

**Centers for Medicare and Medicaid Services (CMS)
Tribal Technical Advisory Group (TTAG)**

August 1 - 2, 2007

National Museum of the American Indian

Meeting Minutes

Wednesday, August 1, 2007

8:30 Valerie Davidson, welcomed attendees.

Robert Moore, gave opening prayer.

Priya Helweg, gave the roll call.

8:45 Valerie Davidson, gave the chairs report. She asked for a motion to accept the agenda. Unanimous consent. Received letter from Tribal Self-Governance Advisory Committee approving Kris Locke.

- Brief IHCIA update:
 - o Sen. Dorgan offered reauthorization of the IHCIA as an amendment to the Senate SCHIP bill. Sen. Baucus, Chairman of the Senate Finance Committee, promised to schedule the IHCIA for markup in the Finance for September if Dorgan would withdraw it as SCHIP amendment and Sen. Reid promised to get it to the floor by November.
- Alaska hosted the CMS video

**9:00 Report from CMS – Jackie Garner, Medicaid Consortium Administrator
Rodger Goodacre, Tribal Affairs Group**

Jackie Garner:

- Oversees 10 regional offices and represents CMS Acting Administrator Herb Kuhn at TTAG
- CMS leadership is being called to Hill a lot recently
- Kerry Weems, intended next Administrator, has been through Congressional hearing. CMS is now answering many questions. Weems would like to come to TTAG, but not permitted during this process
- Acknowledged NACs and introduced Cindy Gillaspie, lead NAC, from CMS Denver office. Most NACs will be at conference in September.

Rodger Goodacre:

- Introduced Melissa Robins from IHS and Sandy Farley who formerly worked at IHS for 17 years
- CMS is moving forward with the budget. It has been submitted and now waiting for internal pass back. Asked for feedback from TTAG.
- Have made progress on IA with IHS for training
- Working on getting satellite network contract back in place
- Plan to support coding training this year

Last term

- TTAG staff went to Nevada and learned about challenges to small clinics in rural areas with Medicare and Medicaid. Hope this will result in strategic outreach and training with IHS
- Involved w Mobile Office Tour-MOT. MOT continues through Sept.
- Trying to prepare for outreach season for Part D

Program challenges over recent term

- MLR – program issues and questions are pouring in on Medicare Like Rates
 - o Tribal Affairs Group working to update manualization – encourages everybody to turn to them when operationalizing.

Attendees, introduced themselves.

Jackie Garner, said that CMS is very close to filling Ernie's former position.

9:15 Report from Secretary – Mickey Percy, Choctaw Nation

- Approval of Minutes

Mickey Percy:

- NAM formerly had the contract to prepare minutes
- Valerie: motion to approve minutes. Unanimously passed.
- Vacancies – Billings and Phoenix Area
 - o Mickey asked Chair to ask Dr. Grim to find candidates to fill those positions

Strategic Plan Subcommittee -- Jim Roberts, Northwest Portland Area Indian Health Board

Jim Roberts:

- Working to dovetail the strategic plan with the CMS budget process and layout
- Sometime in the fall, Mim will be working with TTAG to update
- Want to set a day aside prior to the October meeting to decide what needs to be included in updated plan and consult CMS

Mim Dixon, Technical Advisor to NIHB

- There hasn't been a formal Subcommittee meeting re: info from CMS on, for example what kinds of questions office is receiving and what kinds of workloads and needs there are
- Satellite training systems: Have submitted training priorities, but unclear what and how much training has actually occurred
- Need to do an evaluation in cooperation with CMS
- The first plan was purposefully set up to be TTAG members only – no CMS staff – at CMS's request. The next plan will probably not be set up this way.
- Dorothy said she'd like a revised plan by April. She indicated she'd like budget that's in CMS's standard budget categories. Mim requested information on that before the Subcommittee meeting that will take place the day before the next TTAG in November.
- Need input from CMS re: how much of the previous plan should be included – does it need to be entirely new?

Priya Helweg, asked if there should be a group call before the November meeting. Mim said there's not a lot of time, could probably get a group together for that.

Jim Roberts, said the challenge is a staffing issue. Tribes are covering costs of developing and updating the plan. If CMS willing to commit more resources for this process, that would help.

Mim Dixon, said that in the past Dorothy has done matrix on updates of recommendations, that would be helpful.

Kris Locke, said she's heard that the next plan needs to be developed jointly between subcommittee and CMS. Asked if we could get more resources.

Priya Helweg, said the 07 budget is committed. Don't know about 08. It gives good leverage if the plan is developed by TTAG/Tribes only.

Mim Dixon, said the last time CMS paid for work to produce the plan but not this time. That has made a really big difference.

Mickey Percy, asked if the sweeping process had started and if the group could talk about that with Herb Kuhn the next day.

Jackie Garner, said that resources are extremely tight.

Rodger Goodacre, said they would appreciate the group talking to Herb about that and conveying the need for funding in 08. That's always helpful.

Tribal Consultation Policy – Rodger Goodacre, CMS Tribal Advisory Group

Rodger Goodacre:

- Just got back last of internal comments, after circulating report. Offices commenting include GC, OS, CMSO
- The general tone of comments was that CMS policy should be kept in line with Department policy as much as possible. Invited discussion on how best to accomplish that.

Mickey Percy, said that if Rodger gets the comments together, we can bring the group together to discuss them.

Rodger said his goal is to get the comments together in time for the CMS day of the Annual Consumer Conference.

Carol Barbero (Hobbs, Strauss, Dean and Walker, LLP), said that all agree that CMS policy should be compatible with HHS policy. She asked Rodger if he thought those comments were meant as criticism or endorsement?

Rodger Goodacre, said he thought it was neither – more of an observation. The view was that CMS had recommended policy that was more expansive than HHS policy.

Jim Roberts, said we developed the policy almost 2 years ago. He said he disagrees with that criticism. The strategy was laid out to be consistent with the Department's policy. Doesn't know why CMS hasn't approved it. Portland Tribes feel they need the policy in order to work directly w CMS – absent that Tribes have to fall back on the Department. Other agencies have had their policies in place and are being implemented – but we can't even get ours approved.

Mickey Percy, said we were very careful putting policy together.

Myra Munson (Sonosky, Chambers, Sachse, Endreson & Perry, LLP), said that when the original policy was written and submitted by the committee, there CMS made major changes prior to the public comment period to reverse things that were part of HHS policy. In the second round, the HHS policy was put back and treated as a floor. This delay is frustrating because CMS is the one who took out the HHS policy in first round. The tone of these comments makes no sense in light of that.

Ben Shelly (Vice President, The Navajo Nation; Navajo Area Representative), asked Rodger what the time frame is for CMS to respond to these concerns? Expressed concern about lack of tribal recognition by CMS. Wants direct consultation b/w Navajo and CMS. Navajo staff here will follow up.

Rodger Goodacre, said that, as Mickey suggested, the goal is to have comments together by end of September, before the Annual Consumer Conference CMS day. Failing that, before the next TTAG meeting in November.

Robert Moore (Council Representative, Rosebud Sioux Tribe; Aberdeen Area Representative), said we need to be bolder and compel forward movement. Need to get Tribes involved in the process and make calls.

Priya Helweg, said the comments are relatively minor; the process has been going on for two years.

Robert Moore, said that it is stalled and sitting on somebody's desk.

Priya Helweg, said she and Rodger will take responsibility for that.

**9:30 Medicaid Administrative Match – Aaron Blight, CMSO
Judi Wallace and Sharon Brown, Administrative Claiming Group, CMSO**

Aaron Blight:

- In the Financial Operations Division.
- Introduced Judi Wallace and Sharon Brown
- Underscored that it's been a lengthy laborious process working on Washington State's plan. But said there's been no unique treatment in this review; treatment has been fair and equitable.

Jim Crouch (Executive Director, California Rural Indian Health Board; California Area Representative), asked if Aaron said there has been unequal treatment of the plan approvals because they have been delayed for such a long time.

Aaron Blight, said they were going to go over the review process, and hopefully that would show what has caused the delay. He said that regarding the cost limits regulation: it was issued as a final rule with comment on May 25. Congress included in a war appropriations bill a provision prohibiting CMS from implementing that regulation. So in light of this Congressional moratorium, CMS took the topic off the agenda. Tribal comments and analysis are in the preamble of the regulation, which begins with comment #20.

Judi Wallace, presented PPT: "Tribal Medicaid Administrative Claim"

- Judi and Sharon review all administrative claiming Plans from all claiming entities that come in to CMS. They are charged to work with regional offices to approve MAM plans
- Identified the Department of the Interior as the cognizant agency.
- Currently, Washington, California and Oklahoma have submitted plans and are revising their plans.

Jim Crouch, asked if they understood that Tribal organizations are enfranchised into Medicare and Medicaid, per 2005 letter.

Sharon Brown, said they were.

Jim Crouch, asked if they were aware that there are some Tribal organizations that receive no money from the Department of the Interior.

Myra Munson, said that the cognizant agency for many is the HHS – not Interior - expressly as a matter of law.

Pending state plan approvals:

Judi Wallace, said that in Washington, there are two outstanding issues. WA was asked to delineate when referrals and outreach activities were in-home vs. in a clinic. The other issue is that in their proposal, the time spent completing study would be paid for by Medicaid as general administration.

Sharon Brown, said the recommendation had been that until policy is clarified, these costs cannot be directly claimed as Medicaid cost – though may be indirectly paid by Medicaid.

Jim Roberts, asked what the normal timeline for this process was – considering the assertion that there has been no special treatment of these state plan reviews.

Judi Wallace, said it varies but it's usually one year.

Jim Roberts, said that the two years for Washington is exceptional then.

Sharon Brown, said yes.

Judi Wallace, said the delay may be due to the timing and release of the SMDL letters in 2005 and 2006.

Sharon Brown, said that that is not an excuse. CMS has been recognizing Washington's plan in the interim. It's CMS's goal to approve it. The state wanted assurances that they're in compliance.

Jim Roberts, asked if other states were experiencing these delays.

Sharon Brown, said that Oklahoma's plan admittedly went unrevised for some time. There's no special order. There are only two people who can review. It was noted on a recent Tribal Advisory Group call that they had consulted a Tribal liaison to discuss these concerns. Are other states being held up?

Jim Crouch, said there was a February 2 letter from CMS to California with 6 questions. CRIHB met with CMS the first week of March. California hopes to get its response back to CMS in August.

Sharon Brown, said that's great.

Jim Crouch, said that this all goes back to the bigger concern which is what chance is there that Tribes will be able to do MAM claims and retroactive claiming?

Sharon Brown, said if the state is willing to submit claims based within two year filing limit, assuming they're ultimately able to approve the plan, it would be prospective, but would include language endorsing ability of state to submit claims to adjust for prior period claims. The time study is likely to change, so there is a need to adjust prior period claims.

Jim Crouch, said that some supervising staff working in joint roles b/w Tribes and states aren't 100% dedicated to the oversight process. He asked if we could have a Tribal employee who's only responsibility is overseeing MAM, and this person would be exempt from time study because he/she'd be a Medicaid employee.

Sharon Brown, said that is theoretically possible - under review.

Jim Crouch, said it seems there's blanket prohibition against certified Medicaid providers who aren't doing work reimbursed by AIR from getting the SPMP reimbursement in California.

Sharon Brown, said that for SPMP, you can get the enhanced matching rate of 75%. So far, CMS has not approved anything claimed as SPMP because the activities submitted didn't require SPMP expertise – so they advised removal of the SPMP references in order to get approval was to remove such references for approval.

Jim Crouch, asked what the statutory basis is for the rule that the state may not administer program fees on Tribes or Tribal Organizations.

Sharon Brown, said that is based on a letter by the Medicaid Director from 2005. It is informal guidance from legal counsel saying Tribes must retain 100%.

Aaron Blight, said it's current CMS policy based on the letter – not a statute.

Jim Crouch, said he would like a conference call between his staff and Sharon and Judi.

Sharon's and Judi's contact info is on PPT handout

Sharon Brown, said that once plans are approved, they can be templates for other states.

Mickey Peercy, said that Oklahoma has strong commitment to getting their state's plan approved; it is a priority. They have been working under assumption that the Washington plan will be model, but now will move forward without waiting for it.

Sharon Brown, said it used to make sense to wait for Washington's plan to be approved before moving forward. But now that there are other state plans whose approval is stalled, they want to make sure they're all reviewed timely. CMS has a pretty good track record of turning around state responses quickly.

Judi Wallace, said they are no longer waiting on Washington to complete Oklahoma. They just had call with Oklahoma and gave revisions.

Sharon Brown, said it's possible Oklahoma will be approved first.

Kris Locke, said she understood the need to review and avoid fraud. But it is really disheartening when incoming CMS staff have the same questions and concerns as the previous staff members whom they'd replaced. CMS staff have shown a lack of understanding of Tribal operations. MAM is really good for Tribes, so it is very important that Indians have access to it. There are many small Tribes, and every field that needs to be filled out incurs reporting costs. We know CMS has to comply with rules and regulations, but from a small Tribe perspective, the burden of reporting has been increasing. She commended small Tribes on how well they are doing with this reporting. She asked CMS to keep the small Tribe perspective in mind – it is part of the pushback from Washington. It incurs a huge administrative burden.

Jackie Garner, said if something's sitting in regional office not moving, please call her. She didn't realize there was delay in Oklahoma. Secondly, she said she recognized the timing issue frustration. She commended Sharon's and Judi's courage for coming to speak at the meeting. The timing issue isn't something that should be properly direct at them – that is an issue for Herb Kuhn. He would appreciate hearing and understanding. She thanked Judi and Sharon and said they are doing their best. These problems go beyond their authority.

Carolyn Finster (Director, Pine Hill Health Center; Albuquerque Area Representative), asked if Tribes or Tribal organizations that want to apply to the MAM have to go through the state every time?

Sharon Brown, said that CMS's only authority is to deal with state directly. But if Tribes are joining already existing plan, the state does not need to resubmit that plan for approval – only to alert the region that the Tribe is joining. Tribes can be involved in the discussion and reviewing process, but CMS's direct dealings are with the state.

Carolyn Finster, asked if the first tribe is the guinea pig?

Aaron Blight, said that once a Tribe receives approval of its methodology, that can be the template for other Tribes.

Carolyn Finster, said every Tribe could have different methods.

Sharon Brown, said the particulars can be unique to the Tribes – they only need to come under an umbrella methodology. She said that if your plan gets approved, the home-based portion of it does not, then usually you'll be advised to add language such as "the state agrees to revise [the home-based part of the plan]."

Bill Lance (Oklahoma, Chickasaw Nation), said that Oklahoma appreciates Sharon's and Judi's efforts.

Sharon Brown, said Dennis couldn't be here today, but is looking forward to approving as many plans as possible.

Carol Barbero , asked to what extent MAM covers outreach for SCHIP eligibility. Is it restricted to only Medicaid-enhanced?

Sharon Brown, said that issue is involved in a pending MAM plan. It requires an amendment to the state's CHIP plan. If the state is willing to work with Tribes, yes they can do SCHIP outreach – both SCHIP stand alone programs and Medicaid-enhanced programs.

Roz Begay (Navajo Nation / Division of Health), said that Navajo is entering many IA's, and asked if Arizona has submitted MAM application?

Sharon Brown, said she has not seen one from Arizona, but that they can call CMS to ask.

Valerie Davidson, said we can't call all over CMS. Please provide appropriate contact info.

Mim Dixon, said to Jackie that the process feels very bureaucratic. Is there any initiative to streamline and simplify the process?

Jackie Garner, said that Washington has been a learning experience. Much of the technical requirements are based in law, so CMS can't sidestep them.

Jim Crouch, said he remembers MAM being touted as great new thing for Tribes. That was 8 years ago. He said this is not an example of something that has successfully increased Indian participation in Medicare and Medicaid.

Sharon Brown, said there has been a lot of trial and error in reviewing Washington's plan. They have a fiduciary duty to review these plans. Dennis Smith recognized that there are administrative activities that 638 allows reimbursement for. She said they are not questioning legitimacy of these activities – just need oversight.

Jim Crouch, said that Tribes have been standing on the outside of this program trying to get in year after year. He said he hopes Sharon's leadership will cause increased Tribal participation in MAM.

Valerie Davidson, said this was a good discussion.

Judi Wallace, said to please feel free to contact her, Sharon and Aaron.

Valerie Davidson, underscored Jim C.'s point that some places have been waiting for MAM for years and years. It is especially frustrating that when staffing changes happen in the Administration, that seems to put Tribes back at square one. Tribes are ready to see progress.

Ben Shelly, said that Navajo is working with three states on a plan. If it doesn't work out, they'll have to do some sort of direct funding. The other issue is concern over immigration and an overall increase in population.

Valerie Davidson, said that the conversation we've had with every Administrator of CMS is that if at the end of the day, if eligible AI/AN's don't get enrolled, we have all failed. The key to enrollment is outreach and education – Tribes have no mechanisms to fund those activities except MAM. We need to reach

people in the most remote places in the country. The purpose of this discussion is to ask for CMS's help to reach these people.

Aaron Blight, said he totally agrees and that the Agency's leadership is committed to addressing AI/ANs' needs. He emphasized that there are only two people reviewing the MAM applications and commended their work. He said Medicaid is very complicated. The good news is that the plans will be templates once they are approved. Home-based administrative costs are a new thing. He asked for patience, and said they hope to approve these plans ASAP.

10:15 - Break

10:30 **CMS Regulations: [Analysis and explanation of how CMS responded to tribal comments]**

- **CMS Regulations Process - Michelle Shortt, OSORA**

Michelle Shortt, OSORA:

- She said she was excited to have the chance to meet with the public.
- She has a 30 member staff. They facilitate clearances within HHS and OMB.
- She invited comments on what she can do to help.
- She said the general statutory authority for issuing policy is the Administrative Processing Act and Paperwork Reduction Act.
- The 2nd function of her office is to make sure CMS complies with the Paperwork Reduction Act – specifically with 60 day comment period for Medicare regulations and the 30 day notice for Medicaid regulations.
- The Unified Regulations Agenda (URA) is published twice a year. Her staff examines all policy the components
 - o The October version of the URA gives the regulatory plan. Last year's theme was modernizing Medicare, and this year's theme is expected to be the same.
- Quarterly Provider Update: Each quarter CMS announces its list of regulations items it intends to publish. The list is sent to a listserv you can sign up for each month. They try to send this out the first Friday of the month.
- Michelle handed out a chart showing the internal clearance process:
 1. CMS – clears everything through all its reviewers, including GC, TAG
 2. Office of the Administrator for approval and signature
 3. Office of Secretary
 4. Staff responds to comments received
 5. Forward to OMB – posted on OMB public website. Per Executive Order, OMB has 90 days to approve documents, and often less time per statutory requirement.
 6. Then the regulation is published in Federal Register. It must be displayed at least one day before it can be published.
- Comment period
 - o There are strict rules regarding the public comment period.
 - o 60 days are required for public comment for Medicare rules and 30 days for Medicaid rules
 - o Rules are very clear on how to submit public comments – post office box and electronic submission. But all the agencies are moving toward federal docket management system. CMS will switch over to the federal docket management system on January 1st – Hope this causes no disruption.
 - o All comments are posted on the external website at the close of the comment period.
 - o Comments received untimely are destroyed.

Rick Fenton (CMSO), said that Medicaid is joint Federal-state program. So for a state to participate, it has to voluntarily submit state plan. There is federal law that lists the minimum requirements for participation. The plan has to address all requirements in Title XIX of the Social Security Act. Once a state plan approved, it is eligible to receive federal matching Medicaid funding. He then said that CMS issues notices re: states' availability of funding.

Aaron Blight, said that might happen in SCHIP program. But CMS generally does not redistribute money in Medicaid.

Kitty Marx (National Indian Health Board Legislative Director), asked what sort of process there was for engaging IHS in the development of these regulations.

Rick Fenton, said that IHS can reach out to other agencies. When a regulation is at Secretary clearance stage, that would be an opportunity for other agencies to consult. OMB may also identify other agencies.

Kitty Marx, said there have been regulations that affect Indians that have not gotten IHS clearance. She said that help flagging Indian these would be useful.

Jim Roberts, asked if there is capacity to refer regulations to IHS when it is determined that they will impact IHS?

Rick Fenton, said that Program Coordinators within the Department are good at identifying who should clear.

Michelle Shortt, said that the person who does that for Medicaid is particularly good.

Jim Roberts, asked on average how many regulations are typically in the queue, and if the TAG can engage OSORA.

Priya Helweg, said that the informal process is that the TAG interacts with policy staff and does internal education of CMS staff. TAG gets the list of regulations and tries to monitor it as best they can – but it's a daunting task.

Michelle Shortt, said one thing they can do differently is that TAG could sit in on the meetings they have with OMB in order to get the Quarterly Provider Update cleared for posting on the first day of the quarter. TAG could sit in on that meeting and decide if there are regulations relevant for IHS.

Mim Dixon, asked about how many regulations does OSORA send to IHS and how many do they get comments back on, and does IHS have adequate staff for this?

Michelle Shortt, said she couldn't comment on whether IHS has adequate staff, but that everybody is dealing with budget cuts. They issue 120-170 regulations every year and they always send Medicare, Medicaid and CHIP regulations to IHS.

Mim Dixon, said there was a Medicare Part C regulation that didn't get to IHS.

Aaron Blight, said Tribes are always encouraged to review regulations and comment during public comment period. Don't presume IHS fully represents Tribes.

Sharon Brown, said there is a proposed rule in OS for clearance for which IHS submitted comments for, and CMS responded in writing, so they're included in review of Medicaid regulations.

Myra Munson, asked why is there only a 30 day comment period for Medicaid regulations. Medicaid is very complex – and more difficult than Medicare in some respects.

Michelle Shortt, said the 60 comment period for Medicare regulations is a statutory requirement, and there actually isn't any requirement for a comment period for Medicaid. There could be a policy change.

Carol Barbero, said it seems it would be efficient and productive to involve technicians at IHS at the conceptual stage – rather than putting them in position of having to comment on already developed regulation.

Michelle Shortt, said she can take that comment back, but they rely on the Policy office to decide if other agencies need to give input.

Rick Fenton, said their office used to have ongoing discussions with IHS. He said that IHS sees same statutes, and they're welcome to contact OSORA. They could resume those ongoing discussions.

Michelle Shortt, said that all Medicare and Medicaid regulations are in one section of semi-annual Unified Regulatory Agenda which IHS can review.

- **Medicaid citizenship documentation requirements (CMS-2257-IFC) – Rick Fenton, CMSO**

Rick Fenton, CMSO

- There is a recently published regulation from section 1636 of the Deficit Reduction Act which requires all citizens who declared citizenship to include documentation of citizenship and in some cases documentation of identification. It was passed Feb 2006, with July 1, 2006 effective date. That timeframe left little time to expand permissible documents.
- There is an exemption for people on Medicare and SSI
- The State Medicaid Director letter of June 9, 2006 listed the four tiers of documents.
- July 13, 2006: Interim final regulation – Over the first year, states are required to review documentation of new applicants to Medicaid and renewals – so every person who was currently on Medicaid and every new applicant had to be reviewed.
- The final regulation expanded the acceptable documents list. CMS received over 1400 public comments. In preamble of the regulation, it goes through a detailed analysis of how CMS addressed the comments. In December 2006, Congress revised the regulation to say that anyone who was on SSI or Medicare or in foster care is exempt.
- Some changes were made after comment period.
- The tier process mirrors Social Security Administration. Documents range from passport to affidavit signed by two people.
- A change made was that it clarified the identity requirements to make it easier for children to document their identity.
- The final regulation became effective July 13, 2007.

Tribal Documents

- They were able to allow inclusion on the roll of Alaska Natives to show citizenship, but this is the only type of Tribal documentation they could add for that purpose.
- Rick said he understands there are still concerns in Indian Country.
- He believes everybody should be able to meet these guidelines.

Jim Lamb (Alaska Native Medical Center), shared some of the effects this regulation is having on Alaska Natives. There has been a striking decrease in eligibility for Medicaid enrollment. It decreased by 9.8% since Sept 30, 2006 to May 31, 2007. That is 5700 fewer ANs enrolled in Medicaid. Among the nonnative population Medicaid enrolment decreased by 11%. A cause identified by the state and health department is the citizenship requirement. He has heard anecdotally of a 4 month delay in processing applications because of the citizenship requirement – in contradiction to the officially reported delay of only 30 days. The regulation has seriously impacted cash flow and he fears it will effect delivery of health care.

Rick Fenton, said he has seen reports of decreased enrolment. He said that any sorts of requirements would have a negative effect on enrollment. This rule has been in effect for relatively short period of time - so he hopes it'll improve with time. Every person potentially eligible for Medicaid has been affected. People shouldn't be negatively affected during first year because enrollees are given the opportunity to get documents in order to renew. He said the state should assist with this. Once the documents are in your eligibility file, you shouldn't have to submit them again. States should keep them for as long as their own rules provide for keeping

documents. CMS is currently gathering data to evaluate root causes of the drops in enrolment. He said he will go to the sites provide tech assistance.

Jim Lamb, asked if there is a way to identify which segment of the population views the documentation requirements as insurmountable. He said that many will walk away from the process altogether because of it.

Rick Fenton, said that it would be good to identify those people when doing their analysis.

Valerie Davidson, said a concern of the states informally is that they're not interested in going down to the fourth tier because they're afraid of getting rebuked by CMS for accepting those documents.

Rick Fenton, said that per the regulation's preamble, they prefer 1st tier, but won't turn someone away whose documents from 4th tier fulfill requirements. He said they're not trying to make it a documentation burden.

Jackie Garner, said if there's a need to engage certain states on this topic, let them know which states have issues. She said there are other unrelated audit problems too.

Rick Fenton, said that wanted to convey that eligibility workers in the states know how the regulation is supposed to work.

Jim Crouch, said that per p.38696 of the Federal Register notice of the regulation, Tribal enrolment and blood documentation provide documentation of identity, not citizenship. At Portland, they passed a resolution saying documentation of Tribal association should be sufficient for citizenship. This regulation is cause a lot of anger in Indian communities. He then asked, besides going to Congress, is there some other avenue to make these documents sufficient for showing citizenship?

Rick Fenton, said he had received those comments. Those documents referred to show Tribal lineage, not US citizenship. People from other countries can have Tribal lineage. He said he conveyed concerns to the office.

Mim Dixon, asked if there is any data on what percentage Medicaid applicants have used affidavits?

Rick Fenton, said no.

Mim Dixon, asked if there is some kind of national standardized form people can use for getting affidavits, or does it vary by state?

Rick Fenton, said there is no national form. Each state can come up with one.

Mim Dixon, asked if we could we get national guidance that says that it won't be an audit issue if, for example, up to 20% of Medicaid applications come in the form of affidavits, and if it's a state where there has been a very large drop in enrollment, it won't be an audit issue if up to 50% are in affidavit form.

Rick Fenton, said there probably won't be a declaration of an acceptable number of affidavit applications. It's still new regulation. If it's found a state is not following the rule, CMS will withhold money.

Mim Dixon, asked why not reassure the states that they'll not be penalized for accepting affidavits.

Rick Fenton, said the language of regulation says that affidavits will be accepted "in the rarest of circumstances."

Valerie Davidson, said she can see how states would be nervous about accepting affidavit applications. As CMS staff here today has said, CMS is going to be monitoring, seeing how the states are implementing the requirements – that could make them nervous. CMS should clear up the misconception about affidavits because it is disproportionately affecting Tribes.

Mickey Percy, said regarding the fact that a certificate of degree of Indian blood and a Tribal enrolment card aren't sufficient to show citizenship, but an affidavit signed by two random people is - something inherently wrong with that.

Rick Fenton, said you can't just go to a local bar to get two signers for your affidavit. There are a number of rules surrounding the affidavit requirement, including the penalty of perjury.

Mickey Percy, said that but if there's intent to deceive, a person could and get away with it. He reiterated that there is something inherently wrong with that.

Kris Locke, said she remembered CMS reassuring Indians that they could fall back on affidavits. She told Rick that when he says he is not willing to give states guidance, she knows he means the Agency behind him is not willing. But such guidance would help prevent people from falling off the Medicaid rolls.

Rick Fenton, said he has yet to see a case where person was trying to get documents together, couldn't, and the state subsequently took him or her off the rolls. He said if there are such cases, we should tell CMS about them.

Jackie Garner, said Alaska is not reporting the decline Jim L. spoke about. She said we should get that data to CMS.

Myra Munson, said that the frustration we're trying to express – which is not getting through - is that it's enormously difficult to get AI/ANs to apply for a benefit that they think they're supposed to automatically get for free as part of Federal responsibility – but have learned isn't being provided. They've been filling out paperwork and turned away and aren't going to jump at the chance to do more paperwork and just get turned away again. This regulation is a whole new barrier to service for America's first citizens. The burden should be on the Federal Government to prove that an AI/AN was *not* born in the United States. An AI/AN does not have to be all that elder to have been born at home and not have a birth certificate. CMS not being aware of people being turned away and dropped from Medicaid rolls is not significant – it has no bearing on the fact is that it is happening.

Rick Fenton, said they are just implementing the law.

Jim Lamb, said it seems like a stated goal of regulation is to limit enrolment of non-US citizens in Medicaid. He asked Rick if he knows how many non-US citizens were enrolled.

Rick Fenton, said no, and he is going to look at it.

Jim Lamb, said that is good, because then he can compare the administrative costs of doing that with the money saved by not providing Medicaid to them.

Robert Moore, said that if a Tribal member is not a citizen of the U.S., that does not abrogate the United States' federal responsibility to him or her. Doing so violates the law.

Roz Begay, asked if these tiers determine citizenship in all cases.

Rick Fenton, responded that this is in addition to the interim rule.

Roz Begay, said that in Navajo there was interim way to determine citizenship that accepted certificate of Indian blood.

Rick Fenton, said that is acceptable to the extent it conforms with the rule.

Jim Crouch, said we need legislative vehicle to correct this rule.

Valerie Davidson, said to Rick she was sure the Tribal position clear. She hopes we can count on CMS not to oppose legislation that corrects this rule in front of Congress.

11:15 Medicare like rate regulations– implementation and training activities

Valerie Davidson, congratulated CMS on finally publishing the MLR regulation. She said now it's time to figure out how to implement it.

- Brenda Jeanotte-Smith, IHS
- Joseph Bryson, Provider Billing Group, CMS
- Sarah Shirley-Losso, IP Hospital Team Lead, Provider Billing Group, CMS

Carl Harper, IHS:

- There was a June 5 press release on the regulation. The regulation was presented at the Direct Service Tribes meeting and a training is planned for the NIHB Annual Consumer Conference.
- There was a 2-day training in Phoenix with 300 attendees, about 50% of whom were Tribal. CMS went over the pricier software. Carl said he feels good about meeting and received positive feedback.
- CMS is working on webpage answering FAQ's, and lists the rates. That should be up any day; it has been submitted to IT
- September 12 is a planned CMS broadcast.
- CMS wants to continue making this a priority and move forward. Carl asked the group for suggestions.
- CMS provided \$200K to Areas to be obligated right away for training. There will be an MLR training in Aberdeen.
- It is important that focus be on alternate resources because they have big impact on CHS – alternate resources cover \$3-4 for each \$1 spent.
- CHS programs are hurting for resources, so they need to be maximized.
- Need to focus on purchasing care for the best possible price.
- Carl sees IHS as the leader in ensuring that Tribal and Fed facilities meet Indians' needs.
- Carl asked group what else does IHS needs to do. – Another national training session? Etc.

Sarah Shirley-Losso

- The training PPT will be posted on the web site. It includes instructions on how to download the pricier software.
- At the training, some attendees brought claims and processed them there. They were pleased with the savings.

Gerald Moses (IHS, ORAP)

- The web page will provide a general overview of steps for processing a claim.
- It's not as difficult as some think – except if Tribes want to do it manually; that's complicated.

Valerie Davidson, said the TTAG had sent a letter to Dr. McClellan about MLR concerns. She asked if IHS had responses to those concerns.

Rodger Goodacre, said he would forward that letter to IHS.

Carlyle (American Indian Health Management Program), asked how CMS is ensuring hospitals comply with the new regulation, and what effect this will have on access to CAHs.

Sarah Shirley-Losso, said that Medlearns are being sent to hospitals. They explain that the provider is required to charge the Medicare rate.

Jim Crouch, asked if she could forward those to TTAG members.

Gerald, said a template letter was sent out that can be distributed to providers.

Valerie Davidson, said she was glad for the letters because we don't necessarily have negotiating power to get lower rates – so CMS's influence is helpful and appreciated.

Dee Sabattus (Nashville, LISET, Inc.), said that smaller Tribes need training on the pricier, as well as how to examine claims. She asked how they could get that training.

Sarah Shirley-Losso, said she was not aware of any training on how to examine claims. The pricier training goes over all the fields and how to fill them out.

Kris Locke, said Washington state has met with Washington State Hospital Assn and they said this is the law and they'll comply. For Tribes that use a fiscal intermediary, they send it in and it's done, but some don't have the volume to use a FI and some want to use their own software. The CMS software only processes inpatient services – which are pretty simple. The outpatient processing is more complex. Tribes will benefit from training on claims processing. Is there any planned training on how to process outpatient claims?

Sarah Shirley-Losso, said not specifically, but she can look into it being part of the trainings, and that they will be at CMS day at the ACC.

Jim Roberts, said that Tribal health directors had asked to negotiate lower software rate. The vendor said he'd gotten a number of calls with basic questions on how to use it, so he was reluctant to extend a discount because he was afraid of a barrage of questions. The training should include something to address claims processing.

Carl Harper, said he didn't know specifically if the process for Tribes to buy back into the FI service was addressed by the trainings. But Tribes can buy back in and there will be a cost.

Jim Roberts, asked if the FI will set a price?

Carl Harper, said he can look at it.

Kris Locke, said that Brenda said that what was bundled together was processing and payment.

Valerie Davidson, said but Jim R. asked if Tribes can get those services unbundled.

Carl Harper, said he would have to look at it.

Gerald, said we need to contact Rhonda Nichols on that.

Valerie Davidson, said that if there are enough Tribes interested, it may not be the best use of time to have everybody call Rhonda. If this person values contract with IHS, they might consider allowing the services to be unbundled.

Carl Harper, said he would have to look into it because processing and payment require different processing.

Sarah Shirley-Losso, said that normally claims processing and pricing are bundled together

Carol Barbero, said regarding Tribes' ability to piggyback on the IHS FI contract, how does the FI decide the price – so that Tribes are able to determine if they want to piggyback on the contract or not.

Carl Harper, said that they provide an array of services, but he wasn't sure how they decide the price.

Carol Barbero, said if Carl could ask the FI what is the array of services and price structure, that would help Tribes decide. And she asked to clarify that it says in the contract that Tribes can piggyback, so that should not be an issue.

Carl Harper, said yes, Tribes can piggyback and the FI is flexible. If more Tribes join, the price would probably go up.

Carol Barbero, asked if there is a provider that doesn't comply with the regulation and sends bills to the CHS, what does CMS do?

Sarah Shirley-Losso, said that the hospital can bill whatever they like, but they'll only get paid the MLR.

Carol Babero, said someone has to police that.

Mickey Peercy, said what Carol was saying is what happens if the MLR gets paid and the hospital still sends bills to the CHS? We are looking for some teeth/enforcement for this regulation. CMS would have authority to withdraw Medicare privileges. He asked if it would be the regional office to do that.

Sarah Shirley-Losso, said the process would start at the H H S regional office.

Gerald, said that the regional office should be able to take care of that.

Valerie Davidson, said they could either put the burden on overburdened CHS's who don't have the expertise, or shift the burden to the private hospitals and not allow them to send bills that are higher than the MLR.

Sarah Shirley-Losso, said it's like Medicare – the hospitals bill a lot more than CMS pays. They're not allowed to bill the CHS more.

Jim Crouch, said that they will regardless – that's the nature of the free market.

Myra Munson, said she wants info on pricing to be available ASAP because Tribes could lose their chance to participate in the FI contract. The total contract price of FI might go up – but the per claim price shouldn't. It's true hospitals can bill anything they want, but the regulation says they may not accept any more than the MLR. She suggested attaching the Medicare pricing sheet to the claim so that it'll process more quickly – she asked for thoughts on that kind of system. Tribes might be able to work with hospitals collaboratively. She asked if CMS could talk to the FI about whether they're willing to offer other services because some periodic auditing of claims would be a good idea to ensure Tribes are not overpaying – some Tribes would like to buy that service.

Carl Harper, said his understanding is that the FI does offer that service.

Myra Munson, said but it's only offered to their customers. She suggested the FI sell the auditing service.

Jim Roberts, said the money Portland is receiving for outreach and education is not sufficient to really do any outreach and education. So he asked if they could use that money for an MLR training.

Carl Harper, said from his perspective, yes.

Rodger Goodacre, said that it wasn't the initial thinking that that funding be allocated for that purpose. He didn't think it could be used for that. The MLR training could be part of the agenda, but the funding was planned for a different sort of training.

Jim Roberts, offered a motion to make the O/E money available for MLR training.
The motion was seconded.

Discussion on the motion:

Carol Barbero, said it's a good idea, but they could coordinate with what the FI has to offer. Since CMS does have good pricier software for inpatient services, what Tribes need is pricing software for outpatient services. She asked that we coordinate that with Jim R.'s proposal. She's suggesting doing something with the Tribal Self-Governance committee. She asked to find out what the cost would be and for the auditing services.

Priya Helweg, said the goal of the national trainings is to provide general information on Medicare and Medicaid and SCHIP. If an Area decides MLR is the only topic of training they would miss the larger training opportunity.

Rodger Goodacre, said as clarification – if we want CMS to definitely include MLR training in a 2-day training that's fine. CMS wants to be on record saying it needs to do more than that if it can. CMS can emphasize it. The general purpose of O/E remains guiding principle of what we should do.

Carl Harper, said if it's going to be 2 days, the pricier doesn't take that long.

Kitty Marx, said Sept 27 is CMS day at the ACC, and there'll be time to devote to this.

Myra Munson, said a two day MLR training is a small investment by CMS compared to the two years we waited for the regulation. It could take two days for people to get a feel for it and explore FI options. There is a lot of work. She said she hears from Tribes that they don't want any more overview trainings – they want the nuts and bolts. Every day that passes they're either not paying CHS claims or they're paying too much.

Kathy Hughes (Vice Chairwoman, Sovereign Nation of Oneida; Bemidji Area Representative), said that sometimes priorities have to be reconsidered – and now that the regulation is final, the MLRs are a new priority.

Elizabeth Neptune (IHS Nashville Area Office), said the CHS staff aren't used to looking at claims at the level of the CMS staff – they have a different perspective. Trainings have to be backed up at a more basic level, for example CHS are not used to looking at DRGs – especially smaller Tribes.

Valerie Davidson, asked for objections to the motion.

There were no objections.

The motion carried.

All Inclusive Rates:

Valerie Davidson, asked what's going on with AIR.

Carl Harper, said that is a function of his office. They contract out for cost reports to come up with the costs

Valerie Davidson, said the AIR is published and approved by OMB. What do we have to do to get it to the FI?

Carl Harper, said it should apply retroactively back to Jan 1.

Valerie Davidson, said retro's good, but having it on the front end is better. Tribes don't have the money to front those expenses

Carl Harper, said CMS is working to expedite OMB approval.

Myra Munson, said the question is when will notice go to Trail Blazers, the Tribal Medicare FI. When will they be given the work order?

Robert Moore, said it is critical to get the money up front because Tribes can get penalized and be labeled “high risk” otherwise.

12:00 Lunch

1:30 Medicare Part C: Overview

- **Jerry Mulcahy & Marty Ablen, CBC**

Valerie Davidson, thanked Marty for his patience.

Marty Ablen, CBC

- He said it's an honor to speak in this wonderful place – the National Museum of the American Indian.
- He asked for a general sense of how familiar people were with Part C/Medicare Advantage. – Almost no one said they were *very* familiar

Presented and handed out presentation entitled, PT “Overview of Medicare Advantage”

- Private insurers like Humana run the program, but CMS administers it.
- Coordinated Care Plans: Tend to have PCP, focused on managing health = HMOs Local and Regional PPOs and Special Needs Plans
- All guarantee access to Medicare A and B; some above and beyond and some part D.
 - o Medicare advantage may enable beneficiaries to find additional benefits that are meaningful to them
- Beneficiaries join plan in January and are restricted to it until November = lock in
 - o Exceptions: dual eligibles can switch month to month. There are some other exceptions
- HMOs: Paid capitation payment from CMS which they use to put together provider network they negotiate payments with. CMS is not involved with that negotiation.
- PPOs: Some areas have too many plan choices – and plans administer A, B and D differently. This can be a big challenge to finding best plan. CMS is working on tools to assist beneficiaries with identifying the best plan. PPOs have a preferred network.
- SNP: Required to offer part D. Have the ability to enroll subsets of Medicare beneficiaries (others can't exclude any Medicare beneficiaries, but SNPs don't have that same restriction.)
- Private-fee-for-service plans: don't have to have a network. A beneficiary can show his or her enrollment card to any provider, and they have option to provide services or not. The problem is aggressive sales people have given impression that it is like original Medicare, which it is not because the treatment isn't guaranteed. These can be a good deal, but you have to be wary
- Medical Savings Accounts: high deductible; generally no network.
- Difference between MA and original Medicare – in coordinated care plans, beneficiary pays the price negotiated by provider. Plus Part D is included in a lot of the plans.
- Needs to check on MA-PD rule
- Medigap has nothing to do with MA – Medigap insurance is to cover the Medicare gap. It is illegal to sell Medigap to MA beneficiary because he/she can't use it.
- Note: There has been rapid growth in PFFS enrolment among MA beneficiaries
- Overall there has been really high satisfaction with MA based on CMS survey
- PFFSs are exempt from quality reporting requirements, but encouraged to do it any way.
- A beneficiary can appeal a refusal of service to external entity. There is an expedited appeal process
- He said not to hesitate to call or email him with questions.

Teresa Jackson (Oklahoma / Choctaw Nation), said that numerous salespeople were going door to door in her community. She asked if there is any way they can get out of plans they've bought?

Marty Ablen, said if you were deceived, the regional office has authority to retro you out of the plan back to original Medicare. CMS is aware there have been abuses. The lock-in is relatively new – it used to be you could change from month to month – not any more.

Teresa Jackson, asked if Tribes are going to have to contact PPOs to get their facilities in the network.

Marty Ablen, responded that he believes IHS facilities can be included in the networks. But service areas are normally constructed out of counties. There's no mechanism to exclude non-tribal members from the plan. If you can establish that the Tribe is an employer of most of the Tribal members, you could establish an exclusive plan. That option hasn't been ruled out or in.

Carlyle Begay (American Indian Health Management and Policy), said that as far as we know there is only one IHS provider that's joined a PPO – in Arizona.

Jim Roberts, asked if there is a way to systemize dealing with predatory practices.

Valerie Davidson, said there's a predatory practice of enrolling beneficiaries in a different plan and telling the person it's a new Medicare card.

Jackie Garner, said the process is to contact the case workers in the regional offices. She said CMS needs to get something to the Tribes that explains the systematic process.

Valerie Davidson, asked what is the timeline for remedying this.

Marty Ablen, said he's not sure. The regional offices do it. He can check to find out if it's standardized. He said he'll coordinate with Jackie.

Carol Barbero, had some questions from Mim: A number of features are similar to Part D. Part D requires sponsors to offer network membership to Tribal pharmacies. Is there anything in Part C that requires letting Tribal facilities into network or are they required to use any special contract terms?

Marty Ablen, said no.

Cinda Hughes (National Congress of American Indians), said many Special Needs Plans are warehouses where not a lot is done to deal with chronic health problems or secondary problems. What kind of CMS oversight will there be to ensure quality of care?

Kathy Barchi, said those facilities should be using disease management strategies and dealing with co-morbidities. CMS has added things to the audit guide to include certain SNP characteristics. CMS submitted a report to Congress on this on December 31. The data on this so far is mostly anecdotal.

Roz Begay, asked if these plans go through the state for a state plan amendment.

Marty Ablen, said they have to be state licensed. Regulating sales agents is state role. He said he's not sure news reports about it are always balanced.

Carolyn Finster, asked how has CMS thought this through for Indian Medicare beneficiaries who move to different states in different regions temporarily.

Marty Ablen, said they have to cover for emergent and urgent care out of service. If you travel a lot, you really have to look at array of options. CMS website has tools to find the right plan.

Elmer Brewster (IHS, ORAP), asked if MA plans can reduce the Part B premium.

Marty Ablen, said if plans bid below CMS benchmark, they have savings of which 25% goes back to government

Carlyle Begay, said these plans have lots of flexibility by design and this is opportunity for IHS to take advantage of.

Marty Ablen, said Tribes could look into the Employer Policy Group option. It has flexibility and waives certain requirements.

Valerie Davidson, thanked Marty and said she looks forward to meeting with him again.

Implementing Provisions of DRA pertaining to prescription drugs (CMS-2238-P) – Robert Pittman, IHS Pharmacy Consultant

Robert Pittman:

- Announced that he is moving on to another position and will no longer be the I H S Pharmacy Consultant.
- Deficit Reduction Act
- There is a bill in the House affecting rural and small pharmacies' reimbursements
 - States will change rates to reflect CMS rate
 - Don't expect states to increase dispensing fees to offset
 - There are no plans to raise dispensing fees. Don't have resources to negotiate second rate
 - Expect a drop in reimbursement – don't know how much yet.

Carolyn Finster, asked if is IHS planning to reprogram the RPMS.

Robert Pittman, said they are looking at how they can get organizations that have standard rates to change to the new rates.

Kris Locke, asked if regulations allow I/T/Us to pay states differently from other facilities.

Robert Pittman, said that in order for I/T/Us to pay states differently, they would have to be a special population, and he has not seen anything to that effect.

Kris Locke, asked if there was any wiggle room.

Robert Pittman, said he can go back and look at it. He's tried to sell it to states before – states have said they can't do that because if they give I/T/Us the special price, they have to give everybody the special price.

Myra Munson, said that states can identify provider types, so it is technically possible for states to do that since it's a cap not a specific rate. But whatever they do puts more pressure on other providers

Mim Dixon, asked what is the estimated impact of the regulation on pharmacy reimbursements?

Robert Pittman, said they won't know for sure until states apply their rates, but the current estimate is 3-5%. but don't know until states apply rates. He said that as long as they're within their cap, they can negotiate. We may see dispensing fees go up but not to where our costs would be.

Kris Locke, asked if each state has to file amendment.

Jim Lamb, asked when was the effective date.

Kitty Marx, said October 1.

Jim Lamb, said some pharmacy organizations were estimating 36% loss.

Robert Pittman, said that a lot of those estimates relate to mom and pop pharmacies. The large chains like Wal-Mart get discounts on prescription drugs. Their point is it's pricing small pharmacies out of business. There's a need for some other pricing mechanism if we're going to keep the smaller pharmacies afloat. That estimate is correct for them.

Valerie Davidson, thanked Robert.

Robert Pittman, said he will let the group know as soon as he has a replacement. In the meantime, keep emailing him with questions, etc. and he can forward to the appropriate person.

2:15 CMS Outreach & Education Efforts

- **O&E subcommittee activities – Kathy Hughes & Rodger Goodacre**

Kathy Hughes:

- The subcommittee aims to have a revised O and E plan by January.
- Per Jim R.'s earlier motion, the subcommittee will have to go back and discuss trainings
They are doing an inventory of communication tools
- There's a \$200K budget for all the Areas with \$30K for Aberdeen training
- Kathy said she thinks O&E should be dealing with, for example, Part C. She said it seems that activities are already in the works by the time they get to O&E.

- Rodger Goodacre:

- He said that was a good summary.
- He handed out packet that lists major activities
- The subcommittee is doing outreach on three things directly from the strategic plan
- These include finding communication channels
- The packet has the initial agenda for 2 day Aberdeen training at end of Aug
- The Part D training is a model
- Regarding questions about the Aberdeen training: It was prepared in response to Dorothy's visit to the Aberdeen area in December. Her meetings with IHS and Tribal leaders identified a lot of issues

Robert Moore, said that conversation from that visit was how the state and Tribes can get along with each other. Often they don't. They talked about how CMS can foster that conversation. It was a model conversation for FEMA – which really improved emergency management response.

Rodger Goodacre, said networking and establishing congeniality is part of what CMS does. They had envisioned similar general trainings, based on the strategic plan. CMS divided up the money with the same methodology they did for the Part D trainings.

Jim Roberts, said he thought funds were just divided up by 12 last time. He suggested that for future allocation, look at the number of facilities.

Valerie Davidson, said we need to ensure fair distribution. She asked if CMS will choose a different IHS area for national training every year? She recognized level of need in Aberdeen, but TTAG would've appreciated being part of that decision process.

Priya Helweg, said two things creating a perfect storm that resulted in this large training being planned for Aberdeen: The trainings in Aberdeen took on life of their own. That brought about the idea for having a specialized training every year. Coming from the other direction is the national training effort. It looks like each Area training will have to be a specialized training because the needs are so varied. So it may be moot to ask which Area will host next one.

Valerie Davidson, said her point is that those decisions need to be shared with the TTAG. The group needs to know what are the criteria for distribution of those funds. It can't be that Dorothy's visit to Aberdeen was the only reason the national training was planned there. The point of the TTAG is to advise CMS – which is harder when it learns about these activities at the back end.

Robert Moore, said not totally true that Dorothy's visit was the reason for the training. Her visit compelled the training, but it's been part of a public discussion.

Valerie Davidson, said she was not saying that it isn't necessary. The point is if CMS feels it needs to do a special training to bring everyone up to a minimum level, that shouldn't come out of the TTAG budget.

Mickey Peercy, said this is like when CMS went to NAMS for the minutes contract. The point is, don't just come to TTAG on things you want; come to TTAG on everything.

Priya Helweg, said she wants to be clear that that is understood. She reiterated that the national trainings are in the extremely early stages, and they're a direct request from the strategic plan. The interagency agreement is in place - that's all.

Kris Locke, said the point is we want to learn from experiences and improve and transparency. The Issue is with the \$170K allocated to areas for training is that the distribution doesn't seem fair. She asked if CMS or IHS decided.

Carl Harper, said that IHS decided. He said he understood Kris's point and agreed that IHS should look into a more fair way to distribute the funds. He said IHS values what this group says, as does CMS.

Valerie Davidson, said that that is something they can focus on in the future.

Jim Crouch, asked about the draft curriculum.

Priya Helweg, emphasized that it is very, very preliminary.

Jim Crouch, said that all the programs on the agenda are really complex, and the level of understanding a person needs of them depends on what his or her job is. He proposed revising the agenda so that program time is based on the amount of impacted - which would mean Medicaid got the most time, then SCHIP then Medicare.

- **CMS Day at NIHB – Kitty Marx**

Kitty:

- The next teleconference on CMS day at the NIHB Annual Consumer Conference will be next Friday, August 10 at 11am.

Valerie said to look for email on that. And contact Kitty with any questions.

Enrollment video – Kitty

- The video will be 7-10 minutes long, encouraging AI/ANs to enroll in Medicare and Medicaid. It is to be played in hospital waiting rooms
- The film makers visited Alaska and will visit Rosebud.

Priya Helweg, said that the film is not encouraging AI/ANs to enroll, but to *inquire* about enrolling.

- **Medicine Dish – Satellite: Captain Sandra Farley, CMS**

Sandy Farley

- Broadcasts via the satellite dishes will kick off September 12.
- The first topic of the broadcasts will be the MLRs.
- The broadcasts will be live and interactive.
- It will be possible for viewers to ask questions and make comments without their voices being broadcast if they choose.
- Topics planned for the next 4 months are Part B, Medicare 101, Medicaid 101.
- A schedule of programs will be posted on NIHB, NCIA and IHS websites.
- CMS is not sure which facilities have dishes that will receive the broadcasts. They are currently inquiring to find out which facilities still have dishes and hope to have a detailed list.

Carolyn Finster, asked what kind of hardware is needed to use the dishes.

Sandy Farley, said the dishes were delivered 2-3 years ago.

Carolyn Finster, asked what if a facility does not have dish.

Rodger Goodacre, asked if they had DirectTV.

Sandy Farley, said that for facilities that do not have access, CMS will record the broadcast and make them available on DVDs. They are hoping that by October, the broadcasts will be available for download off the web.

Myra Munson, asked if they will be developing streaming webcast? Dish technology is outdated.

Sandy Farley, said she agrees. They have learned that most facilities have internet access. They are working with what is available right now. Even if you have DirectTV, you need a particular chip in order to get this channel. It's really simple; the dish people can install it for you.

Jim Roberts, said this technology is really old. There is the \$250K line item that goes along with the dish. He asked is there a better use for this money? People with hardware in Portland say there haven't been any trainings there to date. He would like to talk about pulling the plug on this and redirect that funding.

Sandy Farley, said this is a kickoff - there have been no previous trainings yet.

Rodger Goodacre, said the funds were for installation and one or two test broadcasts. Then there was coding training, and then there was no more funding. He said Jim's was a very legitimate question.

Jim Roberts, said they don't want to lose FMIB # of the line item that funds the dish, but we should put the money into something else.

Sandy Farley, said they've have this conversation too, but the dish is what they have right now. They are looking into developing medicinedish.com where streaming would be available. They are about to sign the contract for the broadcasts.

Valerie Davidson, said it sounds like the website needs to happen last week. Alaska has not used dish. There needs to be a discussion about what is the best use of resources. Maybe we should use half of that funding for training for web based training.

Myra Munson, reiterated that the contract wasn't signed yet. She said if the contract is with a dish provider, it better be really short. Nobody wants to get locked into long dish contract.

Rodger Goodacre, said the contract will be over by this time next year.

Valerie Davidson, asked how much money do we put into a dog team when everybody else is driving cars? This discussion seems backwards – would rather cut our losses than try to make old investments pay off.

Jim Roberts, said the new FY takes effect August 1. TTAG needs to make recommendation on use of dish money. Jim made a motion for CMS to hold on the contract with satellite provider.
Discussion on the motion:

Sandy Farley, said they're 07 funds so they have to be spent by September.

Rodger Goodacre, said they were pretty much up against a wall for the 07 money.

Valerie Davidson, asked if we can use the \$100K for the MLR training? We could do it before October 1.

Sandy Farley, said CMS would not realistically be able to redirect those funds into something else before the end of September.

Mickey Peercy, asked if Herb could make that happen.

Jackie Garner, said Herb can influence the budget. It just has to be spent by October. There's no carryover.

Sandy Farley, said this discussion is moot. What we can do and are doing is getting ready for webcasting.

Jim Crouch, said what is important is the content development. The method of broadcast can change over time, but we can reuse the content. Jim recommended that CMS go ahead for now.

Valerie Davidson, asked if the money used for content or broadcast.

Sandy Farley, said the money is used for the broadcast; the content is taken care of.

Myra Munson, asked if they would need additional funds to do the webcast.

Sandy Farley, said CMS experts are developing the content. They are working with Rick Todd to develop other funds.

Myra Munson, said that in any event, will there be DVDs of all trainings available?

Rodger Goodacre, said it's CMS's intention that there will be DVDs of all of the trainings.

Jim Roberts, said it's a waste of resources to sign this contract.

Rodger Goodacre, said we have to make sure it's utilized as good as it can be.

Jim Roberts, would rather reprogram to part 2 of the data study.

Sandy Farley, won't know if there's time to do that.

Valerie Davidson, heard it's possible CMS to do IA with IHS that expends the money and buys time.

Rodger Goodacre, said that's sort of true – that would mean IHS had to obligate by end of year.

Carl Harper, said he didn't know if CMS could reobligate any of this year's funds, so that is off the table.

Priya Helweg, said the content for the broadcasts is being developed in house in the CMS studio.

Kitty Marx, said CMS currently transfers funds to IHS who sends it to NIHB. She asked if we could modify that cooperative agreement so the money went to NIHB.

Carl Harper, said he could follow up on that.

Jim Crouch, said he has a signed contract with a biostatistician and work that's in progress that needs more funding. Jim R. confirmed that there is \$100K per year for bandwidth time.

Valerie Davidson, said it is unclear whether the dishes that have been hooked up are installed adequately, or whether there is a curriculum.

Sandy Farley, said the content is not an issue. CMS hopes to broadcast to 150 subscribers.

Robert Moore, said if we don't proceed, OMB will say they won't give us this money any more.

Jim Roberts, said he would like to preserve the ability to redirect the funds.

Elmer Brewster, asked if the contracting company does webcasts.

Sandy Farley, said they did not.

Jim Roberts, said as chair of the budget committee, he would like to make the recommendation that this money be redirected to support ongoing data research by Jim C. and CRIHB.
The motion was seconded.

Kris Locke, said she agreed in principle, but asked if it was possible.

Sandy Farley, said that if the money cannot be redirected, CMS will go forward with the dish project. It is difficult to move funds at this point.

Valerie Davidson, said we can do a one line amendment increasing the dollar amount in an existing contract with, for example, NIHB.

Mickey Percy, made a motion that if that's the case, CMS will make a decision.

Robert Moore, objected to the motion.
The motion carried with one nay from Robert Moore.

- **Other training needs & resources/funding**

3:45 Special Needs Plans - Donald Warne and Cathy Barchi, CMS

Cathy Barchi:

- In order to offer Special Needs Plans, an organization must also offer part D
- There's a need for a model of care that meets SNP plan for 2008
- For example the everycare model – which is institutional – is defined as someone in a longterm care facility for 90 days or more. Or there can be beneficiaries who meet nursing home criteria for their home state who are cared for at home or by the community.

Jackie said most beneficiaries are dually eligible. So they try to stay involved in the Medicaid loop

Don Warne:

- Handed out and presented PPT on Medicare Advantage (MA) plans
- Chronic care SNPs: Primarily for heart disease and diabetes. The goal is to keep people out of hospital
- MA coordinates Parts A B and D into one package → care coordination; disease management; case management
- No SNPs include Tribal, IHS or urban Indian health center → excluding Tribal elders
- Because of dual eligibility plans, can cover the cost sharing component
- The plans are consistent w Dr. Grim's disease management initiative
- For example, an I/T/U facility could use the fact that costs aren't being met under the rate negotiated by CMS and IHS as basis for negotiation

Cinda Hughes, asked if the plans can include DME?

Don Warne, said, yes, you can include DME in services contract.

Cinda Hughes, said there is the new DME rule, and asked medical equipment and sales is included, because this is very problematic for the purchase of oxygen tanks.

Don Warne, said they haven't looked at the details of what'll happen after 36 mos. He will look into it.

Elmer Brewster, asked if a beneficiary has to have Part B to participate.

Carlyle Begay, said this plan helps manage cost shares and deductibles. They'd get more from this plan than original Medicare. It covers all counties in AZ. It's an opportunity for a health plan that is built around the IHS model.

Cathy Barchi, said please feel free to send her any questions. Her email is cathy.barchi.cms.hhs.gov. She said she has not yet examined the legality of these plans.

Valerie Davidson, asked if the facility that joined was an I/T/U.

Don Warne, said it's for 2009.

Carlyle Begay, said the open access aspect is to provide choice. Contracting with an I/T/U and info sharing allows better care coordination.

Cathy Barchi, said that for treatment to be guaranteed, the facility has to be part of the provider network. Outside the network, there is no requirement for provider to see the MA beneficiary.

Valerie Davidson, asked if a tribal member goes to IHS facility that's not part of SNP – what happens.

Carlyle Begay, said they would bill it just like they would original Medicare.

Carol Barbero, said she didn't understand just what this organization – AIHMP – is.

Don Warne, said they're a consulting group that works with Tribes, the federal government and states to improve health facility management. It is contract work. They were hired by the government.

Myra Munson, asked what's their relationship to CMS?

Don Warne, said they work with CMS to put together trainings.

Valerie Davidson, said this was a question from the last meeting. There was a vendor here Don was presenting with - Excelhealth.

Don Warne, said they're working with Excelhealth to develop networks in AZ. The trainings are a separate project.

Cathy Barchi, said Excelhealth is private but they have insurers that provide SNPs.

Don Warne, said for this particular presentation, they're giving the SNP update in Arizona with Excelhealth.

Cathy Barchi, said she is just the technical advisor.

Elmer Brewster, said they could be marketing this plan to our beneficiaries and we won't know the details and they will have to accept the terms that AIHMP came up with.

Don Warne, said this is been coordinating with Don Davis.

Cathy Barchi, said there is no plan right now. The plan is in development.

Don Warne, said one reason for it being very inclusive is the case management piece. It's a funding stream that I/T/Us currently don't have access to.

Cinda Hughes, said that with 22% of AIs having a disability, this is a big need. It is currently very difficult to get culturally appropriate services for Indians with disabilities.

Carlyle Begay, stressed that this is the first time this sort of program has ever been created.

Jim Lamb, said Tribal facilities historically collect from Parts A and B. It just seems like a shift to your Part C plan. He said he found it difficult to see how the Part C program could pay more than the Part A technical component and the Part B professional component.

Don Warne, said as a provider you can negotiate your rates. For example, if your costs aren't met, that could be a basis for negotiation. By pulling it together there's a financial incentive to keep people healthy. Can add things like dental and vision. So that is correct – it's not new funding streams but it's packaged in way that's better for disease management.

Carlyle Begay, said not all providers have been tapping in to Parts A and B. Also, AIHMP is piggybacking on private programs for O&E.

Myra Munson, asked what exactly were the presenters advising? Was it the potential value of managed care? Of SNPs? If it's a private company that's trying to develop a SNP and get I/T/Us involved, she would appreciate a disclaimer from CMS saying so. So AIHMP is doing some O&E for CMS and piggybacking on private programs that to go to Indians in the area where they're working – is that marketing? That is what people were expressly concerned about when asking for a Part C presentation because there has been so much predatory practice. Everyone is struggling with who exactly AIHMP is in relation to CMS. The information being presented is good – don't want to have to be suspicious.

Priya Helweg, said when CMS was first introduced to AIHMP, they were working on SNP. The report to TTAG last time was about that. This presentation is a follow up on that – a report back. In the mean time, Dr. Warne met with CMS; AIHMP provides many other services. So CMS and AIHMP talked about developing modules for the national training. They have not gone beyond that. They're not doing training in Indian Country; they're not acting on CMS's behalf. The training modules are in the very, very preliminary stage of development. CMS needed a contractor to help and AIHMP has the skills to do that. They have very strong qualifications. The MA/SNP presentation and the training module development are totally separate things.

Kathy Hughes, asked what the end goal is. Are SNPs the next CMS goal for Medicare?
Cathy said an SNP is a planned benefit package that can be offered by any Medicare provider. CMS doesn't implement them; just offers information. CMS does not advocate any particular plan.

Valerie Davidson, said she reviewed Marty's slide on what sort of plans are offered. She asked if a SNP is a MA plan?

Cathy Barchi, said a SNP is a planned benefit package that can be offered by a MA provider.

Carlyle Begay, said MA plans are optional. After development of the SNP program, they have a choice to enroll or not. AIHMP is assisting Excelhealth with development of this plan. They want to keep everyone abreast of its development in AZ.

Jackie Garner, said the MMA of 2003 created MA plans. CMS does not endorse any individual plans. They have rigorous oversight. What was presented by AIHMP is an example of one model – but not with CMS endorsement.

Cathy Barchi, said most of the SNP plans are exclusive and will enroll beneficiaries who meet criteria – e.g. have diabetes.

Cinda Hughes, said all are aware of how difficult it is for people with disabilities to get insurance when it is a preexisting condition. So SNPs are a real need in Indian Country. At least somebody's doing it.

Valerie Davidson, said thank you. Now we know more about SNPs. We know more about one that's being marketed in AZ.

Cathy Barchi, said it's not yet being marketed in AZ. It's being developed.

Valerie Davidson, said we know more about a plan that is being thought through in AZ.

Adjourn

8:30 Herb Kuhn, Acting Administrator, CMS, said Regarding the recent citizenship documentation requirements for Medicare and Medicaid,

Kathy Hughes, said that Tribes and Tribal hospitals just won't enroll, and they could use it. Also, Tribes need nuts and bolts MLR training ASAP. Hopefully we can extend the June deadline to July or August.

Herb Kuhn, said CMS needs to talk to IHS and others about reprogramming resources.

Jim Crouch, suggested that as CMS goes through the year-end sweep process they do some MLR trainings, teaching Tribes how to use software and analyze bills. They buy a lot of specialty care with CMS money. He asked where the House Energy and Commerce Committee came out regarding Tribal documentation in the CHAMP bill. He also asked where CMS is on IHCA.

Herb said they haven't gotten to specific titles in the bill with comments to Congress yet. He was not sure where they are on the IHCA, but Susan would know. Regarding SCHIP: the President has been clear that he doesn't support SCHIP. CMS wants to reauthorize it and right now reauthorization is attached to expansion of SCHIP. The second issue is that the House bill creates a permanent entitlement status for this program. There are already serious issues financing existing entitlement programs. The final issue is how to deliver health care in this country. CBO analysis says that SCHIP causes children to lose private health insurance. The question is does government want to crowd out private health insurance or find room for both.

Valerie Davidson, said that while the expansion debate goes on, Indian Country is trying to get access to *existing* services. We're at the farthest reaches in the most remote places, and have biggest challenges to access. Once we get over the enrolment hurdle, we need to make sure facilities are reimbursed. Valerie asked for Herb's assurance that when we go to the Hill and say CMS said something cannot happen absent a change in law, that Herb and CMS will assist moving the change in the law forward.

Herb Kuhn, said that there will be times CMS will be supportive and times they'll be neutral or not supportive. We need to make sure we exhaust all the admin remedies.

Kris Locke, said that CMS runs Medicare very well; it is a great example of a government program. There is division of what's needed re: MLR training: IHS sites will use the IHS FI so they don't need as much training. Other tribes need the nuts and bolts – they need to know who are the FIs for each state and what's their contact info.

Herb Kuhn, said he will get that info.

Kris Locke, said it would be good to have posted online the cost to charges ratio for each FI so that every Tribe doesn't have to call every FI. Some Tribes will have to purchase commercial software so they will need training on how to use it. She asked that CMS and/or the FIs that CMS has contracts with attend these trainings. Every day Tribes are not processing these MLRs, they're losing money.

Herb Kuhn, said CMS can post that information on the public website. He said those were good suggestions and thanked Kris for them.

Valerie Davidson, asked to discuss the satellite dishes. She asked Herb to please keep in the back of his mind what's the best way to implement O&E. She said regarding the AI/AN Strategic Plan: That plan is a couple years old, and there have been changes at CMS and in Indian Country since it was written. Part of that is need for data – per Jim C. and CRIHB study. We know AI/ANs are disproportionately underenrolled in Medicare and Medicaid. The study shows inaccuracies in data and the needs to do more research work.

Jim Crouch, said the study looks at barriers to understanding Indians' participation in Medicare and Medicaid, the increasing role of managed care and the state-federal partnership. CMS has a good idea of the number of over-65 y.o. Indians, so we can get good info on other data. But CMS's data sets don't identify Indians as citizens of Tribes but by services. Jim said he is waiting on contracts to continue, and needs about \$300K. He asked Herb that when CMS sweeps the accounts, to drop that money on IHS ASAP. Or if CMS has money in the margins next year, to send to IHS. We still don't have an accurate denominator for the number of Indians eligible for Medicaid. Jim asked Herb to take charge to make sure we do this work. There is also need for data access and data sharing, and asked for Herb's help with that too.

Herb Kuhn, said that data is very useful to gauge success and guide services.

Robert Moore, said a long term care committee was recently established, which is very exciting, and they are and looking forward to working with CMS.

Herb Kuhn, said the new flexibility from Congress means we can do good work with that.

Valerie Davidson, said IHS hasn't been able to provide sufficient money to provide long term care in Indian Country. But there has been progress with 638 Tribes who are providing that care themselves. In order for that to work, the Tribes have to decide to do it, get it in funding agreement with IHS. That process has taken a long time They are considered IHS facilities by CMS so that CMS will reimburse. She has spoken with Carl and Dorothy on how to move those long term care issues forward. She asked Herb to please inquire with Dr. Grim on this. Melanie has led the long term care charge in Oklahoma.

Melanie Knight (Secretary of State, Cherokee Nation; Oklahoma Representative), said that in Oklahoma, they're starting a Tribal PACE program in rural Oklahoma. Obstacles are that PACE is CMS not IHS so getting it recognized as IHS program is challenge. It's taken years to get around those issues.

Herb Kuhn, said we need further discussion on how to sync up these programs.

Valerie Davidson, said she had understood from meeting that funding agreements will include language acceptable to CMS.

Carl Harper, said yes IHS has been working with CMS and there are AFAs with good language in them.

Carolyn Finster, said it is important to understand that the data subcommittee's work has just begun and there are recommendations that will have to be decided on by people at a higher level – like adding fields on questionnaires. It is important to keep momentum.

Jim Crouch, said thank you to the CMS staff, and that it has been wonderful working with them.

9:15 Legislative update – Susan McNally, Office of Legislation, CMS

Regarding SCHIP:

- The House passed it 225-204.
- The difference between the House and Senate bills is that in the House, a few Democrats voted no and Republicans voted yes
- The House Energy and Commerce Committee adhered to a formal rule that bills have to be read aloud – which was a strategy for Republicans to delay the markup
- The Senate voted on 7 or 8 amendments
- They seem to have 60 votes in Senate for the bill on floor. Grassley said he's close to getting 67.
- We will see what they negotiate out and if it will still draw veto.
- The Administration made the proposal to redistribute leftover moneys to states that need it. Both bills are allocating more money than the President requested.
- Senate bill would add \$35 billion over five years then it goes to one year funding

- House bill is permanent and estimated at \$50 billion over five years – but it would never have to be reauthorized
- The Administration believes that the state bonuses for enrolling people make it like full federalized health care
- There is discussion whether to extend for extra quarter
- There is discussion on whether to have legislative debate
- Debate over coverage of adults – in 2001 and 2002, states with extra allotments wanted to cover parents and got waivers to do so. The Senate is trying to transition off covering childless adults. The House bill allows coverage of childless adults but there has to be no waiting list – which is what's being done already.
- The Senate bill includes a grant for outreach to find eligible Indian children
- The Senate bill is mostly funded with the tobacco tax. The House bill cuts providers.
- The House bill had originally increased the eligible age to 25 – but the bill that went to floor is has the 21 as the eligible age.
- There's a debate over the appropriate income level. It is now at 400% of the FPL
- Nobody really knows how all the parts interact and what their effect will be.

Jackie Garner, said CMS has not approved any 400% waivers.

Susan McNally, said they sent a letter to Grassley explaining that they're not waivers; they're state plan amendments.

Regarding IHCA reauthorization:

- Dorgan got tentative agreement for Sept 12 Finance Committee markup of the Senate bill.
- Doesn't expect the IHCA to move until Congress is done with SCHIP

Valerie Davidson, said the Senate bill has requirements for outreach and enrolment activities: they have to be on or near the reservation, cooperative agreements to improve access, remove 10% cap for outreach, citizenship documentation provision.

Susan McNally, said that even though Dorgan's amendment was set aside, those are still in Senate bill. Only one of them is in House bill.

Jim Crouch, asked Susan if her office is doing anything about pg 80-1 of the House bill re: citizenship documentation.

Susan McNally, said she's sure they'll be doing something on that. But right now there are other priorities.

Jim Crouch, asked if there is any write up on the IHCA.

Valerie Davidson, said that we keep hearing it has to be done legislatively, so tell the CMS people not to object.

Susan McNally, said she can't really comment on that. She appreciates what Valerie and Jim are saying. But policy officials make these decisions. There are agencies besides CMS interested in this citizen documentation issue that we don't interact with a lot – for example, Homeland Security. If you want to educate people, need to understand that.

Robert Moore, said we shouldn't have to educate people in the agencies; it's in the U.S. Constitution. We'll continue to do our part consulting.

Data Subcommittee report - Jim Crouch

- Jim handed out the Data Subcommittee report. The report tries to respond to the strategic plan objective of capturing data useful for TTAG to advise policy.
- The report demonstrates obstacles to getting accurate statistics.
- The subcommittee is collecting notes and might send to Barbara Kingsolver
- The report also tries to respond to IHCIA language that requires IHS and CMS to do annual reports.
- It goes through Medicare, then Medicaid then SCHIP.
- The take home message is that the next steps are to focus on IHS registered patients and active users of Medicaid. Jim asked for the group's affirmation.
- The contracts are sensitive. The study group is supposed to get additional \$50K, but the work doesn't need to be done exclusively by CRIHB.
- The ongoing role for TTAG is to politically urge the sharing of the data. If IHCIA passes, all data held by Secretary would be available to epicenters under HIPPA
- Want access to unaggregated MSIS.
- Jim encouraged using datamart.
 - He asked that TTAG members please look at the budget.
- We need to develop templates for a Medicare/Medicaid user table.

Mickey Peercy, said the group had a chance to read the report and give input. He suggested to Jim C. that he take input he has received and move forward with the proposed recommendations.

Carol Barbero, said the report makes clear that the data gap is enormous. Myra had recommended adding a big prominent disclaimer that this data should not be relied on or cited.

Jim Crouch, said that was a good idea.

Kathy Hughes, suggested sending letter to Herb Kuhn summarizing what we've learned from Jim's study and report so far, and ask for his political assistance and support for: data sharing; the budget; Jim's proposed focus on IHS facility users.

**Kathy Hughes, made a motion for the TTAG to send that letter.
The motion was seconded.**

Jim Roberts, made a recommendation that the satellite dish money go to this research.

**There was no objection to the motion.
The motion carried with unanimous consent.**

National Annual Training Modules – Priya Helweg and Don Warne, American Indian Health Management (THU)

Priya Helweg:

- TTAG recommended national trainings in strategic plan. It's really ambitious. It's a national training with footing in the Agency that will continue on into future. CMS has Medicare trainers who do the big Medicare trainings. Charlotte Newman is in charge of these trainings. They've been doing it for about 10 years. She said she has talked to Charlotte about lessons learned and how to get the money for the trainings, etc. She said the key was consistent evaluations from the get-go. CMS wants lots of feedback from Tribes and communities, and TTAG guidance. As CMS tries to institutionalize these trainings, they partnered with Don Warne's group, AIHMP. They have a lot of community contacts, and have done these before. They're keeping a running list of topics to cover and as soon as we have first draft of those we'll go to O&E subcommittee. Besides NACs, CMS doesn't currently do Medicaid trainings. Cindy's been doing Medicaid training in her area so she's been advising. Each area or state may require its own training at some point, so they have to be flexible.

- Looking at the agenda – it is more of a list of topics than an agenda at this point.
- CMS wants to tailor the agenda to the specific audience. For example, not a single group they visited in Nevada is billing Medicare.
- Priya said she thinks our goals are same – we just need to keep a really close dialogue.
- The contract with AIHMP was in the interest of time. Also they are native, and they won the bid.

Don Warne:

- Don gave some personal background: He is from Arizona. His MD is from Stanford and MPH from Harvard. He has worked in family practice and for IHS.
-

David Tonemah, introduced himself. He is from Oklahoma. He has an MBA, and degree in health care admin. He worked on CHS, for a Tribe, for an urban program and an IHS program.

Carlyle Begay, introduced himself. He is Navajo and grew up in Flagstaff and Navajo reservation. He has a degree in molecular and cellular biology. He decided to get MHSM because of the lack of federal leadership and Indian voice at the health services table.

Don Tonemah:

- The AIHMP has lots of professional perspectives, but most importantly the native perspective.
- They are working to improve these systems for their own families and communities.
- Have worked at federal, state, tribal, private, tribal consortium levels.

Priya Helweg:

- They expect to have a first draft of the training for the O&E subcommittee in August
- In September, they'll conduct focus groups in Arizona
- They'll do a shorter presentation at CMS day at the ACC

Kris Locke, said very different trainings are required for providers and beneficiaries.

Don Warne, said their trainings focus on the business office side

10:30 Tribal/State Collaboration – Bill Vance, Oklahoma

Bill Vance:

- Oklahoma is implementing the first tribal-state Medicaid consultation policy
- They have tried to formalize their strategy
- They have a Tribal liaison. They got a Tribal leader on the OK Health Care Authority Board. Now they are able to get Indian issues on the Board's strategic plan.
- The strategy is supported by Tribes, and by Medicaid authority/Fogerty.
- Tribal leaders said formal consultation process was very valuable.

Mickey Peercy, said they worked with the National Assn of Medicaid Directors. They got high level people at the meeting. Their relationship is evolving and improving.

Bill Vance, said they have a good relationship with the Health Board, and that has had the secondary benefit of good relationships w other state agencies.

Ben Shelly, said Gov. Bill Richardson did an executive order to have consultation with Tribes. He will have reports later on how well they are doing.

Roz Begay, commended CMS staff for their presence at regional consultations. These do make impact in long run. They are fortunate for the executive order. Five departments collectively worked with Tribal leaders over two years to develop consultation protocol. The President signed off on behalf of Navajo Nation. Glad to see it in OK too.

Deborah Broken Rope (Technical Advisor), asked if they had to use state authority to create extra position on board?

Bill Vance, said no, there was a vacancy. Tribes in OK have a good relationship with governor. It was an executive appointment - not tied to any CMS state plan.

Kathy Hughes, said Tribal leaders are used to slow processes. State consultation is one area we're seeing progress. The Governor has created advisory councils that include Indians. Kathy is on minority health advisory council.

Valerie Davidson, said some of these examples should be highlighted at next meeting with NASMD.

Myra Munson, said that OK has a unique governmental structure in that state agencies are operated by boards that are appointed by governor. So part of administrative cost funding for that probably is from a Medicaid match. But it's included in state plan.

Valerie Davidson, said that at minimum, whatever your state government structure, there's no reason why state Medicaid director can't have quarterly meeting with a Tribal leader. TTAG's always been clear that TTAG meeting's do not take the place of Tribal consultation. Thanks for that reminder.

10:45 Status of GAO report – Carolyn Yocom, GAO

Carolyn Yocom:

- The GAO expects its report out next spring. Valerie thanked Carolyn.
- They consulted: 10 area health boards; 9 TTAG representatives and agency headquarters and area offices.
- They have planned site visits to Wisconsin, Montana, Arizona and some other places.

Robert Moore, said he appreciates the diversity of the site visits. He asked if they would be visiting any urban Indian facilities.

Carolyn Finster, said unfortunately no – they do not have the funding to.

Robert Moore, said that leaves a huge chunk missing, especially considering the IHCI discussion re: race vs. political-based classification of urban Indians. He suggested looking at a city such as Minneapolis-St. Paul.

Valerie Davidson, said that on behalf of TTAG, she appreciates the GAO's research and report and taking an active role by participating in our TTAG meetings. The meeting should compliment the report.

11:00 Reports of Subcommittees:

- Long Term Care subcommittee – Robert Moore
 - o Had first subcom last week. Charter's in briefing book

Robert Moore:

- The subcommittee had its first conference call last night
- They talked about how to implement sustainable long term care activities with long life that can evolve

Jim Roberts:

- They catalogued inventory on what's being provided and what's not
- They identified language that might prohibit Tribes from providing services they can be reimbursed for

Priya Helweg, said there's a survey done by Turner Goines on LTC in Indian Country. Turner is willing to present her findings at the next TTAG meeting.

Jim Roberts, said they want to try it out in some friendly states.

Cinda Hughes, said she thinks there's new legislation that Medicaid will provide vouchers for home-based care when previously would have to be institutionalized to get it paid for.

Robert Moore, said they want to have families and resources take ownership of care. Will need to coordinate with other committees, especially O&E, using what Melanie's been doing as model. Coordinate with state, but tribally managed.

Jackie Garner, said CMS recently awarded transformation grants to states for them to move to community-based system away from institutional care. Can get a list of which states received those and what they're using them for. A lot of CMS's work has been to empower community-based care.

The next subcommittee conference call will be Monday August 27th at 1 pm E,T.

Robert Moore, recognized Jim Roberts, Melanie Knight and Priya Helweg for all of their assistance.

Closing Matters:

Priya Helweg, distributed CMS calendar on the Mobil Office Tour stops.

The next dates for the TTAG meeting are November 6-8.
TTAG conf calls are held the 2nd Wednesday of the month at 2:30-4:00PM ET starting September 12.

Robert Moore, invited everyone to Aberdeen Area training.

12:00 Meeting Adjourned