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July 2008

MEDICARE AND MEDICAID

CMS and State Efforts to Interact with the Indian Health Service and Indian Tribes

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Highlights of GAO-08-724, a report to the Committee on Finance, U.S. Senate

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Why GAO Did This Study

By law, facilities funded by the Indian Health Service (IHS) may retain reimbursement from Medicare and Medicaid without an offsetting reduction in funding. Ensuring that IHS-funded facilities enroll individuals in—and obtain reimbursement from—Medicare and Medicaid can provide an important means of expanding the funding for health care services for the population served by IHS. The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that administers Medicare and oversees states' Medicaid programs, is required by Executive Order and HHS policy to consult with Indian tribes on policies that have tribal implications. This requirement is in recognition of the unique government-to-government relationship between the 562 federally recognized Indian tribes and the federal government.

GAO was asked to (1) describe interactions between CMS and IHS, (2) examine mechanisms CMS uses to interact and consult with Indian tribes, (3) examine mechanisms that selected states' Medicaid programs use to interact and consult with Indian tribes, and (4) identify barriers to Medicare and Medicaid enrollment and efforts to help eligible American Indians and Alaska Natives apply for and enroll in these programs. GAO reviewed documents, interviewed federal and state officials, and visited a judgmental sample of Indian tribes and IHS-funded facilities in six states.

To view the full product, including the scope and methodology, click on GAO-08-724. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

CMS and IHS have interacted to (1) provide support to IHS-funded facilities and tribes in their access to Medicare and Medicaid and (2) address broader policy and regulatory concerns regarding these programs. Their interactions to provide support have included education and technical assistance; the agencies also have interacted to obtain input from tribal representatives on program operations. On broader policy and regulatory concerns, CMS and IHS have worked on policy initiatives aimed at ensuring that existing health care policies meet the needs of IHS-funded facilities and the populations they serve. CMS and IHS have had mixed success identifying whether proposed CMS regulatory changes would affect IHS-funded facilities or their populations and thus warrant IHS review. CMS has been working to improve its identification of such regulations.

CMS has used two key mechanisms—tribal liaisons and an advisory board—to interact with representatives from Indian tribes, and it has relied primarily on annual regional sessions sponsored by HHS as its mechanism to consult with Indian tribes. Tribal liaisons in CMS's central and regional offices generally served as the point of contact for tribal representatives. CMS's tribal advisory board, which is meant to complement but not replace consultation, has provided the agency with advice on policies affecting the delivery of health care for American Indians and Alaska Natives. CMS has used annual HHS regional consultation sessions as the primary basis for consulting with Indian tribes. However, consulting with tribes is an inherently difficult task, in part because of the variation in tribes' size, location, and economic status. Further, these HHS regional sessions—which generally lasted 1 to 2 days and covered all HHS programs—have offered limited time for consultation and discussion.

The six state Medicaid programs we reviewed have used at least one of three mechanisms—tribal liaisons, advisory boards, and regular meetings—to interact and consult with Indian tribes. Five of the six states reported having policies in place that governed the interactions between the state's Medicaid program and Indian tribes, with most of these policies establishing guidelines for how consultation should be conducted. Five states reported consulting with tribes about changes to their Medicaid programs.

American Indians and Alaska Natives have faced several barriers to Medicare and Medicaid enrollment despite efforts to assist them with the application process. Many of these barriers are similar to those experienced by other populations, such as transportation and financial barriers. To help eligible American Indians and Alaska Natives enroll in Medicare and Medicaid, almost all of the IHS-funded facilities we visited had staff who assisted patients with the application process, including helping them complete and submit applications, and collecting required documentation.

In commenting on a draft of this report, CMS noted that it was appreciative of GAO's review of CMS activities related to interactions with IHS and tribes.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
IHS	Indian Health Service
NAC	Native American Contacts
SSA	Social Security Administration
TTAG	Tribal Technical Advisory Group

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United States Government Accountability Office
Washington, DC 20548

July 11, 2008

The Honorable Max Baucus
Chairman
The Honorable Charles E. Grassley
Ranking Member
Committee on Finance
United States Senate

The United States recognizes each of the more than 560 federally recognized Indian tribes as sovereign nations within its borders.[1] These tribes, which are located in over 30 states, vary greatly in population, economic status, and land ownership, and have a unique government-to-government relationship with the federal government. According to federal law, this unique relationship includes a responsibility for the provision of health care to American Indians and Alaska Natives. The Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS), provides or arranges for the provision of health care services for American Indians and Alaska Natives.[2] In fiscal year 2007, IHS provided or arranged health care services for approximately 1.5 million American Indians and Alaska Natives. Services are provided through IHS-funded facilities, including those operated by IHS and those operated by tribes, or purchased from other public and private providers—referred to as contract health services.

IHS is funded through appropriations, which in fiscal years 2006 and 2007 were approximately $3.0 billion and $3.2 billion, respectively. In addition to federal appropriations, IHS-funded facilities can seek reimbursement for services they provide to individuals enrolled in Medicare, the federal health insurance program for elderly and disabled individuals, and for

[1]A federally recognized Indian tribe is an Indian or Alaska Native tribe, band, nation, pueblo, village, or community that the Secretary of the Interior acknowledges to exist as an Indian tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. § 479a.

[2]To be eligible for IHS services, an individual must be a person of American Indian or Alaska Native descent as evidenced by such factors as tribal membership, living on tax-exempt land, owning restricted property, participating actively in tribal affairs, or other relevant factors. The most common standard applied for eligibility for IHS services is that the individual is an enrolled member of a federally recognized tribe.

those enrolled in Medicaid, a joint federal and state health financing program for certain low-income families and low-income individuals who are aged or disabled.[3] Reimbursement from Medicare and Medicaid can increase the amount of funds available to IHS-funded facilities because by law they can retain reimbursement from these programs without an offsetting reduction in their appropriated funding.[4] In fiscal year 2007, IHS reported approximately $677 million in reimbursement from Medicare and Medicaid;[5] however, facilities vary greatly in the total reimbursement obtained from these programs. For example, our prior work found that Medicaid reimbursement across 12 IHS-funded facilities ranged from 2 percent to 49 percent of the total direct medical care budgets of these facilities, and that facilities with higher reimbursement had additional funds to hire staff and purchase equipment and supplies.[6] As a result, ensuring that eligible American Indians and Alaska Natives are enrolled in Medicare and Medicaid, and that IHS-funded facilities obtain reimbursement for services provided to these enrolled individuals, can provide an important means of expanding the funding for health care services available to this population.

Changes to Medicare and Medicaid can affect the enrollment of American Indians and Alaska Natives in these programs and the ability of IHS-funded facilities to claim reimbursement for enrolled individuals. Interactions between Indian tribes, IHS, and the Centers for Medicare & Medicaid Services (CMS), the agency within HHS that administers Medicare and oversees states' Medicaid programs, can help prevent policy changes from having unforeseen effects on tribes and IHS-funded facilities. For example, if changes in a Medicaid program's delivery system—such as moving to a system of managed care—are discussed with tribes and IHS officials, then consequences—such as IHS-funded facilities not being part of managed care systems—may be avoided. Recognizing the unique status of Indian tribes, a 1998 Executive Order required a specific type of interaction between federal agencies and Indian tribes, called consultation, which

[3]IHS-funded facilities can also seek reimbursement from other sources, such as private health insurance.

[4]See 25 U.S.C. §§ 1621f, 1645 (2000).

[5]These data do not account for all collections by IHS-funded facilities because tribally operated facilities are not required to report such information.

[6]GAO, *Indian Health Service: Health Care Services Are Not Always Available to Native Americans*, GAO-05-789 (Washington, D.C.: Aug. 31, 2005).

required federal agencies to have an effective process to ensure meaningful and timely input by tribal officials in the development of regulatory policies that have tribal implications.[7] In 2005, HHS adopted a tribal consultation policy, under which every agency within HHS shares the responsibility to coordinate, communicate, and consult with Indian tribes. Thus, CMS is required to consult with Indian tribes on program issues that have tribal implications. In contrast, states are not subject to the Executive Order or HHS's tribal consultation policy. However, CMS has encouraged state Medicaid programs to consult with tribes when making changes to their Medicaid programs. Moreover, some states have policies requiring consultation between the state Medicaid program and Indian tribes.

Given the importance of CMS programs to American Indians and Alaska Natives, you asked us to examine the interactions between the Medicare and Medicaid programs with IHS-funded facilities. This report (1) describes interactions between CMS and IHS, (2) examines mechanisms CMS uses to interact and consult with Indian tribes, (3) examines mechanisms that selected states' Medicaid programs use to interact and consult with Indian tribes, and (4) identifies barriers to enrollment in Medicare and Medicaid and efforts to help eligible American Indians and Alaska Natives apply for and enroll in these programs.

To describe interactions between CMS and IHS, we interviewed officials from both agencies. Specifically, within CMS, we interviewed officials from its central office and 9 of its 10 regional offices who have responsibility for coordinating issues related to Indian tribes and IHS, as well as other CMS officials, including officials knowledgeable about interactions between CMS and IHS.[8] Within IHS, we interviewed headquarters officials involved in interacting with CMS, including those in

[7]See Executive Order 13084, 63 Fed. Reg. 27,655 (May 19, 1998). The 1998 Executive Order was replaced by Executive Order 13175, issued on November 6, 2000. According to this order, policies that have tribal implications include regulations, legislative comments or proposed legislation, and other policy statements that have substantial direct effects on one or more Indian tribes, on the relationship between the federal government and Indian tribes, or on the distribution of power and responsibility between the federal government and Indian tribes. See 65 Fed. Reg. 67,249 (Nov. 9, 2000).

[8]We did not speak with officials from one region (Philadelphia) because there are no federally recognized Indian tribes in that region.

the Office of Resource Access & Partnerships.[9] We also interviewed officials in each of IHS's 12 area offices identified by IHS executives as being the most knowledgeable about Medicare- and Medicaid-related issues. (See app. I for a map of the locations covered by the IHS area offices and the CMS regional offices.) In our interviews, we asked CMS and IHS officials about their interactions with the other agency. During the interviews we obtained information about the development and review process for regulations and how CMS and IHS interact to identify proposed CMS regulations that may affect IHS-funded facilities. To supplement this information, we interviewed officials from the HHS Office of the Executive Secretariat, which is responsible for determining which agencies within HHS should have the opportunity to review a regulation. We also interviewed officials from the HHS Office of Tribal Affairs about HHS activities related to American Indians and Alaska Natives that involve IHS and CMS. Additionally, we reviewed relevant CMS and IHS documentation to supplement information obtained during our interviews.

To examine mechanisms that CMS uses to interact and consult with Indian tribes, we reviewed information obtained during our interviews with the CMS and HHS officials noted above. We also interviewed tribal representatives to obtain their opinions about interactions with CMS. During the course of our interviews with CMS and HHS officials, we asked them about past and present interactions, including consultations, with tribes. We conducted site visits in 3 of the 12 IHS areas from September through November 2007.[10] We selected these 3 areas to represent a mix in terms of geographic location, level of reliance on contract health services, and the entities operating the facilities (IHS or tribes).[11] (See app. II for more detailed information about the methodology for our site visits.) During our site visits we met with tribal leaders or designated officials from 14 tribes, and interviewed them regarding their interactions with CMS and elicited their opinions about CMS's consultation with Indian tribes. To better understand CMS's consultation activities, we reviewed

[9]IHS's Office of Resource Access & Partnerships works with external organizations and other federal agencies to increase access and resources and to develop partnerships aimed at improving the health status of American Indians and Alaska Natives.

[10]The three IHS areas we visited were (1) Bemidji, which includes Michigan, Wisconsin, and most of Minnesota; (2) Billings, which includes Montana and Wyoming; and (3) Navajo, which includes portions of Arizona, New Mexico, and Utah.

[11]In selecting these areas, we also considered other factors, such as whether we had visited the area previously and experts' views on the relationship between tribes and states in the area.

CMS's involvement in HHS regional consultation sessions. To do this, we interviewed HHS officials from the four HHS regional offices that corresponded to the location of the tribes we visited and reviewed agendas and reports from these regions' consultation sessions.[12] We interviewed over 15 additional tribal representatives, including officials from area health boards—who serve as the voice for tribes in their area on health-related issues—and tribal representatives who are members of CMS's Tribal Technical Advisory Group (TTAG), an advisory board created to inform CMS about issues affecting the delivery of health care to American Indians and Alaska Natives served by CMS programs. Finally, we observed several TTAG meetings and reviewed relevant documentation, such as minutes, from prior TTAG meetings.

To examine mechanisms that selected states' Medicaid programs use to interact and consult with Indian tribes, we interviewed Medicaid officials in the six states that corresponded to the location of the 14 tribes we visited.[13] We asked these officials about interactions and consultations between the state Medicaid program and Indian tribes in the state. We also reviewed relevant documentation, such as state policies that govern interactions with tribes. Additionally, we used information gathered from our interviews with tribal leaders and other tribal representatives.

To identify barriers to enrollment in Medicare and Medicaid and efforts to help eligible American Indians and Alaska Natives apply for and enroll in these programs, we used information obtained from our interviews with CMS, IHS, and state officials as well as tribal representatives. Additionally, during our site visits, we interviewed officials at 25 IHS-funded facilities, 13 of which were operated by IHS and 12 of which were operated by tribes. During these interviews, we asked officials about barriers to Medicare and Medicaid enrollment, enrollment assistance provided, and outreach activities. We also interviewed officials from the Social Security Administration (SSA), the federal agency responsible for Medicare enrollment, about barriers to Medicare enrollment and the agency's outreach activities. In addition, we conducted a literature review about barriers related to enrolling in Medicare and Medicaid. Where available, we reviewed relevant documentation to supplement the information found during our interviews.

[12]The four HHS regional offices were Chicago, Dallas, Denver, and San Francisco. HHS has the same regional office structure as CMS.

[13]The six states are Arizona, Minnesota, Montana, New Mexico, Utah, and Wisconsin.

The information from the six state Medicaid programs provides insight about the interactions and consultations between state Medicaid programs and Indian tribes, but it cannot be generalized to other states. Additionally, the information we obtained from tribal representatives cannot be generalized to all 562 federally recognized tribes. We conducted our work from December 2006 through July 2008 in accordance with generally accepted government auditing standards.

Results in Brief

CMS and IHS have interacted to (1) provide support to IHS-funded facilities and Indian tribes in accessing Medicare and Medicaid and (2) address efforts associated with broader policy and regulatory concerns regarding the two programs.

- With regard to support, CMS and IHS have interacted to educate staff from IHS-funded facilities and tribal members about Medicare and Medicaid, and CMS has assisted these facilities with Medicare and Medicaid billing procedures and other concerns. CMS and IHS have interacted to ensure that they obtain input from tribal representatives at meetings and other sessions designed to inform CMS about issues affecting the delivery of health care for American Indians and Alaska Natives.

- With regard to broader policy and regulatory concerns, CMS and IHS have interacted on policy initiatives aimed at ensuring that existing health care policies meet the needs of IHS-funded facilities and the populations they serve. CMS and IHS have had mixed success identifying CMS regulatory changes that have the potential to affect IHS-funded facilities and their populations and thus warrant IHS review. However, identifying such regulatory changes can be challenging because of factors such as the high volume of CMS regulations. For this reason, CMS has been working to develop and implement additional procedures to identify whether a regulation could affect IHS and the tribes.

CMS has used two key mechanisms—tribal liaisons and an advisory board—to interact with representatives from Indian tribes, and it has relied primarily on annual regional sessions sponsored by HHS as its mechanism for consulting with Indian tribes.

- CMS has tribal liaisons in its central and regional offices who generally served as the points of contact for tribal representatives. These liaisons have provided assistance and obtained input from tribes through activities such as visiting Indian reservations and providing technical assistance and written guidance to Indian tribes.

- CMS has a tribal advisory board, which includes tribal representatives from each IHS area and three Washington, D.C.–based tribal associations. While the advisory board is meant to complement but not replace consultation, its composition, meeting schedule, and organizational structure have provided an opportunity for CMS to obtain input from tribal representatives.

- CMS's efforts to consult with Indian tribes have relied primarily on participating in the annual HHS regional consultation sessions. However, consulting with so many tribes is an inherently difficult task, in part because of the variation in the size, location, and economic status of the Indian tribes. Additionally, these HHS regional sessions—which generally lasted 1 to 2 days and covered all HHS programs—have offered limited time for consultation and discussion.

The six state Medicaid programs we reviewed have used at least one of three mechanisms to interact and consult with Indian tribes: tribal liaisons, advisory boards, and regularly scheduled meetings. All six state Medicaid programs reported using at least one designated tribal liaison who served as a communication and coordination link between tribes and the program and provided training and technical assistance to Indian tribes. Three of the six state Medicaid programs reported using advisory boards to interact, and in some cases consult, with Indian tribes. For example, Utah used an advisory board to determine if proposed changes to the state Medicaid program had tribal implications and thus required additional consultation with tribal representatives. Four of the six state Medicaid programs also reported having regularly scheduled meetings with tribal representatives to discuss Medicaid issues; the meetings ranged in frequency from bimonthly to annually. In addition to these mechanisms, five of the six states we reviewed also reported having policies in place that provided a mechanism to govern their interactions—including consultations—with Indian tribes. Most states reported consulting with tribes when making changes to their Medicaid programs. For example, New Mexico officials reported that consultations with tribes resulted in revisions to a long-term care program, such as requiring the use of tribal liaisons.

American Indians and Alaska Natives have faced several barriers to Medicare and Medicaid enrollment despite efforts to assist them with the application process. Some of these barriers to enrollment were associated with the unique status of the tribal community. For example, one barrier was the belief among some American Indians and Alaska Natives that they should not have to apply for Medicare or Medicaid because the federal

government has a duty to provide them with health care. Other enrollment barriers were similar to those experienced by other populations, such as lack of transportation, financial barriers, and limited access to telephones and other communication devices. Efforts to help eligible American Indians and Alaska Natives enroll in Medicare and Medicaid generally have focused on providing assistance with the application process. Almost all of the IHS-funded facilities we visited had staff who assisted patients with applying for Medicare and Medicaid, including helping them complete and submit applications, and collecting required documentation. In some cases, this application assistance was available directly from Medicaid or Medicare eligibility staff who worked at, or traveled to, IHS-funded facilities. Many organizations—including CMS and IHS—have conducted outreach efforts to educate the tribal community about Medicare and Medicaid and encourage individuals to apply. For example, in 2007, CMS released a video, to be used at IHS-funded facilities, which emphasized the community benefit to enrollment in Medicare and Medicaid.

In commenting on a draft of this report, CMS noted that it was appreciative of our review of its activities related to interactions with IHS and tribes. Technical comments from CMS, Arizona, New Mexico, and Montana were incorporated as appropriate.

Background

The federal government recognizes 562 Indian tribes, which are located in 33 states, and vary greatly in size, economic status, and land ownership.[14] According to the Bureau of Indian Affairs, the tribes range in size from villages in Alaska that have fewer than 50 members to tribes with over 240,000 members.[15] The economic status of tribes also varies, ranging from those with unemployment rates that are more than 90 percent to those with unemployment rates that are below 10 percent. Some tribes also have significant economic opportunities for tribal members, including employment or payments provided to tribal members. With regard to land ownership, reservation lands ranged from 16 million acres to less than 100 acres.

[14] To identify the number of states with tribal locations, we analyzed the 2008 list of Indian Entities Recognized and Eligible To Receive Services (see 73 Fed. Reg. 18,553 (Apr. 4, 2008)). We excluded one state on this list (Indiana) because it did not have reservations or trust lands.

[15] See Department of the Interior, Bureau of Indian Affairs, *American Indian Population and Labor Force Report 2003* (Washington, D.C.: 2003).

Overall, American Indians and Alaska Natives living in IHS areas have lower life expectancies than the U.S. population as a whole and face considerably higher mortality rates for some conditions. For American Indians and Alaska Natives ages 15 to 44 living in those areas, mortality rates are more than twice those of the general population. American Indians and Alaska Natives living in IHS areas have substantially higher rates for diseases such as diabetes, as well as a higher incidence of fatal accidents, suicide, and homicide.

IHS Provision of Health Care

IHS arranges for the provision of health care to American Indians and Alaska Natives who are members of federally recognized tribes. Specifically, in 2007, IHS funded health care delivered to approximately 1.5 million American Indians and Alaska Natives. IHS consists of a system of more than 650 IHS-funded facilities organized into 12 geographic areas of various sizes. Within the 12 areas, direct care services are generally delivered by IHS-funded hospitals, health centers, and health stations.[16] Tribes have the option of operating their own direct care facilities. Thus, direct care is provided by IHS-funded facilities that are either IHS operated or tribally operated. Services not available through direct care at IHS-funded facilities may be purchased by the facilities through arrangements with outside providers; these services are referred to as contract health services.

Eligibility requirements for direct care and contract health services differ. In general, all American Indian and Alaska Native tribal members are eligible to receive direct care at IHS-funded facilities free of charge.[17] To be eligible for contract health services, however, American Indians and Alaska Natives must reside within a contract health services delivery area that is federally established and either (1) reside on a reservation within the area or (2) belong to or maintain close economic and social ties to a

[16]A health station is a facility, physically separated from a hospital or health center, where primary care physician services are available on a regularly scheduled basis but for less than 40 hours a week.

[17]Under IHS regulations, an individual is eligible for direct care if the individual is regarded as an American Indian or Alaska Native by the community in which he or she lives, as evidenced by factors such as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors. In certain very limited circumstances, individuals who are not American Indians or Alaska Natives may be eligible for direct care services. 42 C.F.R. § 136.12 (2007).

tribe based on such a reservation.[18] IHS-funded facilities will not authorize or pay for contract health services for individuals who are eligible to obtain such services through other sources, such as Medicare or Medicaid.

Medicare and Medicaid

Medicare finances health services for approximately 44 million elderly and disabled individuals and consists of several different components, namely:

- *Medicare Part A, Hospital Insurance*—which helps cover inpatient care in hospitals. There is typically no premium for Part A.
- *Medicare Part B, Medical Insurance*—which covers doctors' services, outpatient care, and certain other services, such as physical and occupational therapy and medical supplies. In 2008, the monthly premium for Part B is $96.40 for most individuals.[19]
- *Medicare Part C, or Medicare Advantage*—which provides coverage for Medicare Parts A and B services through private health plans.
- *Medicare Part D, or Prescription Drug Coverage*—a voluntary insurance program for outpatient prescription drug benefits. Most Medicare drug plans charge a monthly premium. However, beneficiaries eligible for both Medicare and Medicaid (dual-eligibles) are generally not required to pay a premium, and certain low-income beneficiaries are eligible for premium subsidies.

IHS has the authority to pay Medicare Part B premiums on behalf of individuals eligible to receive direct care, although the agency has not yet utilized that authority.[20] Some Indian tribes pay the Medicare Part B or Part D premiums of their members.

American Indians and Alaska Natives may also be eligible for health care benefits under Medicaid, a joint federal-state program that finances health care for certain low-income children, families, and individuals who are

[18]In most cases, a contract health service delivery area consists of the county or counties in which a reservation is located, as well as any counties it borders.

[19]Medicare Part B premiums are higher for individuals with incomes above a certain level and a late payment penalty is assessed for individuals who do not apply before the enrollment deadline. Additionally, state Medicaid programs pay some or all of the premium for certain low-income individuals.

[20]IHS does not currently have the authority to pay individuals' Medicare Part D premiums.

aged or disabled. Generally, the federal government and the states share in the cost of the Medicaid program. However, the federal government pays 100 percent of the Medicaid program's cost to provide services to American Indians and Alaska Natives at IHS- or tribally operated facilities.

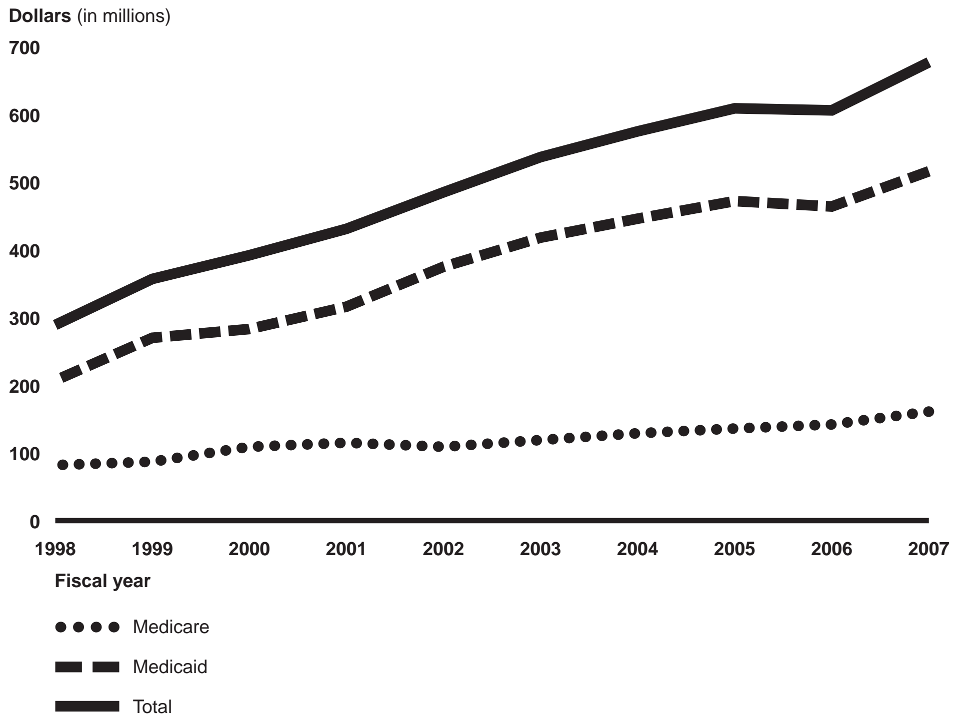
IHS Funding

In fiscal year 2007, Congress appropriated approximately $3.2 billion for IHS, which included funding for the provision of direct care at IHS-funded facilities, contract health services, and other functions. In addition to IHS's federal appropriation, IHS-funded facilities can be reimbursed by other payers, including Medicare and Medicaid, for the services the facilities provide.[21] IHS-funded facilities are allowed to retain reimbursements without an offsetting reduction in their IHS funding. Thus, revenues from Medicare and Medicaid can increase the financial capacity of IHS-funded facilities to provide needed medical services.

According to IHS data, the amount of Medicaid and Medicare reimbursement that IHS has collected has increased over time (see fig. 1). In fiscal year 2007, IHS reported approximately $516 million in Medicaid reimbursement and $161 million in Medicare reimbursement, for a total of $677 million. These data do not account for all collections by IHS-funded facilities because tribally operated facilities are not required to report such information.

[21] IHS has had the authority to bill Medicare and Medicaid since 1976.

Figure 1: IHS Medicare and Medicaid Reimbursement, Fiscal Years 1998 through 2007



Source: IHS.

Note: Data do not account for all collections by IHS-funded facilities because tribally operated facilities are not required to report such information.

Federal Consultation Requirements

In recognition of the unique government-to-government relationship between the federal government and Indian tribes, federal agencies are required by Executive Order to consult with Indian tribes on "policies that have tribal implications."[22] The order states that "[e]ach agency shall have an accountable process to ensure meaningful and timely input by tribal officials in the development of regulatory policies that have tribal implications." The order defines policies that have tribal implications as regulations, legislative comments or proposed legislation, and other policy statements or actions that have substantial direct effects on one or more Indian tribes, on the relationship between the federal government and

[22]See Executive Order 13175, 65 Fed. Reg. 67,249 (Nov. 9, 2000).

Indian tribes, or on the distribution of power and responsibilities between the federal government and Indian tribes.

On January 14, 2005, HHS adopted a tribal consultation policy that formalized HHS's requirement to consult with Indian tribes in policy development. HHS's policy defines consultation as: "An enhanced form of communication, which emphasizes trust, respect and shared responsibility." In addition, the HHS policy explains that consultation is "integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues." Under the HHS tribal consultation policy, every agency within HHS, including CMS, shares in the departmentwide responsibility to coordinate, communicate, and consult with Indian tribes. Among other things, the HHS tribal consultation policy specifies that each of the 10 HHS regions should have an annual consultation session to solicit information on Indian tribes' priorities and needs related to health and human services. Within CMS, issues related to American Indians and Alaska Natives are coordinated by the agency's Tribal Affairs Group and by designated Native American Contacts (NAC) in each of its 10 regional offices.[23]

State Consultation Requirements

While the Executive Order establishes clear requirements for federal agencies to consult with Indian tribes, in general, states determine how to interact, and whether to consult, with the tribes in their states. However, CMS has provided guidance to state Medicaid programs that encourages the programs to consult with tribes and be as responsive as possible to their issues and concerns when making changes to state Medicaid programs.[24] While states have flexibility in making many changes to their Medicaid programs, some changes require states to obtain a waiver of certain Medicaid requirements. Specifically, the Social Security Act authorizes the Secretary of HHS to waive certain federal Medicaid

[23]Although there is a designated NAC in each of the 10 CMS regions, the NAC in the Philadelphia region is not involved as there are no federally recognized Indian tribes in that region. CMS has the same regions as HHS.

[24]CMS provided this guidance through a state Medicaid directors letter issued November 9, 2006.

program requirements under certain conditions.[25] CMS guidance indicates that evidence of consultation with the tribes is one criterion that CMS will use during its review of proposed state Medicaid program changes that require a waiver of Medicaid requirements.[26]

CMS and IHS Have Interacted to Provide Support as Well as Address Broader Policy and Regulatory Concerns

CMS and IHS have interacted to provide support to IHS-funded facilities and Indian tribes in accessing Medicare and Medicaid as well as to address efforts associated with broader policy and regulatory concerns regarding the two programs. With regard to support, CMS and IHS have interacted to educate staff from IHS-funded facilities and American Indians and Alaska Natives about Medicare and Medicaid. Additionally, CMS has assisted IHS-funded facilities with Medicare and Medicaid billing procedures and other concerns. CMS and IHS also have worked to obtain input from tribal representatives through an advisory board and consultation sessions. At a broader policy level, CMS and IHS have worked together on policy initiatives aimed at ensuring that existing health care policies meet the needs of IHS-funded facilities and the populations they serve. CMS's regulatory process—the process through which CMS issues regulations—can necessitate the review of approximately 140 major rule-making documents on a yearly basis. Thus, it has provided an important, but challenging, opportunity for CMS and IHS to identify regulatory changes that may affect American Indians' and Alaska Natives' eligibility for Medicare and Medicaid or these programs' reimbursements to IHS-funded facilities.

CMS and IHS Have Interacted to Provide Education and Assistance as Well as to Obtain Input from Tribal Representatives

CMS and IHS have interacted to educate IHS-funded facility staff and American Indians and Alaska Natives about the Medicare and Medicaid programs. The following are examples of such activities:

- CMS and IHS have interacted to train staff from IHS-funded facilities on Medicare and Medicaid program topics. For example, in August 2007, the two agencies held a training session in the Aberdeen IHS area titled "Working Together – CMS, Tribes and the Aberdeen Area." The session

[25] For example, the Secretary may waive certain federal Medicaid requirements and authorize Medicaid expenditures for experimental, pilot, or demonstration projects that are likely to assist in promoting Medicaid objectives. See Social Security Act § 1115. The Secretary can also waive Medicaid requirements in order to allow long-term care services to be delivered in community settings. See Social Security Act § 1915(c).

[26] CMS provided this guidance through a state Medicaid directors letter issued July 17, 2001.

included presentations by both CMS and IHS officials on strategies to increase Medicare and Medicaid enrollment, changes to contract health service payments, and other topics.

- In 2007, CMS, IHS, and tribal officials coordinated tribal stops on the Medicare prevention tour, a nationwide CMS outreach effort that involved a bus traveling to different venues to encourage Medicare beneficiaries to utilize the preventive services covered by Medicare, such as cancer and diabetes screenings. Through CMS's coordination with IHS and tribes, the CMS Medicare prevention bus visited approximately 15 tribal locations across five different CMS regions.

- CMS has also educated IHS staff about Medicare Part D. For example, CMS has held multiple training sessions in each of the 12 IHS areas to educate IHS-funded facility staff about the Medicare Part D program and encourage American Indians and Alaska Natives to enroll in the program.

Additionally CMS and IHS interactions have included assistance intended to maximize IHS-funded facilities' collection of Medicare and Medicaid reimbursement. Many of these activities have included helping facilities become providers for Medicare and Medicaid, as well as assisting with billing and other concerns. Examples include the following:

- CMS has assisted IHS-funded facilities in becoming Medicare and Medicaid providers, which is necessary to bill these programs. IHS officials from the Bemidji area told us that CMS officials provided instructions to IHS-funded facilities on how to sign up to participate in Medicare and Medicaid. Additionally, in 2007, CMS helped an IHS-operated health center and its satellite clinics to qualify as provider-based facilities, which would allow the facilities to bill Medicare Part A and potentially increase their Medicare reimbursement.[27]

- CMS has provided technical assistance to IHS to resolve billing concerns. For example, CMS and IHS officials corrected a problem with the IHS electronic billing system that according to CMS officials, had resulted in some IHS-funded facilities being underpaid for certain Medicare services.

[27]A provider-based facility is a facility that is owned and operated by a separate inpatient facility, such as a hospital.

- A CMS official helped IHS-funded facilities navigate the CMS survey process, a process through which facilities are inspected for compliance with federal quality standards.

Finally, CMS and IHS have interacted to ensure that they obtain input from tribal representatives. For example, CMS and IHS have interacted through CMS's TTAG, an advisory board created to inform CMS about issues affecting the delivery of health care to American Indians and Alaska Natives served by CMS programs. Specifically, the IHS area offices helped identify and appoint tribal representatives to serve on the TTAG. Additionally, both CMS and IHS officials have attended TTAG meetings and participated in TTAG subcommittees, which focus on specific Medicare- or Medicaid-related issues. CMS and IHS officials also have interacted through annual HHS regional tribal consultation sessions, held in each region as part of HHS's implementation of its tribal consultation policy. In addition to participating in the consultation sessions, CMS and IHS officials may work together to plan the sessions. For example, in the Chicago region, CMS regional and IHS Bemidji area officials served on the planning committee that organized the consultation session.

CMS and IHS Have Interacted about Specific Policies, but Have Had Mixed Success Identifying CMS Regulations Warranting IHS Review

With regard to specific policy issues, CMS and IHS have interacted on issues related to Medicare Parts B and D; they also jointly issued regulations to limit the amount that IHS-funded facilities must pay hospitals for contract health services, as shown in the following examples.

- **Medicare Part B**: CMS and IHS have been determining which American Indians and Alaska Natives are eligible for an exemption from financial penalties incurred for late enrollment into Medicare Part B.[28] This exemption, referred to as equitable relief, is granted to individuals who did not initially enroll because of erroneous information provided by a government agency. In this case, IHS, while operating under specific interagency agreements with CMS, told some individuals not to enroll in Medicare Part B because, at the time, IHS was unable to bill Medicare Part B.[29]

[28] Specifically, an individual may face a late enrollment penalty for Medicare Part B in the form of an increased premium of 10 percent for each 12-month period that the individual was eligible for, but did not enroll in, the program.

[29] IHS received the authority to bill Medicare Part B in 2001.

- **Medicare Part D**: During the implementation of Medicare Part D, CMS and IHS worked to ensure that IHS-funded facilities would be able to bill and receive reimbursement from prescription drug plans. This required special provisions to enable tribally operated facilities to enter into contracts with prescription drug plans, while retaining tribal sovereignty.

- **Contract health services**: In 2007, CMS and IHS jointly issued a regulation requiring hospitals that receive Medicare funds to accept rates based on Medicare as full payment for contract health services provided to eligible American Indians and Alaska Natives.[30] Termed Medicare-like rates, this regulation prevents hospitals from accepting fees from IHS-funded facilities in excess of what Medicare would pay.[31]

With regard to regulations, CMS and IHS have had mixed success identifying CMS regulatory changes that have the potential to affect IHS-funded facilities and their populations and thus warrant IHS review. IHS officials reported reviewing and commenting on CMS regulations addressing Medicare payment issues, Medicaid managed care, and Medicare Part D, noting that CMS made changes to these regulations in response to their comments. For example, IHS informed CMS that regulations implementing a new payment methodology for reimbursing outpatient facilities under Medicare would adversely affect IHS-funded facilities because a number of facilities would have to hire new staff to implement the payment system.[32] As a result of this interaction, CMS exempted IHS-funded facilities from the new payment methodology. In contrast, IHS officials also reported three examples where they did not have an opportunity to review CMS regulations prior to the public comment period. One regulation had the potential to affect Medicaid prescription drug reimbursement for IHS-funded facilities, while the other two regulations had the potential to affect Medicaid enrollment for American Indians and Alaska Natives by requiring documentation of U.S.

[30] See 72 Fed. Reg. 30,706 (June 4, 2007).

[31] This regulation will likely make it less expensive for IHS to purchase contract health services from hospitals.

[32] IHS-funded facilities are generally paid per encounter, regardless of the specific medical services provided; this is referred to as the all-inclusive rate. Given this, IHS-funded facilities may not have sufficient and qualified staff to submit claims under a methodology that pays on the basis of specific medical services.

citizenship and affected tribes' access to federal funds that could be used for Medicaid outreach.[33]

Multiple opportunities exist for CMS and HHS to identify regulations that are important for IHS to review (see fig. 2). However, identifying such regulations can be challenging, as shown below.

- **CMS**: The Tribal Affairs Group has an opportunity to review all draft proposed regulations and notify IHS about regulations it determines are relevant to the agency. However, Tribal Affairs Group officials explained that the large number of regulations (approximately 140 regulatory documents a year), coupled with the size of their staff, means that they have difficulty doing more than a cursory review of the regulations.[34]

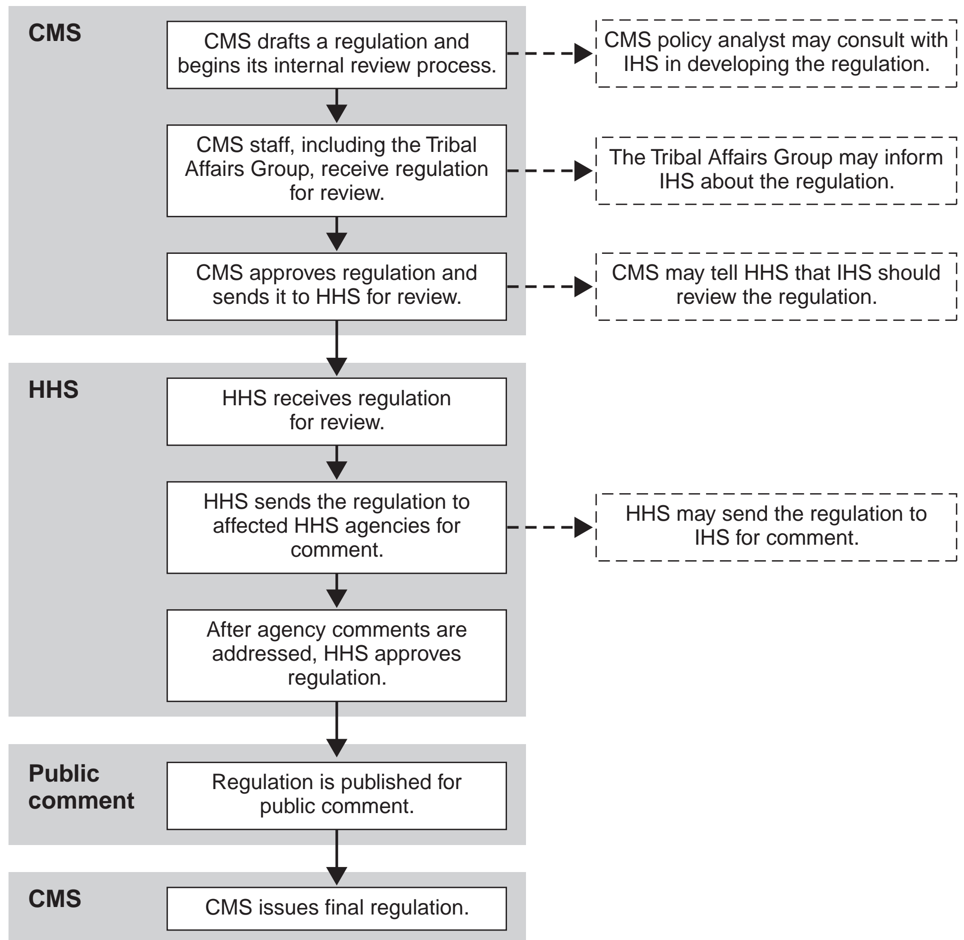
- **HHS**: Responsible for sending proposed regulations to affected agencies, HHS staff use their judgment to determine which HHS agencies should be provided regulations for review. However, the HHS staff making the determination may not have expertise on IHS and thus might not foresee the potential effect a regulation could have on American Indians' and Alaska Natives' eligibility for Medicare and Medicaid or these programs' reimbursements to IHS-funded facilities. HHS officials told us that they make these determinations by reviewing regulations and looking for key legislative terms, such as "Indian," to determine which agencies should be involved in the review. However, it is not clear that the HHS staff consistently used certain key terms, as the three proposed regulations that IHS reported not having the opportunity to review each contained the word "Indian."

If regulations are not identified by CMS or HHS, then IHS may identify proposed CMS regulations that could affect its facilities or service population by reviewing quarterly CMS updates listing regulations and major policy changes under development. IHS may also review the Unified Agenda of Federal Regulatory and Deregulatory Actions, a semiannual listing of the regulatory actions that federal agencies—including CMS—are developing or have recently completed.

[33]See (1) Medicaid Program; Prescription Drugs, 71 Fed. Reg. 77,174 (Dec. 22, 2006); (2) Medicaid Program; Citizenship Documentation Requirements, 71 Fed. Reg. 39,214 (July 12, 2006); and (3) Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership, 72 Fed. Reg. 2,236 (Jan. 18, 2007).

[34]As of March 2008, the Tribal Affairs Group had four staff members.

Figure 2: Points in CMS Regulation Development Process When IHS Can Be Informed about a Proposed Regulation



Source: GAO analysis of CMS regulation process, January 2008.

Note: This figure highlights the steps in the regulations development process that are related to opportunities for IHS to be informed about a proposed regulation. However, it does not depict all steps in the CMS regulation development process. For example, it does not include steps related to the Office of Management and Budget's review of regulations.

Recognizing the difficulties associated with identifying a regulation that could affect IHS and the tribes, CMS has been working to develop and implement additional procedures aimed at improving these efforts. In particular, the CMS Tribal Affairs Group has been working to obtain information from IHS to compile a profile of the types of providers available in tribal locations, which would assist CMS in determining the regulations that could have tribal implications. Additionally, CMS staff

with responsibility for overseeing the regulations process have begun asking the staff who draft a regulation whether it affects tribes. If a potential tribal effect is identified, then CMS will indicate, on a cover sheet transmitting the regulation to HHS, that IHS should be provided the regulation for review.

CMS Has Used Two Key Mechanisms to Interact, and the Annual HHS Regional Sessions to Consult, with Indian Tribes

CMS has used two key mechanisms—tribal liaisons and an advisory board—to interact with Indian tribes and has relied primarily on the annual HHS regional consultation sessions as its mechanism for consultation. CMS tribal liaisons have provided assistance and obtained input from tribes through activities such as participating in conferences and training sessions, visiting Indian reservations, and providing technical assistance and written guidance. The composition, meeting schedule, and organizational structure of CMS's tribal advisory board—the TTAG—also has provided an opportunity for CMS to obtain input from tribal representatives. With regard to consultation activities, CMS has relied on annual HHS regional consultation sessions as the primary mechanism to ensure input from tribal officials in the development of regulatory policies, although CMS officials noted that they have also held consultation meetings with individual tribes. However, consulting with over 560 tribes is an inherently difficult process, primarily because of complexities such as considering the needs and priorities of individual tribes. Tribal representatives' opinions on the effectiveness of CMS's consultation with Indian tribes and the agency officials involved varied considerably.

CMS Has Used Tribal Liaisons and an Advisory Board as Its Mechanisms to Interact with Indian Tribes

CMS has used two key mechanisms to interact with representatives from Indian tribes, namely (1) tribal liaisons, who generally serve as tribal representatives' points of contact within CMS and provide assistance with Medicare and Medicaid, and (2) an advisory board, which provides input to CMS about issues affecting the delivery of health care to American Indians and Alaska Natives.

Tribal Liaisons

CMS tribal liaisons are located in both CMS central and regional offices. In its central office, the CMS Tribal Affairs Group had four staff who served as the points of contact for tribal-related issues; these staff provided assistance to tribes and tribal representatives and coordinated issues

within CMS.[35] Formed in November 2006, the Tribal Affairs Group has served many functions, including (1) serving as an internal resource for CMS staff, educating staff about the needs and priorities of American Indians and Alaska Natives; (2) coordinating the creation of informational materials on CMS programs, such as Medicare and Medicaid, for tribal communities; and (3) representing CMS in communications with Indian tribes and tribal representatives. In addition, the Tribal Affairs Group has served as an advisor to the CMS Administrator, reporting directly to his office and briefing him or his deputy approximately eight times per year about issues raised by tribal representatives.

In addition to the CMS Tribal Affairs Group, each CMS regional office has had a designated official, the NAC, who serves as a liaison between the agency and Indian tribes in the region.[36] Key roles of the NAC have included providing training about CMS programs to Indian tribes in the region; helping address tribal concerns, including assisting tribes and IHS-funded facilities in solving problems and obtaining answers to questions that arose; and serving as a CMS information source on American Indians and Alaska Natives. Except for two regions, the NAC role was a part-time responsibility, with the percentage of time spent on NAC-related duties ranging from 20 to 50 percent.[37] In the remaining regions—Denver and Seattle—the NAC positions are full-time because these staff have additional responsibilities as the lead NACs who coordinate activities across all CMS regions and because there are a significant number of tribes within these two regions. The NAC officials have coordinated their efforts with the CMS central office through monthly conference calls with the Tribal Affairs Group.

The CMS Tribal Affairs Group and NACs have interacted, or coordinated other CMS staff's interactions, with tribal representatives using several methods, including participating in conferences and training sessions,

[35]In 2007, the Tribal Affairs Group had as many as five staff. However, because of an agency hiring freeze, an employee who left the group in November 2007 has not been replaced as of March 2008.

[36]Although there was a designated NAC in each of the 10 CMS regions, the NAC in the Philadelphia region was not involved, as there are no federally recognized Indian tribes in that region.

[37]For the remaining percentage of their time the NACs perform varying functions, including serving as Medicare or Medicaid program staff and organizing CMS outreach and education efforts.

visiting Indian reservations, and providing technical assistance and written guidance to Indian tribes (see table 1).

Table 1: Types of Interactions between CMS Tribal Liaisons and Indian Tribes

Type of Interaction	Examples
Conferences and training sessions	• CMS has sponsored a day at the National Indian Health Board's Annual Consumer Conference, during which staff from the Tribal Affairs Group and NACs participate in sessions about CMS programs. For example, the 2007 conference featured sessions on understanding Medicaid, Medicare and Medicaid outreach, and advising IHS and tribal providers on how to navigate Medicare and Medicaid. • In 2007, the Tribal Affairs Group began producing monthly educational sessions on Medicare and Medicaid topics pertinent to IHS-funded facilities. The sessions are broadcast over satellite dishes provided to some IHS-funded facilities and on the internet. Topics of past sessions include introductions to Medicare and Medicaid and Medicare Part D reimbursement. • In August 2007, CMS staff, including CMS tribal liaisons, provided training in the Aberdeen IHS area to increase overall understanding of the Medicare and Medicaid programs. The training was attended by over 200 people, including representatives from 13 Indian tribes.
Site visits	• During a 2007 visit to a North Carolina tribe, the CMS Atlanta Region NAC discussed an issue related to youth treatment facilities that the tribe was having with the state Medicaid program. • During the CMS Kansas City Region NAC's visits to tribes in the region, she meets with the tribal councils, health officials, or both to update them on CMS program changes and discuss her role as the NAC. • During a 2004 visit to a Nebraska tribe, a CMS NAC and other CMS program staff provided guidance to the tribe on how its medical provider could become a Medicare-certified provider.
Technical assistance	• CMS tribal liaisons have provided or coordinated the provision of technical assistance to Indian tribes and tribally operated facilities on topics including Medicaid eligibility, becoming a Medicare-participating provider, and Medicare and Medicaid billing. • The CMS Tribal Affairs Group worked with another CMS official to assist a tribally operated facility in recovering Medicare funds for over 4 years worth of claims that were underpaid because of an error in IHS's electronic billing system. Additionally, CMS worked with IHS staff to correct the program and ensured that other IHS-funded facilities were notified about the possibility of past underpayment. • In 2007, the Kansas City NAC coordinated technical assistance regarding Medicaid reimbursements for pharmaceuticals and related licensure requirements for IHS-funded facilities. As a result of this assistance, pharmacies at IHS-funded facilities in Kansas will be able to enroll as Medicaid providers and get reimbursed on a fee-for-service basis for pharmaceuticals, including refills.
Written guidance	• In 2006, the Dallas Region NAC distributed a letter to tribal leaders on how tribes can be reimbursed for payments made to Medicare Part D prescription drug plans on behalf of tribal members. • With the help of the NAC, the Administrator of the CMS Kansas City regional office sent a letter to tribal leaders in the region describing an option that groups, such as tribes, have for paying the Medicare Part B premiums for their members.

Source: GAO analysis of CMS and tribal information.

Tribal representatives with whom we spoke had varying opinions on the effectiveness of the CMS tribal liaisons. For example, a few tribal representatives we spoke with praised the efforts of the CMS Tribal Affairs Group staff; one representative noted that the Tribal Affairs Group is a critical link between Indian tribes and CMS, while other representatives noted the group's responsiveness to tribal concerns. Additionally, some tribal representatives mentioned specific interactions with the NAC, such as the NAC's working with the tribe to resolve issues with the state Medicaid program. However, some tribal representatives raised concerns about the liaisons' lack of decision-making authority.

Advisory Board

In addition to liaisons, CMS has received input from tribal representatives through an advisory board. Specifically, in 2003, CMS created an advisory board, the TTAG, to provide it with expertise on policies, guidelines, and programmatic issues affecting the delivery of health care for American Indians and Alaska Natives served by Medicare, Medicaid, or other health care programs funded by CMS. Interactions between CMS officials and the TTAG are meant to complement, but not replace, consultation between CMS and Indian tribes. The TTAG was created to increase understanding between CMS and Indian tribes.

The TTAG has been an important vehicle for CMS to obtain input from tribal representatives. (See table 2 for a description of the TTAG.) The agenda for TTAG meetings has been formulated jointly by tribal representatives and CMS officials, allowing for both CMS and tribal priorities to be discussed. The TTAG's composition, schedule, and structure have provided an opportunity for CMS to obtain input from tribal members. For example:

- The TTAG has members from each IHS area and TTAG members gather information and views about CMS policies from tribes nationwide. Specifically, seven of the eight TTAG area representatives we spoke with indicated that they solicited information and obtained input from regular meetings with tribes in their area, often through the area health board or its equivalent.[38] Similarly, the TTAG representatives from two of the three Washington, D.C.–based tribal associations indicated that they received input from regular meetings with the membership or from the board of their associations.

[38]Area health boards are generally associations created to advocate for health-related issues on behalf of the tribes they represent.

- The TTAG generally has met monthly, which provides an opportunity for tribal representatives and CMS to discuss issues as they arise. For example, in February 2007, TTAG members were able to have a timely discussion with CMS about tribal representatives' concerns that a proposed regulation would prevent tribes and tribal organizations from collecting federal matching funds for Medicaid-related administrative activities, such as outreach. As a result of tribal representatives' concerns, the regulation was revised prior to issuance.[39]

- The TTAG's subcommittee structure has allowed tribal representatives and CMS officials to conduct in-depth analysis, work, and dialogue on Medicare and Medicaid topics that are a priority for CMS, American Indians and Alaska Natives, or both. Subcommittees have focused on topics such as the availability of CMS data on Medicare and Medicaid enrollment and service use among American Indians and Alaska Natives, outreach and education, and long-term care.

Table 2: Description of the CMS TTAG

TTAG	Description
Composition	• TTAG members: An elected tribal leader (or designated employee with authority to act on his or her behalf) from each of the 12 IHS areas and a representative from three Washington, D.C.–based tribal associations.[a] • Technical advisors: Individuals selected by the TTAG members who have expertise in Medicare, Medicaid, and tribal issues.
Meeting schedule	• Generally monthly. • Meetings occur in-person approximately three times a year and through conference calls during the other months.
Organizational structure	• A chair and co-chair are elected annually by the 12 IHS area representatives. • Subcommittees are created to focus on particular Medicare and Medicaid topics affecting American Indians and Alaska Natives; the subcommittees include TTAG representatives, their technical advisors, and employees from CMS and IHS.

Source: GAO analysis of the CMS TTAG, April 2008.

[a]The three Washington, D.C.–based tribal associations are the National Congress of American Indians, the National Indian Health Board, and the Tribal Self-Governance Advisory Committee.

[39]See *Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership*, 72 Fed. Reg. 29,748 (May 29, 2007). Congress imposed a moratorium on this rule delaying its implementation until May 25, 2008. See Pub. L. No. 110-252, § 7001, 122 Stat. 2323.

The TTAG and CMS have worked together on a number of issues. For example, the TTAG worked with CMS and IHS officials to develop a strategy to (1) educate Indian tribes and their members about the Medicare Part D benefit and (2) assist IHS-funded facilities in contracting with the program's prescription drug plans. Additionally, the TTAG created a strategic plan to outline a path for CMS to take over a 5-year period to resolve high-priority issues related to health care for American Indians and Alaska Natives.

CMS Efforts to Consult with Indian Tribes Have Relied Primarily on HHS Annual Regional Consultation Sessions

CMS has used the annual HHS regional consultation sessions as its main mechanism to consult with the 562 federally recognized Indian tribes; CMS is required by Executive Order and HHS policy to consult with Indian tribes about policies that have tribal implications.[40] HHS designed the regional consultation sessions to (1) solicit Indian tribes' priorities and needs on health and human services programs and (2) provide an opportunity for tribes to articulate their comments and concerns on health and human services policy matters related to CMS and HHS. However, consulting with so many tribes is an inherently difficult task, in part because of the variation in the size, location, and economic status of the Indian tribes. Differences in the priorities of tribal participants may also make it difficult to have discussions that are meaningful for all participants.

The HHS regional consultation sessions have offered limited time for consultation and discussion, as the sessions have generally occurred in the spring and lasted 1 to 2 days.[41] Specifically, a review of a sample of eight consultation session agendas found that the time devoted to discussion of CMS-related issues ranged from less than 30 to 90 minutes.[42] Additionally,

[40]While subject to the HHS consultation policy, CMS has been working with the TTAG to adopt its own consultation policy. In April 2007, the TTAG submitted a draft policy to CMS for its review. As of June 2008, the draft policy was under HHS review.

[41]Although there are 10 HHS regions, there are only 7 consultation sessions each year because, at the request of tribes, 3 HHS regions (Atlanta, Boston, and New York) do a combined consultation session. These three HHS regions are included in the Nashville IHS area. Additionally, another HHS region (Philadelphia), which is also in the Nashville IHS area, does not have any federally recognized tribes.

[42]We reviewed consultation session agendas for the Chicago, Dallas, Denver, and San Francisco regions, as well as the combined consultation session for the HHS regions that compose the Nashville IHS Area. For some regions we reviewed agendas from multiple years.

since the consultation sessions only occurred once a year, they may not allow for meaningful discussions in a timely manner, as CMS makes policy changes throughout the year.

While the consultation sessions have been open to all tribes, the number of tribes that have participated is relatively small. According to HHS, representatives from 100 tribes attended a 2006 HHS regional consultation session and representatives from 152 tribes attended a 2007 session; this equates to approximately 18 percent and 27 percent of federally recognized tribes, respectively. Several HHS officials noted that tribal attendance at the consultation sessions has varied, depending on the location of the session, which generally differed each year. Additionally, tribal participation in the sessions may be hindered by the amount of notice provided regarding the date of the sessions. The amount of notice tribes were given about the date of the regional consultation session ranged from 3 to 8 weeks across the four HHS regions we reviewed.

In addition to the CMS-related discussions at the HHS consultation sessions, CMS officials have held consultation meetings with individual tribes or smaller groups of tribes.[43] For example, CMS has consulted with the Navajo Nation about Medicaid issues the tribe has faced since its reservation is located across three states. Additionally, in January 2008, CMS officials traveled to Washington State to consult with the state's Medicaid program and Indian tribes about a proposed amendment to Washington State's Medicaid program that would stipulate how tribes in Washington state can receive federal reimbursement for Medicaid administrative activities.

Tribal representatives had varying opinions on the effectiveness of the CMS and HHS consultations, including varying perspectives on the agency officials involved and the format of the consultation sessions. One tribal representative commented that leaders in CMS attend the meetings and are willing to share information, while another tribal representative commented that the officials who attend the sessions are not able to make decisions. Additionally, a third tribal representative explained that high-level officials who can make decisions attend the consultation sessions, but that these officials do not have the necessary information to answer

[43]CMS officials will also participate in the annual HHS Budget Consultation, which is intended to give Indian tribes the opportunity to present their budget priorities and recommendations to HHS.

questions. This variation may be due, at least in part, to regional differences in participation. Regarding the format of the consultation sessions, one tribal representative commented that the regional consultation sessions were fairly effective at identifying the issues that should be raised at the national level. However, a few tribal representatives commented that the HHS regional consultation sessions were too short and thus did not allow for meaningful tribal input or dialogue.

Selected States' Medicaid Programs Have Used Multiple Mechanisms to Interact and Consult with Tribes

The six state Medicaid programs we reviewed have used at least one of the following three mechanisms to interact and consult with Indian tribes: tribal liaisons, advisory boards, and regularly scheduled meetings. Most of the states also reported having policies in place that provided a mechanism to govern their interactions, including consultations, with the Indian tribes. Most of the state Medicaid programs reviewed reported consulting with Indian tribes about changes to their Medicaid program. Tribal representatives' opinions on state Medicaid program's consultation practices varied.

Medicaid Programs Have Used Mechanisms, Such as Tribal Liaisons, and State Policies to Interact and Consult with Indian Tribes

The six state Medicaid programs we reviewed have used at least one of three mechanisms to interact and consult with Indian tribes: (1) tribal liaisons—who serve as the tribes' primary contact with the states on issues related to Medicaid; (2) advisory boards—which, among other things, inform the state about Medicaid issues affecting American Indians and Alaska Natives; and (3) other regularly scheduled meetings—which states and tribes used to discuss Medicaid issues and identify opportunities for collaboration, technical assistance, and consultation.[44] Additionally, five of the six states we reviewed had policies in place that provided a mechanism to govern interactions, including consultations, between the state Medicaid program and Indian tribes.

Tribal Liaisons

All six state Medicaid programs have used at least one designated tribal liaison in their interactions, including consultations, with tribes about issues related to Medicaid. In addition to serving as a communication and coordination link between tribes and state Medicaid programs, some state tribal liaisons also have provided input on state Medicaid policies affecting

[44]While states are not subject to the Executive Order on consulting with Indian tribes, states may have their own policies governing consultation with Indian tribes.

American Indians and Alaska Natives and training and technical assistance to tribes on Medicaid (see table 3). Additionally, tribal liaisons have been involved in consultations with Indian tribes. For example, one of New Mexico tribal liaisons oversees the Medicaid program's consultations with Indian tribes, while a Wisconsin tribal liaison helps to coordinate an annual tribal consultation session.

Table 3: Examples of Duties Performed by Tribal Liaisons

Roles and duties performed	Examples
Providing input on state policies	• The liaison in Montana presented a report in January 2007 to the Medicaid agency identifying barriers tribes faced in obtaining Medicaid coverage. The liaison also researched ways that tribes could obtain additional Medicaid funding, which were communicated to tribes in a November 2006 letter. • The Utah tribal liaison reported advising the governor's office, Utah legislature, and Utah congressional members about public health policy, including Medicaid, and its implications for American Indians in Utah.
Technical assistance and training	• The New Mexico tribal liaison reported working with the tribes on issues such as Medicaid billing issues, provider enrollment, payment policies, and eligibility. • The Minnesota tribal liaison also reported providing training and technical assistance to the tribes on issues such as Medicaid billing. • The Wisconsin tribal liaison reported having a lead role in ensuring that Medicaid program staff are trained on tribal perspectives and cultural issues.

Source: GAO analysis of six states' information.

Tribal representatives we spoke with had varying opinions on the effect tribal liaisons have had on interactions between the tribes and state Medicaid programs. For example, representatives from a Montana tribe reported that interactions with the state Medicaid program's tribal liaison resulted in changes to the state's Medicaid application. Specifically, after the tribe explained to the tribal liaison that the length of the application was a barrier to American Indians and Alaska Natives enrolling in Medicaid, the state simplified its Medicaid application. Additionally, individuals representing selected tribes in Arizona told us that the establishment of a tribal liaison position in that state's Medicaid program has improved tribes' ability to provide input on health policy issues and resulted in progress regarding those issues. In contrast, representatives from a Minnesota tribe noted that working with the state is difficult even though there is a tribal liaison. Similarly, while officials from a Southwest tribe noted the importance of tribal liaisons, they also expressed concern that tribal liaisons are sometimes kept out of decision making.

Advisory Boards

Three of the six state Medicaid programs—Arizona, New Mexico, and Utah—reported using advisory boards to interact, and in some cases consult, with Indian tribes. For example, Utah has utilized an advisory board to determine if proposed state Medicaid policy or program changes have tribal implications and thus require additional consultation with the advisory board or other tribal representatives.

The Medicaid programs described using two types of advisory boards to interact with the Indian tribes: (1) Indian advisory boards, which address a broad array of issues affecting the provision of health care to American Indians and Alaska Natives, and (2) Medicaid advisory boards, which address issues affecting all Medicaid beneficiaries, including American Indians and Alaska Natives. Specifically, one state Medicaid program (Arizona) reported using Indian advisory boards; one program (New Mexico) reported using its Medicaid advisory board, which includes tribal representation; and one program (Utah) reported using both.

While both types of advisory boards are mechanisms for interactions between the state and tribal representatives, the composition of the advisory boards varied. Specifically, the Indian advisory boards included numerous tribal representatives, while there were fewer tribal representatives on the Medicaid advisory boards. For example, the Utah Indian advisory board, which meets monthly, includes appointed representatives from all of the Utah tribes as well as the state's tribal liaison, other state and tribal officials, and IHS staff. In comparison, Utah's Medicaid advisory board has one individual to represent the seven tribes in the state. New Mexico's Medicaid advisory board has two tribal representatives who may also serve on a subcommittee on tribal issues.[45]

Meetings

Four of the six state Medicaid programs (Arizona, Minnesota, New Mexico, and Wisconsin) reported holding regularly scheduled meetings to interact, and in some cases consult, with Indian tribes.[46] The frequency of these meetings ranged from bimonthly to annually, and states reported discussing issues such as the Medicaid budget and reimbursement. For example, New Mexico officials reported holding an annual meeting to

[45]Additional tribal representatives may participate in meetings of this subcommittee, which are open to the public.

[46]In addition to its regularly scheduled meetings, Arizona and New Mexico officials reported holding ad hoc meetings with tribal representatives. One other state, Montana, also reported holding meetings with tribal representatives on an ad hoc basis.

consult with tribal representatives about pertinent Medicaid policy and program changes and the Medicaid program's budget prior to the state legislative session. A Wisconsin official reported that the state's bimonthly meetings with tribal health directors focus on specific issues, such as increasing Medicaid reimbursements for tribally operated facilities and accessing federal matching funds for tribal Medicaid expenditures.

Tribal representatives' assessments of the value of the regularly scheduled meetings with the states varied. For example, representatives from one tribe, which participates in quarterly meetings with officials who oversee Minnesota's Medicaid program, said that the meetings were successful in helping address tribal needs. However, representatives from two Wisconsin tribes noted that the number of tribes involved and the brevity of the annual meetings with the state made discussing specific issues difficult. Tribes also reported that location was a factor that contributed to the success of these meetings. Specifically, representatives from Wisconsin and Minnesota tribes indicated that holding meetings in convenient locations affects tribal participation and increased the meetings' effectiveness, respectively.

Policies

Five of the six states we reviewed—Arizona, Minnesota, New Mexico, Wisconsin, and Utah—reported having policies in place that govern the interactions, and in most cases consultations, between their states' Medicaid programs and Indian tribes.[47] The states had two types of policies governing interactions with Indian tribes: (1) governor's orders, which specify that all state agencies should interact with Indian tribes on a government-to-government basis and provide for consultation between the state and Indian tribes, and (2) tribal consultation policies, which establish guidelines that state agencies, including Medicaid agencies, should use to consult with Indian tribes. Specifically, one state (Minnesota) reported having a governor's order, two states (Utah and Wisconsin) reported having tribal consultation policies, and two states (Arizona and New Mexico) reported having both.[48] The four states' tribal consultation policies established guidelines with varying degrees of specificity for how consultation between the Medicaid agency and Indian tribes should be

[47]The remaining state, Montana, reported that its state legislature passed a bill in 2003 that instructed the state to develop a government-to-government relationship with the tribes.

[48]Among the four states with tribal consultation policies, one state (Arizona) had a policy specific to its Medicaid program, while the consultation policies in the remaining three states were for the larger department under which the Medicaid program operates.

conducted. Table 4 provides an overview of the guidelines in the four states' consultation policies.

Table 4: Highlights of Guidelines Established by State Tribal Consultation Policies

State	Guidelines
Arizona	• Consultation meetings can be scheduled upon request. • If the Medicaid program identifies a policy likely to have a significant impact on Indian tribes, then it should provide timely written notice to tribal leaders soliciting feedback and recommendations. • At the request of tribal officials, the Medicaid program should provide additional information either verbally or in written correspondence.
New Mexico	• Consultation can be initiated by the state or by tribal leaders. • The state and tribes may engage in direct consultation, establish a work group, or both. • The state and tribes shall meet annually to consult on health and human services issues.

Utah	• The state will initiate consultation following a request from a tribe(s).
	• The consultation process will include, but is not limited to,
	  • an initial meeting to present the intent and broad scope of the policy to the state's Indian advisory board,
	  • discussions with the advisory board to understand the specifics and impact of a proposed policy,
	  • open meetings for all interested parties to receive information and provide comment,
	  • a presentation by tribal representatives of their concerns about the proposed policy,
	  • continued meeting until concerns have been fully discussed, and
	  • a written response from the state as to the action on tribal concerns.
	• When possible, the state will provide 90 days' notice of a proposed policy by making a presentation to the Indian Advisory Board and sending a formal letter to tribal leaders.

Wisconsin	• Annual consultation meeting shall be scheduled with the agenda, date, and location being jointly determined by the state and tribal leaders. • Additional consultation meetings shall be scheduled as deemed necessary by either the state or a majority of tribal leaders. • The state is responsible for drafting an annual implementation plan that shall include (1) a list of programs and services available to tribes; (2) a description of new initiatives, programs, and policies affecting tribes; (3) priority issues for resolution with the tribes; (4) the procedures to be used to consult with tribes; and (5) an evaluation process.

Source: GAO analysis of state consultation policies, January 2008.

Most States Reviewed Reported Consulting with Indian Tribes about Medicaid Changes

Most of the state Medicaid programs we reviewed reported consulting with Indian tribes in their state when making changes to their Medicaid programs.[49] Specifically, four states (Minnesota, New Mexico, Utah, and Wisconsin) reported consulting with Indian tribes on any Medicaid program changes that they believed affected Indian tribes, and one state

[49]Such changes are either made through an amendment to the state's approved Medicaid plan or through a waiver of certain Medicaid program requirements.

(Montana) reported consulting only on Medicaid program changes that required a waiver.[50] The remaining state—Arizona—reported that it has not consulted with Indian tribes about Medicaid program changes.[51] States used a variety of mechanisms to consult with Indian tribes, such as regularly scheduled quarterly meetings with tribal health directors and advisory boards.

The states reported consulting with Indian tribes about a variety of topics. For example, New Mexico officials reported an extensive consultation process with tribes about a new Medicaid program for coordinated long-term services. These consultations resulted in changes to the program, including requiring the program's managed care plans to have tribal liaisons. Additionally, Minnesota noted that it consulted with Indian tribes about changing the process by which Medicaid eligibility determinations are made for children in foster care and adoption assistance programs.

Tribal representatives' opinions on state Medicaid program's consultation practices varied. For example, representatives from one Wisconsin tribe noted that consultation was not hurtful but was also not helpful. They explained that consultation provides opportunities to interact directly with agency officials and voice concerns but does not necessarily lead to changes in agency processes. In contrast, representatives from a Minnesota tribe provided examples of specific actions the Medicaid program took as a result of consultation. A representative from a Minnesota tribe noted that consultation was effective when there was a personal relationship with state officials. However, representatives from several tribes in Montana reported that consultation did not occur. For example, representatives from one Montana tribe noted that rather than consulting with tribes about changes to the Medicaid program, the state informed tribes after changes had already been made.

[50] CMS guidance indicates that evidence of consultation with tribes is a criterion that CMS will use during its review of states' waiver requests.

[51] The state indicated, however, that tribes have been invited to attend general community forums at which proposed waiver requests have been discussed.

American Indians and Alaska Natives Have Faced Several Barriers to Medicare and Medicaid Enrollment Despite Efforts to Assist with the Application Process

American Indians and Alaska Natives have faced several barriers to Medicare and Medicaid enrollment despite efforts to provide assistance with the application process. While two of the barriers to Medicare and Medicaid enrollment are associated with the unique status of the tribal community, most of the enrollment barriers faced by American Indians and Alaska Natives are similar to those experienced by other populations—such as individuals with low incomes. Efforts to enroll American Indians and Alaska Natives have focused on providing assistance with the Medicaid and Medicare application processes. For example, almost all of the IHS-funded facilities we visited had staff who help patients complete and submit Medicare and Medicaid applications. Many organizations, including CMS and IHS, have conducted outreach to educate American Indians and Alaska Natives about the programs.

American Indians and Alaska Natives Have Faced Barriers Enrolling in Medicare and Medicaid

American Indians and Alaska Natives have faced barriers to Medicare and Medicaid enrollment (see table 5). Two of the barriers are unique to the tribal community. First, some officials we spoke with reported that some American Indians and Alaska Natives believe they should not have to apply for Medicare or Medicaid because the federal government has a duty to provide them with health care as a result of treaties with Indian tribes. Second, American Indians and Alaska Natives may not see a personal benefit to enrolling in Medicare or Medicaid because they have access to free health care at IHS-funded facilities regardless of whether they enroll.

Other barriers were similar to those faced by other populations. For example, similar to low-income populations, American Indians and Alaska Natives have experienced transportation and financial barriers, as well as barriers related to limits on access to communication devices, such as telephones and regular mail delivery. While similar to the barriers faced by other populations, some officials believed that there are some distinct aspects to the barriers faced by American Indians and Alaska Natives. For example, application processes, such as the Medicaid requirement to provide documentation of U.S. citizenship, may be especially difficult for American Indians and Alaska Natives as this population was traditionally not born in a hospital. As a result, some officials reported that some American Indians and Alaska Natives, particularly those who are elderly, do not have an official record of their birth.

Table 5: Description of Barriers American Indians and Alaska Natives Have Experienced Enrolling in Medicare and Medicaid

Barrier	Description
Barriers unique to American Indians and Alaska Natives	
Belief in a federal responsibility to provide health care	A belief that the federal government has a responsibility based on treaties with Indian tribes to provide health care for American Indians and Alaska Natives and therefore they should not have to apply for Medicare or Medicaid.
Belief that enrollment provides limited personal benefit	A lack of understanding of the benefit of enrolling in Medicare and Medicaid because of the availability of free healthcare at IHS-funded facilities.
Barriers faced by American Indians and Alaska Natives as well as other populations	
Complex application process	Includes the length of the application; the need to go to eligibility offices; and documentation requirements, such as proof of income and citizenship.
Cultural	Includes American Indians and Alaska Natives' reluctance to pursue enrollment if initially denied, aversion to revealing personal information required for application, and reluctance to apply for Medicaid because of requirements for seeking child support.
Financial	Includes premiums requirements that are associated primarily with Medicare Part B and D enrollment and concerns about losing assets because of Medicaid estate recovery requirements.[a]
Lack of knowledge about the programs	Includes a lack of awareness about the programs' existence, the differences between the programs, and their requirements for eligibility.
Language	Includes limits to understanding, speaking, or reading English.
Limited access to communication devices	Includes a lack of access to reliable and regular mail delivery and phone service.
Mistrust of government	In addition to just a general mistrust of the government, also includes concerns about prejudice, racism, and mistreatment by government officials.
Transportation	Includes a lack of reliable transportation options, including public transportation services, and the need to travel long distances to eligibility offices.

Source: GAO analysis, April 2008.

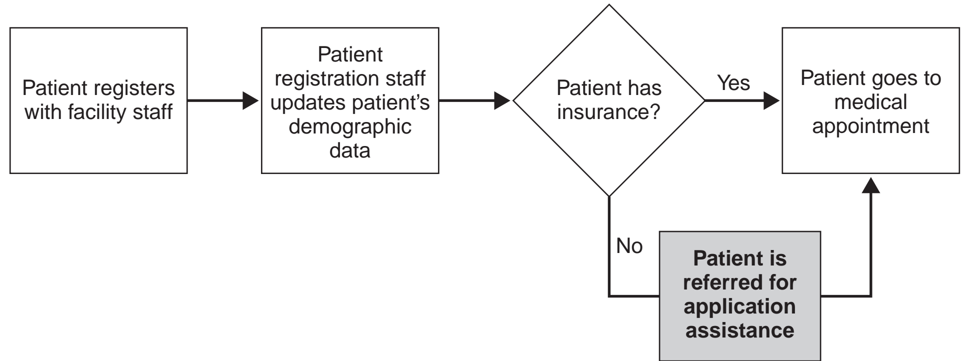
[a]Estate recovery is the requirement that state Medicaid programs seek to collect from the estate of a deceased Medicaid beneficiary the amounts paid on the individual's behalf for certain Medicaid-covered services, such as nursing facility services. While not totally exempt from Medicaid estate recovery, CMS has instituted certain protections on the estates of American Indians and Alaska Natives.

Enrollment Efforts Have Focused on Assisting American Indians and Alaska Natives with Applying for Medicare and Medicaid

Efforts to enroll eligible American Indians and Alaska Natives in Medicare and Medicaid generally have focused on providing assistance with the application process. Specifically, almost all of the IHS-funded facilities we visited offered patients assistance with applying for Medicare and Medicaid.[52] The assistance included helping complete and submit applications, collecting and possibly certifying required documentation, translating application information into tribal languages, and offering these services through home visits. Facility staff generally identified patients needing application assistance through their patient registration process, which is the process through which patients sign in for their medical appointments. For example, facility registration staff used information about a patient's age, employment status, and existence of health insurance to determine whether the patient might qualify for Medicare or Medicaid and thus should be referred to a patient benefit coordinator for assistance (see fig. 3). In addition to the patient registration process, some facilities also generated reports listing individuals who were potentially eligible for, but not enrolled in, Medicare or Medicaid. For example, one facility indicated that it generated monthly reports of (1) individuals aged 65 and older who did not have Medicare and (2) individuals aged 19 or younger without health insurance and thus potentially eligible for Medicaid. This same facility also generated reports of individuals who were age 64 to alert patient benefit coordinators that these individuals may soon be eligible for Medicare.

[52]The two facilities we visited that did not offer such assistance were both satellite clinics of larger facilities, where such assistance was available.

Figure 3: Example of How Facilities Use the Patient Registration Process to Identify Patients Needing Medicare or Medicaid Application Assistance



Source: GAO analysis of IHS-funded facility information, January 2008.

Facilities we visited used staff—referred to as patient benefit coordinators—to provide Medicare and Medicaid application assistance. Among the facilities offering assistance, the number of patient benefit coordinator positions ranged from one to eight; hospitals generally had a higher number of patient benefit coordinator positions.

American Indians and Alaska Natives may also receive application assistance directly from Medicaid or Medicare eligibility staff. State or county Medicaid eligibility staff worked at or traveled to four of the IHS-funded facilities we visited to provide application assistance and conduct on-site eligibility determinations; these eligibility staff were located at two of the facilities full-time, that is, 5 days a week.[53] State or county Medicaid eligibility staff were also located at, or traveled to, tribal offices on three of the reservations we visited.[54] Specifically, one of the reservations had a satellite Medicaid eligibility office, which was open 5 days a week and housed several county Medicaid eligibility staff. The second reservation had a staff member on-site 5 days a week, while a staff member was available on the third reservation 2 days a week. Additionally, a few of the tribes we visited had the authority to determine Medicaid eligibility for at

[53]All four facilities were located in the Navajo IHS area; specifically, two were in New Mexico, one was in Arizona, and one was in Utah.

[54]Two reservations were located in Montana, which is part of the Billings IHS area, while the third was located in Minnesota, which is part of the Bemidji IHS area.

least some tribal members and therefore had additional Medicaid application assistance available at the tribal office where eligibility determinations occurred.[55] Finally, staff from SSA, the federal agency responsible for Medicare enrollment, provided Medicare application assistance at some IHS-funded facilities. Specifically, staff from two of the IHS-funded facilities we visited indicated that SSA office staff visited their facilities at least monthly, while staff from a third IHS-funded facility indicated that SSA staff came to a building nearby at least monthly.

Many organizations, including CMS and IHS, have conducted outreach to educate the tribal community about Medicare and Medicaid and encourage those in the community to apply. For example, beginning in May 2005, there was a concerted effort by CMS, IHS, and SSA to educate and enroll American Indians and Alaska Natives in the Medicare Part D prescription drug benefit, including training for patient benefit coordinators in each IHS area and informational materials, such as posters and fact sheets, targeted to the tribal community. In 2007, CMS and the TTAG released an outreach video, to be used at IHS-funded facilities, which emphasizes the community benefit to enrollment in Medicare and Medicaid.[56] Additionally, in 2007, IHS published a poster and brochure to educate American Indians and Alaska Natives about existing federal and state health benefit programs, such as Medicare and Medicaid.[57] Other outreach efforts targeted to the tribal community included radio advertisements, which a few of the state Medicaid programs we reviewed reported using, and newspaper or newsletter articles, which some IHS-funded facilities reported using. Finally, several of the IHS-funded facilities we visited provide information about Medicare and Medicaid at facility-based or community health fairs and events at schools, senior centers, or other community venues.

[55]Only tribes that operate their own Temporary Assistance for Needy Families program, a cash assistance program for needy families with children, are able to obtain the authority to make Medicaid eligibility determination decisions and generally only for the population covered by their Temporary Assistance for Needy Families program.

[56]The video is entitled *Our Health, Our Community: Medicare, Medicaid and SCHIP Outreach to American Indians/Alaskan Natives*.

[57]The brochure is entitled *Make the Most of Your Benefits: Be ResourceSmart*. IHS also published a reference guide for IHS-funded facility staff entitled *How to Assess & Enroll Patients in Alternate Resources*, which provides an overview of existing federal and state health benefit programs and steps to determine a patient's potential eligibility for a program.

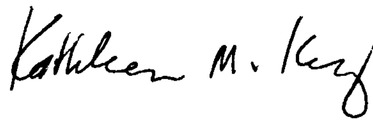
Agency and State Comments and Our Evaluation

We provided copies of a draft of this report to HHS and provided the six states we reviewed (Arizona, Minnesota, Montana, New Mexico, Utah, and Wisconsin) with copies of the portion of the report related to state Medicaid programs' mechanisms for interacting and consulting with Indian tribes. HHS provided us with written comments from CMS (see app. III). We also received technical comments from CMS and three of the six states (Arizona, Montana, and New Mexico), which we incorporated as appropriate.

In written comments, CMS noted that it was pleased that our findings highlight a number of activities that CMS engages in with IHS and commented that the report reinforces the benefit of the multiple processes CMS has put in place in working with IHS and the tribes. CMS acknowledged that it is working to improve its process for identifying whether proposed regulatory changes would affect IHS-funded facilities and the populations they serve. CMS noted that its regulations also affect programs directly operated by tribes, which have broader authority than IHS in operating programs and facilities such as nursing homes. We agree with CMS about the potential impact of its regulations on tribally operated programs and facilities, and we encourage the agency to consult with tribes when developing its regulations as required by Executive Order and HHS's tribal consultation policy.

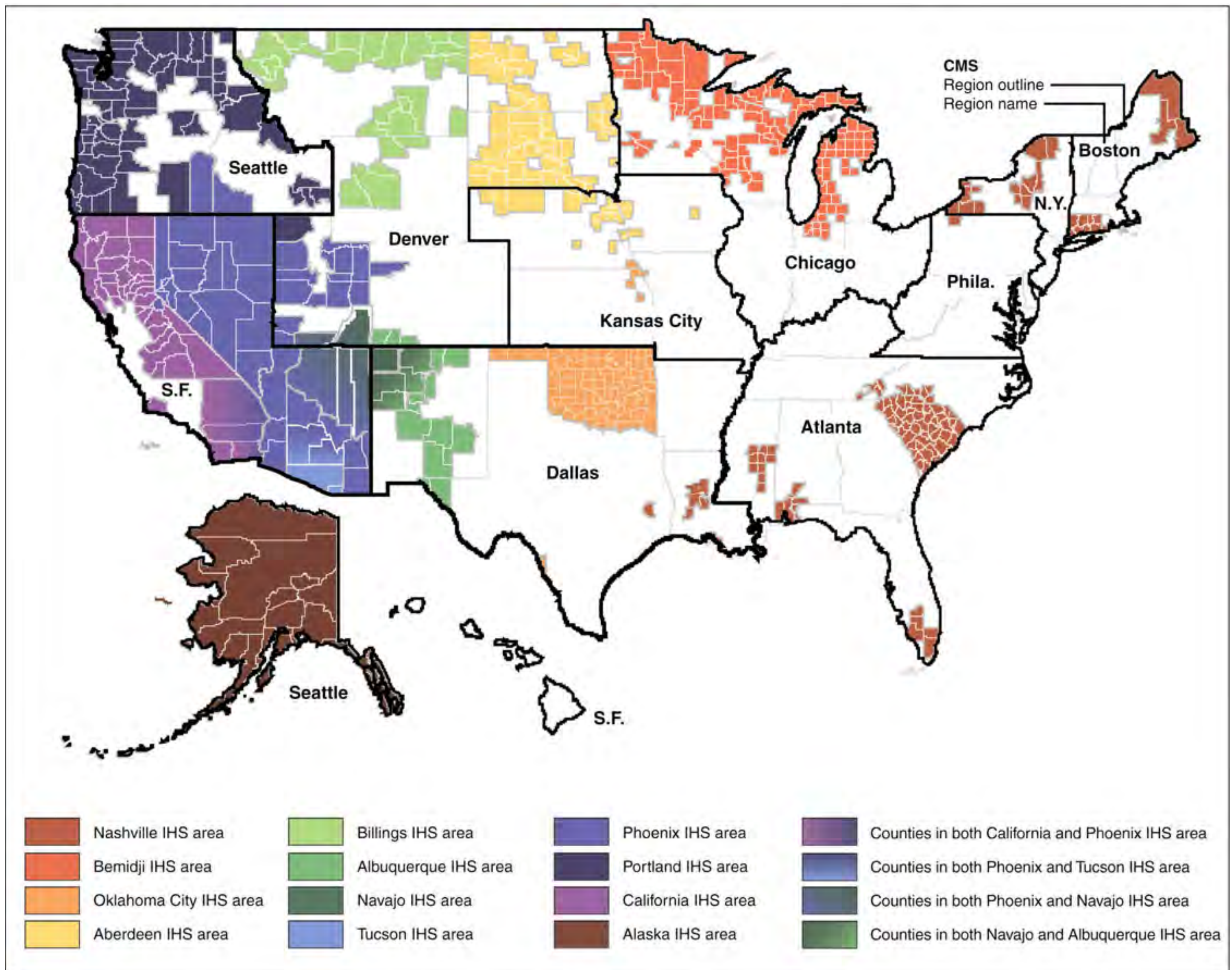
As agreed with your offices, unless you publicly announce the contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to the Administrator of the Centers for Medicare & Medicaid Services and the Director of the Indian Health Service. We will also provide copies to others upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix IV.



Kathleen M. King
Director, Health Care

Appendix I: Locations of Indian Health Service (IHS) Areas and Centers for Medicare & Medicaid Services (CMS) Regions



Sources: GAO-08-90 and information from CMS.

Note: Data on counties in the IHS areas are as of June 2007.

Appendix II: Methodology for Selecting IHS Areas, Facilities, and Tribes Visited

We used a two-tiered approach to selecting facilities and tribes for site visits, which included selecting 3 of the 12 IHS areas and then selecting facilities and tribes within those 3 areas. Based on this approach, we interviewed officials from 25 IHS-funded facilities and leaders (or designated officials) from 14 tribes.

In the first tier, we selected three IHS areas to represent a mix in geographic location, the entities operating the facilities (IHS or tribes), and the level of reliance on contract health services.[1] Table 6 shows the characteristics of the areas selected.

Table 6: Selected Characteristics of IHS Areas Visited

Factors considered	Bemidji	Billings	Navajo
Geographic location	Michigan, Wisconsin, and most of Minnesota	Montana and Wyoming	Parts of Arizona, New Mexico, and Utah
Percentage of facilities operated by tribes[a]	89	14	28
Reliance on contract health services[b]	Moderate	High	Low

Source: GAO analysis of IHS data.

[a]Includes hospitals, health centers, and health stations.

[b]Determined based on contract health services dollars as a percentage of total clinical care dollars for fiscal year 2003.

In the second tier, we selected facilities within the three IHS areas. When selecting facilities, we considered recommendations from CMS and IHS officials and tribal representatives, the type of facility (for example, hospital or health center), and whether it was IHS or tribally operated. We also used pragmatic considerations, such as distance between facilities, to guide our selections. See table 7 for the characteristics of the 25 facilities in which we interviewed officials. For each facility visited, we requested interviews with the leaders of the tribe primarily served by the facility.[2] We were able to interview leaders or designated officials from 14 tribes—7 from the Bemidji area, 5 from the Billings area, and 2 from the Navajo

[1]In selecting areas, we also considered other factors, such as whether we had visited the area previously and experts' views on the relationship between tribes and states in the area.

[2]While IHS-funded facilities may see patients from multiple tribes, we were interested in the tribe that primarily receives services at a given facility.

area. Because of the judgmental nature of our sample, information obtained from the facilities and tribal leaders cannot be generalized.

Table 7: Characteristics of IHS-Funded Facilities Visited

		Operating body	
IHS area	**Facility type**	**IHS**	**Tribe**
Bemidji	Hospital	1	0
	Health center	1	7
Billings	Hospital	3	0
	Health center[a]	2	2
	Health station	1	0
Navajo	Hospital	3	1
	Health center	2	2

Source: GAO summary of information on 25 facilities.

[a]On one reservation, we spoke with officials from the Tribal Health and Human Services Department, which oversees the tribe's health centers, instead of staff from the actual facilities. Although the tribe operates more than one health center, the facilities' operations are centralized. Therefore, for purposes of this report, we counted this tribe's facilities as a single health center.

Appendix III: Comments from the Department of Health and Human Services

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, DC 20201

JUN 24 2008

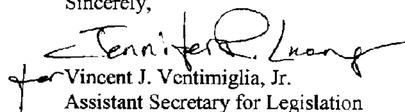
Kathleen King
Director, Health Care
U.S. Government Accountability Office
Washington, DC 20548

Dear Ms. King,

Enclosed are the Department's comments on the U.S. Government Accountability Office's (GAO) draft report entitled, "Medicare and Medicaid: CMS and State Efforts to Interact with the Indian Health Service and Indian Tribes" (GAO-08-724).

The Department appreciates the opportunity to review and comment on this draft before its publication.

Sincerely,



for Vincent J. Ventimiglia, Jr.
Assistant Secretary for Legislation

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

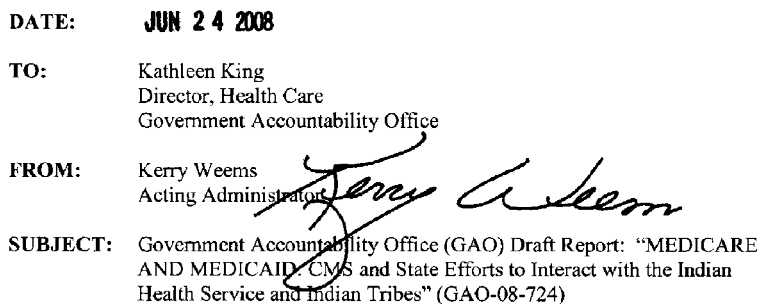
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN 24 2008

TO: Kathleen King
Director, Health Care
Government Accountability Office

FROM: Kerry Weems
Acting Administrator



SUBJECT: Government Accountability Office (GAO) Draft Report: "MEDICARE AND MEDICAID: CMS and State Efforts to Interact with the Indian Health Service and Indian Tribes" (GAO-08-724)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to respond to GAO's draft report entitled, "MEDICARE AND MEDICAID: CMS and State Efforts to Interact with the Indian Health Service and Indian Tribes." CMS has focused on developing a process where the Indian Health Service (IHS) and Tribal programs can learn more about Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) and on reinforcing ways in which Tribes can provide input into the policy development; specifically through the regulations process.

We were pleased to see GAO highlight a number of activities that CMS engages in with IHS in support of the Department of Health and Human Services' (HHS) strategic goals related to increasing the availability and accessibility of health care service, as well as addressing the needs, strengths, and abilities of vulnerable populations. Some of the CMS activities recognized by the GAO include: annual IHS area training sessions, tribal stops in the Medicare prevention tour, and training in the implementation of Medicare Part D. Additionally, as referenced in the report, CMS sponsors an annual CMS Day during the National Indian Health Board Consumer Conference; conducts a monthly TV and Web-based broadcast called Medicine Dish; provides technical assistance to individual Tribes and facilities through the CMS regional office network of Native American Contacts; develops outreach materials specific to the needs of the American Indian and Alaska Native beneficiary populations; and works closely with the CMS Tribal Technical Advisory Group through a series of monthly conference calls and face-to-face meetings with CMS' program staff. The CMS Tribal Affairs Group (TAG), put into place in 2007, is the central point of contact for CMS' activities related to IHS and Tribes. One of the key initiatives undertaken by the TAG is providing annual training to CMS' staff to enhance CMS' ability overall to work more effectively with IHS and Tribal Governments.

Page 2 – Kathleen King

The GAO report contains no recommendations as to areas CMS can improve upon in our work with IHS and Tribes, but expresses that CMS has mixed success in identifying whether proposed regulatory changes would affect IHS-funded facilities and the populations they serve. As the report notes, we are working to improve this process. However, regulations issued by CMS not only impact the IHS-funded facilities, they also impact programs directly operated by Tribes outside of IHS Medicare and Medicaid authorities. We are becoming more familiar with these programs as we work more directly with Tribes. Tribes have broader authorities than IHS in operating programs such as Federally Qualified Health Centers, Assisted Living Facilities, Nursing Homes, and Home and Community Based Services. CMS is committed to continually seeking ways in which we can work more effectively with both the IHS and Tribes in meeting all provider needs; and in this way increasing access to Medicare, Medicaid, and SCHIP services for the populations they serve.

The CMS is appreciative of GAO for its review of CMS' activities related to our interactions with IHS and Tribes. This report reinforces the benefit of the multiple processes CMS has put into place in working with the IHS and Tribes; assisting them to become more knowledgeable of Medicare, Medicaid, and SCHIP, with the goal of increasing access to CMS' program services for the American Indian and Alaska Native beneficiary populations. Understanding that CMS programs are important to the sustainability of health care services for these vulnerable populations, we are committed to continually improving our interactions with IHS and with Tribes.

Attachment

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Kathleen M. King, (202) 512-7114 or kingk@gao.gov

Acknowledgments

In addition to the contact named above, Carolyn Yocom, Assistant Director; Krister Friday; Elayne Heisler; Kevin Milne; Michelle Rosenberg; and Elijah Wood made key contributions to this report.

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