

# Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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November 10, 2009

## Face to Face Meeting - Action Items

Action Item	Timeline	Person Responsible	Status	Notes
Distribute TTAG briefing book electronically.	ASAP	NIHB	Completed	
Approve November 10-11 Agenda.	Nov. 10	TTAG	Completed	
Approve July 30-31, August 19, and October 14, 2009 meeting minutes.	Nov. 10	TTAG	Completed	
Send out draft meeting minutes to TTAG members for simultaneous review with CMS.	Upon receipt	CMS	Ongoing	
Follow up on funding a symposium on the use of Medicare data in Indian Country.	ASAP	TTAG and CMS	Ongoing	
Follow up on funding the required research and production of a Medicaid data report.	ASAP	TTAG and CMS	Ongoing	
Develop and include a statement of TTAG support for the Medicaid data project for submission to IHS.	ASAP	TTAG	Ongoing	
Use proposed Medicaid data report to develop baseline information on health care in Indian Country.	ASAP	TTAG	Ongoing, pending approval of report	
Submit to CMS a written proposal for the development of the Medicaid data report.	ASAP	TTAG	Ongoing	
Plan the HITECH roundtable.	ASAP	TTAG Data Subcommittee and CMS	Ongoing	
Identify strategies for encouraging state consultation with tribes per ARRA.	ASAP	CMS	Ongoing	
Submit examples of challenges/barriers tribes face concerning LTC to the CMS Administrator.	ASAP	LTC Subcommittee	Ongoing	
Incorporate TTAG feedback into CMS MAM options letters for states.	ASAP	CMS	Ongoing	
Initiate communication with states concerning MAM options.	ASAP	CMS	Ongoing	
Develop MAM guidance for states based on options paper.	ASAP	CMS	Ongoing	
Provide TTAG members with copies of the behavioral/mental health services questionnaire.	ASAP	OIG	Ongoing	
Encourage tribal response to the OIG behavioral/mental health services questionnaire.	ASAP	TTAG	Ongoing	
Provide examples of ASB challenges to KAI for possible inclusion in the ASB study.	ASAP	TTAG	Ongoing	

Provide input to KAI on the development of the O&E and ASB research projects.	ASAP	TTAG	Ongoing	
Share information concerning promising models with KAI.	ASAP	CMSO	Ongoing	
Identify priorities for funding tied to strategic plan goals.	November 10	TTAG Subcommittee Chairs	Completed	
Include the proposed Medicare data symposium in the February agenda.	February 2010	CMS and TTAG	Ongoing	
Submit comments concerning HITECH meaningful use via the public comment process.	ASAP	TTAG	Ongoing	
Identify budget placeholders for the FY 2010 TTAG budget.	ASAP	TTAG	Ongoing	
Assist TTAG manage the process for interacting with government councils.	ASAP	CMS	Ongoing	
Identify health care reform priority issues for CMS to track.	ASAP	TTAG	Ongoing	
Work to prevent the sunset of the MMA Section 630 DME provisions.	ASAP	CMS	Ongoing	
Consider holding a conference for the tribal CHIPRA grantees.	ASAP	CMS	Ongoing	
Work to streamline the transfer of funding between HHS agencies and NIHB.	ASAP	CMS	Ongoing	
Seminole Nation, look into why the claims are being denied	ASAP	CMS	Ongoing	

**November 10, 2009**

**Face to Face Meeting - Summary**

<b>Agenda Item</b>	<b>Discussion</b>	<b>Action</b>
<b>Documents Received</b>	<ul style="list-style-type: none"> <li>• TTAG Briefing Book</li> <li>• Handouts (on-site): <ul style="list-style-type: none"> <li>○ Medicare Data Report</li> <li>○ CMS Indian Data Symposium Recommendation</li> <li>○ Medicaid HCBS Long Term Care Options</li> <li>○ “At-A-Glance” Guide to Medicaid Authorities for Integrated Programs</li> <li>○ Office of Inspector General Update – Agenda</li> <li>○ OIG Reports on IHS Programs</li> <li>○ OIG Mental and Behavioral Health Service Request for Information</li> <li>○ KAI Research Design &amp; Approach to Tasks</li> </ul> </li> </ul>	
<b>Welcome</b>	<b>Ms. Valerie Davidson</b> , Chair, Tribal Technical Advisory Group (TTAG) and Executive Vice President and Senior Director, Legal and Intergovernmental Affairs, Alaska Native Tribal Health Consortium thanked all of the participants for their attendance at the meeting.	
<b>Opening Blessing</b>	<b>Dr. Donald Warne</b> , Executive Director, Aberdeen Area Tribal Chairmen’s Health Board, offered the opening blessing.	
<b>Roll Call</b>	<b>Ms. Tyra Baer</b> , CMS Staff Assistant, National Indian Health Board (NIHB), took the roll of the TTAG members present. Thirteen	

	<p>members were in attendance, meeting the requirements for a quorum. Members attending were:</p> <p>Alaska – Valerie Davidson  Aberdeen – Donald Warne  Albuquerque – Carolyn Finster  Bemidji – Phil Norrgard  Billings – absent  California – James Crouch  Nashville – absent  Navajo – Ben Shelly  Oklahoma – Rhonda Butcher  Phoenix – absent  Portland – James Roberts  Tucson – absent  TSGAC – W. Ron Allen  NIHB – H. Sally Smith  NCAI – Jessica LePak  IHS – Carl Harper  NCUIH – Carmelita Skeeter</p>	
<p><b>Report from Chair</b></p>	<p><b>Ms. Davidson</b> announced a change to the agenda. <b>Ms. Charlene Frizzera</b>, Acting Administrator and Chief Operating Officer, Centers for Medicare &amp; Medicaid Services (CMS) had to delay her visit with the TTAG until 2:00 p.m. Therefore, she asked the Outreach and Education (O&amp;E) Subcommittee to make their presentation during the 1:15-2:00 p.m. time slot.</p> <p><b>Mr. Phil Norrgard</b>, Director of Human Services, Fond Du Lac Band of Lake Superior Chippewa, made a motion for unanimous consent to open the agenda, and <b>Mr. James Crouch</b>, Executive Director, California Rural Indian Health Board, Inc., seconded the motion. With no objections raised, the motion carried.</p> <p><b>Ms. Davidson</b> reminded members about the National Association of State Medicaid Directors (NASMD) working lunch on Wednesday morning (November 11).</p> <p>She expressed her appreciation for all of the effort members had put into the various subcommittees and for attending the Medicare and Medicaid Policy Committee (MMPC) the previous day.</p>	
<p><b>Report from Secretary</b></p>	<p><b>Ms. Carolyn Finster</b>, TTAG Secretary and Director, Pine Hill Health Center, directed participants to Tab B of the TTAG briefing book, which contained the minutes for the July 30-31 face-to-face meeting, the August 19 conference call. She asked for any comments on the minutes and received none. <b>Mr. W. Ron Allen</b>, TTAG Vice-Chair representing the Jamestown S’Klallam Tribe, made a motion to approve the minutes, which was seconded by <b>Dr. Warne</b>. The TTAG unanimously approved the minutes.</p>	
<p><b>Discussion: Future Conferences/ Roundtables - Data</b></p>	<p>Because a speaker for the next scheduled topic was delayed, <b>Ms. Davidson</b> elected to address the discussion topics scheduled for November 11. The first topic addressed was the TTAG data project. <b>Mr. Crouch</b> reported on issues related to TTAG data project(s): the</p>	

	<p>completion of the Medicare data report and proposals for a symposium on the Medicare data and for development of a similar Medicaid report.</p> <p>The Medicare data report has just been published. The report is based on patients registered with the Indian Health Service (IHS), which makes it very useful as a resource as TTAG considers Medicare policy. A previous report relied on publically available Medicare data sets for self-identified Indians that do not include good geographic information (by state only). The current report provides much more descriptive information on Indians in CMS data sets.</p> <p><b>Mr. Crouch</b> recommended that CMS fund a symposium to facilitate information sharing and discussion with other researchers (e.g., Georgetown University, Kaiser Foundation, and tribal organizations) about secondary questions stemming from this data and potential analytical projects. He indicated that the symposium should be approximately one-and-a-half to two days in length; be held in Washington, D.C.; and include presentations on specific topics as well as discussions of a more general nature.</p> <p><b>Mr. Allen</b> suggested that symposium invitees should include the National Congress of American Indians (NCAI) Policy Center as well as the Indian colleges. <b>Dr. Warne</b> added that Academy Health should be invited as a partner because this data could be used for health services research intended to improve outcomes as well as to increased third party revenue.</p> <p><b>Mr. Allen</b> made a motion to fully fund a project to put on a symposium to address the use of Medicare data in Indian country. <b>Ms. Finster</b> seconded the motion. As there were no objections, the motion carried.</p> <p>The second topic addressed by <b>Mr. Crouch</b> was the possibility of doing an IHS–Medicaid match study. Such a study would produce data that is as equally fine as that now available for IHS-Medicare patients. There is not enough funding left in the TTAG data budget to do such a study. He asked the TTAG to recommend that CMS and IHS provide additional funding (current fiscal year) to undertake and complete this project and that they cooperate by providing the data and resources necessary for the Medicaid study.</p> <p><b>Mr. Phil Norrgard</b> made a motion to recommend allocation of CMS and IHS resources and access to the required data to produce a Medicaid report. <b>Mr. Allen</b> seconded the motion.</p> <p><b>Ms. Rhonda Butcher</b>, Citizen Potawatomi Nation, asked if the report would also use data from tribes billing Medicaid directly. <b>Mr. Crouch</b> replied that it would be possible to match the Section 638 client list from the tribes with the federally maintained payment list, and to identify the dollar values for both types of facilities and anticipated that the data would be aggregated by IHS area. He added that the researchers can now look at data based on ZIP codes within IHS areas as a result of software developed for the Medicare project.</p> <p><b>Ms. Kitty Marx</b>, Director, Tribal Affairs Group (TAG), Office of</p>	<p>TTAG and CMS will follow up on the motion for CMS to fully fund a symposium on the use of Medicare data in Indian Country.</p> <p>TTAG and CMS will follow up on the motion for CMS to fully fund the required research and production of a Medicaid data report.</p> <p>Develop and include a</p>
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	<p>External Affairs, CMS, asked if Mr. Crouch currently has access to the IHS data needed for this project. <b>Mr. Carl Harper</b>, Director, Office of Resource Access and Partnerships, IHS, replied that they did not yet have the data, but that he believed they had established a process for requesting and obtaining the data through the IHS research review board. He anticipated that the data will be released. <b>Mr. Crouch</b> added that it would be beneficial if a recommendation from the TTAG could be included in the packet for the review board. <b>Mr. James Roberts</b>, Policy Analyst, Northwest Portland Area Indian Health Board, suggested that it would be possible to bypass the review board if the researchers had the IHS provider number and ran a data match by state. <b>Mr. Crouch</b> indicated that he did not have the provider numbers and briefly explained some of the challenges of the approach.</p> <p><b>Mr. Allen</b> suggested that a single page summary be included with the motion to explain the project. <b>Mr. Crouch</b> described the proposed report as consisting of charts (similar to those in the Medicare report) that show Medicaid data by IHS area for IHS clients only. It will offer a demographic profile of the clients, as well as the types of services they consume and the location where they consume them. <b>Mr. Allen</b> further noted concerns over tribes being able to access data on their members receiving services outside of their service areas and identifying those who need help. <b>Mr. Crouch</b> acknowledged the need to have tribal membership data. He indicated that there might be opportunities to do this in the future. It might be possible to include data by tribe in the Medicaid report.</p> <p><b>Mr. Allen</b> and <b>Ms. Butcher</b> talked about their concerns over the existence of and access to data that will help tribes identify their members who may be outside of their services areas and who are not accessing services for which they are eligible. Ms. Butcher indicated that she thought that IHS was the only entity with this type of data. <b>Mr. Crouch</b> noted that if the TTAG can move quickly, they can develop a baseline before national health care is implemented. <b>Ms. Davidson</b> added that it is important pass the “real person test” of being able to identify those individual American Indians/Alaska Natives (AI/AN) who are not receiving services.</p> <p><b>Mr. Roberts</b> asked if the funding for this project would use FY 2010 or FY 2011 money and how much funding the Data Subcommittee would need to continue working on this issue. <b>Mr. Crouch</b> replied that the data project is running on carryover funds until March 2010, at which time, he hopes to have the 2010 allocation of \$100K. He estimated that the Medicaid data report will cost \$150K.</p> <p>The TTAG agreed to revisit this issue later in the meeting during the discussion of the budget and strategic plan. <b>Ms. Marx</b> indicated that CMS would like to see a written proposal for the project and expressed her opinion that it would be a good project for the TTAG to undertake, provided that the data is available.</p> <p><b>Mr. Robin Carufel</b>, Consultant, NIHB, pointed out this is an important opportunity to capture information on Indians within the system, especially those out of traditional boundaries (e.g., in the cities).</p>	<p>statement of TTAG support for the Medicaid data project/ report in the packet submitted to IHS requesting data.</p> <p>TTAG will use the proposed Medicaid data report to develop baseline information on health care in Indian Country.</p> <p>TTAG will submit a written proposal for the development of the Medicaid data report to CMS.</p>
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	<p>Tribes are obligated are to care for all their members. Other federal policies, such as enrollment, make it more difficult for children to qualify for membership. Looking at data as proposed will provide lots of opportunities for tribes to better assist their members.</p> <p><b>Ms. Kris Locke</b>, TTAG Technical Advisor, pointed out the need for the ability to self-declare as Indians, given that the proposed health care reform will exempt Indians from the requirement of carrying insurance. Having the population data from this project would be helpful in this regard.</p> <p>With no other comments offered for discussion, the TTAG unanimously approved the motion to request funding for the Medicaid data project.</p>	
<p><b>Discussion: Future Conferences/ Roundtables - HITECH</b></p>	<p>The committee continued addressing topics on the November 11 schedule by discussing the need for a Health Information Technology for Economic and Clinical Health (HITECH) round table to address the incentives, disincentives, timelines and challenges associated with adopting electronic health Records (EHRs). <b>Ms. Davidson</b> explaining that the TTAG had previously discussed the need for a meeting to learn more about the American Recovery and Reinvestment Act (ARRA) requirements for adopting EHRs.</p> <p><b>Ms. Marx</b> explained that when providers use EHRs to support billing, there are incentive payments for doing so. The proposed HITECH roundtable would provide an opportunity for experts to talk with tribes and urban programs about the incentive program requirements. <b>Mr. Norrgard</b> explained some of the incentives and penalties. <b>Ms. Davidson</b> indicated that during the previous TTAG meeting, the members asked CMS to provide more information in a roundtable setting to allow tribal technical personnel to better understand the requirements so that tribes can take advantage of the incentives and avoid penalties.</p> <p><b>Mr. Allen</b> shared the difficulties that his tribe’s clinic has had reconciling its new system with the existing IHS Resource and Patient Management System.</p> <p><b>Ms. Finster</b> suggested that the roundtable be presented as a webinar in order to reach the maximum number of people nationally. <b>Mr. Harper</b> stressed the importance of scheduling the roundtable in the near future given the pressing need to begin implementing the systems. <b>Mr. Norrgard</b> pointed out that there are multi-dimensional issues associated with HITECH including pharmacy, public health, and case management. <b>Ms. Locke</b> added that it is essential that there be an assessment of what is needed in Indian Country to implement this technology in a meaningful way and how it is going to be funded.</p> <p><b>Mr. Amitava (Jay) Mazumdar</b>, Senior Counsel, Office of the Inspector General (OIG), Office of the Secretary, U.S. Department of Health and Human Service (HHS), explained that HITECH issues relate primarily to EHRs, not billing issues. Quality of care is central to the adoption of EHRs, which allow tracking of conditions, allergies, treatments, etc. The first set of CMS and Office of the National Coordinator</p>	

	<p>regulations will be issued on December 31. Medicaid incentive payments will begin in 2010, Medicare payments in 2011. In order to receive payments, states must submit their implementation plans in 2010. The Medicare program penalties begin in five years. There are no penalties under the Medicaid program. Now is the time to start working with states to make sure tribal interests are addressed.</p> <p><b>Ms. Marx</b> expressed her hope that this roundtable could take place in conjunction with a future TTAG meeting. Funding is available for at least one roundtable (possibly more if needed).</p> <p>The TTAG discussed establishing a new subcommittee to plan the roundtable and to work in an ongoing fashion to support implementation issues. <b>Mr. Roberts</b> suggesting adding this topic to the Data Subcommittee’s responsibilities. <b>Mr. Crouch</b> agreed to include HITECH issues under his committee. <b>Ms. H. Sally Smith</b>, Alaska Area Representative, NIHB and Chairman, Bristol Bay Area Health Corporation, volunteered to serve on the subcommittee.</p> <p><b>Ms. Davidson</b> indicated that the discussion of future conferences/roundtables supporting Child Health Insurance Program Reauthorization Act of 2009 (CHIPRA) activities would be included in the discussion of O&amp;E issues later in the agenda.</p>	<p>The Data Subcommittee will work with CMS to plan the HITECH roundtable.</p>
<p><b>Long-Term Care</b></p>	<p><b>Ms. Anita Yuskauskas</b>, Center for Medicaid and State Operations (CMSO), CMS, provided an overview of long-term care (LTC) and Medicaid and answered member questions. The presentation addressed the Medicaid state plans, managed care authorities, fee for service authorities, and ARRA as they pertain to home- and community-based services (HCBS). She also discussed CMS’ HCBS Advanced Notice of Proposed Rulemaking (ANPRM).</p> <p>There are several ways to provide LTC in tribal communities – payers/providers include tribal communities, IHS, the Administration on Aging, the Department of Veterans Affairs, Medicare, Medicaid, and private insurance – but Medicaid pays for the bulk of LTC in the United States. Over time, LTC has evolved from almost exclusively institutional care to a mix of institutional and HCBS care, with HBCS accounting for approximately 37 percent of Medicaid LTC spending in 2005. HBCS expenditures are growing at a rate of 3 to 5 percent annually.</p> <p><b>Ms. Yuskauskas</b> briefly described the statutory relationship of the TTAG to CMS and the entities within CMS that support tribal LTC issues. Mandatory services covered under Medicaid include nursing facility services. HCBS falls into the optional category, which can lead to waiting lists for these services. As a result, individuals on waiting lists for HCBS who need immediate assistance may end up going into a nursing home because institutional care is mandated. All of the HCBS authorities waive one or more of the requirements.</p> <p>There are multiple funding authorities for LTC, which can be placed into three categories: managed care, fee for service, and combined waiver programs. The 1115 demonstration authority provides the greatest flexibility for waivers under managed care. The 1915 (c)</p>	

authorities provide similar flexibility under the fee for service category. States are becoming more adept at developing programs that meet the needs of their states and combining authorities to maximize what is carved out under these programs.

Some of the requirements that can be waived under the managed care and fee for service authorities include voluntary or mandatory enrollment, statewide or limited geographic areas, selective contracting with providers (limits on choice of providers), optional additional services, cost effectiveness, and renewal options. States currently provide more than 350 services via 1915(c) fee for service waivers, including services customized to people with specific conditions such as AIDS. The purpose of the 1115 demonstrations is to test innovative approaches to LTC. The authority provides the most flexibility for waivers and options for beneficiaries.

Tribal communities can access HCBS services in multiple ways: as an individual state benefit, through qualified tribal providers, and through delegation of state responsibility. She suggested that tribal communities have not fully tapped the possibilities of accessing services through the delegation of state authorities.

ARRA makes tribal consultation a statutory requirement. This applies to program changes such as state plans amendments, waiver proposals, renewals, and amendments and extensions. It also formalizes the relationship of the TTAG to CMS and specifies new managed care rules that allow tribes to focus exclusively on tribal members.

CMSO has been looking at the appropriateness of states using HCBS funds to pay for services provided on the grounds of an institution. The ANPRM was issued to help CMS chart a path forward in dealing with this issue and understand implications of proposed changes. Comments included some that pointed out how changing the definition of community would affect AI/AN communities. **Ms. Yuskauskas** asked committee members for their thoughts on defining community and on issues that CMS needs to be aware of as it develops new rules.

**Mr. Norrgard** pointed out that Indian communities might have very small groups of people who are eligible for LTC. The work that is required for certifications and authorizations for these communities/groups can be a barrier to tribes being reimbursed for services for which other entities are receiving payment.

**Dr. Warne** advocated for resources for training home care attendants (including family members), which would develop an appropriate workforce over the long term. **Ms. Yuskauskas** explained that states can define provider qualifications and training requirements, although states have been creative in how they pay for training. He replied that this situation underscored the role that states play as gate keepers by controlling licensure. **Ms. Yuskauskas, Dr. Warne, and Ms. Davidson** discussed the possibility of having a federal plan for tribal members (freeing them for state-based regulations) and the possibility of having regulations written to allow

	<p>this.</p> <p><b>Mr. Norrgard</b> asked whether CMS has a strategy for dealing with, and possibly sanctioning, states that do not consult with tribes. <b>Ms. Yuskaskas</b> replied that sanctions were not built into the ARRA legislation. It might be possible to use the renewal process to enforce consultation through quality requirements. Currently, the only option CMS has is disapproval of a program, which the agency prefers not to do because of the people who benefit from specific programs.</p> <p><b>Mr. Roberts</b> indicated that states are often unaware of the availability of waivers for many of the things that tribes would like to do. Tribes often encounter difficulties in getting states to talk to them about their concerns and ideas. He asked CMS to develop a mechanism for educating states about using waivers to address tribal concerns. CMS encourages states to consult with it about designing programs to meet specific needs, explained <b>Ms. Yuskaskas</b>. Additionally, the 1996 Memorandum of Understanding between CMS and IHS has never been fully utilized as a means of addressing tribal needs.</p> <p><b>Mr. Norrgard</b> described the situation as one of passive disapproval where states focus on reasons why something cannot be done instead of problem solving. There are programs that are working in Indian Country. He encouraged CMS to proactively promote best practices and help other states use similar approaches. <b>Ms. Jackie Garner</b>, Consortium Administrator, CMSO, agreed that CMS could employ a variety of strategies to help bring states to the table to discuss important issues.</p> <p><b>Ms. Myra Munson</b>, TTAG Technical Advisor, Sonosky, Chambers, Sachse, Miller &amp; Munson, LLP, suggested that CMS should clearly state that tribal health programs can be HCBS providers and that states must recognize them as such. The agency should also eliminate administrative barriers that prohibit providers from doing assessments in order to recognize the cultural traditions and boundaries of tribal communities. Bringing in outside assessors often does not result in appropriate, or even possible, care plans. CMS regulations can do much to enable tribal health programs to be HCBS providers. <b>Ms. Yuskaskas</b> agreed that there is a need to identify ways to break down barriers to getting HCBS services. <b>Ms. Munson</b> replied that the problems are more persistent. States are often reluctant to recognize the political status of tribes. She encouraged CMS to provide more support for Indian-only waivers as well as consider how the basic HBCS regulatory structure can encourage states to recognize the ability of tribal organizations to serve both as providers and assessors.</p> <p><b>Ms. Locke</b> noted that the two biggest barriers to waivers are the delegation of authority by state Medicaid programs to other entities with which tribal agencies do not have relationships (e.g., areas agencies) and selective contracting, which leaves tribal providers ineligible for payment. She asked CMS to provide more clarification on defining community and the possibility of family members providing covered services. <b>Ms. Yuskaskas</b> replied that legally</p>	<p>CMS will identify strategies it can employ to encourage states to consult with tribes per ARRA requirements.</p>
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	<p>responsible family members are allowed to be providers under waiver programs; however, it is only allowable in states that have chosen to exercise this option.</p> <p><b>Carmelita Skeeter</b>, Executive Director, Indian Health Care Resources Center of Tulsa, pointed out that meeting with the state is not enough. States often tell tribes that they are following CMS' directions. Several TTAG members asked for a more proactive role for CMS to educate states about waiver options and to support AI/NA needs.</p> <p><b>Ms. Marx</b> suggested that the LTC Subcommittee focus on these issues in 2010 by providing examples of difficulties to the Administrator. She also pointed out that CMS has increased funding for training, which may make state-by-state training possible. These sessions could potentially include HCBS sessions.</p> <p><b>Ms. Yuskaskas</b> concluded the session by explaining the ANPRM next steps. CMS is currently reviewing comments to determine whether a rule is needed. The definition of community is one of the key issues, as is the definition of populations by states is also an issue.</p>	<p>The LTC Subcommittee will develop a list of examples of challenges/barriers tribes face concerning LTC for submission to the CMS Administrator.</p>
<p><b>Medicaid Administrative Match – CMS Option Paper and MAM Subcommittee Report</b></p>	<p>The session included a review of a Medicaid Administrative Match (MAM) options paper developed by CMS and a report from the MAM Subcommittee.</p> <p><b>Ms. Garner</b> directed members to the option paper located under Tab C of their briefing books. She stressed CMS' commitment to developing solutions to longstanding problems related to MAM. The solutions developed for the State of Washington will set precedents for the rest of the country. As a result, CMS is consulting with the TTAG to get its comments on the options.</p> <p>The options included in the paper described approaches that meet all of CMS' legislative and regulatory requirements. Starting with those that CMS deems most burdensome to tribes and ending with the least burdensome, the options were:</p> <ol style="list-style-type: none"> <li>1. Use the existing MAM claims data that Washington State currently has to meet the requirements of Office of Management and Budget (OMB) Circular 87. <b>Mr. Allen</b> pointed out that a recent Executive Order requires OMB to work with tribes (regulatory issues) and that this option should become less difficult as a result.</li> <li>2. When the number of claiming entities is small, it might be possible to create a random moment time study that is statistically valid. <b>Ms. Garner</b> indicated that this is a significant shift in CMS policy.</li> <li>3. Select five random days for the time studies.</li> <li>4. Select one random week for the time studies.</li> <li>5. Develop an administrative fee for tribes that removes the need for a long-term time study.</li> <li>6. Eliminate time studies and establish a contractual relationship with the state.</li> </ol> <p>CMS is working to inform states that it will support any of the above</p>	<p>CMS will develop MAM options</p>

	<p>options. Once the agency receives feedback from the TTAG, it will develop letters for the states concerning these options.</p> <p>CMS expects to complete negotiations with California on a MAM resolution in the near future. The Washington MAM agreement is almost complete and just needs to be signed and implemented.</p> <p><b>Mr. Roberts</b> thanked CMS for its efforts to work with tribes on MAM issues. Now it is up to the tribes to determine what approach they would like to pursue. He addressed his organization’s reaction to the options, indicating that the third, fifth, and sixth options are all possibilities. Option 3 continues the process by which tribes in Washington have been carrying out MAM programs over the last decade. Option 5 poses administrative challenges relative to pay scales and encounter rates. <b>Ms. Garner</b> stated that CMS could likely find a methodology to address the concerns about encounter rates, given the availability of reasonable baseline data.</p> <p><b>Ms. Butcher</b> asked if tribes could begin working with their states on these options. <b>Ms. Garner</b> noted that CMS has not yet sent out letters; therefore CMS would like to make the initial call to each state with the tribe(s).</p> <p><b>Mr. Crouch</b> noted that the MAM options memo is similar to what <b>Mr. Norrgard</b> had requested for HCBS. He pointed out the need for an explanation of the issue of proportion of Medicaid eligibility ratios. The proportion will vary greatly, especially in very small places. He was concerned about how organizations conducting O&amp;E activities will be paid without fractionating by percentage of Medicaid/non-Medicaid work. <b>Ms. Garner</b> reassured him that CMS was committed to finding a solution to this issue.</p> <p><b>Ms. Garner</b> asked the members if they approved of the options and expressed confidence that any remaining barriers will be resolved. <b>Ms. Marx</b> confirmed that this issue is in the implementation plan of TTAG priority issues. She suggested that CMS develop guidance for State Medicaid Directors based on the options paper. <b>Ms. Davidson</b> supported the idea of having CMS involved in the process of tribes negotiating with states to preempt any hesitancy on the part of the states.</p> <p><b>Mr. Crouch</b> expressed his opinion that it would be appropriate for the TTAG to approve the CMS MAM options using language about how they maximize self-determination and respond to the needs of the various sized tribal programs. He also suggested that CMS send letters to the tribes as well as states concerning these options.</p> <p><b>Mr. Norrgard</b> stated that he was generally pleased with the options and happy with the progress made on this issue. He was hesitant to approve the options at the present, given that the planned conversations with Washington and California could change the approaches.</p> <p><b>Mr. Allen</b> reiterated his concerns that the approaches meet OMB’s interpretation of the A87 requirement in order to prevent difficulties</p>	<p>letters for states that incorporate TTAG feedback.</p> <p>CMS will initiate communication with states concerning MAM options.</p> <p>CMS will develop MAM guidance for State Medicaid Directors based on the options paper.</p>
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	<p>during audits.</p> <p><b>Mr. Allen</b> asked <b>Ms. Garner</b> to confirm that CMS will issue guidance, such as a state Medicaid letter, emphasizing that tribes have a choice of a menu of options.</p> <p><b>Ms. Locke</b> asked if it would be possible to put the responsibility for selecting the option with the tribes, not the states. <b>Ms. Garner</b> replied that it is important that the selection be made cooperatively between the tribes and states.</p> <p><b>Ms. Garner</b> concluded by thanking all of the CMS who worked on the development of the options.</p>	
<p><b>OIG Report and Update: IHS Contract Health Services Program: Overpayment and Potential Savings</b></p>	<p><b>Mr. Mazumdar</b>, in his capacity as the HHS Tribal Liaison for OIG briefly described the function of the office. The OIG provides oversight over all HHS programs. It is an independent organization within HHS. Almost all of the OIG’s 1,500 employees work in the field, primarily in the areas of counsel, evaluation and inspection, audit services, and investigations. He noted that attending the TTAG meetings has provided a wealth of knowledge on beneficiary issues. The OIG has a keen interest in health issues that affect Indians.</p> <p><b>Ms. Anne Bracken</b>, Program Analyst, OIG, HHS, summarized the <i>IHS Contract Health Services (CHS) Program: Overpayment and Potential Savings</i> report, which was included in the briefing materials under Tab E. In cases where an IHS or tribal facility is not available, IHS uses the CHS program to contract with private providers. Because of limited funding, more than 200,000 services were denied or deferred in 2008 for IHS clients. IHS and eight tribes use a fiscal intermediary (FI) for claims processing; the rest of the tribes use independent systems. Hospital services must be reimbursed at a Medicare rate or lower. All other services are paid at negotiated rates.</p> <p>OIG conducted the evaluation to determine the extent to which IHS and tribes paid the Medicare rate for CHS. The goals of the study were to determine whether the Medicare Modernization Act (MMA) requirement that hospital services be paid at or below the Medicare rate is working and to determine the potential for savings if this were applied to the non-hospital side. Data supporting the evaluation consisted of claims submitted between January and March 2008 from IHS and 60 percent of the federally recognized tribes.</p> <p>Findings were:</p> <ul style="list-style-type: none"> <li>• IHS and tribes paid above the Medicare rate for 22 percent of claims (\$1 million in overpayments or three percent of expenditures on CHS). Most overpayments related to outpatient services and may have been caused by differences in payment processing software.</li> <li>• If IHS and tribal payments were capped at the Medicare rate for non-hospital claims, savings would have totaled approximately \$13 million over three months, which could have funded an additional 41,000 outpatient services over the same time period.</li> </ul> <p>OIG recommendations stemming from the evaluation were:</p>	

	<ul style="list-style-type: none"> <li>• IHS and tribes should take appropriate actions to correct overpayment of hospital claims.</li> <li>• IHS and tribes should work with the FI to ensure proper payment of future claims.</li> <li>• IHS should provide technical assistance to tribes to ensure proper payment of hospital claims.</li> <li>• IHS should seek legislative authority to cap payments for non-hospital services.</li> </ul> <p><b>Ms. Brenda Jeanotte-Smith</b>, Director, CHS, IHS, reported on the agency's response to the recommendations.</p> <p>Concerning the first recommendation, IHS, through the FI, found that only two of 205 claims identified by the OIG for review contained errors. The FI worked to get these resolved. <b>Ms. Jeanotte-Smith</b> reported that the FI processes claims at a rate of 99 percent accuracy (this includes the disproportional share for indigent populations and outlier payments).</p> <p>To ensure that future payments are properly calculated, IHS has included language in the FI's contract that requires the use of Medicare-like rates and requires a 95 percent accuracy rate (the FI currently operates at a 97 percent accuracy rate.)</p> <p>IHS provides technical assistance via training at conferences. It is considering offering repricing for tribes, but needs to determine what sort of software is necessary to do this as well as other technical issues related to payment calculation. Employing a consistent method for processing claims is probably a better approach.</p> <p>IHS will work with tribes to pursue a legislative authority to cap payments. IHS asked the FI to identify related potential savings, which were estimated at \$32 million in FY 2008.</p> <p><b>Mr. Mazumdar</b> shared copies of the FY 2010 OIG work plan, which includes a project to audit the processes for determining the encounter rate for the Phoenix, Oklahoma, and Albuquerque IHS areas.</p>	
<p><b>OIG Report and Update: Update on Audit of IHS Cost Reports and IHS/CMS Items on New OIG Work Plan</b></p>	<p><b>Ms. Melinda Golub</b>, Senior Counsel/Supervisory Auditor, OIG, HHS, distributed a list of OIG reports relating to IHS issues. She asked TTAG members for their help in reaching out to tribal providers for input on an ongoing study of IHS and tribal providers on access and barriers to both behavioral/mental health services and dialysis services being conducted by the San Francisco Office of Evaluation and Inspections.</p> <p><b>Ms. Golub</b> explained that OIG criminal investigators, who specialize in Medicare and Medicaid fraud, work in the field throughout Indian Country. She directed TTAG members to contact <b>Mr. Thomas Sowinski</b> if they suspect fraud. OIG is very interested in working with tribes to stop and prosecute fraud.</p>	
<p><b>OIG Report and</b></p>	<p><b>Mr. Crouch</b> asked if OIG could make copies of the packet for the</p>	<p>OIG will provide TTAG members</p>

<p><b>Update: Discussion</b></p>	<p>behavioral health study available to the TTAG members so that they can facilitate tribal participation in the study. <b>Ms. Davidson</b> explained that tribes are accustomed to having conversations about this sort of issue with their TTAG representative.</p> <p><b>Mr. Allen</b> shared his opinion that IHS and tribes have done a good job on the inpatient services, but that improvements can be made on the outpatient side that will improve purchasing power by as much as 50 percent.</p> <p><b>Mr. Roberts</b> asked if OIG knew why the overpaid claims were not reprocessed at Medicare-like rate claims. He cited the cost of software and ongoing training issues as barriers to proper processing and advocated for more training for tribal programs in adjudicating Medicare-like rate claims.</p> <p><b>Mr. Allen</b> pointed out that the government does not cover the full cost of health care in Indian Country, nor does it cover the cost of contract support (administrative functions). Indian resources are stressed and errors should not be surprising. The report should have also looked back at the role lack of government support plays in payment errors.</p> <p><b>Mr. Norrgard</b> thought that the report might have been premature as many of the smaller tribal entities have not had the opportunity to fully implement the payment processing model. He suggested that IHS work to share best practices. He also noted that OIG might receive a better response to its request for information for the ongoing studies if it came from a “friendlier” source such as IHS. <b>Ms. Golub</b> pointed out that OIG anticipates that the report will show the lack of resources and barriers to service in Indian Country. <b>Mr. Norrgard</b> countered that OIG will be more likely to receive responses from organizations that believe they are doing a good job than from those that do not.</p> <p><b>Mr. Roberts</b> expressed his opinion that the study underestimated the amount of Medicare overspending because it only received responses from 60 percent of CHS operating units and emphasized the need for more training. <b>Ms. Jeanotte-Smith</b> indicated that OIG does provide some annual training. CMS seems to have delegated training to IHS. She hoped that IHS would work with OIG to identify issues that should be covered in training sessions. <b>Ms. Davidson</b> suggested that, in addition to the training provided by IHS, this topic might be incorporated into the state-by-state trainings conducted under TTAG O&amp;E activities.</p> <p><b>Mr. Mazumdar</b> noted that 80 percent of the OIG budget is devoted to Medicare and Medicaid. In order to do more work on Indian health, there must be an overlap with Medicare or Medicaid.</p> <p><b>Ms. Skeeter</b> cited examples of tribes in rural Oklahoma that were unable to find providers that would accept the Medicare rate. <b>Mr. Mazumbar</b> replied that providers must accept the Medicare rate in order to participate in the program. <b>Ms. Munson</b> clarified that the law applies to hospital-based services. The proposal to extend</p>	<p>with copies of the behavioral/mental health services questionnaire.</p> <p>TTAG will contact tribes to encourage response to the OIG behavioral/mental health services questionnaire.</p>
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	<p>Medicare-like rates to non-hospital services is where the concerns about providers not accepting the rates or participating in the program come into play.</p>	
<p><b>Outreach and Education: CHIPRA Section 202 – Kauffman and Associates, Inc. Update</b></p>	<p><b>Ms. Jo Ann Kauffman</b>, President and Chief Executive Officer, Kauffman &amp; Associates, Inc. (KAI) provided an overview of KAI’s current contract with CMS to undertake, with input from the O&amp;E and Across State Borders (ASB) Subcommittees, three projects (Ms. Kauffman elected to present all three tasks at this time instead of dividing the presentation between this session and the ASB session):</p> <ul style="list-style-type: none"> <li>• Task A: Analysis of Transportation Barriers to Utilization of Medicare Services by AI/AN Medicare Beneficiaries – The 12-month project will lay the ground work for a future study analyzing transportation barriers. The task will focus on project design, testing of the proposed tools, and assembly of the OMB submission package. KAI anticipates that OMB approval could take as long as six months. CMS will make decisions about future funding for this effort after OMB approves the methodology.</li> <li>• Task B: Across State Borders Issues Research – The purpose of this task is to develop policy recommendations and solutions to ASB issues through the use of case studies. The project will include a literature review and use two case studies illustrating the challenges of securing Medicaid and Child Health Insurance Program (CHIP) reimbursement when crossing state borders. KAI anticipates selecting the case studies in December and conducting interviews and site visits in January 2010. Deliverables for this project are the research plan, the literature review, the case studies summary, and the final report.</li> <li>• Task C: Promising Models Project – This project will analyze existing promising practices related to state/tribal collaborations to increase CHIP enrollment and develop a tool for making these practices easily available to both states and tribes. Some categories of promising models being considered by KAI are MAM, outstationed state workers, authorized local personnel, community health representatives, culturally sensitive materials, and new and developing strategies. KAI will research the various models, assess the pros and cons of each model, develop a print and/or Web-based tool kit, disseminate the tool(s) to states and tribes, and submit a final report to CMS.</li> </ul> <p><b>Ms. Kauffman</b> introduced the KAI staff members who will be working on the three task orders: Dr. Michael Meyer (Tasks B and C) and Dr. Jeanette Hasim (Task A).</p> <p><b>Mr. Crouch</b> asked how KAI will define “promising” and determine that an approach is effective, especially when multiple approaches may be used in a single area. <b>Ms. Kauffman</b> replied that the process will be qualitative and rely on the responses of focus groups and key informants. Promising or effective approaches will be determined by the consensus of informed people working in the field. Additionally, KAI will look at specific aspects of each model that may be effective.</p> <p><b>Ms. Marx</b> pointed out that the information that KAI develops will be used to inform CMS’s guidance for states concerning best practices for collaborating with tribes on Section 202 requirements.</p> <p><b>Ms. Butcher</b> volunteered to share a report that the Oklahoma Area</p>	<p>TTAG members will provide</p>

	<p>had developed on boarding school students and ASB issues. <b>Ms. Davidson</b> offered to share information on Alaska’s situation regarding adults in treatment centers in the Lower 48. <b>Ms. Finster</b> added that the report should also consider Native Americans who cross state lines contiguous to their own areas.</p> <p><b>Mr. Allen</b> asked about the schedule for the deliverables for the three projects. <b>Ms. Kauffman</b> replied that KAI has a 12-month contract. Task A will run for the full contract period; the other two tasks should wrap up sometime in the summer.</p> <p><b>Mr. Norrgard</b> pointed out that there is still a lot of work that needs to be done on the research design and that the TTAG must identify those members who will provide input and determine how KAI will work with TTAG.</p> <p><b>Ms. Carol Barbero</b>, TTAG Technical Advisor, suggested using crossing borders for residence in an adult treatment facility as one example. She also suggested that the literature review include issues related to culturally competent care. <b>Ms. Tammy Clay</b>, Division of Regulatory Affairs, IHS, asked whether KAI will look at youth residential treatment centers. <b>Ms. Kauffman</b> indicated that scenarios would be considered along with those already discussed. <b>Ms. Skeeter</b> cautioned that KAI should determine how many states actually pay for residential treatment (Oklahoma does not) before building a case study around this topic.</p> <p><b>Ms. Lane Terwilliger</b>, CMSO, CMS, who is responsible for implementing the CHIP Section 213 coordinated care model, informed participants that CMS will publish a <i>Federal Register</i> notice inviting comments on this issue. She promised to share information gathered as a result of the comment process to complement the research being done by KAI.</p> <p><b>Ms. Novaline Wilson</b>, Government &amp; Legislative Affairs Associate Navajo Nation Washington Office, shared comments concerning ASB issues from <b>Mr. Anselm Roanhorse</b>, Executive Director, Navajo Nation Division of Health, who could not attend the meeting. Mr. Roanhorse’s comments stressed the importance of including the tribal perspective in any products, of reviewing working models developed in response to hurricane Katrina, and of determining what actions have been taken by CMS following the June 2006 report to Congress on migrant workers. Another conference call will be scheduled before the end of November to follow up on these issues.</p>	<p>examples of ASB challenges to KAI for possible inclusion in the ASB study.</p> <p>TTAG will identify members who will provide input to KAI on the development of the O&amp;E and ASB research projects.</p> <p>CMSO will share information it receives concerning promising models with KAI.</p>
<p><b>Strategic Plan/ Budget Subcommittee Report</b></p>	<p><b>Mr. Roberts</b> stated that the Budget Subcommittee is in the process of developing the budget for the priorities tied to the TTAG strategic plan. The subcommittee will meet with CMS on November 11 to discuss funding mechanisms for NIHB and for expenses such as travel. He asked the various subcommittee chairs to review the strategic plan and send priorities to him prior to the meeting with CMS.</p>	<p>Subcommittee chairs will identify priorities for funding tied to strategic plan goals to Mr. Roberts.</p>
<p><b>Update of TTAG Implementation</b></p>	<p><b>Ms. Frizzera</b> thanked TTAG members for their assistance and noted that CMS had either responded to or tasked out all of the issues</p>	

<p><b>Plan of Priority Issues</b></p>	<p>identified in the matrix found in Tab I of the briefing book. She then took questions from the TTAG members.</p> <p><b>Mr. Roberts</b> indicated that tracking, analyzing, developing policies, and implementing the requirements of proposed health reforms will take a tremendous effort. Tribes do not have the funds to do this. He asked that CMS consider the capacity needs of tribes with regard to policy development and implementation as it considers the next budget cycle. <b>Ms. Frizzera</b> acknowledged his concerns, but cautioned TTAG members against getting too far ahead of the actual status of reform. Because nobody knows what the final legislation will contain, it is impossible to plan for implementation in any specific way. She asked the members to identify issues that are important to Indian Country, so that CMS can track them and report back to the TTAG.</p> <p><b>Mr. Allen</b> noted that exemptions based on historical legal/moral distinctions are a big issue for tribes. The tribes need CMS and IHS to gather data on Indians outside of their tribal service areas (where they are, who is and is not being served, etc.). Additionally, tribes need information technology systems to analyze this information and to manage the requirements of health care reform. <b>Ms. Frizzera</b> replied that CMS is working closely with <b>Dr. Yvette Roubideaux</b>, Director, IHS, to make sure Indian issues are reflected in the regulations.</p> <p><b>Ms. Davidson</b> shared several concerns raised earlier in the day. One was the issue of not incurring tax penalties because Indians receive coverage from IHS. The second concern related to data concerning AI/AN populations. <b>Mr. Crouch</b> summarized the Medicare data report he presented earlier in the day. The report sheds light on the reasons Indians participate in Medicare (e.g., age, disability, end-stage renal disease, etc.). Indian communities have a very high rate of participants based on disability. He added that the TTAG had discussed holding a seminar for researchers from universities and foundations as well as CMS and IHS. <b>Ms. Frizzera</b> stated that this would be a good topic of discussion for the next TTAG meeting and added that this might be a good way to begin leveraging funds from sources other than CMS.</p> <p><b>Mr. Crouch</b> advocated for the need for a Medicaid version of the report, which is supported by the TTAG. He explained that the Data Subcommittee believes it can obtain the needed data from IHS, but requires funding to do the analysis. He also raised the possibility of using an interagency agreement (from the Office of the Secretary) with HHB to ease the transfer of funds.</p> <p><b>Ms. Davidson</b> added that another issue with data relates to the identification of information gaps, such as those related to young people on disability, and how this information can be captured.</p> <p>She also addressed issues related to MMA Section 630, which allows IHS facilities to bill directly for durable medical equipment. The provision expires on December 31. <b>Ms. Davidson</b> asked CMS to support a resolution of this issue by either eliminating the sunset provision or by including a permanent extension in the Senate health</p>	<p>Include a discussion of the proposed Medicare data symposium in the agenda for the February 2010 TTAG meeting.</p>
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	<p>reform legislation.</p> <p><b>Ms. Davidson</b> asked CMS to work with the O&amp;E Subcommittee to push information out to Indian health facilities as it becomes available. TTAG members can then help alert recipients that important information is on its way. <b>Ms. Frizzera</b> asked if communities currently receive information directly from the government (CMS or IHS). TTAG members generally agreed that the issue is how CMS can get its information into the IHS distribution process. <b>Ms. Finster</b> added that tribal clinics and tribal chairmen's offices should be included in the distribution.</p> <p><b>Ms. Finster</b> also asked that CMS to update the TTAG on the status of the \$10 million set aside for CHIP outreach to Indians. <b>Ms. Marx</b> replied that the CHIP Section 201 grant solicitation will be published soon. The October 14 Medicine Dish episode addressed the process for applying for grants using <a href="http://Grants.gov">Grants.gov</a>. <b>Ms. Garner</b> added that CMS held its national CHIP meeting the previous week and alerted states and stakeholders about the upcoming round of grants.</p> <p><b>Ms. Davidson</b> stated that the TTAG was very pleased with the MAM option paper that had been presented earlier in the day. It is an excellent model for alerting State Medicaid Directors about the approaches that tribes and CMS find acceptable and could be applied to other issues such as LTC. She also reported that the TTAG appreciated the calls that Ms. Frizzera had made to states regarding consultation and hoped that she would be willing to make similar calls for LTC issues in the future. The TTAG also hoped that CMS staff would participate in future discussions between states and tribes to facilitate the process. <b>Ms. Frizzera</b> reported that she had heard several concerns about LTC and the need to keep moving toward solutions from the State Medicaid Directors at the NASMD meeting.</p> <p><b>Mr. Crouch</b> stated that TTAG will soon address HITECH issues via a conference/symposium addressing incentives for appropriate use. He encouraged CMS to help facilitate collaboration between IHS, the Section 638 contractors, and tribal organizations to build the infrastructure needed for HITECH adoption. <b>Ms. Frizzera</b> stated that regulations on meaningful use will come out in the near future. She strongly encouraged members to provide comments through the public comment process because CMS needs input on these issues. With regard to the HITECH regional outreach centers, Ms. Frizzera explained that they will be resources for learning how to implement and use EHRs. CMS is finding that the organizations applying to run the centers are those that currently have working EHR systems.</p> <p><b>Mr. Allen</b> asked Ms. Frizzera to speculate on the FY 2010 CMS budget. He also asked her to work with the TTAG to break down the legal/regulatory impediments to TTAG having a direct relationship with NIH. <b>Ms. Frizzera</b> replied that CMS is operating under a continuing resolution. However, the legislative branch has been asking CMS lots of questions about what the agency will need to implement health care reform. CMS is working hard to secure multiple year money. CMS has realized the need for up front place holders; therefore the TTAG should identify projects that it would</p>	<p>TTAG members will submit comments via the public comment process concerning HITECH meaningful use.</p> <p>TTAG will identify budget placeholders for the FY 2010 TTAG budget.</p>
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	<p>like to do much earlier in the process in order to program funds at the beginning of the year.</p> <p><b>Mr. Allen</b> pointed out that CMS received a letter written by the Seminole Nation concerning the primacy of Medicare. Many tribes set up supplemental systems (payor of last resort) for Medicare eligible members. Medicare denied some of the claims on the basis that the tribe was the primary payor because it has this program. Mr. Allen stated that CMS needs to correct the error. <b>Ms. Frizzera</b> asked if CMS had paid these claims in the past and only recently changed its policy or if it is an ongoing issue. <b>Mr. Roger Goodacre</b>, TAG, OEA, CMS, explained that there are two issues: Medicare as secondary payer for employed individuals and special Medicare rules for those with end stage renal disease. CMS is studying the issue. He confirmed that the denials are a recent phenomenon.</p> <p><b>Ms. Frizzera</b> noted that there will be many opportunities for collaboration – White House and HHS councils on Indian affairs – in the near future. Once these activities get started, CMS will be willing to help the TTAG manage the process for interacting with the various councils. <b>Mr. Allen</b> pointed out that the recent Executive Order opens up the possibility for agencies to work together on issues of importance to Indians.</p> <p><b>Ms. Frizzera</b> reported that CMS did not receive much feedback from the White House tribal roundtable. The meeting pointed out the need for increased collaboration between the various HHS components.</p> <p><b>Mr. Norrgard</b> asked if CMS needed the assistance of the TTAG in preparing the report regarding tribal consultation required by the recently signed Executive Order. <b>Ms. Frizzera</b> indicated that it would be a good idea to reconvene and discuss what TTAG would like to see in the report.</p> <p><b>Ms. Frizzera</b> concluded the session by briefly reviewing her list of action items:</p> <ul style="list-style-type: none"> <li>• TTAG will identify priority issues regarding health care reform, and CMS will track them as it moves through the legislative process.</li> <li>• CMS acknowledges the need for more work on HITECH issues.</li> <li>• Ms. Frizzera supported the idea of holding a symposium on the Medicare data report and of producing a Medicaid data report.</li> <li>• CMS will work to prevent the sunset of the MMA Section 630 provisions.</li> <li>• CMS will work with IHS to improving direct outreach to tribes on selected issues and provide TTAG members with advance notice of communications.</li> <li>• CMS will consider holding a conference in the spring for the tribal CHIP grantees.</li> <li>• The MAM work is close to being complete. A similar process should be used for LTC issues.</li> <li>• TTAG will sponsor a roundtable on HITECH incentives and members will provide feedback to CMS on the proposed HITECH regulations.</li> </ul>	<p>CMS will assist TTAG manage the process for interacting with various high-level government councils.</p> <p>CMS and TTAG will follow up on the action items identified by Ms. Frizzera.</p>
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	<ul style="list-style-type: none"> <li>• CMS will look at ways to streamline the transfer of funding between HHS agencies and NIHB.</li> <li>• TTAG will develop a budget for FY 2010 including placeholders for anticipated projects.</li> <li>• CMS and TTAG will meet to refine the agency’s response to the Executive Order on tribal consultation.</li> <li>• Seminole Nation, we’ll look into why the claims are being denied and get back to you</li> </ul>	
<b>CMS Tribal Affairs Group Report</b>	<p><b>Ms. Marx</b> alerted members that the Strategic Plan/Budget Subcommittee would meet at 10:00 a.m. on November 11. She asked the TTAG to identify priority funding projects for FY 2010. CMS received a significant increase in funding, making FY 2010 an opportune year for undertaking pending projects. She anticipated that CMS and subcommittee members would review the strategic plan and discuss the goals associated with LTC, O&amp;E, and data as well as tribal consultation and support of TTAG. With the support of <b>Ms. Frizzera</b>, TAG is benefitting from a higher profile than ever before; therefore it is important to both respond to her requests and to establish meaningful deliverables.</p> <p><b>Mr. John Johns</b> recently joined the TAG at CMS and is now serving as the Project Officer for the TTAG as well as working on LTC issues. Additionally, CMS hired <b>Mr. Jim Lyon</b>, who currently works as the Service Unit Director in Santa Fe for the IHS, to work on HITECH and data issues in TAG. He will serve as the HITECH liaison between CMS, IHS, the tribal program, and the urban programs.</p> <p>CMS is updating its brochures and is working on a DVD of last year’s Medicine Dish shows. This year, Medicine Dish will air every other month, with all-tribes calls taking place on the off months.</p> <p><b>Ms. Marx</b> and <b>Ms. Davidson</b> shared some information on the NASMD luncheon to be held the next day and identified several of the State Medicaid Directors scheduled to attend. The luncheon will provide a very limited time for discussion, so the TTAG would like to focus on the possibility of meeting more frequently to discuss issues of importance to both groups, on the status of the SMDs’ tribal consultations, on the projects the SMDs are working on, and on the possibility of including SMDs in TTAG subcommittees or other working groups.</p>	
<b>NIHB Report</b>	<p><b>Ms. Jessica Burger</b>, Director of Government Relations and Acting Deputy Director, NIHB, reported that NIHB is making great progress on the Intra-Departmental Delegation of Authority (IDDA). She introduced <b>Mr. Carufel</b>, who will be working as a contractor on the IDDA deliverables.</p> <p><b>Mr. Carufel</b> described his background and his work bringing cost effective health care to Indian Country.</p>	
<b>Next Meeting</b>	<p>The TTAG agreed to tentatively schedule the next face-to-face meeting on February 17 and 18, 2010, with the MMPC meeting taking place on February 16 and a HITECH roundtable on February 19.</p>	

<b>Executive Session</b>	<p><b>Ms. Davidson</b> explained that the final item on the day's agenda was a discussion of the TTAG budget in an executive session. Following the completion of the discussion, the TTAG meeting would adjourn.</p> <p><b>Ms. Smith</b> moved to go into executive session. <b>Mr. Norrgard</b> seconded the motion, which was passed with unanimous consent.</p> <p>During the executive session, the TTAG was off the record and no notes were taken.</p>	
<b>Adjourn</b>	<p>With no more business to discuss, the TTAG adjourned the November 2009 face-to-face meeting.</p>	