

# Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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*Delivered via electronic transmission*

April 13, 2011

Donald Berwick, M.D.  
Administrator  
Centers for Medicare & Medicaid Services  
Room 445-G, Hubert Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

RE: Indian Health Addendum for ACA Exchange Plan Provider Network Contracts

Dear Dr. Berwick:

I write on behalf of the CMS Tribal Technical Advisory Group to provide a proposed Indian Health Addendum that we believe should be part of ACA Exchange plan network provider contracts to facilitate participation by programs operated by the Indian Health Service, Indian tribes/tribal organizations and urban Indian organizations (I/T/Us) in those networks. Without inclusion of provisions such as those set out in the Addendum, barriers unrelated to the ACA would likely exclude these Indian health providers from participation.

The idea of using a special Addendum to facilitate participation by Indian health providers is not a novel one. Such a mechanism has been in use by the Medicare Part D prescription drug program since its inception. When implementing that program, CMS directed Part D plan sponsors to offer network contracts to I/T/U pharmacies in their service areas with an Addendum containing conditions specified in CMS guidance. This mechanism has proved to be efficient, effective and easy to use for both Part D plan sponsors and Indian health pharmacies; it is now a standard component of the Part D program.

We adapted the Part D Addendum model in developing our proposed Indian Health Addendum for Exchange plans. Its primary purpose is to recognize in network contracts Indian-specific Federal laws and policies applicable to Indian people and Indian health programs such as: ACA Sec. 1402(d) which shields from Exchange plan cost-sharing Indians served by I/T/Us and prohibits reductions in payments to I/T/Us that would otherwise be due from the enrollee; IHS regulations that define individuals who are eligible for IHS program services; the Federal Tort Claims Act applicable to the IHS as a Federal agency, and extended by law to Indian tribes/tribal organizations and some urban Indian organizations, which precludes a plan from requiring acquisition of private malpractice insurance, a frequent provision in network contracts; and a comprehensive list of Federal laws applicable to Indian health providers. The Addendum also recognizes the sovereign immunity of the United States and of Indian tribes.

Through the proposed Addendum, the TTAG seeks to achieve with Exchange plans a similar outcome achieved in the Part D program – a fair opportunity for I/T/U participation in provider networks through an easy-to-use mechanism. Network status benefits all entities:

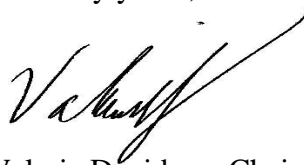
- When specialty care is required for an Indian enrolled in an Exchange plan, the Indian health program can better coordinate care by referring the patient to another provider in his/her plan's network, thus enabling the patient to avoid the red tape and delay occasioned by being served by an out-of-network provider.
- The Indian health program can be assured of receiving payment for covered services by the plans in which its patients are enrolled.
- The Indian health program has an incentive to encourage its Indian patients who do not have another form of insurance to enroll in Exchange plans, thus enlarging plans' customer base.
- Exchange plans benefit from having a wider network of providers to serve their enrollees who are Indian.

It is often necessary for Federal agencies to take pro-active steps to assure that Indian people and the Indian health system can fully participate in Federal health programs. CMS's Medicare Part D regulations are a good example of this. Indeed, the agency has an affirmative obligation to do this in order to carry out the United States' trust responsibility for Indian health, and to protect the unique Indian health system created by the Federal government to fulfill that responsibility.

We are prepared to explain every provision in our proposed Addendum. We believe the best way to proceed is for the TTAG's ACA Policy Committee to meet by conference call with Kitty Marx, Director of the CMS Tribal Affairs Group, IHS personnel and CCIIO officials who are developing guidance to the States for establishment of Exchanges. When fully explained we believe CCIIO and State Exchange officials will welcome the Addendum as an efficient mechanism to help fulfill the responsibility to consult with tribes and to assure Indian people and Indian health programs can fairly participate in the Exchanges.

We are grateful for your openness to TTAG suggestions for including the Indian health system in the important programs created by the ACA.

Sincerely yours,



Valerie Davidson, Chair  
CMS Tribal Technical Advisory Group

Enclosure: Proposed Indian Health Addendum for Exchange plans

Cc: Kitty Marx, Director, CMS Tribal Affairs Group  
Carl Harper, IHS representative on the TTAG  
Lisa Marie Gomez, HHS/CCIIO