

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board 926 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

May 11, 2011

TTAG Conference Call Action Items

Action Item	Timeline	Person Responsible	Status	Notes
Research the ACO eligibility of Indian health programs that serve only Indian populations and report back to the TTAG.	ASAP	Ms. Rodgers	Ongoing	
Submit recommendations for radio and television markets in which CMS should run the CHIP public service announcements.	ASAP	TTAG Members	Ongoing	
Submit ideas for future all-tribes call topics.	ASAP	TTAG Members	Ongoing	
Follow up on the TTAG request for a meeting with Dr. Berwick and report back to the TTAG.	ASAP	Ms. Marx	Ongoing	

May 11, 2011

TTAG Conference Call Minutes

Agenda Item	Discussion	Action
Documents Received	<ul style="list-style-type: none"> • Agenda (Attachment A) • ACO Factsheet: <i>What Providers Need to Know: Accountable Care Organizations</i> (Attachment B) • Summary of Proposed Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Plan (Attachment C) • CMS All Tribes Call: Friday, May 13, 2011 (Attachment D) • CMS Tribal Consultation Policy Subcommittee Draft (5/2/11) for TTAG Review (5/4/11) (Attachment E) • NIHB Analysis of Proposed Rule for Implementation of Section 1332 of the Affordable Care Act: Waiver for State Innovation (Attachment F) 	
Welcome and Call to Order	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 participants.	
Roll Call	<p>Ms. Tyra Baer, CMS Staff Assistant, National Indian Health Board (NIHB), took the roll of the TTAG members participating in the call:</p> <p>TTAG: Alaska – Valerie Davidson Aberdeen – absent Albuquerque – Carolyn Finster Bemidji – Kathy Hughes</p>	

	<p> Billings – absent California – absent Nashville – Donita Stevens Navajo – Roselyn Begay Oklahoma – Rhonda Butcher Phoenix – absent Portland –James Roberts Tucson – absent TSGAC – W. Ron Allen NIHB – absent NCAI – absent IHS – absent NCUIH – Carmelita Skeeter TTAG Technical Advisors: Carol Barbero Danielle Delaney Mim Dixon Linda Frizzell Myra Munson Tribes and Tribal Organizations: Terra Branson Tracy Jones Jim Lamb Gerald Moses Mickey Peercy Jay Steiner John Stevens CMS: Lindsey Cometa Rodger Goodacre Bonnie Hilsberg John Johns James Lyon Kitty Marx Tricia Rodgers Georgeline Sparks Native American Contacts: Cyndi Gillaspie, Lead NAC Nancy Grano, Region I Rosie Norris, Region IX Cindy Smith, Region VII Priya Helweg, Region X NIHB: Tyra Baer Jennifer Cooper Doneg McDonough IHS: Tammy Clay Chris Manydeeds Sherriann Moore Other: Sue Clain Sam Ennis Ed Fox, KAI </p>	
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	<p>Elliot Milhollin</p> <p>Only eight TTAG members were present at the beginning of the call; therefore, Ms. Davidson called the meeting to order as a working session. Later, a ninth member joined the call, bringing the group to a quorum.</p>	
Report from Chair	Ms. Davidson did not offer a report from the TTAG Chair.	
Report from Secretary	<p>Ms. Carolyn Finster, TTAG Secretary and Director, Pine Hill Health Center, recommended that the January 12 (conference call), February 23-24 (face-to-face meeting), and March 9 (conference call) minutes be approved by the TTAG. Because the TTAG had not reached a quorum at the time of the report, the approval of the minutes had to be postponed. Later in the call, the TTAG achieved a quorum. Ms. Finster made a motion for unanimous approval of the three sets of meeting notes, and the motion passed with no comments or objections.</p>	
Accountable Care Organization Proposed Rule	<p>Ms. Tricia Rodgers, Acting Deputy Director, Center for Medicare Performance Based Payment, Centers for Medicare & Medicaid Services (CMS), shared information on the proposed Medicare Shared Savings Program with the call participants (Attachment B).</p> <p>Section 3022 of the Patient Protection and Affordable Care Act (ACA) mandates the establishment of the Shared Savings Program using Accountable Care Organizations (ACOs) by January 1, 2012. CMS released a Notice of Proposed Rule Making (NPRM) concerning this subject on March 31 (Attachment C). The deadline for comments is June 6.</p> <p>Ms. Rodgers explained that the Shared Savings Program is a new approach to the delivery of health care. Its goals are the reduction of fragmentation of care, the improvement of population health, and the lowering of growth in overall health care expenditures. It promotes accountability for the care of Medicare fee-for-service (FFS) beneficiaries, requires coordinated care for all services provided under Parts A and B, and encourages investment in infrastructure and redesigned care processes. ACOs should embrace several goals, specifically:</p> <ul style="list-style-type: none"> • Placing the beneficiary and family at the center of care by honoring individual preferences and values through shared decision making; • Ensuring beneficiaries do not bear the burden of ensuring that all of their health care providers have the information needed to provide care; • Attending carefully to care transitions; • Ensuring the reduction of waste at every step in care to add value for the beneficiary, including preventing illness and promoting population health; • Proactively managing beneficiary care through the provision of reminders and advice; • Collecting, evaluating, and using data to improve care delivery and patient outcomes; • Innovating to improve the quality of health care and patient 	

- satisfaction and to control the growth of health care costs; and,
- Investing in the workforce to build knowledge and teamwork.

Both existing and new organizations are eligible to apply to the program. Eligible organizations include, but are not limited to, group practices, networks of individual practices, joint ventures, and partnerships with hospitals. CMS proposes using Secretarial discretion to expand the list of eligible entities to include other Medicare enrolled providers and suppliers; these entities can be invited to join the groups defined by the statute.

Federally qualified health centers (FQHCs) and rural health clinics cannot independently form ACOs. However, CMS incentivizes ACOs to include them as participants through a higher sharing rate.

CMS worked with the Federal Trade Commission and the Department of Justice to ensure that newly formed ACOs can participate in the program without violating antitrust laws. An antitrust policy statement was published on the same date as CMS' NPRM and outlines and requests comments on the safe harbors related to the creation and operation of ACOs, specifically with regard to collaborations formed after March 23, 2010. A key component of the statement relates to the primary services area (PSA) calculation for percentage share for common services. ACOs must calculate the PSAs, which determine whether ACO applicants must undergo an expedited antitrust review, as part of the application process. ACOs with less than a 30 percent PSA share do not need to undergo an antitrust review. Those with PSA shares between 30 and 50 percent can either undergo an expedited review or agree to comply with a list of conduct restrictions. ACOs with a PSA share above 50 percent will be required to seek an expedited review and must provide a letter of approval from an antitrust agency before entering into an agreement with CMS.

CMS proposes that ACOs in the Medicare Share Savings program be provider-centric and provider-driven. ACO participants are defined as Medicare-enrolled groups of providers or suppliers. A participant must create a legal entity recognized by its respective state laws and have a form of shared governance. The governing body must give the ACO participants proportionate control over decision making. While ACOs are permitted to join with entities such as health plans, the ACO participants must retain 75 percent control over the governing body. ACO governing bodies must also include beneficiary representation.

Ms. Rodgers emphasized the importance of clinical integration in the ACO. Hallmarks of clinical integration include an experienced executive team focused on quality improvement, clinical management by a senior-level medical director, and financial and human investments in the success of the ACO. ACOs are required to build a health information technology (HIT) infrastructure that enables collection and evaluation of data and the provision of feedback to providers at the point of care. CMS proposed that 50 percent of ACO primary care providers must be meaningful users of HIT by the end of the first performance year.

Conditions of participation in the program include a willingness to become accountable for an assigned Medicare FFS population. Beneficiary assignment is the basis for establishing and updating financial benchmarks, quality measurement, and performance. Beneficiaries will be assigned to ACOs based on the plurality of assigned charges for primary care services for primary care physicians (including internal medicine, general practice, family practice, and geriatric medicine). CMS has proposed retrospective assignment with prospective data sharing. CMS hopes that these requirements will create incentives for ACOs to standardize care and treat all Medicare patients in the same way.

Ms. Rodgers next addressed the two-track approach proposed by CMS. The first track has an initial three-year agreement period comprised of two years of one-sided share savings and an automatic transition to a two-sided share of saving or losses in the final year. The second track features a two-sided sharing of savings or losses for the full three-year period. After the initial three-year period, ACOs that choose to continue in the program will use the two-sided model. CMS created the model to help ACOs become familiar with risk arrangements.

ACO participants will continue to be paid under the regular Medicare FFS payment systems. ACOs may share in savings if the actual assigned population expenditures are below the established benchmark, if savings exceed the minimum savings rate, and if the ACO meets the quality performance standards. For each ACO, the annual risk adjusted expenditure target will be calculated based on the assigned patient population, updated using the national Medicare expenditures.

CMS proposes no adjustment for changes in health status between the performance years and the benchmark period to guard against changes due to more complete and accurate coding, rather than actual changes in the population's health status.

The proposed quality standards relate to CMS' three-part aim of improving the quality of care, improving population health, and reducing costs. The measures focus on five areas:

- Preventive health,
- At-risk and frail elderly populations,
- Patient and caregiver experience,
- Care coordination, and
- Patient safety.

CMS proposed that shared savings payments be linked to quality performance based on a sliding scale (better performing ACOs receive higher sharing rates). This approach aligns with Medicare quality and electronic health records (EHR) incentive programs as well as the National Quality Strategy and private sector initiatives.

Stakeholder response to CMS' initial request for information pointed out the importance of data for ACOs. While ACOs should be developing the HIT capability to share data, CMS recognizes that

groups of providers might not have complete data on care provided by outside organizations to their Medicare FFS patients. CMS proposes making beneficiary-identifiable data available to ACO providers for those beneficiaries who have been notified and not declined to have their data shared outside the ACO. CMS also proposes creating aggregated data reports to provide quarterly feedback to ACOs on expenditures and utilization and annual feedback on financial and quality performance.

CMS plans to monitor and assess the performance of ACOs and their providers and suppliers using several methods, including data trend and pattern analysis, site visits, audits, beneficiary surveys, coding audits, and investigation of beneficiary and provider complaints.

ACO agreements can be terminated for reasons such as avoidance of at-risk patients, failure to meet quality performance standards, beneficiary notification or public reporting noncompliance, program integrity issues, or changes in ACO structure or eligibility requirements.

Ms. Rodgers reiterated that CMS will accept comments on the NPRM through June 6 and strongly encouraged the call participants to submit comments.

Mr. Mickey Peercy, Choctaw Nation, Oklahoma Area, asked **Ms. Rodgers** to repeat the due date for comments on the NPRM. She replied that comments are due on June 6 and that they should be submitted through the www.Regulations.gov website. Additional information on the NPRM, including press releases and factsheets, can be found at the Shared Savings Program website, www.cms.gov/sharedsavingsprogram.

Dr. Mim Dixon, TTAG Technical Advisor, Mim Dixon & Associates, asked **Ms. Rodgers** about the possible effects of the Shared Savings Program on tribal health and the Indian Health Service (IHS), specifically with regard to the associated opportunities, incentives, and risks. **Ms. Rodgers** responded by asking whether all of these programs bill CMS for services provided to Medicare FFS beneficiaries. **Dr. Dixon** replied that most do. She was concerned that there is a minimum ACO service base of 5,000 patients. **Ms. Rodgers** confirmed that ACOs must serve a minimum of 5,000 FFS beneficiaries for primary care services. **Dr. Dixon** pointed out that most tribes would not be able to meet the minimum FFS patient base and asked if these tribes would be able to participate with ACOs in their respective areas. In these cases, **Ms. Rodgers** indicated that tribes would be able to participate in ACOs but would not be able to form independent ACOs.

Ms. Finster asked whether tribal or IHS programs that cannot form their own ACOs and cannot join an ACO are at risk for having their Medicare FFS patients assigned to an ACO. **Ms. Rodgers** replied that Medicare FFS beneficiaries are free to go to providers of their choice. If a beneficiary sees multiple providers and one is a member of an ACO, the beneficiary could be assigned to that ACO. This does not

prevent them from seeing other providers who do not belong to that particular ACO.

Ms. Finster further inquired whether Indian health facilities would continue to be paid for services provided to FFS beneficiaries even if they have been assigned to an ACO and what, specifically, it means when one is assigned to an ACO. **Ms. Rodgers** indicated that providers would be paid for services provided to FFS beneficiaries. All Part A and B expenditures during the program year, regardless of where they were provided, will be used for comparison with the benchmark expenditures.

Ms. Finster asked whether tribal programs will continue to be paid for services provided to beneficiaries who generally receive services through an Indian health program but are also counted as part of an ACO. She also asked whether payments would be made at the all-inclusive rate. **Ms. Rodgers** replied that tribal health programs would continue to be paid for services provided to Medicare FFS beneficiaries whether or not they are part of an ACO. Payments will be made in the same way that they are currently being made. The Shared Savings Program allows participating ACOs to receive a share of the savings realized through quality improvements and cost reductions as determined by the data; it does not affect payment in any way.

Mr. Peercy asked if tribes could form a consortium in order to meet the minimum Medicare FFS patient base. **Ms. Rodgers** replied that tribes could form an ACO as long as they have a minimum Medicare FFS patient base of 5,000 and bill under Parts A and B. **Ms. Sherriann Moore**, Senior Program Analyst, Office of Resource Access and Partnerships, IHS, noted that most IHS facilities bill for inpatient Medicare services on an FFS basis and outpatient Medicare services at the Office of Management and Budget all-inclusive rate. She emphasized that the purpose of the ACOS is to improve quality and coordinate care more effectively, not limit beneficiaries' choices concerning where they seek services. **Ms. Rodgers** confirmed this. She added that it would be necessary to look at the type of billing conducted by the various facilities, especially with regard to the outpatient all-inclusive rate. **Mr. Peercy** noted, as way of clarification, that the all-inclusive rate is a nationwide rate that is set on an annual basis

Dr. Dixon was concerned about the risk element of the program and asked whether ACOs could be forced to give back money. **Ms. Rodgers** explained that ACOs choosing the first track, in which the first two years are only the shared savings model, will be able to share in savings during all three years and would be held responsible for returning money to Medicare if they experienced losses only in the third year, not the first two. **Dr. Dixon** asked for confirmation that losses were defined as decreases in billing. **Ms. Rodger** stated that losses refer to overall higher costs for FFS beneficiaries in the ACO during the third year as compared to the benchmark year. **Dr. Dixon** felt that Indian health programs are not billing enough and that if the goal is to increase billing, the ACO program will not help achieve the

goal. **Ms. Rodgers** indicated that the focus of the Shared Saving Program is improving on the benchmark measures.

Ms. Myra Munson, TTAG Technical Advisor, Sonosky, Chambers, Sachse, Miller & Munson, LLP, asked if the calculation of losses or savings would be based on a per capita amount or on total savings/losses in the ACO. She noted that tribal health centers are encouraging tribal members who are eligible for Medicare to enroll in the program. She was particularly interested in learning how CMS would count increases in the overall number of beneficiaries served in the years after the benchmark period. **Ms. Rodgers** replied that ACOS would have new assigned populations in each performance year. At the end of the first performance year, each ACO will be retrospectively assigned beneficiaries. The total costs for these beneficiaries would then be assessed against the benchmark. This process would occur for each of the three performance periods.

Ms. Munson asked how costs would be assigned if a Medicare FFS beneficiary uses services from two different ACOs, such as a tribal health consortium and a large private hospital. **Ms. Rodgers** explained that the ACO that provided the plurality of services during a specific performance year would be the one toward which the beneficiary is counted. She noted that the goal is to better coordinate care for individual beneficiaries. CMS hopes that this model will encourage providers to work together to coordinate care.

Ms. Munson expressed concerns that there would be situations in which the bulk of a beneficiary's primary care is provided through the tribal ACO and the most expensive procedures are provided by another entity. Specifically, she was concerned that the beneficiary would be claimed by the outside ACO because of its large bill. **Ms. Rodgers** clarified that the plurality of primary care services refers to the number of procedures, not the total value. The ACO that provides the higher number of procedures will have the total dollar value associated with that particular beneficiary assigned to it.

Ms. Finster asked how close, in geographic terms, CMS expects the various components of an ACO to be. She asked whether multiple small tribes scattered throughout the eastern and southern part of the country would be able to form an ACO. **Ms. Rodgers** responded that there are no geographic restrictions in either the statute or the proposed rule. She anticipated that some ACOS would be spread out over a wide geographic area.

Mr. Peercy asked how specialty care visits would be counted, as some tribal health program users have to make more visits to their specialists than to their primary care providers. **Ms. Rodgers** confirmed that the assignment of beneficiaries is based on primary care services. However, ACOs are responsible for the full amount of each beneficiary's total Medicare Parts A and B costs. Part D and Part C costs are not included in CMS' calculations.

Mr. Doneg McDonough, Consultant, NIHB, expressed concerns that the lack of billing information related to coding for primary care

services from FQHCs prevents this data from being used to determine beneficiary assignment eventhough FQHCs provide primary care services. He believed that this could result in a beneficiary being erroneously assigned to an ACO from which he or she only received a small portion of his or her overall primary care. **Ms. Rodgers** indicated that the NPRM addresses the lack of FQHC data elements (e.g., service code, physician, physician specialty, attribution of services, etc.). Currently, CMS' system is not set up to accept this in its claims processing. This situation is changing, and **Ms. Rodgers** anticipated that FQHCs would be able to form independent ACOs in the future. She indicated that CMS does not currently have a way to assign beneficiaries in the situation described by **Mr. McDonough**. FQHCs can join ACOs; they cannot form independent ones.

Ms. Finster asked if individuals in states that require beneficiaries to enroll in managed care plans would be eligible to participate in ACOs. **Ms. Rodgers** stated that the Shared Savings Program covers Medicare FFS beneficiaries only; those beneficiaries with Part C plans would not be eligible for assignment to an ACO. **Ms. Munson** asked if the question referred to Medicaid or Medicare beneficiaries. The former can be required by the state to be in a managed care plan, the latter cannot. **Ms. Finster** noted that dual eligible beneficiaries in New Mexico would be in managed care plans. **Ms. Munson** thought that beneficiaries in those plans could still be part of an ACO if the plans were not Medicare Part C plans.

Ms. Rodgers indicated that there are several other ACO eligibility requirements in addition to the 5,000 Medicare FFS beneficiary requirement. These requirements include shared governance of the ACO (not of each participating entity). **Ms. Donita Stevens**, Finance Director, Choctaw Health Center, expressed concerns that existing Indian health programs might not have the required governance structures in place.

Ms. Munson pointed out that there are few, if any, tribes or Indian health programs that could meet the 5,000 Medicare FFS patient minimum; however, multiple tribes could join together to form an ACO and achieve the minimum FFS patient requirements. She asked whether it would be possible for five, 10, or 20 tribes that agree to follow the ACO rules, quality standards, and measures to join together to form an ACO or whether at least one of the entities in the ACO must be able to meet the patient minimum on its own. **Ms. Rodgers** explained that to qualify as an ACO, an entity must have a sufficient number of primary care professionals to be able to handle at least 5,000 Medicare FFS patients. An ACO can have as many individual primary care professionals in as many groups as necessary to reach the patient minimum.

Ms. Munson asked that shared governance be more clearly defined.

Ms. Rodgers stated that ACOs must:

- Have a formal legal structure for the receipt and distribution of payments,
- Agree to participate in the program for at least three years,
- Establish a leadership and management structure that includes

	<p>clinical and administrative systems,</p> <ul style="list-style-type: none"> • Define processes to promote evidence-based medicine and patient management, • Report quality and cost measures, • Coordinate care, • Meet patient-centeredness criteria, • Become accountable for the quality cost and overall care of the assigned beneficiaries, • Provide information concerning information about the ACO professionals to support the assignment of beneficiaries, • Implement quality reporting, and • Determine the shared savings payments. <p>These requirements are detailed in both the statute and the proposed regulation.</p> <p>Ms. Rodgers added that potential ACOS would need to describe their compliance plans, show how they will monitor and work out complaints, describe their plans for retaining documentation, and explain how conflict of interest policies apply to members of the governing body,</p> <p>Ms. Finster asked Ms. Rodgers to describe the potential benefits and pitfalls of joining an ACO for IHS providers. Ms. Rodgers stated that potential benefits include sharing in any savings that are generated as a result of participation, which could be in the millions of dollars depending on performance as compared to the benchmark. Downsides include the possibility of having to pay CMS back for losses. The downside of not participating is that the current system, where services are provided in silos and care is not coordinated, would continue unchanged. This would result in unnecessary copays for beneficiaries and higher costs for CMS.</p> <p>Ms. Finster asked if there is a specific negative consequence for not joining an ACO. Ms. Rodgers indicated that providers that do not join ACOs will still receive their usual FFS payments. In the long term, she felt that those who do not participate will miss out on the earliest opportunities to learn how to better coordinate care, reduce costs and reduce the growth in expenditures. She stressed that there is no requirement to participate and no penalty for not participating.</p> <p>Mr. McDonough asked if CMS has any projections on the numbers of ACOs that will participate in the program and the total number of beneficiaries who will be involved in the initial phase of the program. CMS anticipates that there will be between 75 and 100 ACOs participating in the initial three-year period, stated Ms. Rodgers. She was not sure if CMS has projected the total number of beneficiaries expected to be assigned to these ACOs.</p> <p>Ms. Cyndi Gillaspie, Lead Native American Contact, CMS, asked Ms. Rodgers to address the issue of eligibility criteria, specifically whether the eligibility criteria for participation in IHS and tribal health programs (these programs generally only serve Indians) would prohibit them from joining an ACO. Ms. Rodgers indicated that she</p>	<p>Ms. Rodgers will research the ACO eligibility of Indian health programs that serve only Indian populations and report back to the TTAG.</p>
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	<p>did not think that there would be any problems with these programs serving a defined population, but promised to look into the matter and report back. She indicated that ACOs cannot avoid serving at-risk beneficiaries. The NPRM does not address the limitation of beneficiaries based on criteria for entering a facility such as an Indian health facility.</p> <p>Ms. Kitty Marx, Director, Tribal Affairs Group (TAG), Office of Public Engagement (OPE), CMS, thanked Ms. Rodgers for discussing this matter with the TTAG members and for staying over the allotted time.</p> <p>Mr. W. Ron Allen, TTAG Vice-Chair representing the Jamestown S’Klallam Tribe, asked if it would be possible to develop a sheet of frequently asked questions about ACOs based on this discussion. Ms. Munson noted that it would be helpful to have a report of this discussion as soon as possible to help call participants develop their comments on the proposed rule. Mr. Allen felt that a working document providing an overview of the comments and the general direction of the ACO rule development is all that is needed at this time.</p>	
<p>Report from CMS</p>	<p>CHIP Outreach</p> <p>Ms. Georgeline Sparks, TAG, OPE, CMS, updated call participants on TAG’s outreach efforts related to the Child Health Insurance Program (CHIP). She reported that CMS ran public service announcements in Albuquerque, N.M.; Anchorage, Alaska; Billings, Mont.; Bismarck, N.D.; Oklahoma City, Okla.; Rapid City, S.D.; Sacramento, Calif.; and Tulsa, Okla. All of the announcements, except those in Sacramento, ran on ABC channels. Ms. Sparks indicated that some of the announcements were run beyond their originally scheduled April 30 end date. In some cases, the announcements will run for an additional two or three weeks. She asked whether any of the call participants had seen or heard the announcements in these markets. Ms. Marx was concerned that the announcements were being run at times when there are few viewers, given that none of the call participants had heard or seen the announcements.</p> <p>CMS also anticipates running the public service announcements in additional markets. She asked the call participants to suggest additional markets that CMS should target. Mr. Peercy suggested that the announcements be run in Ft. Smith, Ark., or Texarkana, Texas.</p> <p>Ms. Sparks thanked Dr. Donald Warne, Executive Director, Aberdeen Area Tribal Chairmen’s Health Board, and Ms. Carmelita Skeeter, Executive Director, Indian Health Care Resource Center of Tulsa, for their April 28 discussion on the <i>Native America Calling</i> show concerning the importance of enrolling Indian children in CHIP and Medicaid. The segment can be found at www.NativeAmericaCalling.com under the “archive” tab. Additionally, those interested in purchasing a copy of the relevant show can do so through the website.</p> <p>Ms. Sparks also reported that CMS showed the 60-second public service announcement multiple times on the Jumbotrons at the</p>	<p>TTAG members will submit recommendations for radio and television markets in which CMS should run the CHIP public service announcements.</p>

	<p>Gathering of Nations powwow.</p> <p>Ms. Marx noted that the feedback from the CHIP grantees on the announcements has been positive.</p> <p>All Tribes Calls Ms. Marx reminded call participants that there will be an all-tribes call on the Medicaid EHR incentive program on Friday, May 13 at 1:00 p.m. EDT (Attachment D).</p> <p>CMS plans to hold all-tribes calls on a monthly basis. Currently, CMS plans to hold calls on June 17, July 15, August 19, and September 16. Ms. Marx asked call participants to submit their ideas for call topics. She indicated that there are upcoming NPRMs that could form the basis for some of the call agendas.</p> <p>Ms. Munson asked Ms. Marx if the May all-tribes calls would be limited to a question and answer session about decisions that have already been made concerning the incentive program. She noted that the TTAG has been asking for a consultation session with CMS on the policy. She hoped that CMS would bring an open mind concerning the incentive payments to the upcoming call. Ms. Marx replied that the purpose of the call is to hear from the tribes, tribal programs, and urban Indian programs concerning the way programs that bill as FQHCs or use other Medicaid payment rates are treated under the incentive program. She indicated that CMS is very interested in hearing the tribal perspective on the proposed policy and encouraged the call participants to participate in the May 13 call.</p> <p>Mr. James Roberts, Policy Analyst, Northwest Portland Area Indian Health Board, asked if CMS has made a final decision on this issue. He felt that there is little need for the call if CMS has already made a decision on this issue and if it does not represent an opportunity for the tribes to have meaningful input. Ms. Marx stated that the call provides an opportunity for tribal input that could affect the final version of the policy. While she could not promise that changes would be made, she indicated that tribal concerns would be given full consideration.</p>	<p>TTAG members will submit ideas for future all-tribes call topics.</p>
<p>Subcommittee Reports: Tribal Consultation Policy</p>	<p>Ms. Davidson indicated that the Subcommittee developed a draft tribal consultation policy for TTAG review (Attachment E). Ms. Munson reported that the draft document is based, in great part, on the Department of Health and Human Services (HHS) tribal consultation policy. The Subcommittee met in Portland, Ore., to draft the policy, which was further refined during a subsequent conference call. The Subcommittee reviewed the current HHS policy as well as previous TTAG policy drafts. The Subcommittee recommended that the current draft be reviewed by the TTAG so that it could be approved and forwarded to CMS for review.</p> <p>Mr. Roberts hoped that the TTAG could move this document forward as expeditiously as possible, given that members received the draft approximately one week ago. He anticipated that the internal CMS review, which would result in a document suitable for use in tribal</p>	

	<p>consultation, would be the lengthiest part of the process. Mr. Roberts indicated that the Subcommittee leadership recommended that the TTAG approve the document for forwarding to CMS.</p> <p>Ms. Finster made a motion for unanimous consent to approve the draft consultation policy and forward it to CMS. The motion carried with no comments or objections offered.</p>	
<p>Subcommittee Reports: Behavioral Health</p>	<p>Dr. Linda Frizzell, Northwest Portland Area Indian Health Board, reported that the Tribal Law and Order Act Memorandum of Agreement will be released soon.</p> <p>Additionally, the Substance Abuse and Mental Health Service Administration is taking comments regarding the proposed distribution of funding for prevention grants for federally-recognized tribes. The current proposal would provide \$55,000 to each of the tribes with the balance of funds distributed through other mechanisms.</p> <p>Dr. Frizzell also noted that call participants should check the <i>Federal Register</i> notices for information regarding the eligibility of tribes for block grants.</p>	
<p>Subcommittee Reports: Across State Borders</p>	<p>Ms. Davidson indicated that the Subcommittee is still looking for a new chairperson and asked TTAG members to consider volunteering for the post.</p>	
<p>Subcommittee Reports: Outreach & Education</p>	<p>None.</p>	
<p>Subcommittee Reports: Data</p>	<p>None.</p>	
<p>Subcommittee Reports: Long-Term Care</p>	<p>None.</p>	
<p>Subcommittee Reports: Budget</p>	<p>None.</p>	
<p>Other Business</p>	<p>Ms. Davidson noted that comments on the ACA Section 1332 Waivers for State Innovations are due on May 13. NIHB has drafted comments (Attachment F). Mr. Peercy made a motion for unanimous consent to submit the paper drafted by NIHB as a TTAG paper with a TTAG cover letter. The motion passed with no comments or objections offered.</p> <p>Mr. Allen asked about the status of the meeting that TTAG requested with the CMS Administrator, Dr. Donald Berwick. Ms. Marx promised to follow up on the matter and report back to the TTAG.</p>	<p>Ms. Marx will follow up on the TTAG request for a meeting with Dr. Berwick and report back to the TTAG.</p>
<p>Next Meeting</p>	<p>Ms. Davidson reminded participants that the next TTAG conference call would take place on June 8. There will not be a conference call in</p>	

	July because the face-to-face meeting is scheduled for July 27-28.	
Adjourn	With no other business to be discussed, Ms. Davidson adjourned the meeting.	

Attachment A:

Agenda

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board 926 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

TTAG AGENDA

Conference Call

Wednesday, May 11, 2011, 2:30 – 4:00 PM (Eastern)

Call In Number: 1-877-267-1577 Pass Code: 0808

- 2:30 Welcome** - Valerie Davidson, Chair
Roll Call – Tyra Baer, NIHB
- 2:35 Report from Chair:** Valerie Davidson, Chair
- 2:40 Report from Secretary** – Carolyn Finster, Secretary
- Approve meeting minutes from January 12, 2011 Conference Call, February 23-24, 2011 Face-to-Face Meeting & March 9, 2011 Conference Call (see #7,8 &9 attachment)
- 2:45 Accountable Care Organization (ACO) Proposed Rule** – Tricia Rodgers, Acting Deputy Director, Center for Medicare Performance Based Payment Policy Staff
- Shared Savings website www.cms.gov/sharedsavingsprogram
 - HHS Press Release ACOs:
<http://www.hhs.gov/news/press/2011pres/03/20110331a.html>
 - What Providers Need to Know: Accountable Care Organizations (see # 2 attachment)
 - Summary of Proposed Rule Provisions for Accountable Care Organizations (see #3 attachment)
- 3:05 Report from CMS TAG** – Kitty Marx
- CHIP Outreach – Lindsey Cometa and Georgey Sparks
 - All Tribes Calls-
 - May 13, 2011 Medicaid EHR Program (see # 4 attachment)
 - Topics for future All Tribes Calls
 - June 17, July 15, August 19, September 16
- 3:20 Subcommittee activities/schedules**
- Tribal Consultation Policy** – Ron Allen & Jason Dollarhide
 - UPDATE: Draft Tribal Consultation Policy (see # 5 attachment)
 - Outreach and Education** – Kathy Hughes
 - Data** – Jim Crouch
 - Across State Borders** (need a new chair)
 - Behavioral Health** – Dr. Linda Frizzell
 - Long Term Care** – Dr. Judy Goforth Parker
 - Budget** – Jim Roberts
- 3:40 Other Business/ Discussion** –
- CMS-9987-P: Affordable Care Act sec.1332 Waivers for State Innovation
 - comments due 5/14 COB (See #6 attachment)
- 4:00 Adjourn**

NOTE: Future 2011 TTAG Conference Calls, 1-877-267-1577 meeting ID: 0808

June 8, 2011	October 12, 2011
July 13, 2011	December 14, 2011
August 10, 2011	
September 14, 2011	

Future 2011 TTAG Face to Face Meetings (at NMAI, Washington, D.C.)

July 27-28, 2011	November 9-10, 2011
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3.

Attachment B

**ACO Factsheet:
*What Providers Need to Know:
Accountable Care Organizations***

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



What Providers Need to Know: Accountable Care Organizations

FACT SHEET

On March 31, 2011, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), proposed new rules under the Affordable Care Act to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor’s offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program (Shared Savings Program) will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary.

Under the proposal, ACOs – teams of doctors, hospitals, and other health care providers working together – would coordinate and improve care for patients with Original Medicare – Medicare Parts A and B. ACOs would have to meet high quality standards to ensure patients are happy with the care they receive and have better health outcomes; and if ACOs can help save money by getting patients the right care at the right time, they can share in those savings with Medicare. As proposed, ACOs could also have to pay back Medicare for failing to provide efficient, cost-effective care. The new program would begin on January 1, 2012.

This fact sheet describes the proposals to ensure that ACOs provide high-quality care, including proposed quality measures, and a proposed method for scoring the performance of the ACO for purposes of the Shared Savings Program. There will be a 60 day public comment period on this proposed rule. CMS encourages all interested members of the public, including providers, suppliers, and Medicare beneficiaries, to submit comments so that CMS can consider them as it develops final regulations on the program.

What Is an ACO?

Under the proposed rule, an ACO refers to a group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for the patients they serve in Original Medicare. The goal of an ACO is to deliver seamless, high-quality care for Medicare beneficiaries, instead of the fragmented care that often results from different providers receiving different, disconnected payments. The ACO would be a patient-centered organization where the patient and providers are partners in care decisions.



The Affordable Care Act specifies that an ACO may include the following types of groups of providers and suppliers of Medicare-covered services:

- ACO professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements,
- Networks of individual practices of ACO professionals,
- Partnerships or joint ventures arrangements between hospitals and ACO professionals,
- Hospitals employing ACO professionals, or
- Other Medicare providers and suppliers as determined by the Secretary.

In the proposed rule, the Secretary has made clear that certain critical access hospitals are eligible to participate in the Shared Savings Program.

How Could Providers Participate?

To participate in the Shared Savings Program, providers must form or join an ACO and apply to CMS. An existing ACO will **not** be automatically accepted into the Shared Savings Program. If accepted, they would serve at least 5,000 Medicare patients and agree to participate in the program for three years. Medicare providers who join an ACO that participates in the program would continue to receive payment under Original Medicare Fee-For-Service (FFS) rules.

The statute also requires each ACO to establish a governing body representing ACO providers of services, suppliers, and Medicare beneficiaries. The ACO would be responsible for monitoring and reporting of the care it delivers. The proposed rule outlines a monitoring and reporting plan that includes analyzing claims and specific financial and quality data, producing quarterly and annual aggregated reports, performing site visits, and conducting beneficiary surveys.

How Would Shared Savings Work?

Under the proposed rule, Medicare would continue to pay individual providers and suppliers for specific items and services as it currently does under the Original Medicare payment systems. CMS would also develop a benchmark for each ACO against which ACO performance is measured to assess whether it qualifies to receive shared savings, or be held accountable for losses. The benchmark is an estimate of what the total Medicare FFS Parts A and B expenditures for ACO beneficiaries would otherwise

have been in the absence of the ACO, even if all of those services would not have been provided by providers in the ACO. The benchmark would take into account beneficiary characteristics and other factors that may affect the need for health care services. This benchmark would be updated for each performance year within the three-year performance period.

CMS is proposing to implement both a one-sided risk model (sharing of savings only for the first two years and sharing of savings and losses in the third year) and a two-sided risk model (sharing of savings and losses for all three years), allowing the ACO to opt for one or the other models. CMS believes this approach would have the advantage of providing an entry point for organizations with less experience with risk models, such as some physician-driven organizations or smaller ACOs, to gain experience with population management before transitioning to a risk-based model, while also providing an opportunity for more experienced ACOs that are ready to share in losses to enter a sharing arrangement that provides a greater share of savings, but at the risk of repaying Medicare a portion of any losses.

CMS is also proposing to establish a minimum savings rate (MSR) that would account for normal variations in health care spending. The minimum savings rate is a percentage of the benchmark that ACO expenditure savings must exceed in order for an ACO to qualify for shared savings in any given year. Under the proposed rule, ACOs in the one-sided risk program that have smaller populations (and having more variation in expenditures) would have a larger MSR and ACOs with larger populations (and having less variation in expenditures) have a smaller MSR. Under the two-sided approach, CMS is proposing a flat 2 percent minimum savings rate.

If an ACO meets quality standards and achieves savings exceeding the minimum savings rate, the ACO would share in savings, based on the quality score of the ACO. The proposed rule would provide for additional shared savings for ACOs that include beneficiaries who receive services from a Federally Qualified Health Center or Rural Health Clinic during the performance year.

ACOs that Participate in the Two-Sided Risk Model Can Obtain Greater Shared Savings

To qualify for shared savings, ACOs must meet certain quality and performance standards and have total per capita costs for assigned beneficiaries in the performance year to be both below the estimated updated benchmark and above the minimum savings rate. Once the ACO surpasses the minimum savings rate, it may share in savings if it is eligible to receive shared savings based on its quality performance score. To provide a greater incentive for ACOs to adopt the two-sided risk approach, the maximum sharing percentage is 60 percent for ACOs in the two-sided model compared to 50 percent in the one-sided model. In addition, under the two-sided model, ACOs would receive shared savings for the first dollar after the minimum savings rate is achieved. In contrast, under the one-sided model, ACOs would share on savings after a 2 percent threshold is met, with an exemption for small ACOs in rural or underserved communities. Under both models, an ACO would be eligible for a greater portion of shared savings the higher its quality and performance score.

The proposed rule also provides a methodology for determining shared losses for ACOs in the two-sided model (or year three of the one-sided model) if the per capita cost per beneficiary were more than 2 percent higher than the benchmark. As with shared savings, the amount of shared

losses would be based in part on the ACO's quality performance score. Additionally, CMS is also proposing a shared loss cap of 5 percent of the benchmark in the first year of the Shared Savings Program, 7.5 percent in the second year, and 10 percent in the third year.

Participation in the First Program Year Allows for ACOs to Obtain the Maximum Sharing Rate if They Successfully Report Quality Measures

CMS is encouraging providers to participate in the Shared Savings Program in 2012 by setting the quality performance standard to reporting only. ACOs would be eligible for the maximum sharing rate (60 percent for the two-sided model and 50 percent for the one-sided model) if the ACO generates sufficient savings and successfully reports the required quality measures. This flexibility would allow newly formed ACOs a grace period as they start up their operations and learn to work together to better coordinate patient care.

The Proposed Quality Measurement is Aligned with Other CMS Quality Initiatives

CMS has proposed to measure quality of care using nationally recognized measures in five key domains: patient experience, care coordination, patient safety, preventive health, and at-risk population/frail elderly health. These measures are aligned with the measures in other CMS programs such as the Electronic Health Records (EHR) and Physician Quality Reporting System (PQRS). An ACO that successfully reports the quality measures required under the Shared Savings Program would be deemed eligible for the PQRS bonus.

ACOs may not participate, however, in any other shared savings program or demonstration under the Center for Medicare and Medicaid Innovation or Independence At Home Medical Practice pilot program to ensure that savings are not counted twice.

Existing Clinically Integrated Entities Need Not Form New Entities to Participate in the Shared Savings Program

If an ACO is already comprised of a self-contained financially and clinically integrated entity that has a pre-existing board of directors or other governing body, the ACO need not form a separate governing body or create a new legal entity. The existing entity, however, must be recognized under applicable State law, be capable of receiving and distributing shared savings and repaying shared losses, and meet the other ACO functions identified in the statute.



How ACOs Help Doctors Coordinate Care

Health care providers have reported that an important barrier to improving care coordination is lack of information. While they may know about the services they provide to the beneficiary, they don't know about other services provided to the beneficiary. To better treat patients and to coordinate their care, ACOs would be able to request claims information about their patient from CMS. Before doing so, ACOs must notify a beneficiary in writing that it would request the beneficiary's claims information from CMS. ACOs must allow

beneficiaries to opt-out of having their claims information shared with the physician and the ACO. This opting out of having claims information shared, however, does not affect the patient's participation in the ACO or CMS's use of the patient's data for purposes of assessing quality or cost measures. This notification must happen the first time the ACO cares for the beneficiary.

Alignment of CMS Requirements and Other Federal Laws

CMS has worked closely with agencies across the Federal government to facilitate participation in the Shared Savings Program by coordinating Federal fraud and abuse requirements, tax guidance, and antitrust considerations. In particular, the Federal Trade Commission and the Antitrust Division of the Department of Justice have proposed an antitrust policy statement that clarifies application of the antitrust laws to Medicare Shared Savings Program-approved ACOs that negotiate and contract with commercial payers. For more information, see "Medicare Fact Sheet: Federal Agencies Address Legal Issues Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program."

The Shared Savings Program Notice of Proposed Rulemaking (NPRM) appeared in the April 7, 2011, issue of the Federal Register. CMS will accept comments on the proposed rule until June 6, 2011, and will respond to them in a final rule to be issued later this year. The Shared Savings Program will begin operating on January 1, 2012.



This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This fact sheet was prepared as a service to the public and is not intended to grant rights or impose obligations. This fact sheet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

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Please send your suggestions related to MLN product topics or formats to MLN@cms.hhs.gov.

Attachment C:

**Summary of Proposed Rule Provisions for
Accountable Care Organizations Under the
Medicare Shared Savings Plan**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Summary of Proposed Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program

FACT SHEET

Overview

On March 31, 2011, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), proposed new rules under the Affordable Care Act to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor’s offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program (Shared Savings Program) will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary.

In developing the proposed rule, CMS has worked closely with agencies across the Federal government to ensure a coordinated and aligned inter- and intra-agency effort to facilitate implementation of the Medicare Shared Savings Program (Shared Savings Program).

This fact sheet describes the proposals addressing the proposals for what ACOs are, how they can be created, and other general topics. CMS has posted separate fact sheets on its website to address in greater detail specific aspects of the proposed rule, such as the quality measures and performance scoring.

There will be a 60 day public comment period on this proposed rule. CMS encourages all interested members of the public, including providers, suppliers, and Medicare beneficiaries to submit comments so that CMS can consider them as it develops final regulations on the program.

Background

Section 3022 of the Affordable Care Act added a new Section 1899 to the Social Security Act (the Act) that requires the Secretary to establish the Shared Savings Program by January 1, 2012. This program is intended to encourage providers of services and suppliers (e.g., physicians, hospitals, and others involved in patient care) to create a new type of health care entity, which the statute calls an “Accountable Care Organization (ACO)” that agrees to be held accountable for improving the health and experience of care for individuals and improving the health of populations while reducing the rate of growth in health care spending. Studies have shown that better care often costs less, because coordinated care helps to ensure that the patient receives the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors.

ACOs and the Medicare Beneficiary

An ACO provides an opportunity for Medicare beneficiaries to receive high quality evidence-based health care that eliminates waste and reduces excessive costs through improved care delivery. However, there would be significant differences between ACOs, as described in the proposed rule, and the private managed care plans offered under the Medicare Advantage program. Beneficiaries would not enroll in a specific ACO.

Instead, the proposed rule calls for Medicare to take a retrospective look at the beneficiary’s use of services to determine whether a particular ACO should be credited with improving care and reducing expenditures. This means that an ACO would have an incentive to improve the quality of care for all patients seen by its member providers and suppliers.

The proposed rule would require providers participating in an ACO to notify the beneficiary that they are participating in an ACO, and that the provider will be eligible for additional Medicare payments for improving the quality of care the beneficiary receives while reducing overall costs or may be financially responsible to Medicare for failing to provide efficient, cost-effective care. The beneficiary may then choose to receive services from the provider or seek care from another provider that is not part of the ACO.

The proposed rule would also require each provider in an ACO to notify the beneficiary that the beneficiary’s claims data may be shared with the ACO. This data sharing is intended to make it easier to coordinate the beneficiary’s care; however, the provider may not require a beneficiary to obtain services from another provider or supplier in the same ACO. The provider must give the beneficiary the opportunity to opt-out of those data sharing arrangements. For Medicare beneficiaries who choose not to opt-out of the data sharing arrangements, the proposed rule would limit data sharing to the purposes of the Shared Savings Program and would require compliance with applicable privacy rules and regulations, including the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).



Proposed Eligibility Requirements for an ACO

Under the proposed rule, an ACO refers to a group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for the Medicare Fee-For-Service (FFS) beneficiaries they serve. The goal of an ACO is to deliver seamless, high quality care for Medicare beneficiaries, instead of the fragmented care that has so often been part of FFS health care. The ACO would be a patient-centered organization where the patient and providers are true partners in care decisions.

The Affordable Care Act specifies that an ACO may include the following types of groups of providers and suppliers of Medicare-covered services:

- ACO professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements,
- Networks of individual practices of ACO professionals,
- Partnerships or joint ventures arrangements between hospitals and ACO professionals,
- Hospitals employing ACO professionals, or
- Other Medicare providers and suppliers as determined by the Secretary.

In the proposed rule, the Secretary has used her discretion to add certain critical access

hospitals as eligible to participate in the Shared Savings Program.

The statute also requires each ACO to establish a governing body representing ACO providers of services and suppliers and Medicare beneficiaries. The proposed rule would make each ACO responsible for routine self-assessment, monitoring, and reporting of the care it delivers.

To participate in the Shared Savings Program, the proposed rule would require an ACO to complete an application providing the information requested by CMS, including how the ACO plans to deliver high quality care at lower costs for the beneficiaries it serves. As proposed, the ACO must agree to accept responsibility for at least 5,000 beneficiaries. If the application is approved, the ACO must sign an agreement with CMS to participate in the Shared Savings Program for a period of three years. An ACO will **not** be automatically accepted into the Shared Savings Program.

The proposed rule outlines a monitoring plan that includes analyzing claims and specific financial and quality data as well as the quarterly and annual aggregated reports, performing site visits, and performing beneficiary surveys.

Under the proposed rule, there are a number of circumstances under which CMS may terminate the agreement with an ACO, including avoidance of at risk beneficiaries and failure to meet the quality performance standards.

Tying Payment to Improved Care at Lower Cost

Under the proposed rule, Medicare would continue to pay individual providers and suppliers for specific items and services as it currently does under the FFS payment systems. The proposed rule would require CMS to develop a benchmark for savings to be achieved by each ACO if the ACO is to receive



shared savings, or be held liable for losses. Additionally, an ACO would be accountable for meeting or exceeding the quality performance standards to be eligible to receive any shared savings.

The proposed rule would establish quality performance measures and a methodology for linking quality and financial performance that will set a high bar on delivering coordinated and patient-centered care by ACOs, and emphasize continuous improvement around the three-part aim of better care for individuals, better health for populations, and lower growth in expenditures. The proposed rule would require the ACO to have in place procedures and processes to promote evidence-based medicine and beneficiary engagement in their care. The proposed rule would require ACOs to report quality measures to CMS and give timely feedback to providers. CMS expects that ACOs will invest continually in the workforce and in team-based care. To assure program transparency, the proposed rule would require ACOs to publicly report certain aspects of their performance and operations.

Under the proposed rule, an ACO that meets the program's quality performance standards would

be eligible to receive a share of the savings it generates below a specific expenditure benchmark that would be set by CMS for each ACO. The proposed rule would also hold ACOs accountable for downside risk by requiring ACOs to repay Medicare for a portion of losses (expenditures above its benchmark). To provide an entry point for organizations with varied levels of experience with and willingness to take on risk, the proposed rule would allow an ACO to choose one of two program tracks. The first track would allow an ACO to operate on a shared savings only track for the first two years, but would then require the ACO to assume the risk for shared losses in the third year. The second track would allow ACOs to share in savings and risk liability for losses beginning in their first performance year, in return for a higher share of any savings it generates.

The Shared Savings Program Notice of Proposed Rulemaking (NPRM) appeared in the April 7, 2011, issue of the Federal Register. CMS will accept comments on the proposed rule until June 6, 2011, and will respond to them in a final rule to be issued later this year. The Shared Savings Program will begin operating on January 1, 2012.



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Attachment D:

CMS All Tribes Call: Friday, May 13, 2011

CMS All Tribes' Call: Friday, May 13, 2011 at 1 – 2 pm ET
Call in number is 1-866-288-9872, Passcode 165709.

On Friday, May 13th 2011 at 1 – 2 pm ET, the CMS will host an All Tribes' Call to obtain tribal input regarding how eligible professionals within tribal programs can meet the eligibility criteria for purposes of the Medicaid EHR program.

The call will be facilitated by Kitty Marx, Director, CMS Tribal Affairs Group, Office of Public Engagement. Jackie Garner, Jessica Kahn, and Michelle Mills from the Centers for Medicaid, CHIP, and Survey and Certification (CMCS) will provide information on the CMS Medicaid EHR program and will be available to listen to and hear from tribal officials regarding eligibility for the Medicaid EHR Incentive Program.

Background information on the Medicaid EHR Incentive Program and Treatment of Tribal Programs:

The Medicaid EHR Incentive Program provides incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. For more information on the CMS Medicare and Medicaid EHR Incentives Programs, please visit the CMS website at <http://www.cms.gov/EHRIncentivePrograms>.

In order for Medicaid eligible professionals (physicians, certified nurse midwives, nurse practitioners, dentists, and certain physician assistants*) to be considered eligible for the Medicaid EHR incentive program, they must meet at least one of two criteria:

- 1.) Have equal \geq than 30% Medicaid patient volume (\geq 20% for pediatricians only); or
- 2.) Practice predominantly in an FQHC or RHC with \geq 30% "needy individual"*** patient volume.

For purposes of the Medicaid EHR Incentive program, Tribal clinics have expressed interest in being treated as FQHCs and to utilize the "needy individual" patient volume criteria for #2, above. Tribal and urban clinics fall within the definition of an FQHC under section 1905(1)(2)(B) of the Social Security Act, but these clinics have the option of being paid as an FQHC or at other Medicaid payment rates. The Medicaid EHR Incentive Program is a CMS payment program and CMS' policy regarding provider self-identification for payment purposes needs to be consistent. If CMS considered some clinics as FQHCs under the EHR Incentive Program that are not considered as FQHCs for Medicaid payment purposes, CMS policy would be inconsistent. In order to promote consistency with existing CMS payment policies, CMS determined that only tribal clinics that are reimbursed under the Medicaid program at the state's FQHC reimbursement rate shall be treated as FQHCs for purposes of the Medicaid EHR program. As noted above, this policy is not unique to eligible professionals in tribal clinics' and has been applied for other provider types as well.

On February 9, 2011, the following Frequently Asked Question (FAQ) was posted on the CMS EHR Incentives website:

Can *tribal* clinics be treated as Federally Qualified Health Centers (FQHCs) for the Medicaid EHR Incentive Program?

A 1996 memorandum of agreement (MOA) between CMS and Indian Health Services (IHS) addressed the roles and responsibilities in implementing payment policies covering American Indian and Alaska Native (AI/AN) individuals through health care facilities owned and operated by AI/AN tribes and *tribal* organizations ("*tribal* clinics") with funding authorized by the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as

amended). Under this 1996 MOA, *tribal* clinics may choose between being reimbursed for health care services as an IHS facility or an FQHC. If *tribal* clinics are reimbursed under the Medicaid program at the state's FQHC reimbursement rate, these clinics will be treated as FQHCs for the Medicaid EHR Incentive Program (regardless of section 330 certification). If *tribal* clinics elect to be reimbursed as an IHS facility (or any method other than the FQHC reimbursement rate), they will not be treated as FQHCs for this program.

*Please note physician assistants are only eligible when they practice in an FQHC or an RHC that is *so led* by a physician assistant.

** Needy individuals are defined under statute and regulation as including individuals in the following categories: Medicaid and CHIP or patients furnished services on a free or sliding scale basis based on their ability to pay for the services.

Kitty Marx
Director, Tribal Affairs Group



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Attachment E:

**CMS Tribal Consultation Policy
Subcommittee Draft (5/2/11) for TTAG Review (5/4/11)**

**CMS TRIBAL CONSULTATION POLICY
SUBCOMMITTEE DRAFT (5/2/11) FOR TTAG REVIEW (5/4/11)**

1. PURPOSE

The Centers for Medicare & Medicaid Services (CMS), an agency within the U. S. Department of Health and Human Services (HHS), and Indian Tribes share the goal to establish clear policies to further the government-to-government relationship between the Federal Government and Indian Tribes. The purpose of the CMS tribal consultation policy is to address CMS policies and actions that have tribal implications so that CMS and Tribes can exchange information that leads to mutual understanding and informed decision making. The outcome of this policy is intended to achieve culturally appropriate interaction between CMS and Indian Tribes and greater access to CMS programs by American Indians and Alaska Natives (AI/ANs). Open and continuous tribal consultation creates opportunities for CMS to build meaningful relationships with Indian Tribes. True and effective consultation results in information exchange, mutual understanding, and informed decision-making.

The goal of this policy is to ensure meaningful consultation with Indian Tribes on policy and programmatic issues including, but not limited to eliminating health disparities of Indians and ensuring access to critical health services, including those made available through Medicare, Medicaid, CHIP, and Exchange Plans administered by CMS. The involvement of Tribes in the development of CMS policy allows for culturally appropriate approaches resulting in greater access to CMS programs and positive outcomes for Indian people and the health programs operated by the Indian Health Service, Tribes and Tribal organizations, and urban Indian organizations.

2. Background

Since the formation of the Union, the United States (U.S.) has recognized Indian Tribes as sovereign nations. A unique government-to-government relationship exists between Indian Tribes and the Federal Government. This relationship is grounded in the U.S. Constitution, numerous treaties, statutes, Federal case law, regulations and executive orders that establish and define a trust relationship with Indian Tribes. This relationship is derived from the political and legal relationship that Indian Tribes have with the Federal Government and is not based upon race.

An integral element of this government-to-government relationship is that consultation occurs with Indian Tribes. The commitment of the United States to consult with Indian Tribes was affirmed through Presidential Memoranda in 1994, 2004 and 2009, and Executive Order (EO) 13175 in 2000. The implementation of this policy is in recognition of this special relationship.

This special relationship is affirmed in statutes and various Presidential Executive Orders including, but not limited to:

- The Snyder Act, Pub. L. 67-85;
- Titles XVIII, XIX, and XIX of the Social Security Act;
- The Indian Health Care Improvement Act, Pub. L. 94-437, as amended;

- Presidential Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, November 6, 2000;
- Presidential Memorandum, Government-to-Government Relationship with Tribal Governments, September 23, 2004;
- § Presidential Memorandum, Tribal Consultation, November 5, 2009
- § American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, 123 Stat. 115 (Feb. 17, 2009);
- § Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. 111-3, 123 Stat. 8 (Feb. 4, 2009);
- § Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148, 124 Stat. 119 (Mar. 23, 2010).

Consultation with Tribal governments is especially important for CMS programs because Indian Tribes serve many roles in their tribal communities. They are employers and health care providers, and their tribal members are beneficiaries of services provided by the Indian Health Services (IHS), a federal agency within HHS, and beneficiaries of the Medicare, Medicaid, Children's Health Insurance Program (CHIP) and Exchange Plan programs administered by CMS.

Health care is provided to AI/ANs through the IHS, through tribal health programs operating under the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, and through urban Indian health programs operating under Title V of the Indian Health Care Improvement Act. Under Title IV of the Indian Health Care Improvement Act, the IHS and tribal programs have authority to bill Medicare, Medicaid and the Children's Health Insurance Program (CHIP) for services provided in IHS and tribal facilities. This authority assures a source of revenue that is critical to overcoming the chronic underfunding of the IHS delivery system. Revenues from CMS programs can represent up to 50% of IHS and tribal operating budgets. The IHS and tribal health programs are substantially reliant on CMS operated programs to provide services to AI/ANs, thus changes in CMS policy have a direct effect on Indian tribes and Indian health providers.

3. TRIBAL SOVEREIGNTY

This policy does not waive any Tribal Governmental rights and authority, including treaty rights, sovereign immunities or jurisdiction. Additionally, this policy does not diminish any rights or protections afforded other American Indians or Alaskan Natives (AI/AN) or entities under Federal law.

The special government-to-government relationship between the Federal Government and Indian Tribes, established in 1787, is based on the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders, and reaffirms the right of Indian Tribes to self-government and self-determination. Indian Tribes exercise inherent sovereign powers over their citizens and territory. The U.S. shall continue to work with Indian Tribes on a government-to-government basis to address issues concerning Tribal self-government, Tribal trust resources, Tribal treaties and other rights.

Tribal self-government has been demonstrated to improve and perpetuate the government-to-government relationship and strengthen Tribal control over Federal funding that it receives, and its internal program management. Indian Tribes participation in the development of public health and human services policy ensures locally relevant and culturally appropriate approaches to public issues.

4. PHILOSOPHY

Federally recognized Tribes have an inalienable and inherent right to self-government. Self-government means government in which decisions are made by the people who are most directly affected by the decisions. As sovereign nations, Federally recognized Tribes exercise inherent sovereign powers over their members, territory and lands.

CMS has a long-standing commitment to working on a government-to-government basis with Indian Tribes and to work in partnership with AI/ANs. CMS is committed to enhancing the collaboration with other HHS Divisions to address Tribal issues.

The Congress found that “a major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States.” 25 U.S.C. § 1601(3). To further the achievement of this goal, CMS is committed to:

- 4.1 Significantly increasing the rate of health coverage for all American Indians and Alaska Natives;
- 4.2 Financially strengthening Indian health providers so programs can expand service capacity and increase access to quality health care services;
- 4.3 Significantly reducing health disparities of American Indians and Alaska Natives so that they have the same or better health status as the general population;
- 4.4 Ensuring that Tribal leaders and Indian health program staff receive training to understand CMS programs and are supplied with adequate resources to educate and enroll community members in new or expanded health programs;
- 4.5 Ensuring that all Indian communities directly benefit from CMS funding opportunities, grants and initiatives in a way that compliments the cultural context of their existing health programs;
- 4.6 Recognizing that the Indian health system is very different from the mainstream health delivery system and, therefore, assure that it is protected from any adverse consequences not intended by statute, and that it receives express recognition in regulations in order to achieve this outcome;
- 4.7 Supporting Indian Health Programs to achieve CMS’s overarching policy goals of:
 - 4.7.1 Better care for individuals by focusing on safety, effectiveness, patient-centeredness, timeliness, efficiency and equity;
 - 4.7.2 Better health for AI/ANs by focusing on “the upstream causes of so much of our ill health,” such as poor nutrition, physical inactivity, substance abuse, unwise behavioral choices, violence and economic disparities; and

- 4.7.3 Lowering health care costs through improvement and by eliminating waste and needless hassles.
- 4.8 Requiring all CMS Components responsible for Tribal issues engage in meaningful Tribal Consultation that respects the special federal trust responsibilities and legal obligations and Government-to-Government relationship with Indian Tribes.

5. OBJECTIVES

In order to fully effectuate this Consultation Policy, CMS will:

- 5.1 Establish improved communication channels with Tribal officials and other AI/AN organizations, as necessary, to increase knowledge and understanding of CMS's programs;
- 5.2 Create opportunities for Indian Tribes to raise issues with CMS and for CMS to seek consultation with Indian Tribes and communication with Indian organizations when new issues arise;
- 5.3 Establish a minimum set of requirements and expectations with respect to consultation and participation for the levels of CMS management;
- 5.4 Conduct Tribal consultation regarding CMS's policies and actions that have tribal implications and upon request by Indian Tribe(s) for consultation and technical assistance in obtaining CMS resources;
- 5.5 Require and encourage States to engage in tribal consultation as required by law and regulation;
- 5.6 Coordinate with IHS and other Divisions of HHS on issues of mutual concern;
- 5.7 Coordinate among CMS Regional Offices and Central Office to assure consistent policy interpretations, interactions of all levels of CMS with Indian Tribes, and direction to State Agencies regarding issues that have Tribal implications; and
- 5.8 Enhance partnerships with Indian tribes that will include technical assistance and access to CMS programs and resources.

6. ROLES

- 6.1 **Indian Tribes:** The government-to-government relationship between the U.S. and Federally recognized Indian Tribes dictates that the principal focus for HHS consultation is Indian Tribes, individually or collectively.
- 6.2 **Tribal Organizations.** Pursuant to the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended, Indian Tribes have the authority to delegate their right to carry out programs of the Indian Health Service to a "tribal organization." To the extent this has occurred, CMS will provide such tribal organizations an opportunity to fully participate in tribal consultation under this policy. Such participation will not substitute for direct consultation with Indian Tribes, but shall occur in addition to consultation with Indian Tribes.

- 6.3 Indian Organizations:** At times it is useful that the HHS communicate with Indian organizations to solicit Indian Tribe(s) advice and recommendations. The government does not participate in government-to-government consultations with these entities; rather these organizations represent the interest of Indian Tribes when authorized by those Tribes. These organizations by the sheer nature of their business serve and advocate Indian Tribes issues and concerns that might be negatively affected if these organizations were excluded from the process. [HHS 2010]
- 6.4 Urban Indian Organizations:** Urban Indian organizations are funded under Title V of the Indian Health Care Improvement Act to provide health services to eligible Indians living in urban areas. As health care providers these organizations advocate for and provide services (directly and through referral) to urban Indians. Urban Indian organizations are represented on the TTAG and States in which there are urban Indian organizations are required to consult with them on matters that are likely to have a direct effect on their programs.
- 6.5 IHS:** IHS has a unique historical understanding and role that requires close coordination with CMS. CMS is committed to working closely with IHS on Tribal issues in the administration of CMS programs. This is achieved through HHS processes, the TTAG, as well as direct communication between IHS and CMS. While the communication with IHS is critical, it does not substitute for tribal consultation.
- 6.6 Indian Health Providers:** Indian health providers, which includes IHS, tribal health programs, and urban Indian health programs, deliver culturally appropriate direct and purchased health care services for AI/ANs, and often serve as critical rural health care providers in communities with few, if any, other health care providers. Their full participation in consultation is important to assuring that these vital resources are not negatively affected by CMS policies and actions.
- 6.7 CMS**
- 6.7.1 Central Office.** The Tribal Affairs Group (TAG) within the Office of Public Engagement is identified as the component within CMS for coordinating and monitoring compliance with Executive Order 13175 and the Agency's Tribal Consultation Policy. TAG advises the CMS Administrator, senior staff and CMS components on Indian health issues, serves as the liaison between tribes and the CMS components, and represents the Administrator and Principal Deputy Administrator in communications with Tribal officials.
- 6.7.2 Regional Offices:** The ten (10) HHS Regional Offices share in the Department-wide responsibility to consult, coordinate and communicate with Indian Tribes on issues that affect Indian Tribes and HHS programs, services and resources available to Indian Tribes through States. To the extent CMS issues are discussed in such meetings, reports will be provided to CMS Tribal Affairs Group, Office of Public Engagement. Through Regional Offices, CMS will assist Indian Tribes to establish or maintain regular communication regarding Medicare, Medicaid, CHIP and Exchange Plan, policy development and implementation and operational issues, including eligibility, scope of covered services and providers, billing and reimbursement, adequacy of resources, effect of the program on improving health status, and other issues. Further, the CMS Regional Administrators will work closely with the respective Indian Tribes and State Governments to assure continuous coordination and communication between Tribes and States. .

6.7.3 Tribal Technical Advisory Group (TTAG). In September 2003, CMS established a Tribal Technical Advisory Group comprised of representatives of Tribal Governments and national Indian organizations based in Washington D.C. The TTAG was codified by statute in the American Recovery and Reinvestment Act in 2009, under which representatives from a National Urban Indian Organization and the Indian Health Service were added.

The TTAG operates according to a Charter, that was incorporated by reference in the ARRA that broadly defines the scope of issues about which it advises CMS and its participation in policy development, implementation and consultation.

The TTAG serves as an advisory body to CMS, providing expertise on policies, guidelines, and programmatic issues affecting the delivery of health care for AI/ANs served through programs funded in whole or part by CMS. Interaction by CMS with the TTAG does not substitute for Tribal consultation, but assists CMS to make consultation most effective including advising on the type of consultation needed on particular issues. The TTAG plays an integral role in the CMS consultation and will be offered the opportunity to participate in consultation events.

7. POLICY

7.1 Before any action is taken that has Tribal implications for Indian Tribes or Indian health programs, CMS, to the extent practicable and permitted by law, will consult with Indian Tribes. . .

7.1.1 Such actions refer to policies that have Tribal implications, and are likely to have direct effects on:

7.1.1.1 one or more Indian Tribes or Indian health providers,

7.1.1.2 the relationship between the Federal Government and Indian Tribes, or

7.1.1.3 the distribution of power and responsibilities between the Federal Government and Indian Tribes.

7.1.2 Such actions include, but are not limited to:

7.1.2.1 Changes in individual eligibility for CMS programs;

7.1.2.2 Changes in payment rates or reimbursement methodology, including conditions of participation, provider status, application and enrollment fees and requirements;

7.1.2.3 Changes in covered services; or

7.1.2.4 Other actions that have financial or operational implications for Tribes and Indian health providers.

7.2 Nothing in this policy waives the Government's deliberative process privilege. Examples of the government's deliberative process privilege are as follows:

7.2.1 The Department is specifically requested by Members of Congress to respond to or report on proposed legislation, the development of such responses and of related policy is a part of the Executive Branch's deliberative process privilege and should remain confidential.

7.2.2 In specified instances Congress requires CMS to work with Indian Tribes on the development of recommendations that may -require legislation, such reports,

recommendations or other products are developed independent of a CMS position, the development of which is governed by Office of Management and Budget (OMB) Circular A-19.

- 7.3 Through the Office of Public Engagement, Tribal Affairs Group, CMS shall have an accountable process as defined in Sections 8 of this policy to ensure meaningful and timely input by Indian Tribes in the development of policies that have Tribal implications. The Tribal Affairs Group will serve as the lead component and point of contact for CMS to conduct tribal consultation and will provide assistance to the other CMS components in coordinating the appropriate form of tribal consultation.
- 7.4 To the extent practicable and permitted by law, CMS shall not promulgate any regulation that has Tribal implications, that imposes substantial direct compliance costs on Indian Tribe(s), and that is not required by statute, unless:
- 7.4.1 Funds necessary to pay the direct costs incurred by the Indian Tribe or Indian health provider in complying with the regulation are provided by the Federal Government; or
- 7.4.2 CMS, prior to the formal promulgation of the regulation,
- 7.4.2.1 Consulted with Indian Tribes throughout all stages of the process of developing the proposed regulation;
- 7.4.2.2 Made available to the Administrator any written communications submitted to CMS by Tribal officials and Indian health providers.
- 7.4.2.3 Provided a Tribal summary impact statement in a separately identified portion of the preamble to the regulation as it is to be issued in the *Federal Register* (FR), which consists of a description of the extent of CMS's prior consultation with Indian Tribes, a summary of the nature of their concerns and CMS's position supporting the need to issue the regulation, and a statement of the extent to which the concerns of Tribal officials have been met; and
- 7.5 To the extent practicable and permitted by law, CMS shall not promulgate any regulation that has Tribal implications or that preempts Tribal law, unless CMS, prior to the formal promulgation of the regulation,
- 7.5.1 Consulted with Tribal officials throughout all stages of the process of developing the proposed regulation;
- 7.5.2 Made available to the Administrator any written communications submitted to CMS by Tribal officials.
- 7.5.3 Provided a Tribal summary impact statement in a separately identified portion of the preamble to the regulation as it is to be issued in the FR, which consists of a description of the extent of CMS's prior consultation with Tribal officials, a summary of the nature of their concerns and CMS's position supporting the need to issue the regulation, and a statement of

the extent to which the concerns of Tribal officials have been met; and

- 7.6 On issues relating to Tribal self-governance, Tribal self-determination, Tribal trust resources, or Tribal treaty and other rights, CMS shall make all practicable attempts where appropriate to use consensual mechanisms for developing regulations, including negotiated rulemaking.

8. TRIBAL CONSULTATION PROCESS

- 8.1 Issue Identification.** An effective consultation between HHS and Indian Tribes requires trust between all parties which is an indispensable element in establishing a good consultative relationship. The degree and extent of consultation will depend on the identified critical event. A critical event may be identified by HHS and/or an Indian Tribe(s). Whenever a Center, Office, or other component of CMS determines regulations may be necessary or required due to new legislation or implementation of new policy direction, the CMS component shall contact the Tribal Affairs Group/Office of Public Engagement, which will contact the Tribal Technical Advisory Group to seek advice and input on whether the potential action has tribal implications and the extent to which tribal consultation and/or other tribal advice and input should occur.

Upon identification by a CMS component, the TTAG, or an Indian Tribe(s) of a critical event significantly affecting one or more Indian Tribe(s), CMS will initiate consultation regarding the event. In order to initiate and conduct consultation, the following serves as a guideline to be utilized by and Indian Tribes:

- 8.1.1 Identify the Critical Event: Complexity, implications, time constraints, and issue(s) (including policy, funding/budget development, programs, services, functions and activities).
- 8.1.2 Identify affected/potentially affected Indian Tribe(s)
- 8.1.3 Determine Consultation Mechanism – The most useful and appropriate consultation mechanisms can be determined by HHS and/or Indian Tribe(s) after considering the critical event and Indian Tribe(s) affected/potentially affected. Consultation mechanisms include but are not limited to one or more of the following:

- 8.1.3.1 Mailings;
- 8.1.3.2 Teleconferences;
- 8.1.3.3 Face-to-face meetings at the local, regional and national levels between the HHS and Indian Tribes;
- 8.1.3.4 Roundtables
- 8.1.3.5 Annual HHS Tribal Budget and Policy Consultation Sessions.
- 8.1.3.6 Other regular or special HHS Division or program level consultation sessions.

8.2 Communication Methods: The determination of the critical event and the level of consultation mechanism to be used shall be communicated to affected/potentially affected Indian Tribe(s) using all appropriate methods and with as much advance notice as practicable. These methods include but are not limited to the following:

- 8.2.1 *Correspondence:* Written communications shall be issued within 30 calendar days of an identified critical event. The communication should clearly provide affected/potentially affected Indian Tribe(s) and Indian health providers with detail of the critical event, the manner and timeframe in which to provide comment.
- 8.2.2 *Official Notification:* Within 30 calendar days, and upon the determination the consultation mechanism, proper notice of the critical event and the consultation mechanism utilized shall be communicated to affected/potentially affected Indian Tribe(s) and Indian health providers using all appropriate methods including mailing, broadcast e-mail, FR, and other outlets. The FR is the most formal HHS form of notice used for consultation.
- 8.2.3 *Meeting(s):* The Division shall convene a meeting, which may occur by teleconference, webinar, or face-to-face, within 60 calendar days of official notification, with affected/potentially affected Indian Tribe(s) and Indian health providers to discuss all pertinent issues in a national, regional, and/or local forum, or as appropriate, to the extent practicable and permitted by law, when the critical event is determined to have substantial impact.
- 8.2.4 *Receipt of Tribal Comment(s):* The CMS shall develop and use all appropriate methods to communicate clear and explicit instructions on the means and time frames for Indian Tribe(s) and Indian health providers to submit comments on the critical event, whether in person, by teleconference, and/or in writing and shall solicit the advice and assistance of the Principal Advisor for Tribal Affairs, IOS/IGA.

8.2.5 *Reporting of Outcome:* The CMS shall report on the outcomes of the consultation within 90 calendar days of final consultation. For ongoing issues identified during the consultation, the Division shall provide status reports throughout the year to IOS/IGA and Indian Tribe(s).

8.3 NPRM.

If in the event, a Notice of Proposed of Rulemaking (NPRM) is identified as having tribal implications and tribal consultation has not occurred as described in Section 8.1, the following sentence shall be inserted in the Regulatory Impact section of the NPRM:

This proposed rule has been identified as having tribal implications, and in accordance with E.O. 13175 and this Tribal Consultation Policy, CMS will consult with Tribal officials prior to the formal promulgation of this regulation.

8.4 States

8.4.1 Pursuant to section 5006(e) of the American Recovery and Reinvestment Act of 2009, CMS will enforce requirements for States to give notice to Tribes of any State Plan amendment or waiver request, and any other State policies or other Federal law that will have an effect on AI/ANs or Indian Tribes. To the extent applicable law requires the State to have consulted with Indian Tribes, or otherwise to have communicated with them, CMS will develop criteria for evaluating whether such requirements have been met and will assure that they are prior to taking action on the State's request for a Plan amendment or waiver or other action.

8.4.2 The Affordable Care Act (Section 1311(d)(6)) requires that insurance exchanges consult with a variety of key stakeholders in the planning, establishment and ongoing operation of Exchanges. The Center for Consumer Insurance Information Office (CCIIO) will require each State that has one or more federally recognized Tribe(s) to establish a process of consultation with such Tribe(s) regarding the start-up and ongoing operation of the Exchanges and continue to conduct and document such Tribal consultations for Exchange matters.

9. BUDGET FORMULATION.

9.1 Annual HHS Budget Formulation. HHS conducts an annual, Department-wide Tribal budget consultation session to give Indian Tribes the opportunity to present their budget recommendations to the Department to ensure Tribal priorities are addressed. CMS will comply with section 11 of the HHS Tribal Consultation Policy regarding Budget Formulation and will work with:

9.1.1 Regional Offices to identify CMS related tribal budget priorities at the local level and communicate these to the Tribal Affairs Group;

9.1.2 The TTAG to identify national program budget priority recommendations; and

9.1.3 CMS components to pursue funding of priorities as identified by Tribes and the TTAG.

9.2 TAG and TTAG Budget. The TTAG develops and updates on an American Indian and Alaska

Native Strategic plan which focuses on specific policy and annual budget priorities identified by the TTAG. In developing its annual budget request the Tribal Affairs Group will fully consider all recommendations for funding priorities and amounts established by the TTAG. .

10. CMS TRIBAL CONSULTATION PERFORMANCE EVALUATION

CMS is responsible for evaluating its performance under this Tribal Consultation Policy. To effectively evaluate the results of the consultation process and the ability of CMS to incorporate Tribal recommendations, CMS will assess its performance on an annual basis based on the reporting requirements outlined in Section 12 of the HHS consultation policy. The TTAG will have an opportunity to review the draft performance evaluation and its views shall be included in the report. [CMS 12/2005, Sec. 12, as amended.]

11. MEETING RECORDS AND ADDITIONAL REPORTING.

11.1 Meeting Records. CMS is responsible for making and keeping records of its Tribal consultation activity. All such records shall be made readily available to Tribes through the Annual HHS consultation report, including a summary of meetings and recommendations made throughout the year by the TTAG.

11.2 Reports to Tribes. CMS will comply with HHS annual reporting requirements.

11.3 CMS Website. CMS shall post all of the meeting records referred to in section 11.1 and official communications from the TTAG on the CMS website.

12. CONFLICT RESOLUTION.

The intent of this policy is to promote partnership with Indian Tribes that enhances the Department's and CMS's ability to address issues, needs and problem resolution. However, Indian Tribes and CMS may not always agree and inherent in the government-to-government relationship, Indian Tribes may elevate an issue of importance to a higher or separate decision-making authority.

Nothing in the Policy creates a right of action against the Department or CMS for failure to comply with this Policy.

13. TRIBAL WAIVER. CMS will fully comply with Section 15 of the HHS Tribal Consultation Policy on waivers and process all requests routinely received for waivers under existing program authorities with the statutorily set timeframes.

14. EFFECTIVE DATE.

This Policy is effective on the date of signature by the CMS Administrator.

15. DEFINITIONS.

15.1 Agency – Any authority of the United States that is an “agency” under 44 USC 3502(1) other than those considered to be independent regulatory agencies, as defined in 44 USC 3502 (5).

15.2 Communication – The exchange of ideas, messages, or information, by speech, signals, writing, or other means.

15.3 Consultation – An enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties (including the TTAG), which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

15.4 Coordination and Collaboration – Working and communicating together in a meaningful government-to-government effort to create a positive outcome.

15.5 Critical Events – Planned or an unplanned event that has or may have a substantial impact on Indian Tribe(s), e.g., issues, policies, or budgets which may come from any level within HHS

15.6 Deliberative Process Privilege – Is a privilege exempting the government from disclosure of government agency materials containing opinions, recommendations, and other communications that are part of the decision-making process within the agency.

15.7 Executive Order – An order issued by the Government’s executive on the basis of authority specifically granted to the executive branch (as by the U.S. Constitution or a Congressional Act).

15.8 Federally Recognized Tribal governments – Indian Tribes with whom the Federal Government maintains an official government-to-government relationship; usually established by a Federal treaty, statute, executive order, court order, or a Federal Administrative Action. The Bureau of Indian Affairs (BIA) maintains and regularly publishes the list of Federally recognized Indian Tribes.

15.9 Indian – Indian means a person who is a member of an Indian tribe as defined in 25 U.S.C. 479a and, for the purposes of CMS programs and implementation of the Affordable Care Act includes those persons defined as Indian in 42 C.F.R. § 447.50. Throughout this policy, Indian is synonymous with American Indian/Alaska Native.

15.10 Indian Health Provider – Indian health provider means a health care program, including a contract health services program, operated by the IHS or by an Indian tribe, tribal organization, or urban Indian organization.

15.11 Indian Organizations:

15.11.1 Those Federally recognized tribally constituted entities that have been designated by their governing body to facilitate DHHS communications and consultation activities.

15.11.2 Any regional or national organizations whose board is comprised of Federally recognized Tribes and elected/appointed Tribal leaders. The government does not participate in government-to-government consultation with these entities; rather these organizations represent the interests of Tribes when authorized by those Tribes.

15.12 Indian Tribe –an Indian or Alaska Native tribe, band, nation, pueblo, village, or community that the Secretary of the Interior acknowledges to exist as an Indian tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a and any other entity included in the definition of Indian Tribe pursuant to the Indian Health Care Improvement Act, 25 U.S.C. § 1603(14).

15.13 Joint Tribal/Federal Workgroups and or/Task Forces – A group composed of individuals who are elected Tribal officials, appointed by Federally recognized Tribal governments and/or Federal agencies to represent their interests while working on a particular policy, practice, issue and/or concern.

15.14 Native American (NA) – Broadly describes the people considered indigenous to North America.

15.15 Policies with Tribal Implications – Refers to regulations, statutes, legislation, and other policy statements or actions that have substantial direct effects on one or more Indian Tribes, on the relationship between the Federal Government and Indian Tribes, or on the distribution of power and responsibilities between the Federal Government and Indian Tribes. Tribal implications that have substantial direct effects on one or more Indian Tribes, include, but are not limited to:

15.15.1 Changes in eligibility of Indians for CMS programs and insurance exchanges;

15.15.2 Changes in payment rates and reimbursement methodologies;

15.15.3 Changes in covered services; and

15.15.4 Any other actions that have significant financial and operation implications for IHS, Tribes or the health programs they operate or authorize, and urban Indian organizations. The significance of the funding impact shall be determined based on the operating budgets of the affected entity and on the overall available funding for Indian health programs.

15.16 Self Government – Government in which the people who are most directly affected by the decisions make decisions.

- 15.17 Sovereignty** – The ultimate source of political power from which all specific political powers are derived.
- 15.18 Substantial Direct Compliance Costs** – Those costs incurred directly from implementation of changes necessary to meet the requirements of a Federal regulation. Because of the large variation in Tribes, “substantial costs” is also variable by Indian Tribe. Each Indian Tribe and the Secretary shall mutually determine the level of costs that represent “substantial costs” in the context of the Indian Tribe’s resource base.
- 15.19 To the Extent Practicable and Permitted by Law** – Refers to situations where the opportunity for consultation is limited because of constraints of time, budget, legal authority, etc. Permitted by law shall be interpreted to include anything that is not expressly prohibited by law.
- 15.20 Treaty** – A legally binding and written agreement that affirms the government-to-government relationship between two or more nations.
- 15.21 Tribal Government** – An American Indian or Alaska Native Tribe, Band, Nation, Pueblo, Village or Community that the Secretary of the Interior acknowledges to exist as an Indian Tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 USC 479a.
- 15.22 Tribal Officials** – Elected or duly appointed officials of Indian Tribes or -Tribal organizations.
- 15.23 Tribal Organization** – The recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities: Provided, That in any case where a contract is let or grant made to an organization to perform services benefiting more than one Indian tribe, the approval of each such Indian tribe shall be a prerequisite to the letting or making of such contract or grant.
- 15.24 Tribal Resolution** – A formal expression of the opinion or will of an official Tribal governing body which is adopted by vote of the Tribal governing body.
- 15.25 Tribal Self-Governance** – The governmental actions of Tribes exercising self-government and self-determination.
- 15.26 Urban Indian Organization** – A program that is funded by the Indian Health Service under Title V (Section 502 or 513) of the Indian Health Care Improvement Act.

Attachment F:

**NIHB Analysis of Proposed Rule for Implementation of
Section 1332 of the Affordable Care Act: Waiver for State Innovation**

National Indian Health Board



Delivered via electronic transmission

May 11], 2011

DRAFT

Dr. Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9987-P
Room 445-G
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Mr. J. Mark Iwry
Senior Advisor to the Secretary and Deputy
Assistant Secretary
Office of Benefits Tax Counsel
Attention: Waivers for State Innovation
Room 3050
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Subject: Application, Review, and Reporting Process for Waivers for State Innovation (CMS-9987-P)

Dear Administrator Berwick and Mr. Iwry:

Please find attached comments prepared by the National Indian Health Board¹ (NIHB) in response to the joint Centers for Medicare and Medicaid Services of the Department of Health and Human Services (HHS) and the Department of the Treasury (Treasury) proposed rule on the Application, Review, and Reporting Process for Waivers for State Innovation (CMS-9987-P; (Proposed Rule) pertaining to section 1332 of the Patient Protection and Affordable Care Act (ACA).

In summary, NIHB is recommending the following two modifications to the Proposed Rule.

- To ensure American Indians and Alaska Natives are not worse off under a State waiver, representations made by a State and determinations made by the Secretaries pertaining to a State satisfying the requirements for granting waivers under sections 1332(b)(1)(A), (B) and (C) of the ACA must consider the specific impact on American Indians and Alaska Natives and not limit the representations to the population as a whole.
- NIHB strongly supports § 33.112 of the Proposed Rule that highlights the requirement for States to undertake a process for meaningful consultation with Tribes but recommends that States be encouraged, in developing a waiver application under the Proposed Rule for ACA section 1332, to review and adapt procedures already established to satisfy tribal consultation requirements under a State's Medicaid program.

Thank you in advance for consideration of these recommendations as we jointly work to advance the health status of American Indian and Alaska Native individuals and communities across the United States.

Sincerely,

Cathy Abramson
Chairman, National Indian Health Board

Cc: Valerie Davidson, Chair, Tribal Technical Advisory Group to CMS
Kitty Marx, Director, CMS Tribal Affairs Group
Stacy Bohlen, Executive Director, NIHB
Jennifer Cooper, Legislative Director, NIHB

Attachment: NIHB Analysis of Proposed Rule for Implementation of Section 1332 of the Affordable Care Act: Waiver for State Innovation

¹ Established nearly 40 years ago, NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives. NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service ("IHS") Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act ("ISDEAA"), or continue to also rely on IHS for delivery of some, or even most, of their health care, NIHB is their advocate.

NIHB Analysis of Proposed Rule for Implementation of Section 1332 of the Affordable Care Act: Waiver for State Innovation

1. STATEMENT OF THE ISSUE.

The Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (HHS) and the Department of the Treasury jointly issued a proposed rule on the Application, Review, and Reporting Process for Waivers for State Innovation (CMS-9987-P) (Proposed Rule) under section 1332 of the Patient Protection and Affordable Care Act (Affordable Care Act or ACA).² ACA section 1332 creates a new Waiver for State Innovation and provides authority to the Secretary of HHS or the Secretary of the Treasury (Secretaries) to waive any or all of the requirements under the following sections of the ACA for health insurance coverage within a State for plan years beginning on or after January 1, 2017.

- Part I of subtitle D of Title I of the Affordable Care Act (relating to the establishment of qualified health plans);
- Part II of subtitle D of Title I of the Affordable Care Act (relating to consumer choices and insurance competition through health benefit exchanges);
- Section 1402 of the Affordable Care Act (relating to reduced cost sharing for individuals enrolling in qualified health plans); and
- Sections 36B (relating to refundable credits for coverage under a qualified health plan), 4980H (relating to shared responsibility for employers regarding health coverage), and 5000A (relating to the requirement to maintain minimum essential coverage) of the Internal Revenue Code.

These requirements may be waived, though, only after a determination by the Secretaries that the State plan:

- a. Will provide coverage that is at least as comprehensive as the coverage defined under the “essential health benefits” requirements in section 1302(b);
- b. Will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as provided under the ACA;
- c. Will provide coverage to at least a comparable number of its residents; and
- d. Will not increase the Federal deficit.

NIHB is concerned that if the impacts on American Indian and Alaska Natives, as well as on the Indian Health Programs³ and urban Indian organizations that serve them, are not sufficiently considered during the waiver development and review process, the broad authority to waive provisions of the ACA, along with the coordinated waiver process identified in section 1332(a)(5) involving waiver authorities that existed prior to enactment of the ACA, may result in reduced access to quality health care services for American Indians and Alaska Natives. An insufficient understanding of potentially adverse impacts on American Indians and Alaska Natives may occur, in particular, if the Secretaries make the above determinations for a State’s population as a whole and not in regard specifically to American Indian and Alaska Native residents of the State.

2. PRINCIPAL FINDINGS.

The Affordable Care Act contains several critical Indian-specific provisions designed to increase the access of American Indians and Alaska Natives to quality, affordable health care services. The authority granted to the Secretaries under section 1332 to waive requirements of the ACA includes sections of the ACA containing some of these Indian-specific provisions. A State waiver

² The Affordable Care Act, pursuant to Section 10221 of the ACA, includes amendments made to the Indian Health Care Improvement Act (Public Law 94-437), as the ACA incorporated by reference S. 1790 as reported by the Committee of Indian Affairs of the Senate.

³ Indian Health Programs means programs operated by the Indian Health Service (IHS), an Indian Tribe, or tribal organization.

changing Indian-specific and non-Indian specific provisions of the law may have a direct impact on American Indians and Alaska Natives, Indian Health Programs, and urban Indian organizations. To ensure American Indians and Alaska Natives are not worse off under a State waiver, representations made by a State and determinations made by the Secretaries pertaining to a State satisfying the requirements for granting waivers under sections 1332(b)(1)(A), (B) and (C) of the ACA must consider the specific impact on American Indians and Alaska Natives and not limit the representations to the population as a whole. The Proposed Rule, in § 33.112, highlights the requirement for States to undertake a process for meaningful consultation with Tribes but does not encourage States to adapt procedures established to satisfy tribal consultation requirements under the State's Medicaid program. The discussion of each of these findings follows.

3. ANALYSIS.

3.1 Indian-Specific Provisions in the ACA. The Affordable Care Act contains several important Indian-specific provisions designed to increase the access of American Indians and Alaska Natives to quality, affordable health care services. Some of these provisions are within the waiver authority granted the Secretaries under section 1332 (and are indicated in paragraph 3.2 below.)

Other Indian-specific provisions were not included in the section 1332 waiver authority granted to the Secretaries. For example, a host of Indian-specific provisions were enacted under section 10221 of the ACA which amended and permanently reauthorized the Indian Health Care Improvement Act. These provisions are not included within the Secretaries' section 1332 waiver authority. [Some of the Indian-specific provisions enacted under section 10221 of the ACA and outside the scope of the section 1332 waiver authority include:

1. The right of Indian Tribes and tribal organizations to recover from insurance companies and other liable third parties reasonable charges or the highest amount the payor would pay a non-governmental provider for health care services provided (section 206 of the IHCA⁴);
2. The ability of certain Tribes and tribal organizations and urban Indian organizations to purchase health and life insurance through the Federal Employees Health Benefits Program (section 409 of the IHCA); and
3. The requirement for the Departments of Defense (DoD) and Veterans Affairs (VA) to reimburse the Indian Health Service and tribal health programs for services provided to beneficiaries of DoD or VA (section 405 of the IHCA).]

Other Indian-specific provisions are contained in sections throughout the Affordable Care Act.

3.2 Indian-Specific Provisions within the Section 1332 Waiver Authority of the Secretaries. The authority granted to the Secretaries under section 1332 to waive requirements of the ACA includes sections of the ACA containing some of the Indian-specific provisions. These include:

- [Under Part I of subtitle D of Title I of the Affordable Care Act (relating to the establishment of qualified health plans) –
 - No Indian-specific provisions.]
- Under Part II of subtitle D of Title I of the Affordable Care Act (relating to consumer choices and insurance competition through health benefit exchanges) –
 - Special monthly enrollment period for Indians provided under section 1311(c)(6)(D).
 - [Required inclusion in health insurance plan networks of “essential community providers that serve predominantly low-income, medically-underserved individuals” as called for under section 1311(c)(1)(C). Essential community providers include certain Indian Health Program and urban Indian organization providers as these providers meet the stated definition and, moreover, are largely included in the examples of essential community providers cited in the same section of the ACA, which are health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act.⁵]

⁴ Indian Health Care Improvement Act, as amended by Public Law 111-148.

⁵ See NIHB Issue Paper: I/T/U Are Essential Community Providers, February 8, 2011.

- Under Section 1402 of the Affordable Care Act (relating to reduced cost sharing for individuals enrolling in qualified health plans) –
 - The issuer of a qualified health plan offered in the individual market in a health insurance exchange (Exchange) shall eliminate any cost-sharing under the plan for an Indian whose household income is not more than 300 percent of the poverty line for a family of the size involved (section 1402(d)(1)).
 - [If an Indian enrolled in a qualified health plan is furnished an item or service by the Indian Health Service, an Indian Tribe, tribal organization, or urban Indian organization or through referral under contract health services, (a) no cost-sharing under the plan shall be imposed under the plan for such item or service and (b) the issuer of the health plan shall not reduce the payment to the provider of such item or service by the amount of any cost-sharing that would be due from the Indian but for (a) (section 1402(d)(2)).^{6]}
- Under sections 36B (relating to refundable credits for coverage under a qualified health plan), 4980H (relating to shared responsibility for employers regarding health coverage), and 5000A (relating to the requirement to maintain minimum essential coverage) of the Internal Revenue Code –
 - No penalty for failure to maintain minimum essential coverage shall be imposed on members of Indian Tribes, pursuant to section 500A of the Internal Revenue Code as established under section 1501(e)(3) of the ACA.

3.3 Potential Impact on American Indians and Alaska Natives from Changes to Indian-Specific and Non-Indian Specific Provisions. A State waiver may have a direct impact on American Indians and Alaska Natives, Indian Health Programs, and urban Indian organizations from changes in Indian-specific and non-Indian specific provisions of the law.

Modifications to Indian-specific provisions of the ACA and other Federal health laws under a State section 1332 waiver could have a significant impact on American Indians and Alaska Natives. For instance, if the exemption under section 5000A of the Internal Revenue Code for American Indians and Alaska Natives from penalties for failing to maintain minimum essential coverage were altered, AI/AN could be subjected to substantial Federal tax penalties.

Likewise, modifications to non-Indian specific provisions could also have a direct impact – favorable or adverse – on American Indians and Alaska Natives. For example, it is estimated there are about 472,000 AI/AN without health insurance living in households with incomes between 133% and 300% of poverty.⁷ If eligible for enrollment in the individual market in an Exchange, and if subsequently enrolled in an Exchange plan in the individual market, the American Indian or Alaska Native would then receive services without cost-sharing requirements.⁸ Any change that has the effect of altering who is eligible and/or able to enroll in a plan through the individual market in an Exchange would impact American Indians and Alaska Natives.

Similarly, a modification proposed to a non-Indian specific provision under a State waiver application may impact an Indian-specific provision, resulting in direct, and potentially adverse, impacts on American Indians and Alaska Natives. For example, such a result could occur if certain modifications to the benefit package were allowed to be made, as may be permitted under the section 13332 waiver authority.

Under §155.1308(a)(2)(iv)(C)(4)(i) of the Proposed Rule, a State is to provide the data necessary to determine that the State’s proposed waiver will “provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) of the Affordable Care Act” and under § 155.1308(a)(2)(iv)(C)(4)(ii) will “provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable...” Under one such scenario, a proposed State plan change may alter the scope of services covered by the plan and adjust the percentage of the costs covered by the plan for the remaining covered services. Such a change could be allowable under a Waiver for State Innovation if it were considered “at least as comprehensive”

⁶ The HHS Secretary is to pay to the issuer of the qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of the elimination of the cost-sharing and the adjustment in the payment made by the plan to the provider to compensate for the elimination of the cost-sharing.

⁷ Carol Korenbrot and James Crouch, California Rural Indian Health Board, “Uninsured American Indians and Alaska Natives with Incomes 133% to 300% of Poverty: Data for Health Insurance Exchange Outreach”, November 2010.

⁸ It is estimated that an additional 185,000 – 380,000 uninsured AI/AN who report some access to Indian health program providers will be eligible for Medicaid under the expansion provided for under section 2001 of the ACA.⁸ If these projections are realized, this could represent as much as an 80 percent increase in the number of AI/AN with Medicaid coverage. Source: National Indian Health Board, “Medicaid Expansion under ACA for American Indians and Alaska Natives”, April 14, 2011.

and “at least as affordable” for the population at large. But the impact on American Indians and Alaska Natives could very well be negative. This could be the case in this instance if the value of the cost-sharing protection for those (remaining) covered services was effectively lessened and an American Indian and Alaska Native end up paying the full costs for services that are no longer covered by the plan.

3.4 Need for Indian-Specific Assessment of the Impact of a Proposed Waiver. To ensure American Indians and Alaska Natives are not worse off under a State waiver, representations made by a State and determinations made by the Secretaries pertaining to a State satisfying the requirements for granting waivers under sections 1332(b)(1)(A), (B) and (C) of the ACA (§155.1308(a)(2)(iv)(C)(4)(i), (ii), and (iii) of the Proposed Rule) need to consider the specific impact on American Indians and Alaska Natives and not limit the analysis, representations and determinations to the population as a whole. This could be achieved by adding language to the Proposed Rule to indicate that, in States with one or more Indian Health Program(s) or urban Indian organization(s) operating, the information required to be provided under §155.1308(a)(2)(iv)(C)(4) needs to be sufficient to make such a determination for American Indian and Alaska Native residents of the State.

3.5 Ensuring Adequate and Efficient Consultation with Tribes and Input from Urban Indian Organizations. The Proposed Rule, at § 33.112, highlights the requirement for States to undertake a process for meaningful consultation with Tribes. The provision requires a State, prior to submitting an application for a new section 1332 waiver, to provide a public notice and comment period and “such public notice and comment period shall include, for a State with one or more federally-recognized Indian tribes within its borders, a separate process for meaningful consultation with such tribes.” NIHBS is in strong support of the inclusion of this provision.

The tribal consultation provision, though, could be improved by encouraging better coordination with other existing tribal consultation requirements. These requirements include Presidential Executive Order 13175, “Consultation and Coordination with Indian Tribal Governments” as well as the HHS tribal consultation policies.⁹

This improved coordination could be achieved by encouraging States, in developing a waiver application under the Proposed Rule for ACA section 1332 to review and adapt procedures already established to satisfy tribal consultation requirements under a State’s Medicaid program.

The need for coordination with existing tribal consultation requirements, and the potential use by a State of the tribal consultation process established under Medicaid program requirements, has particular applicability in this instance as the section 1332 authorizes a “coordinated waiver process.” The Proposed Rule, at 31 CFR 33.102 and 45 CFR 155.1302 (section 1332(a)(5) of the ACA), permits States to submit “a single application to the Secretary for a waiver under section 1332 of the Affordable Care Act and a waiver under one or more of the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Social Security Act, or under any other Federal law relating to the provision of health care items or services, provided that the application is consistent with the procedures described in the [Proposed Rules], the procedures for section 1115 demonstrations, if applicable, and the procedures under any other applicable Federal law under which the State seeks a waiver.”

Earlier this year, HHS issued guidance to States on tribal consultation with regard to implementation of Exchanges under the Affordable Care Act. HHS included the following language in its January 20, 2011 announcement for the second round of funding to States for the planning and implementation of Exchanges –

In the spirit of Executive Order 13175 the Secretary is anticipating requiring each State that has one or more federally recognized Tribe(s) located within its borders to provide documentation that it has (1) established a process of consultation with such Tribe(s) regarding the start up and ongoing operation of the Exchanges; (2) implemented that process; and (3) assurance that it will continue to conduct and document such Tribal

⁹ In 2009, Congress amended Titles XIX and XXI of the Social Security Act to require States to provide a process under which a State seeks advice on a regular, on-going basis from designees of Indian Health Programs (i.e., the Indian Health Service, Tribes and tribal organizations) and urban Indian organizations. This requirement applies in States in which one or more Indian health programs or urban Indian organizations furnish health care services, and must be met prior to the submission of any changes in the Medicaid and CHIP programs that are likely to have a direct effect on Indians, Indian health programs, or urban Indian organizations.

*consultations for Exchange matters... States are encouraged to review and adapt to procedures for State Medicaid consultation.*¹⁰

Because of the heightened attention to tribal consultation requirements in recent years by HHS, States are familiar with these requirements¹¹ and have been required to comply with them.¹²

4. ACTION NEEDED.

4.1. Assessment of the Impact of a Proposed Waiver on American Indians and Alaska Natives. In section §155.1308(a)(2)(iv)(D)(4) of the Proposed Rule regarding “additional information”, add the following after paragraph (ii) –

(iii) A explanation of how the waiver will meet the requirements of sections 1332(b)(1)(A), (B) and (C) of the Affordable Care Act as they pertain to American Indian and Alaska Native residents of the State.

Adjust the numbering of subsequent paragraphs under §155.1308(a)(2)(iv)(D)(4).

4.2. Tribal Consultation. In § 33.112 of the Proposed Rule, add the following underlined sentence to paragraph (a)(2) –

(2) Such public notice and comment period shall include, for a State with one or more federally-recognized Indian tribes within its borders, a separate process for meaningful consultation with such tribes. The State shall provide documentation that it (1) established a process of consultation with such tribe(s) regarding the development of the waiver application; (2) implemented that process; and (3) gives assurances that it will continue to conduct and document such tribal consultations for waiver-related matters. States are encouraged to review and adapt procedures established to meet the requirements for tribal consultation under the State Medicaid program.

¹⁰ HHS Office of Consumer Information and Oversight, Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges, Funding Opportunity Number: IE-HBE-11-004, January 20, 2011. (emphasis added)

¹¹ CMS, Dear Medicaid Director Letter: ARRA Protections for Indians in Medicaid and CHIP, January 22, 2010.

<https://www.cms.gov/smdl/downloads/SMD10001.PDF>

¹² An October 1, 2010 Dear State Medicaid Directors letter from CMS to States indicated: “CMS cannot approve the [State Plan Amendment] until the required tribal consultation has occurred. To approve the SPA without the required consultation would violate Executive Order 13175 and the sec. 1902(a)(73) consultation requirements, as added by the Recovery Act.”