Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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April 29, 2010
Face-to-Face Meeting - Action Items

Action Item	Timeline	Person Responsible	Status	Notes
Develop a shared understanding of the PPACA requirements, definitions, and goals with regard to Indian Country.	ASAP	TTAG and CMS	Ongoing	
Identify goals and related measures of success for PPACA provisions that apply to AI/ANs.	ASAP	TTAG Members	Ongoing	
Revise the CMS organizational chart to indicate the importance of tribal affairs.	ASAP	CMS	Completed	
Review applicable PPACA provisions and determine which require CMS guidance.	ASAP	TTAG	Ongoing	
Develop a proposed strategy for TTAG use in reaching out to other HHS agencies concerning PPACA implementation issues.	ASAP	CMS	Ongoing	
Provide PPACA implementation flowcharts and charts of responsibilities.	ASAP	CMS	Ongoing	
Provide guidance on the all-inclusive rate for patients enrolled through exchanges.	ASAP	CMS	Ongoing	
Identify points of contact within CMS and IHS concerning the data sharing agreement.	ASAP	CMS	Ongoing	
Develop short-term solutions to the problem of accessing federal funds for health care services currently administered under state Medicaid programs.	ASAP	TTAG and CMS	Ongoing	
Follow up on the identification of state/tribal consultation best practices.	ASAP	CMS	Ongoing	
Review new rules concerning aspects of DRA implementation guidance and provide feedback on the guidance to CMS.	ASAP	TTAG	Ongoing	
Provide TTAG with data concerning the scope of the expansion of Medicaid benefits in Indian Country as a result of PPACA.	ASAP	Ms. Wachino	Ongoing	
Share a factsheet on states providing Medicaid coverage for adults.	ASAP	Ms. Barbero	Ongoing	
Provide updates on PPACA implementation at future TTAG meetings.	ASAP	Ms. Wachino	Ongoing	
Create a temporary subcommittee to work on PPACA implementation issues.	ASAP	TTAG	Ongoing	
Identify examples of improperly counted income/erroneous removal from Medicaid rolls for CMS.	ASAP	TTAG	Ongoing	
Share information concerning more liberal treatment of MMI funds to support	ASAP	CMS	Ongoing	

discussions with other states once the proposed Montana SPA is approved.				
Include information on the Montana SPA in the CMSC bulletins to states.	ASAP	Ms. Terwilliger	Ongoing	
Follow up on the improper counting of IIM funds in North Dakota.	ASAP	CMS	Ongoing	
Incorporate ARRA implementation information/training in I/T/U guidance and tribal leader letters.	ASAP	CMS	Ongoing	
Coordinate use of mailing lists	ASAP	IHS and CMS	Ongoing	
Consult with the Portland area service unit about the use of the Chemawa School for a case study site.	ASAP	Mr. Roberts	Ongoing	
Submit ideas for CMS Day speakers and session/workshop topics.	ASAP	TTAG Subcommittees	Ongoing	
Compile subcommittee requests for end of year funding for discussion at a future TTAG meeting.	ASAP	Budget Subcommittee	Ongoing	
Review the current TTAG membership roster and submit corrections to CMS.	ASAP	TTAG	Ongoing	
Coordinate NIHB and IHS PPACA training sessions.	ASAP	NIHB and IHS	Ongoing	
Consult with TTAG concerning the content of its PPACA training sessions.	ASAP	NIHB	Ongoing	
Reformat the information in the NIHB report (handout) into a simpler format.	By April 30	NIHB	Ongoing	
Review the current status and budgeted funds remaining for FY 2010 Strategic Plan projects.	ASAP	Budget/Strategic Plan Subcommittee and NIHB	Ongoing	
Develop the scope of work, deliverables, and budget for FY 2011 Strategic Plan projects.	ASAP	Budget/Strategic Plan Subcommittee and NIHB	Ongoing	

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April 29, 2010
Face-to-Face Meeting - Summary

Agenda Item	Discussion	Action
Documents Received	• TTAG Briefing Book • *American Indian and Alaska Native Medicaid Program and Policy Data* – CRIHB Report • NIHB Board of Directors Report • NIHB LTC Summary Spreadsheet	
Welcome	**Ms. Valerie Davidson**, Chair, Tribal Technical Advisory Group (TTAG) and Executive Vice President and Senior Director, Legal and Intergovernmental Affairs, Alaska Native Tribal Health Consortium thanked all of the participants for their attendance at the meeting.	

Opening Blessing	**Mr. Anslem Roanhorse**, Executive Director, Navajo Nation Division of Health, offered the opening blessing.	
Roll Call	**Ms. Tyra Baer**, CMS Staff Assistant, National Indian Health Board (NIHB), took the roll of the TTAG members present. Fifteen members were in attendance, meeting the requirements for a quorum. Members attending were: Alaska – Valerie Davidson Aberdeen – Absent Albuquerque – Carolyn Finster Bemidji – Kathy Hughes Billings – absent California – James Crouch Nashville – Carol Barbero (proxy for Dee Sabattus) Navajo – Anslem Roanhorse Oklahoma – Tracy Jones Phoenix – David Reede Portland – James Roberts Tucson – absent TSGAC – W. Ron Allen NIHB – H. Sally Smith NCAI – Jason Dollarhide IHS – Carl Harper NCUIH – Carmelita Skeeter	
Report from Chair	**Ms. Davidson** reflected on how far the TTAG has come with regard to issues that are important to the communities it represents. In 1999, many felt that the goals of the Indian Health Care Improvement Act (IHCIA) National Steering Committee were impossible to achieve. Thanks to the constant efforts and hard work of many people, many of these goals have become reality with the passage of the IHCIA.	
TTAG Discussion with CMS Leadership	<u>**TTAG Priorities**</u> **Ms. Charlene Frizzera**, Executive Project Management Officer, Centers for Medicare & Medicaid Services (CMS), began by announcing that **Ms. Marilyn Tavenner** has been appointed the Acting CMS Administrator. She will take over Ms. Frizzera's role with regard to working with the TTAG. Ms. Frizzera will focus on implementing health reform. She indicated that she was very proud of the work she had done with TTAG, highlighted the many achievements of the partnership, and praised the excellent relationship that the group shares with CMS. She thanked the TTAG members for all of their work. **Ms. Frizzera** reviewed some of the recent changes at CMS. The agency expanded the responsibilities of the Office of External Affairs and renamed it the Office of External Affairs and Beneficiary Services (OEA). Previously, beneficiary services did not belong under any particular entity within CMS. This change enables CMS to put a stronger, more directed emphasis on serving beneficiaries. CMS created four centers under the Office of the Administrator. The Center for Program Integrity will work on fraud, waste, and abuse issues. It is led by **Dr. Peter Budetti**. The Center for Strategic Planning, which is headed by **Mr. Anthony Rodgers**, will incorporate	

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	the Center for Innovation as well demonstrations and policy functions. Medicare fee-for-service and managed care have been combined into the Center for Medicare. **Mr. Jonathan Blum** will serve as its director. **Ms. Cindy Mann** will lead the Center for Medicaid, CHIP, and Survey & Certification (CMCS). CMS has also created the position of Principal Deputy Administrator within the Office of the Administrator. Each of the center directors also serve as Deputy Administrators. These changes were made to make it easier to identify where particular issues fall in terms of responsible offices and personnel. Additionally, **Dr. Donald Berwick** has been nominated to be the CMS Administrator. Finally, **Ms. Caya Lewis**, formerly with the Office of Health Reform, will serve as the Chief of Staff. The recently passed health care reform legislation made the IHCIA permanent. Provisions of interest to the TTAG include those that ease costs or other health care burdens. American Indians/Alaska Natives (AI/ANs) benefit from special enrollment periods for the health exchanges, exemption from penalties tied to failure to obtain or maintain insurance coverage, exclusion of health benefits provided by tribal benefits from gross income calculations, and prohibition of cost sharing for Indians with incomes below 300 percent of the poverty level who are enrolled in a health exchange. Other provisions relate to research efforts, including a study to determine the feasibility of treating the Navaho Nation as a state Medicaid agency. CMS' role in reform will include expanding payment for all Part B services to Indian/Tribal/Urban (I/T/U) providers and expanding catastrophic drug coverage under Part D.	
	Ms. Frizzera noted that a major part of the CMS/tribal partnership is the accountability CMS has to the tribes. She asked the TTAG to work with CMS to ensure that both groups understand and agree upon the Patient Protection and Affordable Care Act (PPACA) requirements and have robust discussions to define goals and ways to measure success with regard to AI/ANs.	TTAG and CMS will work toward a shared understanding of the PPACA requirements, definitions, and goals with regard to Indian Country.
	Mr. W. Ron Allen, TTAG Vice-Chair representing the Jamestown S'Klallam Tribe, asked who in CMS is responsible for interacting with the White House Office of Health Care Reform concerning implementation issues. **Ms. Frizzera** replied that she will be responsible for developing the implementation plan and related goals and metrics. She offered to help the TTAG in the initial stages of developing any issues that the TTAG would like to bring to CMS. She asked the TTAG to define goals and metrics that would indicate success for the provisions that relate to AI/ANs. **Ms. Tavenner** would probably be the individual who works directly with the office.	TTAG members will identify goals and related measures of success for individual provisions of PPACA that apply to AI/ANs.
	Mr. James Roberts, Policy Analyst, Northwest Portland Area Indian Health Board, asked if the new CMS organizational chart would have a dashed line connecting the Tribal Affairs Group (TAG) to the Office of the Administrator. He noted that previous charts included this feature, which is symbolically significant as it indicates the importance of tribal affairs to CMS. **Ms. Frizzera** promised to take this back to CMS and determine whether the addition of a TAG box	**Ms. Frizzera** will look into revising the CMS organizational chart to indicate the importance of tribal affairs.

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	and dashed line is possible. **Ms. Frizzera** provided updates on several issues addressed at previous TTAG meetings: • CMS provided $2.4 million to support TTAG Strategic Plan activities in FY 2010, which is three times the FY 2009 funding. • The Data Subcommittee has published reports on how AI/ANs use Indian Health Service (IHS) and Medicare/Medicaid programs. Based on TTAG recommendations, CMS will host a data symposium to disseminate this information to a wider audience. • Health Information Technology for Economic and Clinical Health (HITECH) implementation is ongoing. CMS is using incentives to encourage meaningful use. She anticipated that CMS would be doing more work with the TTAG on this issue. CMS has been working with NIHB and the TTAG to develop outreach materials. • CMS has issued guidance to states indicating that tribal documents fulfill citizenship requirements. **Ms. Frizzera** reiterated her request that the TTAG bring issues of concern to CMS as soon as they are identified so that issues do not become full-blown problems. **Ms. Davidson** reported that during the most recent Region X consultation, CMS was held up as the example for other agencies to follow. She noted that the opportunity to work with CMS and IHS directly is very effective. The tracking matrix brings a high level of accountability to the relationship and is a very effective tool for moving issues forward. She expressed the TTAG's pleasure that **Ms. Frizzera** would continue to work with the group on reform issues. She stated that the TTAG felt that the provisions of the IHCIA are self-executing (when no effective date was specified) and became effective upon signature by the President. She asked for clarification concerning the prioritization of the various provisions and stated that the TTAG understood that provisions with the earliest effective dates would have greatest priority. **Ms. Frizzera** indicated that CMS is developing a schedule for completing all of the required elements by the due dates mandated in the legislation. It is important to define "self-implementing" (no explanation needed) and "effective upon date of enactment" (may require guidance). She suggested that the TTAG go through the applicable provisions and determine which require CMS guidance and which do not as well as when the guidance is needed. **Ms. Davidson** pointed out the importance of individual AI/ANs being able to participate in the new opportunities (e.g., eligibility, benefits, etc.) offered under IHCIA. Outreach and education is critical to ensure that individual AI/ANs have access to this information from the sources with which they interact most without regard to language or location. Additionally, she was concerned that all Indian health facilities – whether operated by IHS, tribes/tribal organizations, or urban programs – have the opportunity for meaningful participation. She asked that CMS consider the effects of	TTAG will review the applicable PPACA provisions and determine which require guidance from CMS.

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	the various provisions on individual AI/ANs, determine how the AI/ANs will learn about specific programs/benefits, and decide whether providers need specific information or guidance to implement them. In the past, lack of specificity in the guidance has resulted in Indian programs being left out. **Mr. Allen** noted that tribes with members outside of their respective service areas are severely constrained in what they can do for these individuals (urban programs have very limited resources). He asked CMS to provide assistance to tribes to help them inform their members, especially those outside of their service areas, about the programs available to them and ensure that they are benefitting from everything that is available to them. **Ms. Frizzera** suggested that the TTAG might include this as one of its measures of success for implementation. **Mr. James Crouch**, Executive Director, California Rural Indian Health Board, Inc. (CRIHB), expressed his hope that CMS engage in preliminary conversations with the TTAG, similar to those held in relation to Section 5006 of the American Recovery and Reinvestment Act (ARRA), concerning PPACA implementation. He felt that this approach helped to facilitate the development of rules and guidance while making the most of the resources and knowledge brought to the table by the TTAG. **Ms. Carol Barbero**, TTAG Technical Advisor, asked **Ms. Frizzera** to discuss to the organization of the implementation of reform at the Department of Health and Human Services (HHS). She asked whether CMS' activities would be limited to Medicare, Medicaid, and state Child Health Insurance Programs (CHIP) or extend to the exchanges and/or workforce development issues. **Ms. Frizzera** stated that CMS is accountable for the provisions related to CMS. However, the agency is working with the Office of Consumer Information and Insurance Oversight (OCIIO) that is responsible for the "private" reform provisions (e.g., exchanges, pre-existing conditions, coverage to age 26, etc.). Approximately 25 CMS staff members are currently detailed to OCIIO and working on some very short implementation deadlines. Departmentally, HHS has a coordinating committee that meets weekly to report on and coordinate implementation activities and issues.	
	Ms. Barbero asked if it would be appropriate to approach representatives of the various HHS entities to ensure that Indian health issues are considered in the process of implementation. **Ms. Frizerra** responded by suggesting that TTAG reach out to the various agencies that are responsible for provisions relating to Indians. She promised to work with **Ms. Teresa Niño**, Director, OEA, CMS, to propose a strategy for connecting TTAG to the other HHS agencies. **Ms. Niño** stated that CMS was aware of the time and resources the tribes and tribal organizations devote to meetings and consultations with the various government entities. CMS is looking for a way to incorporate time with representatives of other HHS agencies into TTAG activities to limit these burdens.	CMS will develop a proposed strategy for the TTAG to use in reaching out to other HHS agencies concerning PPACA implementation issues.

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	Mr. Allen asked CMS to expedite the sharing of the flowcharts and charts of responsibilities related to PPACA implementation. This information will be very important to the TTAG and other Indian organizations because it will help them know where to direct their concerns, feedback, priorities, etc.	CMS will provide TTAG with implementation flowcharts and charts of responsibilities for PPACA implementation within HHS.
	Ms. Tracy Jones, Director, Business Office, Chickasaw Nation Health System, asked CMS to provide guidance on the eligibility for and use of the all-inclusive rate for patients enrolled through exchanges.	CMS will provide guidance on the all-inclusive rate for patients enrolled through exchanges.
	Mr. Crouch requested that CMS include a subroutine in its race/ethnicity data collection mechanism to compare IHS active users with the identified clientele in an institution. This would allow CMS to look at which Indians are being served by which institutions and the relationship between these individuals and Indians that are served through other systems or the private market.	
	He also pointed out that the process for releasing funds for the TTAG data analysis work has been slow. Additionally, access to IHS patient services data has been challenging. CRIHB needs this data by June 1. He asked CMS for assistance in identifying the individuals within CMS and IHS with the ability to negotiate a data sharing agreement.	CMS will identify points of contact within CMS and IHS concerning the data sharing agreement.
	Ms. Davidson noted the challenge of enrolling AI/ANs in programs such as Medicaid at a time when states are significantly rolling back the scope of these programs. She advocated for a unique benefits package for the Indian population based on the special political relationship between Indians and the federal government. She requested guidance on addressing the immediate crisis in California and states facing similar problems as well as guidance concerning the broader issue for all of Indian country. **Ms. Frizzera** asked the TTAG to provide CMS with some idea of how it would like to see this issue resolved. **Ms. Vikki Wachino**, Director, Family and Children's Health Program Group, CMCS, added that CMS is tracking this issue in states that are considering significant cutbacks in benefits. In some cases, CMS might enforce a Maintenance of Effort violation. The agency is currently developing guidance on the Maintenance of Effort violation.	TTAG will provide information to CMS concerning preferred outcomes related to effects of state Medicaid cutbacks on AI/ANs.
	Ms. Wachino reported that CMS awarded $10 million in outreach and enrollment grants to tribal groups on April 16. She hoped that the grants would identify effective approaches for enrolling children and applying these lessons to tribes and to the new populations that will become eligible.	
	Mr. Roanhorse reiterated **Ms. Davidson's** concerns related to the financial difficulties being experienced by states and the resulting cuts in Medicaid and other health coverage. He expressed hopes that the feasibility study could address some of these issues.	
	Ms. Davidson briefly reviewed the process by which AI/ANs access care through IHS facilities and states pay for these services using federal funds. Based on the funding mechanisms, AI/ANs are caught in a Catch-22 situation when trying to access care in states experiencing financial difficulties. She reiterated her earlier point	TTAG will work with CMS to develop short-term solutions to the problem of accessing federal funds for health care services that are currently

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	that the solution to this problem rests in the recognition of the political – not racial – relationship the tribes share with the government. **Ms. Frizzera** agreed that the nature of the relationship has been a longstanding issue. She suggested that the TTAG work with **Ms. Wachino** to identify strategies, such as waivers, that can be used to direct the funding appropriately. CMS understands that it needs to continue to work on the bigger issue (providing funding directly instead of through the states). **Ms. Davidson** suggested that demonstration projects could be used to address this problem in the near term. **Mr. Crouch** proposed a way to implement coverage in California by having the state approve a defined set of benefits for all AI/ANs in a specific geographic area. **Ms. H. Sally Smith**, Alaska Area Representative, NIHB and Chairman, Bristol Bay Area Health Corporation, indicated that her organization often receives questions on why federal dollars cannot flow directly to tribes and tribal organizations. **Ms. Frizzera** pointed out that the states are generally in favor of directing this funding directly to tribes; however, current law prevents this arrangement. It is important that CMS provide real answers, suggest available alternatives, and work with the states to implement them. **Ms. Wachino** emphasized that CMS is aware of both the funding issue and the California proposal and is working to find resolutions.	administered under state Medicaid programs.
	Mr. Allen felt that the consultation requirements in the new law are very important. He asked CMS about plans for communicating with states about implementing the consultation requirement and the consequences for not doing so. **Ms. Frizzera** reminded participants that CMS had reached out to the states with the least effective consultation policies to determine the underlying problems. CMS identified using best practices models as one approach to help states develop their consultation processes and provide an opportunity to discuss the challenges they are experiencing.	CMS will follow up on the identification of state/tribal best practices.
	Mr. Roberts noted that states often cite the Deficit Reduction Act (DRA) as a barrier to establishing a special benefits package for Indian people. States maintain that CMS guidance is insufficient for the proposed benefits package. He asked CMS to provide additional guidance on this issue, especially with regard to restrictions based on medical necessity, geography types, or provider types. **Ms. Wachino** replied that CMS has rules on benchmark benefits and cost sharing related to the implementation of the DRA coming out in the near future. She suggested that the TTAG review these rules and reconvene with CMS to discuss how well the rules address the members' concerns and whether additional guidance is needed.	TTAG members will review the new rules concerning aspects of DRA implementation guidance and provide feedback on the sufficiency of the guidance to CMS.
	Ms. Davidson observed that tribal health facilities vary greatly in the level of their adoption and use of electronic health records (EHRs). She pointed out that the acquisition and initial implementation of an EHR system can be costly; many facilities in Indian Country cannot afford them. The CMS incentives are only available after specific milestones, which are currently unattainable for many IHS and tribal facilities, have been met. She noted that it is important for the incentives to be structured in way that is achievable by IHS and tribal facilities (e.g., definition of eligible providers needs to include	

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	providers such as community health aides). She asked CMS to work with the TTAG to find ways that these facilities can participate in the incentive program. **Ms. Frizzera** replied that many of the requirements and milestones are defined by law. She suggested that facilities consider participating in the Medicaid incentive program as it will likely be more in line with the facilities' situations. She also promised to review the comments TTAG and the various Indian health boards submitted concerning the meaningful use rule. **Ms. Frizzera** briefly summarized her list of action items resulting from the discussion: • CMS will draw a dotted line linking the TAG and the Office of the Administrator on the CMS organizational chart. • TTAG will provide definitions of success concerning implementation of PPACA. • CMS and TTAG will continue to use the matrix of tasks for accountability purposes. • TTAG will provide a list of PPACA provisions related to Indians that it considers "self-implementing" versus "effective upon enactment." • Discussions concerning enrollment and outreach will continue. • CMS and TTAG will work on developing approaches for serving tribal members outside of defined service areas. • Preliminary discussions concerning the development of regulations will continue. • CMS will provide information to TTAG concerning reaching out to other HHS agencies. • CMS will provide organizational charts related to PPACA roles and responsibilities. • CMS will work to facilitate a data sharing agreement with IHS to support the current TTAG data matching study. • Discussions concerning the development of a unique benefits package for Indians will continue. • CMS will look into the possibility of using demonstrations to facilitate the use of federal funds for Indian health care. • CMS will follow up on the status of the tribal consultation best practices. • CMS will look into the issue of meaningful use of EHRs and the possibility of Indian health facilities participating in the Medicaid incentive program. **<u>Outreach and Communications</u>** **Ms. Niño** reported that the CHIP grants previously mentioned by **Ms. Wachino** would fund 41 outreach and education projects undertaken by I/T/U health programs throughout the country. CMS is considering the need for a conference later in the year to support the dissemination of information and programs developed as a result of the grants. **Ms. Davidson** concluded the session by thanking **Ms. Frizzera** for all of her support over the past 15 months. She acknowledged the high degree of accountability Ms. Frizzera brought to all of her interactions with the group and looked forward to working with her on PPACA implementation activities.	

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CMCS Update	**Ms. Wachino** took a moment to express her pleasure at being able to work with the TTAG on tribal issues. Inspired by the discussion with **Ms. Frizzera** about health reform, she felt the need to provide a more in-depth update on CMCS's activities through 2014 in hopes that it would spark ideas about ways CMCS could best collaborate with the TTAG. CMCS is using 90-day work plans to help it meet the early PPACA deadlines. The office is also working with states to create an implementation process working group. CMS would like to work with tribes in a similar way. This would allow CMS to identify challenges and issues early in the process, develop solutions in a timely fashion, and avoid errors in implementation. The single largest change in Medicaid under PPACA is the expansion of coverage to all people falling below 133 percent of the poverty level that do not qualify for coverage due to age or disability. This provision, which remedies historic inequities regarding eligibility for Medicaid, becomes mandatory in 2014. **Mr. Crouch** asked about the range of percentage of poverty levels used by states to determine Medicaid eligibility. **Ms. Wachino** replied that the parent threshold is approximately 67 percent of the federal poverty level. Some states use waivers to cover childless adults up to 100 percent of the poverty level. **Mr. Crouch**, who was attempting to get an idea of how large the expansion of coverage would be in Indian Country, further asked if standard eligibility would adjust to the 133 percent level. **Ms. Wachino** replied affirmatively and noted that children are already covered to that level or beyond. Families will see a change in the availability of coverage through the exchanges. She agreed that this change would represent significant increases in the number of Medicaid-eligible individuals for most states. **Ms. Wachino** promised to provide the TTAG with information on the anticipated expansion of Medicaid within the Indian population and how that breaks down by category. **Ms. Barbero** offered to share a factsheet from Families USA identifying states with state-funded coverage for adults. The expanded coverage for all or part of the Medicaid population became optional for states on April 1. In 2014, exchange coverage becomes operational. At that time, Medicaid coverage of adults becomes mandatory (federal funds will wholly support the expansion for the first several years) and the Medicaid income standard will be revised and based on modified gross income as reported on tax returns. **Ms. Kris Locke**, TTAG Technical Advisor, expressed concerns over how the new income system would handle Indian income, which is categorized in complex and unique ways. **Ms. Wachino** noted that the next four years would be marked by a large and ongoing effort to help states move into the new income system and structure their exchange coverage. CMS is working with the states to identify key issues and determine the order in which guidance should be issued. Issues currently under consideration include enrollment, the process for enrolling in coverage through an exchange, and the need to help	**Ms. Wachino** will provide TTAG with data concerning the scope of the expansion of Medicaid benefits in Indian Country as a result of PPACA. **Ms. Barbero** will share a factsheet on states providing Medicaid coverage for adults. **Ms. Wachino** will provide updates on PPACA implementation at future TTAG meetings.

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	consumers move through the enrollment process. She asked the TTAG for advice on the best ways to work with tribes on these issues. She promised to make updates on PPACA implementation a regular feature of the TTAG meetings. **Mr. David Reede**, Vice Chairman, San Carlos Apache, asked **Ms. Wachino** to confirm that Medicaid expansion after 2014 can be programmed by states through the exchanges. He was concerned that the exchanges could have a negative effect on Indian Country, especially with regard to regional exchanges. **Ms. Wachino** replied that each state would either set up an exchange or have one setup for it by the federal government. **Mr. Reede** asked to what degree CMS would be involved with states on developing and implementing the expansion. CMS will work with states on the Medicaid expansion, and OCIIO will work with them on the exchanges, stated **Ms. Wachino**. **Mr. Reede** feared that states might move forward on the design of the exchanges without understanding the effects on tribes. Additional PPACA-related activities that CMSC is working on include rules relating to the family planning option, waiver transparency, and options to expand CHIP coverage to children of state employees. **Ms. Barbero** asked which agency would be responsible for the implementation of the new maternal/childhood visitation program that was added to Title 20 of the Social Security Act. **Ms. Wachino** indicated that the Health Resources and Services Administration would be responsible for this. **Ms. Davidson** stated that the TTAG would appreciate regular updates on implementation activities at the TTAG meetings. She added that it might be possible to create a new, temporary subcommittee to address specific issues.	TTAG will create a temporary subcommittee to work on PPACA implementation issues.
Report from Secretary	**Ms. Carolyn Finster**, TTAG Secretary and Director, Pine Hill Health Center, directed participants to Tab B of the TTAG briefing book, which contained the minutes for the February 17 and March 10 conference calls. Having received no comments on the minutes, she moved that the documents be approved. **Mr. Allen** seconded the motion. The TTAG unanimously approved the minutes.	
Implementation of Section 5006 of ARRA	**Ms. Cyndi Gillaspie**, Lead Native American Contact, CMS, and **Ms. Lane Terwilliger**, Family and Children's Health Program Group, CMCS, CMS, reported on implementation activities related to five provisions in ARRA Section 5006. **Ms. Terwilliger** reported that CMS issued guidance on Section 5006 on January 22. **Cost Sharing** The original cost-sharing rule, which was part of the DRA, has been revised several times. Currently, the new provisions related to Indians are anticipated to begin the 30-public comment period on June 1. CMS anticipates that the revised final rule, which amends the November 25, 2008, final rule, will take effect at the close of the comment period. With regard to implementation, **Ms. Terwilliger** stated that CMS is	

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	providing technical assistance to states to ensure that the provisions are properly carried out. Assistance is being given on a state-by-state, agreement-by-agreement basis. **<u>Resource Exclusions</u>** **Ms. Gillaspie** pointed out that the January 22 letter explains in detail how the exclusion works, with monies from specified resources – including Individual Indian Money (IIM) funds – no longer counting as income in the month of receipt.	
	CMS has been working with states to ensure that their policies are in line with the law. She encouraged TTAG members to report any instances of resources being incorrectly categorized as income. **Ms. Gillaspie** reported that CMS has received a request for a State Plan Amendment (SPA) from Montana to do a more liberal treatment of this resource by excluding these monies beyond the month of receipt through the first purchase. The first item purchased using this money would be forever excluded from the resource test. Funds put into savings would also be excluded as long as they remain identifiable. She anticipated that this SPA would be approved. She encouraged participants to work with their states on similar arrangements and committed to providing information to support such efforts. **Mr. James Roberts**, Policy Analyst, Northwest Portland Area Indian Health Board, asked if CMS would make this approach available to the public as a promising practice. **Ms. Gillaspie** indicated that it would become publically available if it were approved, but that CMS would not designate it a promising practice. **Ms. Davidson** observed that the Montana approach would solve problems being experienced throughout Indian Country. She asked if CMS could send out a letter or other form of communication indicating that this is an allowable practice and that SPAs using this approach would be likely to be approved. Widespread adoption of this policy would effectively level the burdens throughout Indian Country.	TTAG members will share examples of improperly counted income/erroneous removal from Medicaid rolls to CMS. CMS will share information concerning more liberal treatment of MMI funds to support discussions with other states on the proposed SPA is approved.
	Ms. Terwilliger noted that CMSC has recently begun using bulletins to communicate in a more informal way with states. She thought that the bulletins might be an appropriate way to share information on the Montana approach with other states, once the SPA is approved. **Ms. Terwilliger** will work with CMSC leadership on this. **Ms. Kathy Hughes**, Vice Chairwoman, Sovereign Nation of Oneida, asked if it would be possible for CMS to share the document with the TTAG. **Ms. Gillaspie** replied that the document could be requested from CMS or the state once it is approved. **Ms. Barbero** asked if the segregated bank account requirement is a CMS or a Montana requirement. **Ms. Gillaspie** answered that the Montana SPA requires that the funds remain identifiable but does not require a separate account.	**Ms. Terwilliger** will work to get information on the Montana SPA into the CMSC bulletins to states on the SPA is approved.

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	Ms. Kris Locke, TTAG Technical Advisor, asked if the states must go through the SPA process to implement an approach similar to Montana's or if they can simply make such a determination on their own. **Ms. Gillaspie** noted that SPA or waivers are the vehicles by which CMS approves such flexibilities. **Ms. Locke** inquired about how approaches are defined as flexibilities rather than as being permissible under the law. The designation is based on Office of the General Council opinions and governing portions of the Social Security Act, replied **Ms. Gillaspie**. **Ms. Kitty Marx**, Director, TAG, OEA, CMS, asked whether Montana consulted with the tribes before submitting the SPA. **Ms. Gillaspie** noted that the state has been following this policy without benefit of the authority, so it does not represent a change in how it handles excluded monies. **<u>Estate Recovery</u>** **Ms. Gillaspie** stated that there were a small number of states that were not following the CMS policy on estate recovery that has been in place since 2003. Section 5006 incorporates the policy into law. She was unaware of any problems with regard to this. **Mr. Roberts** asked if Transmittal 75, which addresses estate recovery, would be updated to reflect the new law. **Ms. Gillaspie** anticipated that it would be included in any updates to the state Medicaid manual. She noted that since this is now part of the law, all states must adhere to the provision. **Ms. Terwilliger** added that CMS is having trouble updating the Medicaid manual in a timely fashion. It is receiving calls from state agencies seeking guidance. As a result, CMS is identifying practices that are not in compliance with various ARRA provisions. CMS is planning to hold a series of regional calls to address the issues it has identified. **Ms. Madonna Azure**, Three Affiliated Tribes, reported that her tribe had met with the state of North Dakota and that the state's representative assured them that IIM funds are not being counted. However, individual Indians are still being dropped from the Medicaid roles based on IIM funds. **Ms. Gillaspie** and **Ms. Terwilliger** promised to work with Ms. Azure to resolve this issue. **<u>Managed Care Protections</u>** The provision allows Indians to use I/T/Us and requires the states to make the facilities whole by paying up to their full reimbursable amounts for medical services. **Ms. Gillaspie** indicated that CMS has not received feedback on how well this is working and asked the TTAG members to report back on the situation within their respective states. **<u>Consultation</u>** **Ms. Gillaspie** reported that CMS has been working with the TTAG as it develops guidance related to the consultation provisions. **Ms. Terwilliger** addressed the pre-print that CMS has developed. The document started off as a checklist of consultation-related steps. Thanks to input from TTAG, CMS determined that states need to	CMS will follow up with **Ms. Azure** to resolve the improper counting of IIM funds in North Dakota.

	provide narrative descriptions of their consultation activities, including any consultation activities undertaken before submission of a SPA. The pre-print is scheduled to be published for review on May 7. The review process will take a couple of weeks, after which the document will be submitted to the Office of Management and Budget for final review. She indicated that CMS would share any changes in the document that result from the comment and approval process. States are not obligated to submit consultation SPAs until the pre-print has been approved. **Ms. Gillaspie** stated that CMS is taking a proactive approach to ensuring that states are developing consultation processes. She conducts bi-weekly calls with each Regional Office to review all of the SPAs and waiver requests that have been submitted to ensure that consultation has occurred, if appropriate. In cases where appropriate consultation has not occurred, CMS stops the process and ensures that the proper steps are taken. CMS is using a variety of outreach channels – conferences, webinars, etc. – to educate states and tribes about the Section 5006 provisions. **Mr. Roanhorse** alerted CMS that there have been problems with Region VIII, especially with regard to South Dakota. **Ms. Gillaspie** indicated that CMS has been working on these challenges through the Regional Office and is beginning to have some success in resolving them. **Ms. Smith** pointed out that Arizona has effectively abolished its CHIP program. **Ms. Marx** clarified that Arizona had reinstated its Kids Care program, but capped the eligibility requirements. **Mr. Crouch** asked if California has been working with CMS on the restoration of optional benefits. **Ms. Terwilliger** indicated that she has had some contact with the issue. She reported that discussions are ongoing, and thought that the issue (the 1115 waiver) is back in the state's court.	
	Ms. Locke thought that implementation of the ARRA provisions was going very well. She was concerned that implementation of PPACA would result in the ARRA implementation being neglected. She was also very concerned that information does not get down to the eligibility workers or to I/T/U program staff. She asked if CMS could incorporate training about the ARRA provisions into I/T/U guidance or a "Dear Tribal Leader" letter. **Ms. Terwilliger** felt that it would be possible to incorporate the information from the state guidance into a tribal leader letter. She promised to work with CMS leadership to do so. **Ms. Marx** added that IHS has sent out such letters in the past and suggested that working with IHS on a new letter might be the most efficient way to get this information disseminated. **Mr. Crouch** pointed out problems with a recent IHS mailing and cautioned CMS about potential problems (e.g., delays, incomplete mailing lists, etc.) associated with relying on IHS for mailings. **Ms.**	CMS will incorporate ARRA implementation information/training in I/T/U guidance and tribal leader letters.

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	Marx indicated that CMS does not have an internal list of tribal leaders and relies on IHS for this information. **Ms. Davidson** suggested that these letters be sent to the TTAG members, who can forward them to the appropriate individuals and organizations. **Mr. Carl Harper**, Director, Office of Resource Access and Partnerships, IHS, stated that he would meet with TAG to coordinate efforts and ensure that letters are going where they need to go.	IHS will meet with CMS to better coordinate the use of mailing lists.
Subcommittee Reports	**<u>Outreach & Education</u>** **Ms. Hughes** reported that the Subcommittee usually meets for one hour by telephone on the first Tuesday of the month. There will be 21 regional IHS/CMS training sessions this year. CMS allocated $450,000, or a little more than $21,400 per session, for FY 2010 training. Regions will be allowed to determine the content of the sessions. Kauffman and Associates, Inc. (KAI), is developing the CHIP promising practices toolkit, which is due to CMS by August 31. The toolkit will consist of a Webpage shell with information on tribal programs. Funding for this project is $150,000. The transportation project was funded with $100,000 and is being undertaken by KAI. The preliminary deliverable is due to CMS by June 30 for review, with a final submission date of July 15. The Subcommittee continues to work on updating the CHIP video and related materials. The video should be ready for distribution by late 2010 or early 2011. There is $100,000 available for this project. The Medicare 101 handbook is still in the clearance process. There is a great need for this out in the field. **Ms. Marx** added that the handbook has passed through program review and is in the process of final clearance. In order to get the handbook out to users more quickly, CMS has proposed pulling all of the reference documents out of the handbook and releasing them as a separate, stand-alone volume. All of the documents have already been approved, so the volume could be printed immediately. The balance of the handbook would be much smaller, easier to update, and easier to get through the clearance process. NIHB is working on a state/tribal consultation best practices project, which has a budget of between $50,000 and $100,000. The deliverable due date for this project is July 1. **Ms. Hughes** concluded by expressing the Subcommittee's appreciation for the extra money it received this year and stressed the importance of completing the various projects in a timely manner. **<u>Across State Borders</u>** **Mr. Roanhorse** reported that the Across State Borders (ASB)	

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	Subcommittee has held several conference calls since the last face-to-face meeting in November. He thanked **Mr. Rodger Goodacre**, TAG, OEA, CMS, for all of his support. Tab E in the briefing materials contains the first draft (February 19) of the ASB literature review report. KAI submitted the final version of the report to CMS on March 26. The Subcommittee originally identified seven ASB issues and eventually narrowed the study focus to three scenarios that highlight ASB issues: Indians crossing state borders for medical treatment, Indians going to another state for specialty care, and Indian youth who attend out-of-state boarding schools. The report examined the available literature on general ASB issues (not just focused on Indians), on ASB issues affecting migrant farm workers, and ASB problems experienced by those dislocated by Hurricane Katrina. Additionally, the report addressed the issue of culturally competent care. A limited amount of data illustrating ASB issues was also included. The Subcommittee tentatively approved two case study sites: the Chemawa School in Oregon and the Chief Gall youth residential treatment facility (YRTC) in South Dakota. If time and resources permit, KAI will look at a third site (Circle of Nations School) near Chief Gall. The Subcommittee has also given tentative approval to the focus group and key informant interview questions for each site. The draft of the final report is due on July 15, and the final review should be complete by July 30. The deliverable deadline for the final report is August 30. **Ms. Barbero** asked why both case studies are youth oriented, leaving out the adult population. **Dr. Mike Meyer**, Project Manager, KAI, noted that the ASB case studies would continue on in the future. With this in mind, the selection of two sites that involve young people provided an appropriate point of comparison. Other issues could be handled in subsequent projects. **Ms. Finster** asked if it would be possible to send a researcher to the upcoming powwow in Stanford to capture the adult perspective using the case study questions. **Ms. Carmelita Skeeter**, Executive Director, Indian Health Care Resources Center of Tulsa, confirmed that the key issue under examination was the difficulty of getting Medicaid to pay for services received outside of the beneficary's home state. **Dr. Meyer** replied affirmatively and indicated that the study would look at the both the patient and the facility perspective. The case studies highlight a particular problem at a particular time and place, much like a snapshot. **Mr. Roberts** expressed his desire to consult with the service unit in the Portland area before agreeing to have Chemawa listed as a site. He noted that Chemawa has mostly resolved its problems with the	 **Mr. Roberts** will consult with the Portland area service unit before approving the use of the

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	state and recommended looking at a facility that has not had much success resolving Medicaid payments. He also asked whether the study would focus on any of the instruments or processes used to overcome these challenges. **Dr. Meyer** replied that the reason for including the Circle of Nations School would be to provide a comparison to Chemawa. When KAI arranges for the site visits, they will ask to review any documents that might be relevant. **Mr. Harper** asked if KAI was going to do a cross-section of the states to identify best practices. **Mr. Goodacre** replied that resources for the project are limited. He anticipated that the inquiry would be widened in the future. **Ms. Davidson** asked why Chemawa was selected as a primary site over Circle of Nations when the latter draws students from 17 states and is still experiencing problems related to crossing state borders. **Dr. Meyer** replied that he felt there would be enough funds to visit all three sites. **Mr. Goodacre** added that the Subcommittee based its selection of the two sites primarily on the fact that schools and YRTCs represent a large portion of Medicaid funds. **Ms. Barbero** asked if the case studies would include interviews with the providers that serve out-of-state individuals, particularly I/T/U providers. **Dr. Meyer** responded that KAI will conduct both individual and group interviews with staff members with knowledge of and involvement in ASB issues. He indicated that it might be possible to visit the I/T/U near the Circle of Nations school. Chief Gall is an IHS facility. **Ms. Marx** noted that the issues are both direct care and CHS funds (finding a provider). **Ms. Myra Munson**, TTAG Technical Advisor, Sonosky, Chambers, Sachse, Miller & Munson, LLP, asked if any consideration had been given to conducting a survey of state regulations concerning enrollment across state borders and the rules for Medicaid enrollees receiving services in another state. **Mr. Goodacre** felt that would be an excellent next step in the research process. The intent of this initial report is to make the case for pursuing additional research. **<u>Long-Term Care</u>** **Mr. Reede** reported that the Subcommittee is preparing for a long-term care (LTC) conference in Phoenix in early May. Looking forward, the Subcommittee will focus on identifying needs and expanding consultation. **<u>Data</u>** **Mr. Crouch** presented the data report that was originally shared with the TTAG in November 2009 and subsequently approved. He thanked CMS for producing a handy version of the document that clearly illustrates, through color, the complexity of the Contract Health Services Delivery Areas. The report provides a good sample of racial Indians who use the IHS system. The next study, which should begin on June 1, will focus on the active I/T/U user population. The most recent conference call occurred on March 19 and addressed the IHS data request and the upcoming data symposium	Chemawa School for a case study site.

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	($30,000 award from TTAG funding). The symposium will bring together academics, health policy specialists, congressional staff, and TTAG members to review the three completed data documents and discuss ways to utilize this information (secondary analyses). **<u>Medicaid Administrative Match</u>** **Mr. Roberts** reported that the Subcommittee has not convened a conference call since the last face-to-face meeting. A guidance memo to the states is currently in the CMS review process. Washington State is working with tribes to select Medicaid Administrative Match (MAM) options from the six outlined in the CMS options letter. **Mr. Crouch** reported that California expects to write the first MAM check in May. **<u>Tribal Consultation</u>** **Ms. Marx** reported that CMS has not finalized its consultation policy. The HHS Office of Intergovernmental Affairs (IGA) is holding tribal consultation sessions on the Department's policy. Once this is complete, the IGA will form a work group to report back. After that, CMS will reconvene its Tribal Consultation Policy Subcommittee and finalize its policy. **Ms. Davidson** indicated that the TTAG would appreciate a new starting point (compared to the last draft of the policy). **Mr. Roberts** noted that the policy has been under development for approximately two years. Over time, changes were made that were not mutually agreed upon by TTAG and CMS. Additionally, changes associated with legislation need to be incorporated into the policy. He suggested that the earlier drafts be reviewed as the process moves forward (instead of the most recent version of the policy). **<u>CMS Day</u>** **Ms. Marx** reported that the Subcommittee has met several times. Planning for the event is only in the preliminary stage. The NIHB Consumer Conference will be held the week of September 20 in Sioux Falls, with CMS Day taking place on September 22. Tentative plans are to have a plenary speaker address PPACA. Possible workshops topics include how to become a federally qualified health center, Medicaid options under PPACA, tribal/state relationships and consultation, affordable care, LTC, behavioral health, HITECH, Medicare and Medicaid 101, and the use of social media. There might also be a site visit to a nearby Indian health facility. The Subcommittee is looking for suggestions for keynote speakers, plenary session topics, and workshop topics.	 Subcommittee members will submit ideas for CMS Day speakers and session/workshop topics.
CMS Tribal Affairs Group Report	**Ms. Marx** alerted participants that copies of the 2009 *Medicine Dish* series are now available. Additionally, the updated Medicare/ Medicaid/CHIP brochure is also available for order online. CMS has excellent resources for developing graphics, printed materials, and	

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	culturally appropriate messaging. OEA is very willing to work with TAG and TTAG. CMS is working to build its photo library of Indians. With regard to the 2010 budget, CMS met with the Budget/Strategic Plan Subcommittee. CMS anticipates the FY 2011 budget will include an 11 percent increase over the current year. The 2012 budget will include a possible 4.3 percent decrease; however, there is a chance for an increase. **Mr. Roberts** added that there are also smaller bits and pieces of available funding ($100,000 or less) that are not as closely scrutinized with regard to budgetary cuts. **Mr. Crouch** noted that it would be helpful if CMS could develop an Intra-Departmental Delegation of Authority (IDDA) with NIHB to help remedy the problems CRIHB has experienced with delays in the receipt of allocated funds. **Ms. Davidson** expressed her hope that TAG is able to access resources for outreach and education related to the rollout of PPPACA for efforts aimed at AI/ANs and the providers who serve them. **Ms. Marx** reminded participants that there was a $10 million set-aside for AI/AN outreach within the national CHIP enrollment campaign. She anticipated that there would be many resources available for PPACA outreach and education efforts, including resources for AI/AN outreach. **Ms. Marx** asked TTAG members to think about end of year funding requests. She asked the group to submit ideas for projects that are tied to the Strategic Plan that have not been funded or for research projects such as the transportation project as soon as possible. **Mr. Roberts** noted that the Budget/Strategic Plan Subcommittee estimated that it needs approximately $30,000 to update the Strategic Plan**. Ms. Hughes** pointed out the important role the Strategic Plan plays in the TTAG's ability to get funding. Because of this, it is very important to maintain and update the document. **Mr. Roanhorse** noted that the ASB subcommittee would need additional funds to continue research. **Ms. Davidson** saw a need to reserve some of the TTAG's resources in anticipation of issues that will come up as PPACA implementation moves along. **Mr. Harper** stressed the importance of having a mechanism for getting any additional funding out through the system (e.g., IDDA). **Ms. Hughes** pointed out the important role the Strategic Plan plays in the TTAG's ability to get funding. Because of this, it is very important to maintain and update the document.	
	Ms. Davidson asked the subcommittees to forward their end of year funding requests (one per subcommittee) to **Mr. Roberts**. The Budget Subcommittee will compile the requests for discussion at the July face-to-face meeting. With regard to the membership list, **Ms. Marx** asked the members to review the current list and provide any corrections to CMS. **Ms Marx** also alerted participants that the Center for Medicare is disseminating guidance allowing Part B services to be billed retroactively back to January 1 in response to the elimination of the	The Budget Subcommittee will compile subcommittee requests for end of year funding for discussion at a future TTAG meeting. TTAG members will review the current membership roster and submit corrections to CMS.

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	Part B sunset provision. I/T/U providers should receive instructions from their Medicare contractors on how to submit these claims.	
NIHB Report	**Ms. Stacy Bohlen**, Executive Director, NIHB, began her remarks by recognizing the important role **Ms. Baer** plays in NIHB's work supporting the smooth operation of the TTAG. **Ms. Bohlen** reported on the health care reform briefing presented the previous day by NIHB, the National Congress of American Indians, and the National Council of Urban Indian Health, which addressed both PPACA and new provisions of the IHCIA. Copies of the briefing books distributed at the event will be updated with information from the presentations and be made available at the self-governance meeting. The day concluded with a celebration honoring the Members of Congress who were key to ensuring the passage of the IHCIA. **Mr. Robin Carufel**, Consultant, NIHB, reported that NIHB requested and received a no-cost extension through the end of May to complete its work on LTC issues and participate in the upcoming LTC conference. Additionally, NIHB actively participates in several of the TTAG subcommittees, with **Ms. Baer** coordinating calls through the listserve. Subcommittees in which NIHB participates include the Data, ASB, LTC, and ARRA Protections Subcommittees a well as the TTAG/National Association of State Medicaid Directors work group. **Mr. Carufel** briefly described some of the work NIHB has undertaken regarding state consultation policies (including identifying best practices and developing a toolkit) and LTC issues that were addressed more fully in the NIHB report provided to participants. With regard to LTC, NIHB anticipates using the National Indian Council on Aging survey instrument to gather data at the upcoming LTC conference.	
	Ms. Bohlen commented that during the previous day's listening session, participants asked if the NIHB regional training concerning PPACA would be coordinated with IHS' listening sessions. She confirmed that NIHB and IHS would coordinate their sessions and hold them in tandem. NIHB will look to TTAG for guidance as it develops the training.	NIHB and IHS will coordinate their PPACA training sessions. NIHB will consult with TTAG concerning the content of its PPACA training sessions.
	Mr. Carufel next addressed NIHB's tracking of regulations posted in the *Federal Register*. NIHB submitted comments concerning the interstate enrollment coverage process for children and the Medicare/Medicaid incentive program for adoption of EHRs. NIHB also looked at Medicaid waivers listed on the CMS website and cross-reference them to the states. He noted the importance of continuing to track new options coming out in the near future, such as money-follows-the-person and estate recovery.	
	Ms. Davidson asked NIHB to identify the projects undertaken as part of IDDA-supported work and the status of the associated deliverables/work products and budget. **Ms. Bohlen** replied that the	NIHB will reformat the information in its report (handout) into a simpler

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	NIHB Board of Directors Report provides that information in narrative form. NIHB can reformat the information in the report into a simpler and more easily accessible manner for distribution on April 30. **Ms. Hughes** asked that the NIHB report tie the various projects and deliverables back to the Strategic Plan. **Mr. Roberts** confirmed that the work under discussion was covered under the 2009 IDDA. He felt that there was a disconnect between what the TTAG expected would be completed and what was presented to the group. Some of this might be a result of poor definition of work products and timelines. It is essential that the Budget/Strategic Plan Subcommittee understand the status of each deliverable, the amount expended, and the amount of any remaining funds. Of particular concern was the need to be able to use available funds for unplanned needs. He indicated that the Subcommittee chairs should schedule a meeting with NIHB to review the status of each project. Moving forward, he indicated that the Subcommittee should work with NIHB to develop the scope of work, deliverables, timelines, and budget for FY 2011 once the IDDA is posted in the *Federal Register*. **Ms. Bohlen** requested that the meeting occur the following week during the self-governance meeting.	format. The Budget/Strategic Plan Subcommittee will meet with NIHB to review the current status and budgeted funds remaining for FY 2010 Strategic Plan projects. The Budget/Strategic Plan Subcommittee will work with NIHB to develop the scope of work, deliverables, and budget for FY 2011 Strategic Plan projects.
Open Discussion	**Ms. Davidson** reminded participants that the HITECH Roundtable would take place on April 30. **Mr. Jim Lyon**, TAG, OEA, CMS, stated that the session would include an overview of the initiative, a report from IHS on addressing the meaningful use requirements, and an open discussion of needs and next steps. Briefing books for the meeting were distributed at the close of the TTAG meeting. **Mr. Crouch** requested that NIHB send a representative to discuss the regional extension centers. **Ms. Barbero** asked if CMS or IHS plans to hold meetings for the tribal health programs to educate them about options and obligations related to EHRs. **Mr. Lyon** replied that IHS has hosted 13 webinars on the subject and is planning another. CMS has had multiple open door forum calls and webinars. It has also made presentations at multiple conferences. He anticipated that CMS would conduct additional outreach once the regulations are finalized. **Ms. Marx** announced that in response to the discussion with **Ms. Frizzera**, the CMS organizational chart had been changed to indicate TAG's direct access to the CMS Administrator.	
Next Meeting	**Ms. Davidson** reminded TTAG members that the next TTAG face-to-face meeting is scheduled to take place on July 28-29. The final 2010 face-to-face meeting will take place on November 9-10. TTAG conference calls are scheduled for May 12 and June 9. **Mr. Jason Dollarhide**, Chair, National Congress of American Indians	

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	and Second Chief, Peoria Tribe, asked when the next Medicare and Medicaid Policy Committee (MMPC) would take place. **Mr. Roberts** replied that the target date for the next meeting is June 24-25 in Denver, Colo., pending approval by the members. **Mr. Harper** noted that IHS had targeted those dates for a Contract Health Services Workgroup meeting, but he did not think that the group's membership overlapped with that of the TTAG or MMPC. **Mr. Crouch** added that CRIHB is anticipating the award of the Data Symposium contract and anticipates that the Symposium will take place on July 30, immediately following the TTAG face-to-face meeting.	
Adjourn	With no more business to discuss, the TTAG adjourned the April 2010 face-to-face meeting.	

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