for CMS to direct its focus to improve quality of care and increase access to such care for AI/ANs wherever they reside geographically.

**7. How could CMS further support MA plans' efforts to sustain and reinforce program integrity in their networks?**

- We encourage CMS to increase oversight of MA plans in order to ensure program integrity. The more resources that the agency can put into ensuring that these plans act appropriately and in the best interest of their patients, is necessary to achieving the agency's goal of health equity.

**8. What new approaches have MA plans employed to combat fraud, waste, and abuse, and how could CMS further assist and augment those efforts?**

- It is unclear what approaches MA plans have employed to combat such issues, but we encourage CMS to increase oversight of these plans to ensure that they are not contributing to the fraud, waste, and abuse that occurs because of the way these plans operate. In concert with the many comments above, we would like to reiterate that we have received many complaints and heard many concerns over how MA plans operate in Indian Country. We trust the agency hears this concern and adequately adjusts its operations to attend to these concerns and to hold these plans accountable for their

inappropriate behavior in communicating with and enticing beneficiaries to enter plans that may not be beneficial to them.

### ***Section E. Engage Partners***

**1. What information gaps are present within the MA program for beneficiaries, including enrollees, and other stakeholders? What additional data do MA stakeholders need to better understand the MA program and the experience of enrollees and other stakeholders within MA? More generally, what steps could CMS take to increase MA transparency and promote engagement with the MA program?**

- We appreciate the agency's recognition of the need for changes related to marketing and communications around Medicare Advantage (MA) plans, and we support changes to strengthen CMS oversight of the aggressive marketing tactics we have seen in Indian Country.
- As noted by the agency, CMS has seen an increase in beneficiary complaints about marketing practices of third-party marketing organizations (TPMOs) who sell MA products. While it is unclear if AI/AN communities are being intentionally targeted by these TPMOs, we are hearing from Tribes across the country that their citizens and health care workers are frustrated with the TPMOs coming onto reservations and using deceptive tactics to entice beneficiaries to switch from Medicare coverage to MA plans.
- We have heard of insurance agents showing up to homes unannounced and unprompted, causing confusion for beneficiaries, and impacting care options for our citizens. Due to deceptive marketing tactics in these encounters, some beneficiaries believe they are dealing with Medicare, rather than a private plan, which further exacerbates the confusion and frustration.
- Even more, commercials for MA plans discuss free options and reduced costs, but advertisers are not always clear about the impact of switching to an MA plan. Tribal members are often enticed to enroll in Part C to access covered devices such as eyeglasses or hearing aids, but they need to be aware of other implications of enrollment. AI/AN citizens may enroll in an MA plan unknowingly or without understanding that the coverage will not be optimal for them.
- Insurance carriers must be transparent about what MA plans can offer and ensure anyone enrolling understands how the plan change will affect access to benefits they are used to. For example, the change impacts eligibility for Purchase/Referred Care (PRC) for medical and dental care through the Indian Health Service (IHS). When a Tribal member enrolls in MA, they must go to their new primary care provider, who would be a non-IHS provider, and would therefore no longer be eligible for PRC.
- Tribal leaders and their citizens, along with providers in Tribal communities, need to be aware of this impact. Sometimes, even insurance agents do not understand that MA plans may not work for Tribal members, since the agents are unfamiliar with the relationship CMS has with IHS and Tribal facilities providing care to Medicare beneficiaries.

**2. How could CMS promote collaboration amongst MA stakeholders, including MA enrollees, MA plans, providers, advocacy groups, trade and professional associations, community leaders, academics, employers and unions, and researchers?**

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- Continue to engage with communities, and increase engagement at the local level, in order to truly understand the needs of the community itself and how MA plans can and should be providing their care. This is increasingly important in the enforcement of the requirements and restraints that MA plans are beholden to. As noted elsewhere in this RFI, we have heard increasing concern over the marketing practices of MA plans in AI/AN communities.

**3. What steps could CMS take to enhance the voice of MA enrollees to inform policy development?**

- Create a portal on CMS.gov for enrollees and any potential enrollees and other Medicare beneficiaries, organizations, etc. to report on inappropriate actions taken by MA plans. This has been a request by Tribal citizens as a resource that would improve the patient experience and to encourage MA plans to abide by appropriate practices.

**4. What additional steps could CMS take to ensure that the MA program and MA plans are responsive to each of the communities the program serves?**

- Continue to (or begin) actively engaging in Indian Country. No two Tribal nations are the same – they all face their own challenges and their own barriers to care – and therefore, the solution to increasing care and service to AI/AN enrollees is different for each Tribe.
- Increase outreach and education activities in Indian Country. Work to educate AI/AN elders on their options regarding MA plans and ensure that MA plans are not taking advantage of our communities. There seems to be significant misinformation circulating around MA plans and the benefits to enrolling in a plan – and this is inducing people to make the switch from Traditional Medicare without fully understanding the impact this switch may have on their care and their service options.

**Conclusion:**

We appreciate the agency's consideration of the above responses and look forward to engaging with CMS further in improving the experience that AI/AN enrollees have Medicare Advantage plans moving forward.

Sincerely,



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