Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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February 23-24, 2011
Face-to-Face Meeting – Action Items

Action Item	Timeline	Person Responsible	Status	Notes
Provide instructions concerning application fee waivers to the enrollment contractors.	ASAP	CMS	Ongoing	
Submit ideas to CMS concerning the acceptable reasons for granting hardship waivers for the provider/supplier application fee.	ASAP	TTAG Members	Ongoing	
Prepare a document outlining the justification for provider/supplier application fee waivers based on the special trust responsibility for Indian health care.	ASAP	TTAG	Ongoing	
Provide comments on access to dental care and share suggestions for improving childhood oral health care.	ASAP	TTAG Members	Ongoing	
Submit comments on the draft CMS oral health strategy.	March 4	TTAG Members	Completed	
Share the results of the dental health focus groups with the TTAG.	ASAP	CMS (Ms. Wachino)	Ongoing	
Share reactions to the focus group results with CMS.	ASAP	TTAG Members	Ongoing	
Share ideas for innovating health care delivery systems with the Center for Innovation.	ASAP	TTAG Members	Ongoing	
Follow up with the Office of the Administrator and relevant CMS components concerning the four requests made by TTAG.	ASAP	Ms. Marx	Ongoing	
Visit IHS facilities to learn more about the innovations they are currently using.	ASAP	Innovation Center Staff	Ongoing	
Share ideas concerning the structure of the exchanges and how the they can meet the needs of AI/ANs.	ASAP	TTAG Members	Ongoing	
Discuss the need to include expectations regarding tribal consultation in the grant making process with CCIIO staff.	ASAP	Ms. McWright	Ongoing	
Provide CCIIO with information on the need to designate I/T/Us as essential community providers and the implications of not doing so.	ASAP	TTAG	Ongoing	
Forward the NCAI-approved definition of Indian to CCIIO.	ASAP	Ms. Rose	Ongoing	
Share a model Indian addendum with CCIIO for adaptation for use in exchange plans.	ASAP	TTAG	Ongoing	
Examine the possibility of including Indian-specific components into the early innovator grants.	ASAP	Ms. McWright	Ongoing	

Share concerns and questions related to the dual eligible population with FCHCO.	ASAP	TTAG Members	Ongoing	
Provide FCHCO with copies of the TTAG AI/AN Medicare data report.	ASAP	TTAG	Ongoing	
Provide comments on the ACA regulation review report to NIHB.	ASAP	TTAG Members	Ongoing	
Report back to CMS on TTAG concerns about the secondary payer rule and request written clarification of the rule.	ASAP	Ms. Marx	Ongoing	
Look into Oregon's denial of a tribe's secondary payer status for its self-funded plan that is part of its CHS program.	ASAP	TAG	Ongoing	
Provide NACs with the information necessary to address the Medicaid secondary payer situation in their states.	ASAP	TAG	Ongoing	
Draft language concerning the secondary payer rule for possible use in TAG guidance.	ASAP	TTAG	Ongoing	
Identify states in which the cost-sharing exemptions are not working as well as possible.	ASAP	TTAG Members	Ongoing	
Share the list of states that are working with CMS on the cost-sharing exemptions with the TTAG.	ASAP	Ms. Gillaspie	Ongoing	
Provide comments on the IHS letter concerning CHS and cost sharing to Ms. Gillaspie.	ASAP	TTAG Members	Ongoing	
Consider adding language to the SMD letter concerning the consequences of non-compliance with cost-sharing exemption rules.	ASAP	CMS	Ongoing	
Report any difficulties constituents are experiencing with the implementation of ARRA resource exclusion, estate recovery, and managed care protections to Ms. Gillaspie.	ASAP	TTAG Members	Ongoing	
Share examples of good and poor applications of outstationing of enrollment workers.	ASAP	TTAG Members	Ongoing	
Review and comment on the updated LTC Subcommittee charter.	ASAP	TTAG Members	Ongoing	
Provide comments for the HHS Budget Consultation Meeting to TAG.	Before March 2	TTAG	Completed	

February 23, 2011
Face-to-Face Meeting – Summary

Agenda Item	Discussion	Action
Documents Received	• TTAG Briefing Book • Final Required Screening and Levels of Risk (Spiegel handout) • U.S. House and Senate Notification Re CMS Issues Final Rule on Provider and Supplier Screening Requirements….1/21/11 (Spiegel handout) • Slides: Improving Access to Children's Oral Health Care (Wachino handout)	
Welcome	**Ms. Valerie Davidson**, Chair, Tribal Technical Advisory Group (TTAG) and Executive Vice President and Senior Director, Legal and	

	Intergovernmental Affairs, Alaska Native Tribal Health Consortium, welcomed the TTAG members and other meeting participants.	
Opening Blessing	**Ms. Juana Majel Dixon**, Secretary, National Congress of American Indians (NCAI), offered the opening blessing.	
Roll Call	**Ms. Tyra Baer**, CMS Staff Assistant, National Indian Health Board (NIHB), took the roll of the TTAG members present. Fourteen members were in attendance, meeting the requirements for a quorum. Members attending were: Alaska – Valerie Davidson Aberdeen – Donald Warne Albuquerque – Carolyn Finster Bemidji – Kathy Hughes Billings – absent California – James Crouch Nashville – Donita Stevens Navajo – Roselyn Begay Oklahoma – Rhonda Butcher Phoenix – absent Portland – James Roberts Tucson – Grace Manuel TSGAC – W. Ron Allen NIHB – absent NCAI – Juana Majel-Dixon IHS – Carl Harper NCUIH – Carmelita Skeeter A quorum being present, **Ms. Davidson** called the meeting to order and asked all of those in attendance to introduce themselves.	
Report from Chair	**Ms. Davidson** expressed her appreciation for the dedication of those working in the areas of Medicare, Medicaid, and Children's Health Insurance Programs (CHIP).	
Report from Secretary	**Ms. Carolyn Finster**, TTAG Secretary and Director, Pine Hill Health Center, reported that she has reviewed the minutes of the November 9, 2010, face-to-face meeting and the minutes for October 13, 2010; December 8, 2010; and January 12, 2011, TTAG conference calls. She did not have any recommendations for changes. **Ms. Finster** made a motion for unanimous consent to approve the four sets of minutes. **Ms. Donita Stevens**, Finance Director, Choctaw Health Center, seconded the motion, which carried with no comments or objections offered.	
Tribal Affairs Group Report	**Ms. Kitty Marx**, Director, Tribal Affairs Group (TAG), Office of External Affairs and Beneficiary Services (OEABS), Centers for Medicare & Medicaid Services (CMS), updated meeting participants on several projects. **<u>FY 2010 and FY 2011 Funding</u>** **Ms. Marx** reported that for FY 2010 TAG received: • <u>$1.8 million for fed admin</u>: This money supports the TTAG meetings, conference calls, and minutes/notes. It also funds,	

	through the Intra-Departmental Delegation of Authority (IDDA) with NIHB, data analysis research and regulatory analysis work. This money also funds a contract that studies long-term care (LTC), examines the effects or implications of the Patient Protection and Affordable Care Act (ACA), and develops outreach and education tools. • Funding for CHIP outreach. • $150,000 for MedOps: These funds will be used for training on ICD-9 and for an event co-sponsored with the National Indian Council on Aging. • $100,000 for Health Information Technology for Economic and Clinical Health: This money will support training for non-Resource and Patient Management System users. The session will take place on March 30-31 in Palm Springs, Calif. • $100,000 for research: This will support the study of transportation barriers in the Medicare program. TAG is sending out solicitations for additional contracts to continue funding for FY 2011. She indicated that TAG currently has approximately $1.7 million to spend, with the potential for additional funding once Congress passes a budget for FY 2011. She indicated that CMS would use the $1.7 million to fund the Indian Health Service (IHS)/CMS trainings in each of the 12 IHS areas. This year, the trainings will focus on the 10 CMS regions. TAG is working with the Native American Contacts (NACs) and the IHS business office coordinators to develop the training content. Feedback from previous sessions indicates an ongoing need for basic information on Medicare, Medicaid, and CHIP, as well as content tailored to the specific needs of each area. Additionally, TAG will use the funds to support research on transportation and LTC, the development of tools and materials to support outreach and education, and analysis of tribal consultation on a state-by-state basis. TAG continues to work with IHS to fund projects through an IDDA. These projects include ongoing work on the data analysis project and on the review of new and upcoming regulations. TAG is also requesting funds for updating the TTAG Strategic Plan to reflect the changes resulting from the ACA. **Tribal Consultation** Finally, TAG plans to support work to finalize the CMS tribal consultation policy. The CMS policy has been under development for several years. TTAG requested that it be put on hold. The U.S. Department of Health and Human Services (HHS) finalized its policy in December 2010. TTAG has scheduled a Tribal Consultation Subcommittee meeting for the afternoon of February 24 to restart work on the CMS policy. **Ms. Marx** hoped that the CMS policy would be operational in nature and provide guidance to CMS program staff. She also hoped that by reconvening the Subcommittee, it would raise awareness of tribal consultation requirements within CMS and begin the process of developing a mechanism that will trigger consultation with both the TTAG and tribes when policies and regulations are being developed. She noted that CMS is committed to getting input from tribes and other stakeholders.	

	Ms. Davidson stressed the importance to TTAG of being able to engage with CMS in meaningful dialogue before regulations are issued. She was pleased to learn that CMS is open to incorporating early discussions with the TTAG and tribes into the consultation policy. She felt that the time is right to restart the work on the CMS consultation policy with an emphasis on creating opportunities for input prior to ideas being put into writing. **Ms. Majel Dixon** pointed out that one of the major themes at the latest tribal leadership conference was the evolution of consultation within the various agencies. While tribal recommendations seem to reside at the deputy director level, the regulations and policies never seem to reflect tribal recommendations. Too often, the rule making stages do not include further input from tribes. Tribal leaders feel that this is contrary to the orders issued by President Barack Obama concerning tribal consultation. There is generally no discussion with tribes between the consultation and the rule making process. **Ms. Marx** pointed out that CMS' consultation policy must be consistent with the HHS policy. Because CMS issues so many regulations, it must balance the deliberative process, rules concerning the sharing of information, and the timelines associated with each regulation. The most challenging part is determining when information can be shared with tribes (CMS must share information with its constituents equally).The concern is that once information becomes public through the consultation process, other parties, including states and hospital associations would also want access. **Ms. Majel Dixon** felt that the presidential order stipulates a different kind of engaged conversation with tribes than with other groups. **Ms. Rhonda Butcher**, Citizen Potawatomi Nation, stressed that the tribes are not the same as the hospital organizations and other interested parties due to the trust responsibilities and the government-to-government relationship. **Mr. W. Ron Allen**, TTAG Vice-Chair representing the Jamestown S'Klallam Tribe**,** expressed his belief that the CMS consultation policy should be at least as robust as the HHS policy. **Mr. Allen** and **Ms. Marx** discussed the importance of having the appropriate documents available for review and discussion during the Tribal Consultation Subcommittee meeting on February 24. **Ms. Marx** indicated that CMS would have copies of the previous consultation policy draft available for Subcommittee members to pick up following the conclusion of the day's meeting. **<u>CMS Implementation Plan</u>** **Ms. Marx** noted that TAG continues to track numerous issues of interest to Indians through the ACA implementation process. CMS held several all-tribes calls in November and December 2010 to discuss specific ACA implementation issues and hopes to resume them shortly. She also reported that American Recovery and Reinvestment Act (ARRA) implementation activities are ongoing. **Ms. Cyndi Gillaspie**,	

	Lead Native American Contact (NAC), CMS, would report on ARRA implementation of the Medicaid state/tribal consultation plans and other issues such as cost sharing later in the meeting. **Miscellaneous** Another issue on which TAG is working is the discontinuation of the optional Medicaid services due to state budget difficulties. She hoped that there would be a resolution of this issue in the near future. **Mr. Allen** stressed the need to update the TTAG Strategic Plan. He hoped that funds would be available to allow the TTAG to work on the plan and to have the draft finished by the next face-to-face meeting in July. He also felt that there are several items in the current Strategic Plan that need to be discussed by the Budget Subcommittee and CMS. He hoped that in the future, the Budget Subcommittee would have more control over the TTAG budget and have a better relationship with CMS based on transparency and accountability. **Ms. Marx** pointed out that it is difficult to share dollar amounts related to solicitations, but indicated that she had provided a budget overview for FY 2010 and an estimate for FY 2011. She reiterated that the IDDA would include funds for updating the Strategic Plan. **Mr. Allen** acknowledged the restrictions under which TAG must operate but felt that the special relationship with tribes could make it easier to share information. **Mr. Allen** also stressed the importance of ensuring that funding for projects is awarded to entities that are trusted by the TTAG and that it is provided in a timely fashion. **Ms. Marx** replied that CMS is working with IHS to release the IDDA funding in a more efficient way.	
Medicare/Medicaid Additional Screenings and Application Fees and State Licensure Requirements and Tribal Provider Participation in Medicaid	**Mr. John Spiegel**, Director, Medicare Program Integrity Group, CMS, spoke about the proposed rule on "Medicare, Medicaid, and Children's Health Insurance Programs: Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" (Tab C in the meeting materials). He stated that he began to feel as if CMS had inadvertently left the TTAG out of the consultation process when he read the comments submitted toward the end of the comment period. He apologized for any breakdowns in the process and indicated that his group had learned from the experience. He noted that CMS often gets caught up in the requirements of the Administrative Procedure Act, which addresses to whom government agencies can talk and when these conversations about policy making can occur. He stated that CMS could have done a better job of communicating during the public comment period. **Mr. Spiegel** stated that the rule was first published in September 2010 as a Notice of Proposed Rule Making (NPRM. It was republished in January 2011 as a final rule. It implements several provisions in the ACA and gives CMS new authorities with regard to provider screening and enrollment; temporary enrollment moratoria to combat fraud, waste and abuse; suspension of payment during investigations of	

	credible allegations of fraud; and collection of fees for the screening of applications submitted by institutional providers. The ACA requires the HHS Secretary to determine the level of screening based on the risk posed by different categories of providers. The statute requires CMS to determine the level of risk associated with levels of providers (not by individual providers). The final rule created three levels of risk (limited, moderate, and high) to which CMS assigned whole categories of providers. CMS made assignments based on past experiences with fraud, waste, and abuse cases; on General Accountability Office reports; and on information from a wide range of additional sources. The higher the level of risk, the higher the level of scrutiny providers receive. Limited risk providers are screened in a way very similar to that currently employed. Provider types in the moderate risk category undergo the same screening as the limited risk group, but also receive a site visit. Providers in the final group, the high-risk level, receive the standard screening, the site visit, and fingerprinting and a criminal background check. CMS is currently developing subregulatory guidance and operational guidance related to implementing the fingerprinting and background checks. **Mr. Spiegel** informed participants that the Indian Health Service (IHS) facilities and tribal facilities are classified as limited risk facilities. CMS received a wide range of comments, mostly regarding reasons that specific provider types should be classified as low risk. With regard to facilities and entities that participate in Medicare and Medicaid, Medicaid will be able to use the Medicare screening. This prevents duplication of effort and simplifies the administrative requirements. For facilities that do not or cannot participate in Medicare but do participate in Medicaid or CHIP, states are responsible for conducting the screening that would have been done by Medicare. **Mr. Spiegel** anticipated that, in these cases, the states would develop categories of risk, assign provider types to each category, and conduct incremental oversight based on the level of risk. States should use Medicare's models for risk categorizations as the basis for their decisions and actions. The high-risk category will initially be limited to newly enrolled home health agencies and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers. The regulation includes examples of triggers that would immediately reclassify individuals or entities into the high-risk category. Beyond the framework for screening, the regulation also includes a mechanism for the collection of application fees ($505 in 2011) from institutional providers. CMS received a large number of comments on the proposed fee collection method. **Mr. Spiegel** explained that the fee is limited to institutional providers (e.g., hospitals, nursing homes, DMEPOS suppliers, community mental health centers, ambulance services, labs, etc.). He noted that the ACA originally included fees for individual providers, but that this was eliminated during reconciliation.	

	Mr. Spiegel recognized that the application fee is an important issue for the TTAG. He reported that CMS met with the IHS and the Health Resources and Services Administration to determine whether it made sense to charge the fee to entities that are otherwise funded by federal funds. He indicated that CMS considered the possibility of creating a carve-out for Indian/Tribal/Urban (I/T/U) programs with regard to the fee. The ACA does not provide enough flexibility to waive the fee for I/T/Us. There is a hardship exception for Medicare and a waiver for hardship in accessing services under Medicaid. However, the statute is silent on what constitutes a hardship. Entities can petition for a waiver of the application fee. CMS needs to provide instructions concerning application fee waivers to the contractors responsible for enrollment screening. CMS is considering sending out guidance on unacceptable reasons for waivers. For example, it would be difficult for a large, urban hospital to make the case for a waiver but much easier for a two-day-a-week clinic on a reservation that would have to limit services to pay the fee. He asked the participants to share their ideas about possible reasons for granting the waivers. **Ms. Davidson** expressed her opinion that the TTAG took the correct position on the waiver of the application fee for I/T/Us. She noted that I/T/U providers are not usually part of a provider group. I/T/U providers are typically associated with the regional hospital that is closest to them. For example, in Alaska, the providers associated with the hospital in Bethel are scattered over an area the size of Oregon. Paying the $505 fee is truly a burden to many Indian providers, especially considering that Indian health programs are funded at only 50 percent of need. **Mr. Spiegel** clarified that physicians do not have to pay the fee (only entities such as clinics and hospitals that enroll in Medicare). He noted that waivers would be decided on a case-by-case basis. CMS is seeking help to determine what would be an appropriate circumstance under which it should waive the application fee. **Ms. Finster** stated that her organization operates a clinic in a remote area of New Mexico as a Section 638 facility. She was concerned that because the facility has a clinic Medicare number and an ambulance Medicare number, it would be required to pay two separate fees, which would be an added hardship. **Mr. Spiegel** replied that to the extent that the ambulance provider enrolls separately, it would pay a separate fee. He explained these situations are the type of situations CMS might consider as it develops guidance on the fee waiver. **Ms. Finster** noted that the Drug Enforcement Agency (DEA) has given the IHS and Indian health providers an exemption from DEA fees. She thought that this exemption should have been moved over to CMS. **Mr. Spiegel** replied that the CMS statutes are different from the DEA statutes. He indicated that CMS had to be careful not to appear to choose favorites as it wrote the rule. **Ms. Carmelita Skeeter**, Executive Director, Indian Health Care Resource Center of Tulsa, asked about the turnaround time for approval of applications. **Mr. Spiegel** stated that the contractors'	CMS will provide instructions concerning application fee waivers to the enrollment contractors. TTAG members will submit ideas to CMS concerning acceptable reasons for granting hardship waivers for the provider and supplier application fee.

	agreements specify a 60-day time limit. **Ms. Skeeter** thought that 60 days was a long waiting period. **Mr. Spiegel** stated that after a request for a fee waiver has been denied, applicants have a 30-day window in which to pay the fee. Applicants do not need to restart the application from the beginning. Those that request hardship waivers can opt to send in the fee along with their application and have the fee refunded if the request is granted. **Mr. James Roberts**, Policy Analyst, Northwest Portland Area Indian Health Board (NPAIHB), asked whether the guidance CMS provides to the states would include instructions on implementing tribal consultation consistent with those in ARRA Section 5006 to ensure that states have a process to engage with tribes on rules or processes that could have an adverse effect on Indians. **Mr. Spiegel** replied that such guidance was not part of the proposed or final rules, which would make it difficult to issue such guidance. CMS has had lengthy interactions with states concerning the implementation of the rule. Because many of the entities with which the TTAG and its constituency are involved are Medicaid-only entities, he recommended that they seek out the states because the states will be responsible for conducting the screenings for Medicaid-only programs. The fees go into effect for newly enrolling providers and suppliers on March 25. He anticipated that it would take the states some time to get their processes in place for Medicaid-only entities. By contacting them early, the tribal entities could potentially influence the states' approaches to this. **Mr. James Crouch**, Executive Director, California Rural Indian Health Board, Inc. (CRIHB), asked how long CMS would wait before cutting off funding if I/T/Us do not comply. **Mr. Spiegel** replied that the statute makes screening for newly enrolled providers and suppliers effective March 25; for currently enrolled providers and suppliers, it becomes effective March 23, 2012. There is a staggered reevaluation period for all current enrollees that ends on March 23, 2013. After that date, entities cannot be enrolled unless they have been screened. He encouraged entities that are enrolling for the first time to send in their applications and fees and/or requests for waivers as soon as possible. Screenings cannot begin until the fee has been paid and the money is deposited and credited to the Treasury. Although CMS is working to ensure that claims processors and enrollment contractors are prepared to begin work, he anticipated that the initial period would include a learning curve. **Mr. Crouch** felt that the staging was reasonable.	
	Ms. Myra Munson, TTAG Technical Advisor, Sonosky, Chambers, Sachse, Miller & Munson, LLP, suggested that CMS could issue an exemption based on the special trust responsibility for Indian health programs, specifically, the federal obligation to provide free health care to all American Indians and Alaska Natives (AI/ANs). She noted that every budget justification that comes from HHS acknowledges that there are insufficient funds in the Department's budget to support and satisfy the obligation. This means that every health provider in the system is rationing health care. She believed this is	The TTAG will prepare a document outlining the justification for the waiver of the provider/supplier application fee based on the federal government's special trust responsibility for Indian health care.

	sufficient justification for the exemption and that CMS guidance should indicate so. If this is not possible, she advocated for a policy of limiting the number of fees that any Indian health program must submit to only one. **Mr. Spiegel** indicated that it might be possible to include a paragraph citing examples of reasonable basis for providing a hardship waiver as well as ask for consideration of the special trust relationship with the federal government. He agreed that the goal is to gain the maximum number of waivers for Indian facilities as possible while following reasonable guidance. **Ms. Davidson** indicated that the TTAG would prepare a document that **Mr. Spiegel** could use to present this approach to the relevant staff at CMS. **Ms. Munson** asked how CMS plans to notify providers that it is time to revalidate. She was concerned that all of the providers could be processed within the specified timeframe and that there would be no breaks in providers' enrollments during the validation process. **Mr. Spiegel** replied that CMS would work to break the workload up into reasonable chunks. Additionally, CMS is working to streamline the process in an effort to shorten the processing time, eliminate backlogs, and generally speed up the application process. If there is a backlog caused by CMS, he anticipated that the agency would pay because the error was its own. **Mr. Roberts** asked for confirmation that individual physicians and mid-level practitioners are not subject to the fee. **Mr. Spiegel** confirmed that this is correct. **Ms. Davidson** thanked **Mr. Spiegel** for speaking with the TTAG and welcomed the news that processes would be in place to include the TTAG earlier in the process in the future.	
Dental Clinic Initiative	**Ms. Vikki Wachino**, Director, Children and Adults Health Program Group, Center for Medicaid, CHIP, and Survey & Certification (CMCS), CMS, briefly described her office's areas of responsibility before addressing CMS' Oral Health Strategy for Medicaid and CHIP. CMS launched its oral health strategy in response to access issues in the Medicaid and CHIP programs. Children under the poverty line are twice as likely to suffer from untreated tooth decay as those above the poverty line. Approximately 80 percent of childhood oral disease is concentrated in only 25 percent of children, many of whom are lower income. CMS established two national oral health goals: • To increase the rate of children ages 1 to 20 enrolled in Medicaid or CHIP who receive any preventive dental service annually by 10 percent over a five-year period, and • To increase the rate of children ages 6 to 9 enrolled in Medicaid or CHIP who receive a dental sealant on a permanent molar by 10 percent over a five-year period. **Ms. Wachino** stated that the draft strategy for achieving these goals (Tab D in the briefing materials) consists of an action plan template that asks each state to identify past and future actions related to the goals. It also provides technical assistance from CMS to help states	

	develop strategies for improving access to oral health care. In this regard, CMS has identified states that have made progress in improving children's oral health care and asked them to share their experiences as best practices with the other states. The agency anticipates providing much more technical assistance in conjunction with stakeholders and funders. **Ms. Wachino** asked the TTAG members for their input on barriers to access that they see in their communities and for strategy suggestions for improving oral health care for Indian children. **Ms. Butcher** stated that Oklahoma suffers from barriers to dental care access that are probably greater than those to medical care. She cited the lack of dentists and the lack of facilities/equipment from which dentists can practice. Mobile dental chairs have helped some (these dentists can hold daylong clinics), but not enough to mitigate the problem. **Ms. Skeeter** agreed that the shortage of dentists is a problem, but cited lack of parental education about early dental care as a significant factor. Parents often believe that dental care is not terribly important because children will lose their baby teeth anyway. This results in many cases of bottlemouth and fillings. **Mr. Roberts** noted that 20 to 25 percent of dental positions within the Indian health system go unfilled. He pointed out that the average workload for a dentist in the Indian health system is approximately 2,800 patients per provider, significantly greater than the average of 1,500 patients per provider in the general population. **Mr. Roberts** cited statistics that showed that Indian children have much higher rates of dental caries and untreated tooth decay than children in the general population. He stated that this is a direct result of lack of access to dental providers. **Mr. Roberts** hoped that CMS could work with states to develop a mid-level practitioner program designed to address the dental shortage in Indian Country. He felt that states might be reticent to undertake this and that CMS' support could help to encourage states in this direction. **Ms. Wachino** stated that CMS has been working with the American Dental Association's Coding Committee to ensure that mid-level providers can bill and use codes for evaluation and screening. **Ms. Davidson** described dental care in Alaska approximately 30 years ago. Most children were lucky if they saw a dentist once a year. Dentists would bring a mobile chair to the school clinic and many children had teeth pulled out under traumatic circumstances because of lack of dental care. She reported that similar scenarios happen today. Indian communities have very high rates of dental position vacancies. Dentists have little incentive to practice in Indian communities (little opportunity for profit, difficult living conditions, etc.). Incentives have not worked. Volunteer dentists require lots of support to travel around within communities and communicate with patients who speak different languages. She stressed the importance of changing behavior patterns in early childhood. Individuals need to	 TTAG members will provide comments on access to dental care in Indian Country and share suggestions for improving childhood oral health care.

	have good dental experiences at an early age in order to make good, lifetime health choices. **Ms. Davidson** indicated that Alaska would like to see its dental training program expanded throughout Indian Country. She cautioned that dental organizations are well funded and well organized, which makes it extremely important to have tribes at the table when conversations about similar programs occur. **Ms. Wachino** asked participants to share their comments on the draft strategy within the next week. She also stated that a State Medicaid Director (SMD) letter clearly describing the agency's oral health goals is in the clearance process and will be sent out soon. CMS has hired a polling/research firm to conduct focus groups with parents concerning impressions of coverage and oral health care within the general population. **Ms. Wachino** offered to share the results of the focus groups with the TTAG and have a small group of TTAG members share their reactions to the results as a way to stimulate discussion about these populations.	TTAG members will submit comments on the draft CMS oral health strategy by March 4. CMS will share the results of the dental health focus groups with the TTAG. TTAG members will share their reactions to the focus group results with CMS.
TTAG Discussion with CMS Leadership	**Ms. Davidson** welcomed **Dr. Donald Berwick**, CMS Administrator. **Dr. Berwick** began his remarks by stating his agreement with **Ms. Davidson's** comments about the importance of access to early dental health services. He indicated that he and **Dr. Richard Gilfillan**, Acting Director, Center for Medicare and Medicaid Innovation, CMS, hoped to listen and receive advice from the TTAG. **Dr. Berwick** stated that CMS is moving into the implementation phase of the strategic plan that the agency developed over the past several months. The plan has four main elements: • Improving Internal Operations: This element focuses on excellence in operations and takes steps such as simplifying rules and developing capacity for improving skills (e.g., how to improve processes). CMS continues to focus on its fraud and abuse work. • Improving Individual Care: The main focus of this element is patient safety. CMS is working on a major, Departmentwide project to improve the safety of patients in hospitals care through error prevention and infection prevention. Additionally, CMS is addressing issues of patient centeredness (improving patient power while in care) and of improving care for dual eligibles, who often have chronic illnesses and need good coordination of care. • Improving Integration of Care: The purpose of this element is to improve the flow of care across the system, especially for chronically ill individuals. This includes approaches that will improve the coordination of care through approaches such as payment for bundles of services, medical homes, and accountable care organizations (ACOs). • Improving Prevention: These element focuses on ways CMS can be more effective in helping prevent illness. The two main areas on which CMS will focus this year will be cardiac prevention (heart attacks and strokes) and perinatal care and disparities.	

	Dr. Berwick stated that all of these activities are embedded in the National Quality Strategy, which is a Department-level framework for improving quality of care. The ACA mandated the establishment of a center for dual eligibles and a center for innovations. The Center for Medicare and Medicaid Innovation (the Innovation Center) has $10 billion in funding over a 10-year period to foster innovations in health care that simultaneously improve quality of care and reduce costs. **Dr. Gilfillan** explained that the mission of the Innovation Center is to identify, validate, and spread new models of payment that reduce program expenditures for Medicare, Medicaid, and CHIP while maintaining or improving quality of care. He stressed the importance of keeping both cost reduction and quality of care in mind at all times. CMS' new mission is to be a trustworthy partner and a constructive force for continuous improvement in health and health care for all Americans. Currently, CMS, health plans, and private insurers in the United States pay for care in segments, which influences how care is provided. Care feels fragmented for patients and doctors, quality of care is inconsistent, and costs are high. The emphasis is not on the patient. CMS' new mission is to help transition to a system that provides seamless, coordinated care focused on outstanding results. In order to move into this new system, CMS needs to find ways to pay for seamless, coordinated, integrated care. This will require new care models, new ways of delivering care, and new payment systems. The Innovation Center works within communities to support the development of innovative payment and care models and to spread these ideas by identifying additional communities in which to test them. By measuring results, the Center can identify approaches that reduce costs and maintain and improve quality. This will provide the HHS Secretary with the evidence needed to change, through rulemaking, the ways in which CMS pays for health care. Once CMS changes the ways it pays for care, many other payers will do so as well. To date, the Innovation Center has hired many staff members and established its website. The website (www.innovations.cms.gov) will soon include information on guidelines and the Center's business model; criteria for evaluating models of care; priority areas (including ACOs, medical homes, bundled payment approaches, and population outcomes); systems of care, especially for those with chronic illnesses; dual eligibles; and health homes. The Center anticipates asking for input on areas of interest and releasing requests for proposals for ideas for new care models.	
	Dr. Gilfillan invited the participants to sign up for the Center's listserve and asked them to share ideas for innovating health care delivery systems and for reaching out to different constituencies nationwide.	TTAG members will share their ideas for innovating health care delivery systems with the Center for Innovation.
	Ms. Davidson indicated that CMS is pleased that **Dr. Berwick** has	

	much knowledge about the Indian health system. She stressed the importance of communicating his commitment to Indian health clearly and repeatedly within CMS. She also emphasized the need to include the TTAG early in discussions about new rules and policies. Sometimes the TTAG learns about rules and policies too late to have as much input as it could provide. **Ms. Majel Dixon**, in looking at the eight states selected for the Multi-Payer Advanced Primary Care Practice Demonstration, expressed concerns about being able to participate in the demonstration or create similar models that are inclusive of Indians. **Dr. Gilfillan** noted that the demonstration to which she referred is one project that originated in the CMS component traditionally responsible for demonstrations, the Office of Research Development Information (ORDI). The Center is working with ORDI on this project as it looks into the medical home model. **Dr. Gilfillan** concluded his remarks by noting that success is defined by better health, better care, and reduced costs through continuous improvement. This will apply to all of the projects undertaken by the Center. The Center is starting out by requesting information from all constituencies about where they think they can make the greatest difference. **Dr. Donald Warne**, Executive Director, Aberdeen Area Tribal Chairmen's Health Board, identified two areas in need of better coordination of care within the Indian health system. The first is dialysis. IHS does not provide dialysis directly (it is usually uses private sector providers). Most dialysis patients are dual eligibles. Patients often have to travel long distances three times a week for treatment and then come back to the IHS facility for diabetes education, podiatry, optometry, etc. He believed that it would improve quality of care if these wraparound services could be provided at the dialysis center. He felt that the situation would improve if the payment systems were also better integrated. **Dr. Warne** offered to work with the Center to develop a model to address this in South Dakota. **Dr. Gilfillan** replied positively about the model. He noted that the Center could waive some of the basic Medicare payment methodologies; Medicaid is a different situation. **Dr. Warne** also noted that most diabetes patients also have behavioral health problems, especially depression. The most common way to self-medicate depression is through alcohol use, which worsens blood sugar and starts a downward spiral. In most states, medical Medicaid and behavioral health Medicaid are two separate entities. In order to treat these conditions, patients could have to navigate through multiple Medicaid systems as well as IHS. This results in uncoordinated care and in worse outcomes than for just diabetes management. **Dr. Berwick** asked how many individuals in the Aberdeen Area might fall into this category. **Dr. Warne** estimated that there are approximately 100,000 active users in the IHS system, with about 35 percent of those over 30 years of age having diabetes in some communities. This figure is as high as 50 percent in Arizona. Anecdotally, he reported seeing a high rate of depression and alcoholism among his patients. **Dr. Berwick** noted	

	that the Center should keep and eye on the diabetes, alcoholism, and depression triad. **Dr. Gilfillan** observed that this might be a perfect opportunity for using the health home approach. State Medicaid programs have an option to use health homes to address dual eligibles and the medical/behavioral health issues. The ACA offers a 90 percent match from the federal government. **Mr. Crouch** supported **Dr. Warne's** comments and felt that the medical home model might be a good fit for this context. He noted that the TTAG has supported data mining efforts (descriptive statistics) and suggested that the Center staff speak with **Ms. Marx** about the resulting products. **Mr. Crouch** noted that the data work indicated that the average age of Indian dual eligibles is much younger than that of dual eligibles in the national population. With regard to excellence in operations, **Mr. Crouch** pointed out that the ACA established a certain set of primarily Medicaid-based benefits for Indians, including no co-pays for referral patients. This makes it essential for CMS to identify recipients who are defined – politically, not racially – as Indians. CMS is working on its systems to enable it to make these identifications, but there is no system for providers to do so. Additionally, the national requirements for the system do not require states to use definitions of Indian in their systems that conform to CMS'. **Ms. Roselyn Begay**, Navajo National Division of Health, reminded participants that the Navajo Nation is located in three states and three federal regions and has a diverse health care system. The Medicaid population is approximately 85,000 within the three states. One of the Section 638 facilities in Arizona is feeling the adverse affect of the state budget deficit. The state has held tribal consultation on ways to protect the Native American benefits package. Beginning in October, the state implemented drastic changes, including reducing coverage, reducing eligibility, and reducing rates. These reductions affected several services for diabetes patients including the elimination of non-emergency transportation, the reduction in podiatry care, and the elimination of dental care. Because of these reductions, IHS or the Section 638 entities assumed the costs of these services. As a result, the Fort Defiance Indian Board suffered a $2.5 million deficit. She did not see how states like Arizona would be able to undertake the innovations that the Center would like to support. **Ms. Davidson** noted the ongoing challenges of ensuring that AI/ANs know that these programs exist and that they can enroll (e.g., translating forms). Indian Country is struggling to catch up to the rest of the country with regard to eligibility and enrollment at a time when states are slashing their programs. States are looking to CMS to define ways to exempt Indians from State Medicaid cuts. She indicated that Indian Country would appreciate more specific communications and leadership from CMS. **Dr. Berwick** indicated that the financial stress being experienced by the states and its cascading effects are of great concern to CMS. The agency is analyzing options under existing authorities for Indian-specific health benefits including waiver demonstrations. He committed to keeping	

	the TTAG informed on the developments in this area. **Dr. Berwick** asked how the Section 638 entities were responding to having to pick up the slack created by the state cuts. **Ms. Begay** replied that they are using Contract Health Service (CHS) dollars, Medicare reimbursements, or third party reimbursements from other services to cover costs. **Ms. Davidson** indicated that the facility mentioned by **Ms. Begay** estimates a $6.5 million reduction in revenue over the course of a single year.	
	Ms. Davidson asked **Dr. Berwick** for his assistance on four issues. The mandatory admission of I/TU/s, IHS direct service, tribally-operated, and urban Indian health centers as essential community providers to the provider networks of health plans in the exchanges is essential. Based on past experience, if Indian I/T/Us are not explicitly mentioned or guidance provided by CMS, these programs will be left out. A second issue related to citizenship documentation for the state exchanges. The TTAG hoped that CMS would make a determination early on. A third issue was the designation of I/T/Us as federally qualified health centers (FQHC) for the purpose of determining patient volume for the meaningful use incentives. This designation is critical. She noted that TTAG would prefer that I/T/Us treated as FQHCs for the limited purpose of qualifying for meaningful use incentive payments (not as FHQC providers). The final issue raised by **Ms. Davidson** was the possible revision of formulas for pharmacy drug costs and dispensing fees for Medicaid. The TTAG is very concerned that these new regulations could negatively affect I/T/U pharmacies. The TTAG would like to be involved in the conversation prior to the writing of the regulations. I/T/U pharmacies provide many services in addition to dispensing medications, including translation and counseling. **Ms. Marx** committed to following up on these issues with **Dr. Berwick** and the relevant CMS components. Following **Dr. Berwick's** departure, **Ms. Davidson** redirected the conversation back to the subject of innovation. She expressed her opinion that there is no greater investment that CMS can make than that made in the Indian health system. The system has been a good steward of federal funds and it does more with less than any other program. **Ms. Butcher** noted Indian Country's commitment to the entire well being of the individual, eventhough it is stymied in this effort by payment silos. This commitment to full care for the individual makes Indian Country an excellent testing ground. **Dr. Gilfillan** agreed and mentioned that a meeting of 10 organizations that CMS gathered to discuss quality criteria for ACOs illustrated this point. The representative from Indian Country discussed how his organization measured everything and worked across all of the pieces. Other organizations had difficulty doing this because they were focused on one element. The key to caring for populations is the commitment of organizational leadership. In 95 percent of cases, the leadership is not sufficiently committed to this. Since Indian Country is committed to population care, he anticipated that there would be natural opportunities to work with the Indian health system, even in an era	**Ms. Marx** will follow up with the Office of the Administrator and the relevant CMS components concerning the four requests made by the TTAG.

	of limited resources. **Dr. Gilfillan** reiterated the Innovation Center's commitment to identifying and spreading best practices. **Ms. Butcher** suggested that the Center set a side a portion of its demonstration funding for Indian Country as it is very difficult for Indian programs to compete with major academic and medical centers. **Dr. Gilfillan** stated that the Center is committed to looking for ideas from organizations other than the usual leaders in the field. **Mr. Crouch** stressed the diversity of Indian Country. Alaska is very different from California. **Dr. Gilfillan** pointed out that the various areas have different challenges. The Center is interested in learning about how different places have solved their unique challenges. **Mr. Carl Harper**, Director, Office of Resource Access and Partnerships, IHS, reiterated **Ms. Butcher's** request that funds be set aside for Indian-specific projects. **Dr. Gilfillan** stated that there is a commitment on the part of CMS to address disparities. The Center will be looking for unique models that address Indian disparities. **Ms. Skeeter** noted that the 34 urban programs have fewer resources than any other programs. These programs are very innovative in the ways they develop their services. She gave **Dr. Gilfillan** two reports that illustrate urban programs' high degree of innovation. **Dr. Linda Frizzell**, NPAIHB, reiterated that the Center should consult with tribes before issuing any requests for proposals or applications. This will help CMS phrase its wording appropriately and result in better results. **Dr. Gilfillan** noted that this was a good suggestion. **Ms. Marx** stated that there is a provision under one of the demonstration projects that talks about testing a model in certain geographic areas including IHS or tribal programs using telehealth services. **Dr. Gilfillan** replied that the Center is interested in telemedicine, especially for rural areas.	
	Ms. Stevens echoed previous comments about stretching funding for Indian health and the necessity of innovating to meet the health care needs of patients. The innovation is already in place; however, the Indian health system needs help getting dollars to its facilities. She suggested that the Center visit IHS facilities to learn more about their innovations. **Dr. Gilfillan** replied that the Center would make a point of doing so. **Ms. Stevens** suggested that CMS solicit success stories from Indian Country. **Dr. Gilfillan** asked the participants to share such stories. He stressed that the Center is looking for any approach that offers better health, better care, and lower costs. **Dr. Gilfillan** asked if Indian health managers are able to access data on Indian populations. **Mr. Crouch** replied that IHS has an embryonic patient management system that helps them understand population-based health. There is widespread use of an electronic health record (EHR) system that has some aspects that are being certified. Additionally, some systems use certified, off-the-shelf EHR packages. TTAG funded studies that organized existing data by IHS structures (areas). He also reported that CRIHB is finishing a matching study	Innovation Center staff will visit IHS facilities to learn more about the innovations they are currently using.

	(funded by TTAG and approved by IHS) that compares 1.5 million Indian names from IHS data with Medicaid paid claims data for 35 Indian states. CRIHB has been able to identify approximately 85 percent of the names as representing true Indian individuals. CHRIB will be able to identify every paid claim for each individual by provider type, geography, specific provider, and IHS area. This will produce the first national snapshot of CMS' investment, through Medicaid, in the Indian community. Additionally, the TTAG sponsored a Medicare study that is not as in-depth that looks at those known to be Indians by IHS. **Dr. Gilfillan** stated that the ACOs with which the Center has met need data on their populations. He asked if Medicare claims data would fill out the data set in meaningful ways. **Ms. Davidson** stated that the TTAG would love to do more data work and she advocated for CMS funding to do so. **Ms. Marx** noted that ACOs must manage populations of at least 5,000 individuals. She pointed out that Indian hospitals and clinics know their beneficiaries. **Mr. Crouch** noted that the barriers to sharing IHS data are increasing, not decreasing. He also added that small Indian health systems that serve only 2,000 or so clients cannot produce statistically significant data but can produce data that is very useful for managing those 2,000 clients. This data is coming increasingly from EHRs and evolving management practices. **Mr. Doneg McDonough**, Consultant, NIHB, suggested that Indian communities be included in the sites that are selected for the various demonstrations so that successful approaches can be expanded in the future to other Indian sites. **Dr. Frizzell** stressed that the data in the system is episodic data. Given the issues surrounding Indian access to care, any data on behavioral health should be used with caution. **Ms. Davidson** added that the limited number of epidemiological centers in Indian Country is a challenge, as is getting states to share epidemiological data. She indicated that CMS could help by communicating the importance of sharing this data with states. **Ms. Majel Dixon** asked if the funds for the state program designs (15 states funded at $1 million each) come from the same source of funds that would be used if Indian Country developed its own set of designs. **Dr. Gilfillan** replied that the money would come from different sources. The project **Ms. Majel Dixon** referenced was one that the Center undertook on behalf of the CMS dual eligibles office. The solicitation is for states only. Other solicitations will be open to other entities such as Indian tribes and health systems. **Ms. Majel Dixon** asked if models to be tested would address women's health needs. **Dr. Gilfillan** explained that this was one of the areas Congress thought the Center might address when it wrote the statutes establishing the Center. The Innovation Center is not required to pursue this topic. **Ms. Majel Dixon** noted the lack of resources to address the high rate of violent crime and victimization of women in Indian Country. She suggested that there is good data	

	on this that should be merged with Medicare/Medicaid models. **Dr. Gilfillan** acknowledged the urgent need to address this problem. The Center could consider projects that improve the models of care affecting women's health. The Center is interested in quality of care – including the quality of the experience of care – and the quality of outcomes. **Ms. Davidson** summarized the major points of the discussion, and emphasized the need to set aside Innovation Center funds for Indian programs. She also stressed the importance of involving Indian Country in discussions early in the process to ensure that the application process for specific projects is not prohibitively cumbersome.	
Center for Consumer Information and Insurance Oversight	**Ms. Davidson** reminded participants that Office of Consumer Information and Insurance Oversight (OCCIIO) recently moved into CMS and became the Center for Consumer Information and Insurance Oversight (CCIIO). Because this was the first opportunity that the TTAG and CCIIO had to meet, she gave a brief description of the TTAG and its work and asked the TTAG members to introduce themselves. **Ms. Laurie McWright**, Director, Health Plans and Exchange Standards Group (HPESG), CCIIO, stated that the CCIIO's predecessor, OCCIIO, was created, as a required by statute, to rapidly implement some of the provisions of the ACA. The way OCCIIO was originally set up was not sustainable given the level of effort required to implement all of the provisions, particularly the exchange provisions. Approximately two months ago, OCCIIO merged into CMS. She estimated that the Center is half way through the merger process. HPESG is responsible for creating the rules related to the standards for the exchanges and the plans that will participate in them. **Ms. McWright** expressed her excitement about being able to speak directly with the TTAG and begin a dialogue on the rule making process. She stressed the importance of the TTAG's input. **Ms. MsWright** hoped to accomplish three things during the meeting: provide an update on ACA mandates as they relate to the exchanges, describe the rule making process and associated timelines, and begin the dialogue between the TTAG and CCIIO, specifically identifying areas of particular concern to the TTAG. She felt that it is always easier to engage with CMS leadership after discussing matters directly with groups such as the TTAG. **Ms. McWright** stated that the exchanges will offer health insurance coverage to individuals and small employers beginning in 2014. The hope is that the exchanges will offer private health plans that are more affordable and better fit individuals' and families' needs. Historically, the opportunity to enroll in health care has often been marked by adverse selection, in which a plan has a sicker population than the population overall. This causes higher administrative costs and premiums. **Ms. McWright** noted the importance of developing sustainable models that include both healthy and less healthy populations within the exchanges.	

	The goal of the ACA is to group the individual and small business markets into risk pools to address adverse selection. The exchanges will spread risk around more broadly, leverage the market, and take advantages of economies of scale that have traditionally been enjoyed by large businesses. CCIIO hopes that there will be a large number of options within the individual and small business markets. This coverage will be delivered through state-based exchanges. The federal government will step in if the states cannot or choose not to offer exchanges. The overall goal of the exchanges is to help the insurance marketplace organize in a way that allows easy comparison of options (one-stop shopping). CCIIO is looking beyond policy options to things such as specifications for websites to ensure that individuals and businesses can begin shopping on the exchanges on January 1, 2014. With regard to eligibility, **Ms. McWright** noted that most individuals would be required to have health insurance by 2014. Individual qualifications include U.S. citizenship or legal residency and lack of access to affordable health care through an employer. Small businesses and employers will be able to shop for coverage that makes use of economies of scale.	
	CCIIO's guiding principles include the state-based nature of the program, the flexibility and efficiency of the exchanges (e.g., ability to respond to local market conditions and unique needs of special populations), and the additional of value (not just another administrative layer). She asked the TTAG to share their ideas about how the exchanges should be structured and how they could meet Indian needs. The exchanges can play a role in streamlining access to care and ensuring continuity of care. She anticipated that there would be much movement in and out of the exchanges. Therefore, it is essential that the exchanges screen people for all of the available programs. For those who come in and out of coverage, there should be options available that do not disrupt the continuity of care. **Mr. Roberts** pointed out that the first round of planning grants that went to states did not include the relevant sections about the need to consult with tribes. The new solicitation for the Phase 3 grants does a good job of including citations about consulting with tribes and demonstrating the consultation. The TTAG is concerned that if consultation is left up to the states, they might not comply with the requirements in an adequate manner. He asked what steps CCIIO plans to take to ensure that states consult with tribes during the planning process and to work with states that are not willing to consult. **Ms. McWright** indicated that she would share more information on this issue later.	TTAG members will share ideas concerning the structure of the exchanges and how the exchanges can meet the needs of AI/ANs.
	Ms. McWright pointed out the importance of public outreach and stakeholder involvement. All relevant populations must be included. CCIIO wants to develop rules that work the affected groups. She	**Ms. McWright** will discuss the need to include expectations regarding tribal consultation in

	emphasized that the funding opportunity language was crafted to make it clear that states need to involve all relevant stakeholders, especially tribes. She promised to discuss the implications of the need for consultation on the upcoming grant making process with CCIIO staff, specifically with regard to monitoring and determining whether expectations are being met. The exchanges need to be accountable with regard to reporting (i.e., plans reporting to the exchanges and the exchanges reporting back to the government and the public). For outreach purposes, it is essential that consumers and stakeholders have the best possible understanding of the available options and know how to compare them. There will be a large number of first time users, many of whom are unfamiliar with the process of making these decisions; therefore, the education process at both the federal and exchange level must be as meaningful as possible. Additionally, there is a financial accountability component at both the federal and state level. **Ms. McWright** stated that CCIIO is in the process of developing proposed rule language for the NPRM. She indicated that it would likely be divided into three parts: requirements for states, requirements for plans, and requirements for employers. CCIIO is working to meet a late spring deadline for the proposed rule. This timeline is a consistent goal at both CMS and the Department level. She indicated that CMS has a formal decision making process that results in greater levels of engagement within the agency. CCIIO hopes to include as much as possible in the NPRM, although it will not include a discussion of the essential health benefits because that rule is on a different timeline. The essential benefits package rule is predicated on a survey being conducted by the Department of Labor that will not be complete until sometime in March. Additionally, the HHS Secretary has contracted with the Institute of Medicine to undertake a public meeting process to engage stakeholders and develop a framework for defining the essential benefits package. This work will not be complete until late August. CCIIO anticipates publishing the second proposed rule in September. The comments from the first and second proposed rules will be combined. **Ms. McWright** did not know if CCIIO would ultimately publish one or two final rules. She expressed her hope that sessions with stakeholders, such as this one, will enable CCIIO to develop a strong rule that reflects stakeholder concerns from the outset. She expressed her hope that the NPRM would make proposals and ask questions that stimulates the submission of feedback. **Ms. Davidson** noted that a recurring theme of TTAG meetings is the way that the TTAG becomes involved in the rule making process much too late. She was encouraged by **Ms. McWright's** comments on early input. She invited CCIIO to participate in work group meetings with small groups of TTAG representatives and technical experts and stressed the importance of having participation by staff with decision-making authority. **Ms. Davidson** stated that the tribes are not clear on how they will fit into the exchange system. She reiterated **Mr. Robert's** point that states need repeated, explicit, written guidance for CMS about the need to work with states. **Ms.**	the CCIIO grant making process with Center staff.

	McWright assured the TTAG members that CCIIO is in a position to ensure that their concerns are heard. She indicated that she could share information on issues with which CCIIO is struggling and that she could carry information from TTAG back to the decision makers. She promised to represent the TTAG's issues accurately and adequately. **Mr. Allen** indicated that he appreciated CCIIO's attitude and approach to pursuing its agenda. He pointed out that the TTAG represents a complex set of communities. The way in which services are provided to these communities is unique within the United States. Too often, Indians are treated as an afterthought in the policy development arena. Policies are put in place before Indian issues have been considered. He promised to provide ongoing advice and support regarding Indian issues. The ACA opens up opportunities to serve Indians who have not been – but are supposed to be – served, particularly those outside of the IHS service areas. It also creates challenges for tribes because they are the first place to which Indians will turn for advice (as opposed to the state system). **Ms. McWright** asked the TTAG how they would define a meaningful consultation process at either the federal or the state level. **Mr. Allen** noted the complexity of the consultation process. There are 565 communities and multiple urban providers. The TTAG can provide information on ways to consult with tribes and providers that involve both formal and practical processes. **Ms. Davidson** stated emphatically that TTAG meetings do not substitute for tribal consultation. The TTAG provides technical guidance to CMS on behalf of Indian Country to ensure that CMS is prepared to go forward with tribal consultation as it develops rules, programs, and policies.	
	Ms. Davison indicated that CMS could very quickly facilitate access by designating the I/T/Us as essential community providers that must be admitted to the networks of any plan within the exchanges. Based on past experience with multiple programs, I/T/Us will lose out on reimbursements for care provided unless they are specifically designated as essential community providers. **Ms. McWright** asked the TTAG to share any information it has supporting a broad designation of essential community providers. **Ms. Davidson** agreed to provide this information to CCIIO. **Mr. Roberts**, going back to the tribal consultation question, noted that the process varies from state to state. He indicated that a state sending a letter to tribes informing them of the content of its submission to CMS and requesting comments within a very short timeframe in not consultation. The process needs to be deliberative and needs to engage tribes in a discussion. **Ms. McWright** thought that the process could involve face-to-face discussions, webinars, and other educational opportunities to identify what is at stake as a first step followed by an opportunity for comment and dialogue. **Mr. Crouch** pointed out that there is an official role for the TTAG as an advisory body to CMS. CCIIO's move into CMS gives it access to the expertise of the TTAG, which includes expertise on data concerning Indians and health care. He informed the CCIIO staff in	TTAG will provide CCIIO with information on the need to designate I/T/Us as essential community providers and the implications of not doing so.

	attendance that there are approximately one-half million American Indians who have incomes greater than 133 percent of the poverty level who are not otherwise insured. Approximately one-third of these live in areas served by the I/T/U system, the rest do not. He noted that the latter group is eligible for a set of benefits, under the CCIIO program, worth approximately $2,000 per Indian. CCIIO needs to identify these individuals and ensure that they receive the benefit. He expressed his concerns that the "no wrong door" application process will actually translate into a "single door entry." Should there be any difficulties with this single point of access, the problems will trickle down to individual Indians. **Mr. Crouch** stated that CCIIO must define who is an Indian. CMS defined Indians in 42 CFR 447.50. CCIIO needs enrollment mechanisms that recognize Indians, allow for errors concerning Indian status to be corrected, and prevent non-Indians from taking advantage of the program. He encouraged CCIIO to integrate the definition of Indian into its data infrastructure design so that there is a meaningful way for Indians to be identified by the system, to be able to identify themselves to the system, and to be known to providers. **Ms. McWright** asked the TTAG to confirm that they worked together to reach consensus on the definition of Indian cited by **Mr. Crouch** and that they felt that the definition is a good one. **Ms. Marx** stated that the definition was actually published by CMS in a regulation. **Mr. Crouch** added that the definition came from IHS, OCIIO, and Medicaid legislation.	
	Ms. Ahniwake Rose, Policy Analyst for Health and Education, NCAI, noted that this issue has been discussed extensively in Indian Country. During its last national meeting, NCAI – which represents all 565 federally recognized tribes – passed a resolution in support of a uniform definition of American Indian. The approved definition resembles that included in the briefing book. The definition includes specific language to ensure that it is only applicable to the way in which CCIIO carries out its ACA duties and that tribes and funding are not adversely affected by it. She indicated that she would forward the definition to CCIIO. **Ms. McWright** asked how the CMS definition of Indian dovetails with the concept of federally-recognized tribes. **Ms. Munson** stated that the ACA bases the phrase "member of an Indian tribe" on three different statutory citations. All three make reference to the federally-recognized tribes. Each also includes other definitions of tribes (Tab F in the briefing materials). **Ms. McWright** stated that the issue is both a definitional one and a functional one (how tribes become federally recognized). **Ms. Munson** explained that the definition of Indian does not make reference to the federally-recognized tribes. The three definitions in the ACA refer to "any Indian tribe, band, or nation." The tax code includes pueblos. The ACA also includes the phrase, "or other organized group or community including any Alaska Native village," as part of its definition. All three laws that define Indian also include the phrase "or region or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, which is recognized as eligible for the special programs and services provided	**Ms. Rose** will forward the NCAI-approved definition to CCIIO.

	by the United States to Indians because of their status as Indians." She noted that the three definitions vary by only four or five words. CMS considered all of the definitions and the implementation of the rules adopted by the IHS in carrying out programs that incorporate the relevant provisions. The regulations were the subject of multiple consultations and multiple rounds of publication and comment. All of the major, national Indian organizations have endorsed the adoption of this definition by CMS. **Ms. Davidson** stated that the CMS definition of Indian (42 CFR 447.50) is the one that CCIIO should use. Establishing citizenship for AI/ANs was resolved through the clarification of citizenship documentation. Any citizenship requirements adopted by CCIIO should build on those already used by CMS. For purposes of establishing identity or citizenship, evidence of tribal membership or tribal documentation satisfies the requirements. CCIIO does not need to develop new definitions.	
	Ms. Davidson indicated that it would also be helpful to have a model Indian addendum template for the exchange plan participation agreements similar to that used with the Part D plans. This prevents plans from having to reinvent the wheel. **Ms. Davidson** promised to provide CCIIO with an example of a model Indian addendum. **Ms. Kris Locke**, TTAG Technical Advisor, thanked the CCIIO staff for coming and starting the dialogue with TTAG. She stated that TTAG could provide advice on solutions to things it does not think will work well and on things that will help expedite access. With regard to tribal consultation, **Ms. Locke** noted that in November 2010, IHS sent out a letter to tribal leaders asking for input on the exchanges and the ACA. Many of the tribes and NIHB sent letters in response. To the best of her knowledge, there has been no effort to use the information provided by tribal leaders to start a dialogue. She asked how the TTAG could share information with CCIIO and have a two-way dialogue on an ongoing basis. **Ms. McWright** indicated that there is a balance between soliciting so much comment that groups do not know what others are saying and not soliciting enough comment. She acknowledged the importance of the comments received for various purposes over the past several months. **Ms. McWright** agreed that it is valuable to bring together responsible CCIIO staff and the TTAG to discuss the issues. **Ms. Munson** urged CCIIO to consider establishing a policy committee with participation by the TTAG subject matter experts. Such a committee would help both sides understand the others' interests in advance of the publication of the Advanced Notice of Proposed Rule Making.	TTAG will share a model Indian addendum with CCIIO for adaptation for use in exchange plans.
	Mr. Roberts recommended that the early innovator grants include an Indian component in each project. Because five of the grantees are in Indian states, he thought that CCIIO should ask them to include an Indian-specific component in other projects. **Ms. McWright** replied that CCIIO would see if this might be possible	**Ms. McWright** will look into the possibility of including Indian-specific components into the early innovator grants.

CHIP Video	**Ms. Gale Marshall**, Two Feathers Management, thanked TAG staff for the opportunity to provide another outreach video for CMS. She noted that the first outreach video that Two Feathers produced for CMS in 2009 is still playing in tribal clinics throughout Indian Country. The new video is designed to increased enrollment in CHIP by encouraging parents, caregivers, and guardians to find out if their children are eligible. Initially, Two Feathers planned to focus on the benefits to the tribe of enrolling, specifically that tribes would be able to provide more services if people enroll in CHIP. Focus group testing showed that this approach did not motivate people to enroll. However, the focus groups indicated that most participants thought of their Indian health benefits as insurance. Focus group participants were very concerned that young women do not receive the prenatal care that could be available to them under CHIP. One of the difficulties in convincing people to enroll in CHIP that they think they already have insurance and they do not understand why they need more. Another barrier is the fear that signing up for CHIP will somehow interfere with the Indian health benefits and/or private insurance families already have. **Ms. Marshall's** stepdaughter – who has two children, is eligible for CHIP, and feared losing something as a result of enrolling – is a prime example of this. **Ms. Marshall** was able to convince her to apply for CHIP and report about her experience. She noted that there is a general lack of knowledge and understanding of these programs. As a result of the information gained through the focus groups, Two Feathers changed the central message of the video to emphasize the importance of learning more about CHIP. The video could not address details because the program varies from state to state. **Ms. Marshall** stated that this video is less didactic than the first CHIP video. The new video took a "real people, real stories" approach. **Ms. Marshall** showed the full video before asking meeting participants for their feedback. **Ms. FInster** noted that the color seemed foggy. **Ms. Marshall** replied that the color is impeccable, because the video is high definition. Running it through an LCD projector washes out the color. **Ms. Munson** was very positive about the video. She had reservations about the idea of the first step toward health for children being enrolling in CHIP. Prenatal care is the real first step; having a partnership with a health care provider is the second. Insurance as the way to wellness is not the right message. **Ms. Finster** noted that the video shows a young mother stating that she can get referrals quicker with CHIP, but does not explain why. **Mr. Crouch** recommended that the section where **Ms. Davidson** refers to being able to "get more" should be reshot to indicate that	

	CHIP helps children get the care they need. **Ms. Skeeter** though that the video should indicate that enrolling in CHIP "helps us [the clinic or agency] give you more services." **Ms. Marshall** indicated that this message did not resonate with focus group participants. They had an attitude of "we get what we get"; therefore, they did not see the connection between more coverage and more services. **Dr. Mim Dixon**, Mim Dixon & Associates, suggested that Two Feathers cut the scene of the child getting the shot (not a "feel good" image), the family walking down the hall (looks like mother is pulling child along by the hand), and the boys throwing things out of the truck (out of context and looks like littering). She also thought that the second list went too fast (especially the telephone number) and required too much reading. **Ms. Marshall** indicated that the graphics are not final and will be improved before the video is finalized. **Ms. Stevens** expressed her appreciation for another tool to help encourage Indians to sign up for resources. She added that her facility still shows the first video. **Ms. Carol Barbero**, TTAG Technical Advisor, Hobbs, Strauss, Dean & Walker, suggested that the segment about being able to access care when out of state be reworded to reflect the universal principle of CHIP and Medicaid that urgent out-of-state care is covered (recognizing that restrictions might apply). **Ms. Marshal** noted that many young parents were excited at the possibility of being able to go outside their counties or off the reservation for care, but Two Feathers had problems getting some people to say this or to get permission to use film of people saying so. In some cases, she thought that the underlying issue related to the quality of service at the local IHS clinic. **Ms. Tracy Jones**, Director, Business Office, Chickasaw Nation Health System, suggested that the video include references to online applications, if they are available.	
Federal Coordinated Care	**Ms. Melanie Bella**, Director, Federal Coordinated Health Care Office (FCHCO) provided an overview of the office's responsibilities and activities. The purpose of the office is to address the needs of and issues related to the dual eligible population and to improve their experience within Medicare and Medicaid. These improvements relate to communication with dual eligibles, the way beneficiaries navigate through the system, the care that they receive, and the cost-effectiveness of that care. The primary goal is to put the person first. The statute also emphasizes improving the state/federal relationship. **Ms. Bella** stated that the Office's sole purpose is to work with dual eligibles. As such, it helps the Medicare and Medicaid sides of the agency better understand each other. Additionally, its personnel serve as "staff extenders" for CMS components with issues touching on dual eligibles. The Office, which officially came into being on December 31, 2010, is focusing on three main areas: program	

	alignment, data analytics, and care models and demonstrations. **Program Alignment** FCHCO is responsible for identifying all of the areas in which Medicare and Medicaid bump up against each other and make it difficult for people to access the care they need. Some of the responsibilities of the program alignment group include grievances and appeals, eligibility and enrollment, coverage standards, home health therapies, quality measurement mechanisms, and financial misalignments. FCHCO is creating an inventory of all of the areas in which there is an opportunity to promote better alignment. The inventory will examine the number of beneficiaries affect by the misalignment, its source (policy, regulation, or statute), and possible ways to rectify the misalignment. As part of its efforts to be transparent, FCHCO will publish a *Federal Register* notice requesting comments in the next few months. In preparation for this, FCHCO has been consulting with its counterparts throughout HHS. The office has a mailbox for comments and hopes to see an increase in comments as it becomes more widely known. **Data Analytics** The focus of this area is the development of a quality measurement strategy for dual eligibles. FCHCO is working on integrating Medicare and Medicaid data. Of particular interest is the various subsets of the dual eligible populations, including those under age 65 (including better understanding the presence or absence of mental illness or substance abuse in this group). Additional subsets mentioned by **Ms. Bella** include those related to functional or clinical conditions and to institutionalization. The goal is to determine how to improve the delivery system, care models, financial mechanisms, and measures and to tailor them for the various subsets to ensure that real people get the care they need. FCHCO is also doing a pathway analysis to compare the experience of those who start out on Medicaid and age into Medicare to that of Medicare beneficiaries who experience functional or financial decline into Medicaid, and to identify points of opportunity for working with beneficiaries and providers. Finally, FCHCO is developing profiles of the dual eligibles at the state and national levels to characterize these individuals, understand the drivers of their care needs, and identify ways to improve the provision of care and reduce costs. **Care Models and Demonstrations** FCHCO is working with the Innovation Center to test new care and payment models. With regard to payment mechanisms, the Office hopes to address the misalignment of payment incentives that can result in poor care (e.g., the difficulty of transfer between Medicaid payment for nursing home care and Medicare payment for hospital care). The Office is also interested in understanding the effect of new care models, such as the accountable care organizations, for complex	

	populations, particularly with regard to social and other supports. Also of concern is how the blending of funding streams will work in a shared savings model to create incentives while preventing opportunities for cost shifting. FCHCO is also working with existing models, specifically the Pharmaceutical Assistance Program and special needs plans, to study integration issues. The goal is to enhance and expand the experience of dual eligbles by taking advantage of these programs as well as programs at the state and local level that are available to dual eligibles. **Ms. Bella** stated the FCHCO is required by statute to produce an annual drug study for all full-benefit dual eligibles. FCHCO must also report on access, outcomes, and expenditures. She anticipated that this report would be challenging to produce because it is difficult to define access let alone measure it. The final report is a report to Congress that will be included in the Secretary's annual budget submission. This report provides FCHCO an opportunity to make statutory recommendations.	
	She asked the TTAG members to share their thoughts and questions about issues that might fall under the Office's area of responsibility. **Ms. Bella** then turned the discussion portion of the session over to **Ms. Sharon Donovan**, FCHCO, CMS.	TTAG members will share their concerns and questions related to the dual eligible population with FCHCO.
	Mr. Crouch stated that the TTAG invested in data research that produced mostly descriptive statistics. One report focused on Medicare and Indians nationally. This report would help FCHCO understand dual eligibles in Indian Country. He noted that Indian dual eligibles are significantly younger than those in the rest of the nation, with disease and lifestyle being the primary reasons for dual eligibility. He indicated that TAG could provide FCHCO with a copy of the report. **Ms. Davidson** stated that getting care through an ITU program further complicates the challenges dual eligibles face with regard to accessing health care and to the reimbursements providers receive for this care. Additionally, the AI/AN population has a higher rate of military service than the national population, which means a relatively large portion of Indians is also eligible for veterans' benefits. This further complicates the process of navigating the system for veterans. With regard to the pathway analysis, **Ms. Davidson** suggested beginning from birth and comparing IHS beneficiaries with non-IHS beneficiaries as they move through Medicaid and CHIP eligibility, reservation residency and non-reservation residency, military service, aging into Medicare, and a host of other variables. She hoped that once the Office begins working on its dual eligibles pathway analysis, it could begin looking at other variables populations face to identify and eliminate barriers to service, coverage, and reimbursement. **Mr. Crouch** added that that FCHCO should also look at the effect of end-stage renal disease (ESRD) on the dual eligible population. ESRD	TTAG will provide FCHCO with copies of the TTAG AI/AN Medicare data report.

	is another condition that begins earlier in Indians than in the general population. **Ms. Butcher** indicated that it would be very helpful if FCHCO would look at the coordination between the Veterans Administration (VA) and the IHS. **Ms. Grace Manuel**, Legislative Council Health Committee, Tohono O'odham Nation, pointed out that there are problems with people, particularly veterans, having to travel long distances (60 or miles each way) for individual services. It would be much easier if they could get their care and/or information in one place. **Ms. Locke** expressed her concern that some of FCHCO's work has the potential to damage Indians and their providers over time. She cited the example of the institution of managed care plans under state Medicaid programs, which had the effect of virtually eliminating Medicare reimbursements from tribal health programs. Additionally, these new plans prohibited referrals to the providers that affected individuals had been seeing. There was much confusion and, as a result, much effort was put into figuring out how these individuals could continue to receive the care they had before the institution of these plans. She stressed that Indians and their providers must fully understand any carve-outs that are being considered and that they must have the ability to opt out of them. **Ms. Locke** also expressed her hopes that FCHCO would work with the tribes to identify and create models for use in Indian Country. She concluded by indicating her disappointment that tribes were not specifically included in FCHCO's list of entities for which it provides technical assistance. **Ms. Bella** indicated that the document to which **Ms. Locke** referred could be changed to be more explicit about potential partners and technical assistance. She indicated that FCHCO is very open to learning about new models **Dr. Dixon** pointed out that the complex of issues for dual eligibles in Indian Country is different from those in the rest of the country. In Indian Country, the problem is the absence of resources (especially nursing homes and home and community-based services), not duplication of resources. Solutions that are culturally appropriate and geographically acceptable are often not financially feasible. **Ms. Donovan** indicted that she has been thinking about these issues and welcomed the opportunity to begin a conversation on this from the population perspective. **Ms. Finster** noted that in New Mexico, dual eligibles make up a large part of the population using Native American and IHS clinics. The state moved toward managed care and a coordinated care model for Medicaid, which resulted in delays in payment of more than one year. She hoped that FCHCO could look into this. **Ms. Munson** urged that FCHCO build in an exception to the rule concerning economies of scale. Because of the small populations, rural settings, and need for culturally appropriate approaches, programs designed for Indians serve very small populations. This means that such programs will cost more on a per capita basis than	

	other programs. However, they are the only way those individuals will likely receive care that is appropriate to their needs. **Ms. Donovan** agreed that the point is valid, especially in areas such as Montana or New Mexico. FCHCO will need to be very strong in its explanations of why this type of more costly care is important.	
NIHB Update	<u>**Regulations Review Report**</u> **Mr. McDonough** began the session by describing the regulation review report (Tab H in the meeting materials) produced by NIHB. The report summarizes regulations issued over the past year that are of interest to Indian Country. While not comprehensive, the report covers the most important regulations. It consists of a summary of each regulation and identifies the issue date, version (proposed or final rule), whether NIHB or TTAG provided comments, and whether the comments were incorporated into the regulatory action. NIHB updates the report on a monthly basis (currently it is updated biweekly). The report consists of three parts. Table A identifies the regulations included in the report, the information available on each regulation, and status within the rule making process. Table B consists of a list of the regulations, a summary of the regulation, and bulleted points about the comments. Table C matches up specific recommendations with subsequent actions, if any. The report provides a way of tracking the various regulations that are in development by CMS and offers CMS a tool within CMS to monitor the associated issues. **Mr. McDonough** welcomed TTAG comments on the report. **Ms. Marx** noted that the project is funded under the IDDA with IHS. She indicated that this project provides research on issues of concern in Indian Country and helps TAG determine whether comments on a proposed regulation had an effect on the final regulation. NIHB is only looking at CMS regulations, not those being issued by other HHS components. **Ms. Locke** was pleased to see that this research was being done. She thought it would help bring together multiple entities to discuss the implications for their programs and that it fills a need for information. **Ms. Rose** agreed with **Ms. Locke** and praised NIHB for the quality and quantity of its work on regulatory issues. She felt that the report would help organizations identify issues of which they should be aware and guide their thinking on regulatory issues. **Mr. McDonough** noted with sadness that the upcoming retirement of **Ms. Barbero** would be a major loss in terms of available resources for these issues. **Ms. Barbero** asked what TAG does with the report, especially with regard to other components within CMS. **Ms. Marx** replied that it helps TAG track the issues and enables TAG to follow up with program staff on the various issues. **Ms. Barbero** asked if this report could help bring the tribal interests into the regulatory development process at an earlier stage. **Ms. Marx** felt that the report could be an effective tool both with regard to showing that the normal NPRM	 TTAG members will provide comments on the ACA regulation review report to NIHB.

	process works to incorporate Indian concerns and as a means of following up on regulations that might have slipped under Indian Country's radar. **Mr. Harper** felt that the report could serve as a single point of information concerning the developing regulations. It has the potential to help organizations plan and prepare their responses to the various notices. **Ms. Munson** asked whether the intent of the report is to look at all NPRMs and identify those with Indian implications or whether it is to catalogue those that have already been identified as having Indian implications. She did not see how it would be possible to do the former, considering the work required to do so. **Ms. Marx** indicated that TAG is tracking regulations on its own. The NIHB report serves as a double check and ensures that TAG is not overlooking anything. **Ms. Munson** stated that she was inquiring about the scope of work concerning the report. She noted that it seems that the report focuses on regulations that have already been determined to have Indian implications and have been commented on. She was concerned that NIHB might be held responsible for missing the identification of an opportunity to comment when it has not been given the appropriate resources to review all proposed regulations. **Mr. McDonough** reiterated that this project focuses on tracking comments that have been submitted to CMS, not on identifying regulations on which to comment. **Mr. Crouch** asked for clarification about who – the funding agencies or NIHB – chooses which regulations NIHB includes in the report. **Mr. McDonough** replied that the analysis of research on regulations and comments provided by NIHB and the TTAG is the basis on which these groups decide whether they will comment on specific regulations. The report tracks the regulations on which NIHB or TTAG commented as well as those on which they did not (including the reasons why comments were not submitted). **Mr. Crouch** thought that there is a great degree of randomness in terms of the regulations that are included. **Ms. Marx** stated that there is a process in place for reviewing the *Federal Register* for notices of interest to Indians, which reduces the randomness factor. The discretionary element relates to the decision on whether to comment or not. **Mr. McDonough** stressed that there is an underlying framework to the process. He noted the burdens developing comments places on the various groups. The list is finite and cannot list all of the issues of concern to Indian Country. **Ms. Munson** commented that reviewing the *Federal Register* for notices is one thing, but reviewing each of the notices is a much more time consuming task because NPRMs can exceed 300 pages. Simply reading each NRPM is beyond the scope of resources available at NIHB or the entire tribal system. The randomness comes in determining which NPRMs should be read and identified as requiring comments from Indian Country. She was concerned that there will be no expectation that the NIHB process provide a meaningful opportunity to comment on all of the relevant regulations.	

	Mr. Crouch expressed his gratitude for the rigorous process used to produce the report. **Budget Update** **Ms. Evangelyn Dotomain**, Deputy Director, NIHB, reported on the implications of the lack of a cooperative agreement with IHS for FY 2011, including the implications for funding the Medicare and Medicaid Policy Committee (MMPC) and the TTAG. IHS notified NIHB that the FY 2011 cooperative agreement will be posted as a limited competition award, not a sole source award. She anticipated that the competition would be announced sometime in March. She did not have any information on the anticipated award timeline. **Ms. Dotomain** reported that NIHB is currently operating under a no-cost extension of the FY 2010 IDDA through the end of June. Not accounting for the charges related to the current TTAG face-to-face meeting and accrued personnel charges, $23,000 remains for MMPC and $45,000 for TTAG. **Mr. Allen** expressed his displeasure with the process for funding NIHB and the TTAG. By converting the award to a competitive one, IHS has injected a degree of uncertainty into the system. He was concerned that the bidding organizations would not have the required understanding of the issues or the capacity to undertake the needed projects. **Ms. Rose** noted that NCAI is having similar problems with one of its projects. She suggested that the TTAG draft a letter supporting NIHB that could be reviewed by the tribal leaders at the NCAI Winter Session Conference. She anticipated that the leaders would lend their support to this issue. **Ms. Dotomain** added that there will be a $500,000 cut to the IHS cooperative agreement for FY 2012 **Ms. Skeeter** made a motion to take the meeting into a closed session to continue discussing the budget issues raised by **Ms. Dotomain**. **Mr. Crouch** seconded the motion. The motion carried unanimously and the meeting transitioned into a closed session.	
Adjourn	In recognition of the motion to go into closed session, **Ms. Davidson** adjourned the public portion of the meeting.	

February 24, 2011
Face-to-Face Meeting – Summary

Agenda Item	Discussion	Action
Documents Received	• Outreach and Education Subcommittee Summary Report • TTAG Long-Term Care Subcommittee Charge • Data Research and Analysis Report (Data Subcommittee) • HHS Budget Consultation Meeting – Draft Agenda	
Call to Order	**Ms. Davidson** thanked the participants for their attendance at the second day of the TTAG meeting.	
Follow Up on February 23 Budget Session	**Ms. Davidson** stated that there would be an opportunity to follow up on the previous day's closed session budget discussion later in the morning. At that time, **Ms. Begay** would be available to participate in the discussion via conference call. Additionally, there was a possibility that **Mr. Randy Grinnell**, Deputy Director, IHS, or another IHS representative would be able to participate in the discussion. The group scheduled the session for 11:00 a.m.	
Veterans Administration Reimbursement Requirement in the IHCIA	**Ms. Davidson** explained that delays in receiving VA reimbursements could inhibit tribal facilities' ability to seek other reimbursements, such as Medicare and Medicaid, which are payers of last resort. The ACA became effective almost one year ago. Every day that passes without a mechanism for reimbursement is a day that compromises Indian health care providers' ability to provide veterans the care to which they are entitled. She advocated for speeding up the process of solving the problem of streamlining payments. The TTAG requested that it be allowed to participate in the VA/IHS work group to help identify solutions to this problem. **Ms. Kathy Hughes**, Vice Chairwoman, Sovereign Nation of Oneida, felt that CMS should also be included in the group as many of the Indian veterans seeking care in the Indian system are Medicare and/or Medicaid recipients. It is important that all of the potential payers are seated at the table to discuss streamlining the payment process. **Mr. Harper** reported that he had spoken with **Dr. Yvette Roubideaux**, Director, IHS, and that the streamlining of payment is a priority and has been put on a fast track. **Ms. Butcher** stated that this situation is a perfect example of fragmentation of care. **Mr. Crouch** agreed with **Ms. Butcher** and added that he was initially very disappointed to see that the document did not address the payment issue. **Ms. Marx** indicated that TAG has been working with IHS and the VA to provide assistance in this area. The agencies are discussing the possibility of a single application that would address Medicaid eligibility. CMS is also prepared to address the secondary payer rule. IHS and VA need to determine which services will be covered and at what level they will be reimbursed. CMS cannot determine how the secondary payer rules will work until these decisions have been made.	

	Ms. Munson noted the need for a document from CMS describing reimbursement policies during the period in which IHS and VA are negotiating secondary payer issues for audit purposes. Audits tend to run three or four years behind the activities being audited. By the time audits come around, there is no guarantee that the people who are currently in positions that would interact with auditors would still be in those positions when the audits occur. There might not be anyone available to explain that tribes could not bill until IHS and the VA had worked out the payment issues. CMS should indicate in writing that the secondary payer rules do not apply until IHS and VA reach an agreement. **Ms. Butcher** added that a simple instruction in the Office of Management and Budget circular is all that is needed to prevent all tribal programs from having to deal with this issue at audit time. **Ms. Marx** replied that Medicare and Medicaid would suspend the secondary payer rule until the IHS and VA reach agreement. She promised to take this information back to CMS for consideration and possible written clarification.	**Ms. Marx** will report back to CMS on the TTAG's concerns about the secondary payer rule and request written clarification of the rule.
Tribal Funded Health Benefits and Medicare/Medicaid Secondary Payer Issues	**Mr. Roberts** framed the issue by explaining a recent decision in Oregon. The state Medicaid program informed one of the tribes that their self-funded plan, which is part of their CHS program, is primary to the Medicaid program with regard to payment. This is a similar situation to that addressed in the January 13, 2010, CMS decision letter regarding the Medicare secondary payer situation with the Seminole Tribe of Florida (Tab J in the meeting materials). The tribe contributed its own resources to its CHS program and developed a self-funded benefit plan for tribal members. The plan is administered as part of the CHS program. Because of this, the TTAG believes that Medicare should be primary to the self-funded plan with respect to Indian health resources. He indicated that this is a CHS benefit plan that has gotten caught up in the context of self-funded plans and erroneously interpreted as a group insurance plan. **Mr. Roberts** requested that CMS provide guidance for the NACs so that they could, in turn, provide technical assistance to states on this issue. **Mr. Rodger Goodacre**, TAG, OEABS, CMS, asked **Mr. Roberts** to clarify whether the plan was self-funded by the tribe or whether it was a tribally-purchased indemnity plan. **Mr. Roberts** replied that it was a self-funded plan. **Ms. Locke** pointed out that tribes might decide to take this route because self-funded plans are set up so that services are leased or purchased. This allows tribes to manage and pay claims (which could reduce the cost of the CHS program). Additionally, self-funded plans can contract with provider networks that offer discounts that would not otherwise be available for CHS. She felt that it is clear that this is not insurance and that the Seminole letter is correct. **Ms. Hughes** noted that, in many cases, tribes match funds with their own dollars in order to keep clinics open and operating. **Ms. Marx** asked if the program in Oregon has received a denial. **Mr. Roberts** replied affirmatively. **Ms. Marx** indicated that TAG would	TAG will look into Oregon's denial of a tribe's secondary

	look into the matter. **Ms. Munson** thought that it is important to move away from the idea of this as a self-funded plan. In actuality, it is a case of a tribe using its own funds and merging them with IHS CHS funds. It is convenient for IHS beneficiaries who receive CHS services to think of it as an insurance plan because they receive benefits. Functionally, it is not an insurance plan. The label "self-funded plan" is not appropriate in this case. **Ms. Marx** asked if the program pays for referrals under the CHS program and follows all regulations. **Mr. Roberts** indicated that it is administered as part of the CHS program and follows all of the program guidance. **Ms. Barbero** observed that Oregon misunderstood the nature of the plan. She thought that the tribe should work with CMS to go back to the state and clear up any misunderstandings. **Mr. Harper** noted that this area is ambiguous. In the past, CMS has considered tribal self-insurance plans as the primary payer. This hinges on the definition of self-insurance plans. Too often, an individual can be eligible for Medicare, Medicaid, and tribal self-insurance and still not be able to receive care because each payer claims it is not the primary payer. The simplest solution to this problem would be for CMS to determine that tribal self-insurance programs are secondary payers to Medicare and Medicaid. **Ms. Davidson** stated that the question under discussion is whether the tribal program in Oregon is truly a self-insurance plan. If it does not meet the requirements for such a plan, the rule cited by the state does not apply. **Mr. Crouch** noted that both types of arrangements exist in Indian Country. At one time, the Indian Health Care Improvement Act identified tribally self-funded indemnity plans as something that IHS could not bill. Negotiations allowed IHS to bill in cases where the tribes desired it. He did not think that the arrangement described by **Mr. Roberts** met the definition of insurance. It would be very helpful to have some assistance in sorting out the various types of arrangements. **Ms. Hughes** stated that the Oneida Nation has self-funded life insurance that provides birth to death coverage for all tribal members. The situation is different for health care. The nation funds the clinic. If members can come to the clinic, their care is provided to them. The tribe cannot afford health insurance plans for all of its members around the world. **Ms. Davidson** asked what action **Mr. Roberts** would like taken on this matter. He asked that TAG reach out to the NACs and provide them with the information needed to address this issue. **Ms. Marx** indicated that TAG would follow up with the NACs.	payer status for its self-funded plan that is part of its CHS program. TAG will provide the NACs with the information necessary to address the Medicaid secondary payer situation in their states.

	Ms. Stevens suggested that the problem could be avoided by moving the tribal dollars into the health program, where they could be used to supplement the individual members' needs. **Mr. Roberts** felt that the problem was a misunderstanding about the definition of self-funded plans. **Ms. Munson** suggested that the TTAG draft the language that it would like for TAG to consider. She thought it might be helpful to have things explained in more detail. **Ms. Marx** indicated that TAG would appreciate such a document.	TTAG will draft language concerning the secondary payer rule for possible use in TAG guidance.
ARRA Section 5006 Update	**Ms. Cyndi Gillaspie**, Lead NAC, CMS, began the discussion of the Indian exemptions from cost sharing, co-pays, and premiums by noting that there are five major protections contained in ARRA Section 5006. The first protection is the cost-sharing exemption. CMS is working with states on an individual basis until the changes in policy are released. She reported that the letter outlining the changes is in the CMS clearance process. **Mr. Crouch** asked if the letter was an official SMD letter. **Ms. Gillaspie** replied affirmatively and noted that the initial guidance on this matter tied the exemption to CHS referrals. The new guidance indicates that anyone who has ever used an I/T/U or a contract health service is exempt from all cost sharing in the program. **Mr. Crouch** asked if the letter includes guidance concerning the ways in which providers can identify eligible individuals. **Ms. Gillaspie** indicated that tribal documents and active user letters are acceptable documentation for the exemption. **Mr. Crouch** was concerned that there was no guidance for state plans concerning methods for identifying those who are eligible for this benefit. **Ms. Gillaspie** stated that CMS would consider developing such guidance and noted that there are other populations that are eligible for cost-sharing exemptions in Medicaid. In general, these groups are identified on their Medicaid cards and in the Medicaid Management Information System (MMIS). She indicated that this information would be included in the implementation discussion. **Ms. Gillaspie** noted that CMS is developing a new pre-print; she thought this information could be included in the document. **Ms. Barbero** thought that these types of ideas could be very helpful to states. She asked if CMS was familiar with the various markers states are using to identify AI/ANs who are eligible for this benefit. **Ms. Gillaspie** indicated most states are using a flag on the eligibility system that tells providers not to charge cost sharing as well as a flag on the MMIS that tells the payer not to subtract the cost sharing from the payment. **Ms. Barbero** asked how these markers are added to the individual files. **Ms. Gillaspie** indicated that states use different methods, including marking files in which there has been at least one claim paid to an I/T/U. **Dr. Dixon** thought that a spreadsheet showing the systems for identifying those eligible for the exemption within each of the states would be helpful to tribes. States will need to employ the same type	

	of systems as they begin implementing the exchanges. **Mr. Crouch** noted that producing such a report is a very big project. The Data Subcommittee produced a 20-page report on this subject prior to the implementation of this particular benefit. The NACs are not familiar with how states identify eligible beneficiaries. He was surprised to learn that not all providers have an electronic way to look up beneficiaries. **Ms. Hughes** reported that she recently participated in an NIHB meeting in Atlanta convened to address these types of issues. Participants included representatives from CMS, IHS, and tribes as well as seven SMDs. Cost sharing was one of the topics discussed, and meeting participants shared the ways in which they deal with it. She thought that NIHB would follow up on this discussion with another meeting. **Ms. Stevens** stressed the importance of tribes having guidance from CMS. Written guidance from CMS helps tribes inform the local offices responsible for enrollment about the exemption requirements. **Ms. Gillaspie** asked the TTAG members to identify states in which the exemptions are not working as well as they should so that CMS can step in and provide assistance. **Ms. Davidson** asked CMS to provide very clear guidance on the exemption to SMDs. The TTAG, NIHB, NCAI, and other Indian organizations and leaders should also receive copies of the guidance so that they can further distribute it to their communities and constituencies. She also requested that providers receive guidance on this. Finally, she asked **Ms. Gillaspie** to share the list of states that are currently working with CMS with the TTAG members. **Ms. Gillaspie** promised to do so. **Ms. Lane Terwilliger**, Family and Children's Health Program Group, CMCS, CMS, pointed out that states generally end up working with CMS on the exemptions because they originally sought help on other aspects of their cost-sharing arrangements. Problems with the Indian exemptions only become apparent as CMS begins working with the states on other issues. **Ms. Hughes** asked whether states have consulted with tribes on the language that they have in their plans. **Ms. Gillaspie** stated that the cost-sharing compliance was mandated by statute in 2009; therefore, this should not be something new that comes in as a change in a state plan. With regard to other changes in the state plans, CMS is requiring consultation, proof of consultation, and a summary of tribal and I/T/U feedback with the state's response to it. **Ms. Barbero** asked if the statutory requirement is part of the audit items for the state Medicaid plans and part of the compliance effort. **Ms. Gillaspie** replied affirmatively. The CMS regions have a process for initiating compliance actions when a state does not comply with an administrative function.	TTAG members will identify states in which the cost-sharing exemptions are not working as well as possible. **Ms. Gillaspie** will share the list of states that are working with CMS on the cost-sharing exemptions with the TTAG.

	Ms. Munson noted that there are several things under discussion and that she would like to clarify them a little more. First, she asked whether the letter included under Tab K of the meeting materials is a letter developed by IHS for use by CHS programs to remind CHS providers that the referred patient is exempt from co-pays (It is an IHS letter). She thought that this letter should have clarified that referrals from the tribe constitute CHS referrals, which have no co-pays. Many CHS administrators and staff in tribal and IHS locations still think the program only applies when the IHS or tribal program has committed to payment. **Ms. Munson's** second issue was the way in which states identify Indians for various purposes. She pointed out the difficulties resulting from the lack of an electronic means for sharing this data with providers. It is important to discuss the multiple means by which CMS, IHS, and state Medicaid agencies can work together to provide documentation to individual Indians that can be shown to providers in cases where the state data is inadequate. **Ms. Gillaspie** noted that the letter referenced by **Ms. Munson** is one of the pieces that will help with the exemptions. She indicated that she had recently sent a draft rewrite of it to **Ms. Marx**. She indicated that TTAG input on the letter would be helpful. **Mr. Jim Lamb**, Alaska Area Alternate and Director, Patient Financial Services, Alaska Native Medical Health Consortium, stated that providers expend a tremendous amount of resources ensuring that they remain in compliance. He asked if CMS would consider adding language to the SMD letter concerning the consequences for non-compliance. **Ms. Gillaspie** indicated that she could ask about this at CMS. **Ms. Stevens** noted that there are ongoing problems with enrollment staff not understanding the citizenship documentation requirements for Indians. **Ms. Locke** asked if CMS is also working on the ACA cost-sharing exemptions for Indians. She felt that the implementation of the ACA exemptions would be as challenging as the ARRA implementation. **Ms. Terwilliger** replied that some of the staff members in her office are working on ACA in various work groups. She noted that eligibility for cost sharing has not changed under ACA. With regard to AI/ANs with incomes over 133 percent of the poverty level, her office is working with CCIIO on the definition of Indian and the transitions between Medicaid and the exchanges. Currently, the focus is on resolving multiple issues within the Medicaid cost-sharing program. **Ms. Locke** felt that many of the same problems that are currently being addressed could show up again during ACA implementation. She thought that it might be beneficial to start thinking about these issues now while the exchanges are being developed. **Ms. Gillaspie** agreed that it would be beneficial to have all of the processes associated with cost sharing in place before the exchanges get started. Before this can happen, the involved parties need to agree that the same group of people will receive the benefits.	TTAG members will provide comments on the IHS letter concerning CHS and cost sharing to **Ms. Gillaspie**. CMS will consider adding language to the SMD letter concerning the consequences of non-compliance with cost-sharing exemption rules.

	Mr. Crouch asked what could be done to speed up the process in California. On July 1, a mandatory co-pay requirement goes into effect in California. He asked what he could do to advance the implementation of the cost-sharing exemption. **Ms. Gillaspie** indicated that CMS needs to work with the state to ensure that the exemptions are being implemented. **Ms. Terwilliger** asked if he was referring to the new demonstration requirements or to the state plans. **Mr. Crouch** indicated that he was referring to both. **Ms. Gillaspie** turned the discussion to the next three protections: resource exclusions, estate recovery, and managed care. She stated that the NACs and the Regional Offices have some work plan requirements for the coming year focused on the institutionalization of these three items in the states. CMS has found that, in many cases, Medicaid complies with the managed care protections but many CHIP plans do not. She asked the TTAG members to report any problems related to these requirements of which they are aware. **Ms. Gillaspie** also addressed the outstationing of enrollment workers at tribal and urban clinics. She asked the TTAG members to share any information that they might have on states that are doing a poor job or on ones that are fulfilling the requirement well. **Mr. Roberts** noted that his group would be pleased to have CMS come out to Idaho to see how the program is doing. He indicated that outstationing is a significant issue in Idaho. He asked how CMS determines whether the optional mechanism for outstationing workers meets the needs of tribes (e.g., length of travel, frequency of staffing). **Ms. Gillaspie** noted that the opportunity to apply must exist at any tribal or urban Indian organization. The requirements include the ability to protect application data, conduct interviews, and gather verifications. **Ms. Gillaspie** indicated that most of the reviews would likely take place in the summer. **Mr. Crouch** asked if states with functioning application programs are exempt from the outstationing requirements. **Ms. Gillaspie** stated that no state is exempt from the requirements. She also indicated that there could be many different ways of fulfilling the requirements, including online applications. The key is demonstrating the ability to apply at the specified sites. **Ms. Stevens** asked what determines the frequency with which an outstationed worker comes to a particular facility. **Ms. Gillaspie** indicated that states base the frequency on the estimated number of Medicaid and CHIP recipients. **Ms. Stevens'** organization received two different explanations. One explanation was that population was the determining factor. Her organization asked the state to count the immediate area and outlying areas around the clinic (where all women in the area come for prenatal care). Instead, the state is counting the population of each of the outlying communities, which are too small individually to justify a visit by an outstationed worker. They have also had trouble getting the schedule for the workers who do come to match up with their peak times for maternal health visits at the clinic. **Ms. Stevens'** organization has also been told that outstationing is based on the volume of applications, which cannot be known ahead of time. **Ms. Gillaspie** stated that this is an example	TTAG members will report any difficulties their constituents are experiencing with the implementation of the ARRA resource exclusions, estate recovery, and managed care protections to **Ms. Gillaspie**. TTAG members will share examples of good and poor applications of outstationing of enrollment workers.

	of the types of situations CMS needs to know about so that it can develop common sense approaches to this requirement. The final protection about which **Ms. Gillaspie** reported related to state/tribal consultation policies. CMS has received 31 state consultation plans. One state withdrew because it submitted its policy with other materials and intends it resubmit it as a single document. One additional state has submitted a draft consultation policy. There are only a handful of states that have not yet submitted their policies to CMS for review (i.e., Illinois, Montana, New York, North Dakota, and South Dakota). Submitted plans range from robust, well thought out policies to ones that will need to be completely rewritten. **Ms. Terwilliger** stated that, in all cases, CMS needs to confirm that the states have discussed their plans with their respective tribes. Additionally, CMS encourages all of the states to actually call their tribes and not limit their communications to email. She reported that two state/tribal consultation plans have been approved so far and that several more are very close to receiving approval. **Ms. Terwilliger** added that her office deals with thousands of state plan amendment requests each year. CMS has many tools to help it determine whether state consultation has occurred. This process will be much easier when the state plans, which describe the consultation process, are in place. In cases where a state's plan is not sufficient to meet the CMS requirements and the state does not withdraw the proposed plan, CMS must move to issue a disapproval of the policy, **Ms. Terwilliger** explained. While CMS has come close to issuing disapprovals, the states have always decided to withdraw them. CMS takes tribal consultation seriously and monitors what happens in each state closely. **Ms. Stevens** asked **Ms. Gillaspie** and **Ms. Terwilliger** to keep an eye out for New York's tribal submission. She had heard reports about the state in the past that raised concerns over the type of consultation policy the state might submit. **Ms. Gillaspie** replied that Associate Regional Administrators for each of the states that have not submitted policies reach out to the states to remind them that they must work with the I/T/U and develop a their consultation policies.	
TTAG Member Recognition	**Ms. Marx** presented **Ms. Barbero**, who will retire in the near future, a plaque in recognition of her work on behalf of the TTAG and Indian issues. **Ms. Barbero** thanked TAG and the TTAG for the privilege of working with them and expressed her appreciation for the cooperation offered by the federal staff and the support and talent provided by the tribal community.	
Budget Discussion (Closed Session)	At this time, the TTAG held a closed session in order to continue the budget discussion begun the previous afternoon.	

Subcommittee Reports	**<u>Outreach and Education</u>** **Ms. Hughes** referred participants to the summary report handed out during this session. **<u>Data</u>** **Mr. Crouch** reported that participants received a handout containing an updated timeline for the deliverables for the Medicaid/IHS data report. Additionally, members received via email frequency counts from the first national matching study of Medicaid paid claims files and IHS patient registration data. **Mr. Crouch** reported that approximately 37 percent of the IHS active users are enrolled in Medicaid. Medicaid enrollment varies between 24 percent and 74 percent. He stated that additional information from the study would be available in six months. **<u>Long-Term Care</u>** **Mr. John Johns**, TAG, OEABS, CMS, reported on the Subcommittee's activities on behalf of the Subcommittee Chair, **Dr. Judy Goforth Parker**, Administrator, Chickasaw Nation Division of Health, who was unable to attend. The Subcommittee has held three calls since it resumed meeting late last year. The members drafted a new charge, copies of which were handed out at the meeting. **Mr. Johns** requested that the TTAG members review the charge and share any comments they might have with the Subcommittee. The Subcommittee is also advising Kauffman and Associates, Inc. about the research it is conducting on LTC under its contract with TAG. Specifically the Subcommittee provided recommendations concerning focus groups and potential focus group participants.	TTAG members will review and comment on the updated LTC Subcommittee charter.
HHS Budget Consultation	Participants received a copy of the draft agenda for the HHS Budget Consultation Meeting. **Ms. Marx** reviewed the agenda for the March 2-3 meeting. **Ms. Davidson** stated that the TTAG is in the process of developing comments for the meeting. **Ms. Marx** asked that a copy of the comments be sent to her prior to the meeting. **Ms. Locke** asked if there were any items that she thought should be included in the TTAG comments. **Ms. Marx** suggested that updates to the Strategic Plan, the ability to work directly with NIHB on projects, and additional FTEs for TAG staff might be recommendations to include in the comments. **Ms. Skeeter** report that the national urban programs also submitted testimony and that she will attend the meeting and testify.	TTAG will provide its comments for the HHS Budget Consultation Meeting to TAG prior to March 2.
Tribal Affairs Group Report (continued from February 23)	**Ms. Davidson** reminded participants that **Ms. Marx** had reported on the ACA Implementation Plan during the meeting on February 23. **Ms. Marx** stated that copies are now available but added that the discussions held over the course of this face-to-face meeting created the need to revise the plan. She recommended that TAG revise the document, distribute it to the TTAG and the MMPC, and discuss it	

	during the March TTAG conference call. The group decided to postpone the discussion so that copies of the updated plan could be distributed and used for reference purposes during the next TTAG conference call. **Ms. Davidson** reminded participants that the call is scheduled to take place on March 9 from 2:30 p.m. to 4:00 p.m. EST. **Ms. Marx** announced that copies of the CRIHB draft reports were available for pick up at the conclusion of the meeting. The first report focused on uninsured individuals with incomes between 133 percent and 400 percent of the poverty level based on the American Community Survey. The second report is based on a Medicaid survey. Finally, she stated that the meeting room would be available for Subcommittee meetings in the afternoon and requested that the Tribal Consultation Policy Subcommittee meet at that time.	
Adjourn	With no more business to discuss, **Ms. Davidson** adjourned the meeting.	