Tribal Technical Advisory Group to CMS
November 2012 Report

A. Introduction to the TTAG

The Tribal Technical Advisory Group (TTAG) to the Centers for Medicare and Medicaid Services (CMS) was created in November 2003. The TTAG serves as an advisor to the Administrator of CMS on policy issues affecting American Indian and Alaska Native (AI/AN) beneficiaries and the Indian Health Service (IHS), Tribally-operated programs, and Urban Indian programs (collectively “I/T/U”). Membership of the TTAG includes a representative from each of the 12 IHS Areas as well as a representative of the National Indian Health Board, the Tribal Self-Governance Advisory Committee, the National Congress of American Indians and the IHS. Some of the work has been to provide general education to CMS staff, especially regarding the unique status of AI/ANs; other work has focused on specific reimbursement issues, such as Medicare Part D; and other work has been developing relationships with others who have an impact on our people and programs. Recent work has focused on the implementation of the Affordable Care Act (ACA). Specifically, we are working to ensure that AI/ANs have every opportunity to benefit from the ACA benefits, and that I/T/U providers are ready to meet the increased demand for care.

TTAG Accomplishments - The TTAG has been effective in advising CMS to implement policy in a number of ways that have been beneficial for AI/ANs and tribal health programs since its inception. Some of the more notable accomplishments include:

- Avoided application of prospective payment system rules to I/T/U hospital reimbursement;
- CMS implementation of cost sharing protections, including the definition of “Indian” in 42 C.F.R. § 447.50, which includes all Alaska Native descendants;
- Medicaid Administrative Match retained (it was seriously threatened and took more than a year of TTAG negotiation to protect);
- Requirement by CMS that Medicaid managed care plans result in full encounter rate reimbursement to Indian health programs;
- Inclusion of Indian Addendum to Medicare Part D Prescription Drug Plans;
- Implementation of Medicare-Like Rates regulations, which allowed I/Ts to pay for contract health services at rates similar to Medicare rather than full-billed charges;
- Allowing tribal documentation to be accepted for citizenship documentation requirements of the Deficit Reduction Act;
- Allowing tribal health organization funds to count toward the state’s share of Medicaid Administrative Match (MAM) for outreach and education;
- Guidance from CMS that States must demonstrate adequate tribal consultation before CMS will approve State Plan Amendments or 1115 Waiver applications for Medicaid and State Children’s Health Insurance Programs.
- See also C1 and C2 below.

Enrollment Efforts - The TTAG has been working with CMS to improve education and outreach efforts for enrollment into Medicaid, Medicare, SCHIP, Exchange Plans and Medicaid Expansion opportunities. CMS contracted with the National Indian Health Board to create a
video, *Our Health, Our Community*, to motivate tribal members to learn more about how Medicare, Medicaid and SCHIP can help to improve health care for themselves, their families and their communities. The 9 minute video is designed to be played in clinic lobbies or anywhere patient interactions occur. To request copies of *Our Health, Our Community*, please send an email to kitty.marx@cms.hhs.gov. Additional videos expected to be released soon.

**B. General Education**

Much of our work to date has been educating CMS staff about special status of Tribes, about the structure of the Indian Health System, and the impacts that CMS has in Indian Country. We have made efforts to:

1. **CMS AI/AN Strategic Plan** - The TTAG undertook an effort to institutionalize the special relationship between Tribes and the federal government in the agency by developing its third CMS AI/AN Strategic Plan. The new strategic plan covering federal fiscal years (FY) 2013 to 2018 has 5 goals:
   a. CMS engages in meaningful **Consultation** with Tribes and works closely with TTAG.
   b. CMS enacts and implements **policy** through regulation, guidance, review, and enforcement to align CMS programs to serve AI/ANs by improving enrollment processes, assuring access to care, having efficient payment systems, and increasing the I/T/U capacity to deliver integrated, comprehensive programs.
   c. CMS improves and expands opportunities for development and delivery of **Long Term Services and Support** throughout Indian Country.
   d. Through **outreach and enrollment** activities, all I/T/U programs are fully informed about CMS programs and AI/ANs know about benefits to which they are entitled.
   e. Develop and improve CMS **data systems to evaluate** and expand the capacity of CMS to service American Indians and Alaska Natives.

2. **CMS Consultation Policy** - CMS approved its tribal consultation policy in November 2011. The policy basically requires CMS to consult with tribes when Medicaid, Medicare and State Children’s Health Insurance Programs have an impact on individual AI/ANs or on the programs that provide health care on their behalf.

   It was encouraging that CMS finally adopted a formal tribal consultation policy. However the policy neglected to incorporate many of the recommendations of TTAG. Tribes raised many of there concerns with the consultation policy on a national conference call in December 2011. Particularly troublesome for Alaska is the fact that consultation with tribal organizations under the policy is permissive rather than mandatory. The TTAG is working with CMS to update the policy to address these concerns.

**C. Specific Reimbursement Issues**

1. **Waivers and Exemptions for AI/AN from Medicaid Cuts**

   As many states face increasing tight budgets over the coming years, it is likely that they will increasingly look to save money by reducing Medicaid benefits. TTAG is recommending to CMS that it support a position that if states reduce benefits from their current levels to the general population, that benefits provided to AI/ANs through IHS and the tribal health system be
exempted from those cuts, as these services receive 100% FMAP and thereby does not cost the state anything.

This argument made successfully with the State of Arizona which applied for and was granted an agreement in principal from CMS, in a February 17 letter, to exempt services and benefits that were provided through IHS and tribal sites from a proposed reduction.

2. Evaluation of ARRA 5006 Implementation

Section 5006 of ARRA requires solicitation of tribal advice/input prior to the submission of a Medicaid state plan amendment (SPA) that has a direct impact on I/T/Us (this tribal input requirement also applies to CHIP). The template SPA that was issue in May 2011 requires a state submitted a SPA to describe how tribal advice was sought in the process. Without meeting this requirement a SPA will not be accepted. This was the case when a California SPA to change cost sharing requirements was rejected February 6, 2012 by CMS for not having satisfied the tribal input requirement. The rejection of California’s SPA sets a very positive precedent that the input of tribes must be solicited in the important stages of drafting SPAs that potentially directly affect tribes. The State of Kansas also was prevented from advancing their program change due to inadequate consultation with tribes. The TTAG requested of CMS that it post all the approved and rejected SPAs online so as to be easily assessable to tribal programs.

D. Patient Protection and Affordable Care Act (ACA) Implementation

1. Regulation Review. The TTAG continues to monitor and analyze all of the regulations regarding the implementation of ACA and other critical legislation. Comments have been submitted by the TTAG on the following Notices of Proposed Rulemaking (NPRM):
   - Medicare Advantage Quality Bonus Payment Demonstration
   - Notice of Denial of Medical Coverage (Or Payment)
   - Draft Multi-State Plan Program Application
   - Health Care Reform Insurance Web Portal Requirements
   - Data Collection issues for ACA Implementation
   - Health Insurance Exchange Enrollment
   - Solicitation of Information & Recommendations for Revising OIG’s Provider Self-Disclosure Protocol (Safe Harbor)
   - General Guidance on Federally-Facilitated Exchanges
   - National Data Hub
   - Medicaid Program; Outpatient Drugs
   - HHS Essential Health Benefits Bulletin
   - Health Insurance Premium Tax Credit
   - Establishment of Exchanges and Qualified Health Plans
   - Medicaid Program Eligibility Changes under ACA
   - Standards Related to Reinsurance, Risk Corridors and Risk Adjustment
   - Establishment of Consumer Operated and Oriented Plan Program
   - Enabling Indian Sponsorship under the Exchange Plans
   - Various Meaningful Use Comments
I/T/Us as Essential Community Providers
Definition of Indian under the ACA
Proposed Outcome Measures for AI/ANs and ACA

Numerous and lengthy new NPRMs pertaining to ACA implementation, that have
direct and indirect impacts on I/T/Us, continue to be issued and a brisk pace. A lot of
TTAG’s work in the near future will be to analyze and comment on these NPRMs to
address on possible impacts on I/T/Us. Copies of the 70+ TTAG letters may be found
at cmsttag.org.

2. Indian Addendum for Health Insurance Exchanges. The TTAG continues to
stress the need for an Indian Health Addendum that can be used by Qualified Health
Plans (QHPs) and Indian Health Providers (IHPs) to address the special rules and
regulations that apply to I/T/U programs that will apply all network provider
agreements the QHP enters into. TTAG sent an April 2011 to CMS on this issue.
The addendum would be beneficial to both IHPs and network providers. Among the
more notable provisions in the draft Indian Health Addendum are:
a. Waiver of cost-sharing for AI/ANs.
b. No payment reduction to IHPs for cost-sharing requirement.
c. Exemption from state licensure requirements for providers working at I/Ts.
d. Including all IHPs in the QHP network.

3. Federally Facilitated Exchange Comments. Recognizing that many tribes are
going to be subject to the Federal Facilitated Exchanges (FFE), the TTAG continues
to also urge CMS to engage with Tribes early and often for successful
implementation at a minimum in the following ways:
a. Operational guidance is needed is necessary to assist Federally Facilitated
Exchanges (FFE) and state based exchanges with verification of Indian status that
does not overly burden AI/AN applicants and tribes.
b. Enrollment assistance (including Navigators, in-person assistance and Medicaid
Administrative Match) will be necessary to ensure AI/AN people are enrolled in
exchange plans, Medicaid and State Children’s Health Insurance Programs
c. Provide guidance to states that CMS will allow tribal specific Medicaid
Expansion opportunities even when a state has declined to do so.
d. Meaningful tribal consultation must occur with the tribes for successful
implementation of exchange plans.

4. Definition of Indian – The TTAG continues to urge the Administration to rely on
the CMS definition of Indian found at 42 CFR 447.50 to permit a uniform application
process for Medicaid, State and Federally Facilitated Exchanges and related IRS rules
to ease the burden on individuals, states, tribes, the federal government and exchange
plans. See also Need for Uniform Operational Guidance in Determining Eligibility
for Indian-Specific Benefits and Protections under the Affordable Care Act by the
Northwest Portland Area Indian Health Board.
E. Medicare, Medicaid & Health Reform Policy Committee of the National Indian Health Board

The Medicare, Medicaid & Health Reform Policy Policy Committee (MMPC) of the National Indian Health Board is a national workgroup dedicated to work on Indian policy issues. Chaired by H. Sally Smith, the MMPC also provides technical support to the TTAG. The MMPC is open to any individuals who are authorized to represent I/T/Us. To join the MMPC distribution list, please contact Liz Heintzman at eheintzman@nihb.org.

F. For More Information

If you need further information please feel free to contact me:

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