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MEDICAID ADMINISTRATIVE MATCH HEARING
January 18, 2008

HELD AT 2201 SIXTH AVENUE
SEATTLE, WASHINGTON
10:00 a.m.

REPORTED BY: Mindy L. Suurs, CCR
DATE: January 18, 2008

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Barbara Richards: Good morning, everyone. We'd like to welcome you to our office. It's an honor and a privilege to be here. I know a lot of people have worked hard on this issue. This is our person who's recording -- this is our transcriber, so we have an outside transcriber who is taking notes, so we have to project.

I'm Barbara Richards. I'm the acting associate regional administrator here in the Seattle office. As the transcriber just said, we have to project, so please speak up. As I said, it's an honor and a privilege to be hosting this important event, and we welcome our tribal leaders and members from many tribes across the state. We also welcome our state partners who

have been working for quite some time on this issue, and we'd also like to welcome our fellow CMS colleagues, Dennis Smith and Jackie Garner, who have traveled quite some ways to get here.

In terms of the agenda, you have an agenda in front of you, and we will try to stick to that agenda because there are a lot of issues we would like to get through.

In terms of housekeeping, we've got beverages over there, so please take a break when you need

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one. We haven't scheduled a formal break, so if you need to get up and take a break, please do so. Women's bathrooms are on the left, men's are on the right. Ask a staff person if you can't find them.

The last thing is we are having an opening prayer, a closing prayer, and after the opening prayer, we'll do introductions, and Andy Joseph is going to do the opening prayer.

(Opening prayer.)

SPEAKER: Doug, we're going to turn it over to you for the State issues after the introductions.

SPEAKER: I'll start by introducing myself. My name is Doug Porter. I'm the Assistant Secretary for the Health and Recovery Services Administration here in the State of Washington for the Department of Social and Health Services.

SPEAKER: My name is Roger Gantz. I'm also with the Department of Social and Health Services, Recovery Services Administration. I deal with legislation and policy. Pleasure to be here today.

SPEAKER: My name is Chris Locke, and among other things, I'm the interim director for the American Indian Health Commission, and I understand Marilyn Scott, who is the chair of the American Indian Health Commission, is on her way.

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SPEAKER: I'm Steve Kootz. I'm a tribal council member for the Cowlitz Indian Tribe, also vice-chair of the health board, and manage our health clinic.

SPEAKER: I'm Jim Sherrill, Health and Human Services Director, Cowlitz Indian Tribe.

SPEAKER: I'm Lee Brewer, and I'm site manager for the Lower Elwha.

SPEAKER: Cindy Gamble. I'm Health Services Director for Chehalis Tribe.

SPEAKER: Good morning. My name is Helen Fenrich, and I'm the Governmental Affairs Liasion for the Tulalip Tribe and member at large on IPAP.

SPEAKER: My name is Frank Schneider. I'm the Financial Management Branch Manager for Region 10 in Seattle and for CMS.

SPEAKER: Good morning. My name is Roger Goodacre. I'm with the Tribal Affairs Group of CMS in Baltimore.

SPEAKER: I'm Treva Womath. I'm the financial analyst for CMS, and I review the Medicaid expenditures for the state of Washington.

SPEAKER: I'm (Inaudible) Greenway. I'm the Native American contact for CMS Region 10.

SPEAKER: Good morning. I'm Judy Wallace,

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and I'm with CMSO, Center for Medicaid and State Operations, and I work in the Administrative Claim Program in Baltimore, and I'm very pleased to be here.

SPEAKER: Good morning. I'm Dennis Smith. I'm the Director of the Center for Medicaid and State Operations.

SPEAKER: Good morning. I'm Jackie Garner. I'm the Consortium Administrator for all of the Medicaid programs in the regional offices throughout the country.

SPEAKER: (Inaudible) from Port Gamble (inaudible) Tribe from Kingston, Washington. I'm the Health Director, and actually, Port Gamble (inaudible) was the first one to pilot the administrative match program in 1998.

SPEAKER: Christina (inaudible), Port Gamble (inaudible) Tribe.

SPEAKER: Mariah Ralston, (inaudible) Nation, building coordinator.

SPEAKER: Good morning. My name is Jerry Folsom. I'm the Self-Governance Director for the Lummi Nation.

SPEAKER: Good morning. My name is Willie Jones. I'm the vice-chairman for the Lummi Nation, and I

also run the Self-Governance Advisory Council and work with (inaudible).

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SPEAKER: My name is Kim Zillyett-Harris. I'm with Shoalwater Bay Indian Tribe. I'm the contract (inaudible) manager and we've been doing MAM since 1999.

SPEAKER: Jim Roberts, Policy Analyst for the (inaudible). Also serve as the (inaudible).

SPEAKER: (Inaudible). Good morning. My Indian name in my dad's language is Badger. I'm Andy Joseph, Jr. I chair the Health and Human Services Committee for the (inaudible) tribes. I'm the vice-chair for the Portland Area Health Board, represents 43 tribes in Washington, Idaho, and Oregon and also the secretary for American Indian Health.

SPEAKER: I'm Ed Fox sitting in, keeping the seat warm for William (inaudible) who's confirmed he's downstairs somewhere. I'm the technical representative for T-TAG. I'm an alternate for Northwest Portland area Health Board, and a delegate -- (inaudible) Washington state and (inaudible) Health and Human Services at Squaxin Tribe, which is a tribe in (inaudible).

SPEAKER: Good morning. I'm John Stephens. I'm the Programs Administrator for the Swinomish Tribe.

SPEAKER: Good morning. My Indian name is (inaudible). My name is Brian Cladoosby. I'm the chairman of the Swinomish Tribe.

SPEAKER: My name is Todd Slevett. I'm with

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Department of Social and Health Services, Health and Recovery Services Administration, and I'm the tribal Medicaid Administrative Match Program Manager.

SPEAKER: My name is Deb Sosa, and I'm Health Recovery Sources Administration, Native Health Program Manager.

SPEAKER: I'm Alan Himsl. I'm with Health Recovery Services Administration. I'm section manager for Medicaid Administrative Match.

SPEAKER: Good morning. My name is Doug (inaudible.) I'm the Program Administrator for the Department of Social and Health Services, Indian policy.

SPEAKER: Brett (inaudible) with CMS (inaudible).

SPEAKER: My name is Julia Ortiz. I work for Youth Enrichment Social Services, Lummi Nation.
SPEAKER: Penny Hillaire, Lummi Nation.
SPEAKER: Julie Jefferson with (inaudible) Regional Manager.
SPEAKER: I'm Debbie Byrne from Nooksack, and Clinic Administrator, I think. I just had my interview.
SPEAKER: I'm Rosy Jones, and I work for the Lummi Care Program, which is the chemical dependency program at Lummi.

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SPEAKER: Rosalie Scott, director of the Lummi alcohol program.
SPEAKER: Good morning. My name is Liz Tries. I'm the tribal liaison for Medicaid and the Division of Medicaid and Children's Health.
SPEAKER (MR. PORTER): Well, Dennis and I have been associated with the Medicaid program off and on since 1987 in three states, all of whom have tribes in Maine, California, and Washington. And today has an historic feel to it because in all that time, I've never had a consultation with central office and the state representatives and regions and the tribes, so this is a first for me, and I hope this ends as well as it started.
I'm going to ask that Todd hand out a graph because I want to set the stage. Knowing that Dennis is a proud and effective steward of taxpayer dollars, I want to help him understand the scope and scale of the program we're talking about.
I'm the Medicaid director for a program that serves 1,000,000 people in the state of Washington and probably spends somewhere in the ballpark of about $5,000,000,000 a year state and federal funds, and I think -- you correct me if I'm wrong, Dennis -- I think we have one of the more modest administrative claims programs in the country. You'll see in this chart that we're

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looking at a total expenditure outside of the administrative costs within my agency on the order of -- I'm going to say -- is this state and federal? -- so 60,000,000 all together, of which 30,000,000 is federal.
Most of that you'll see in this chart is the

local health jurisdiction, the health departments. Second in the running here, about 31 percent of that expenditure are school districts. And what we're talking about here today is only 2 percent of that total, which, on federal scales, is a tad over one-half million dollars.

The next chart -- next document I want you to take a look at is the timeline. I want to share with you a little bit, Dennis, of the journey we've been on. And as you'll see, this started with our very first contract in this state with the Clallum Tribe, Port Gamble.

We had a number of conversations about our school-based administrative claim with CMS in the regional office and had a number of very painful conversations with our local school districts about how they had to be more accountable for and be more responsible for an audit trail of how those dollars were being claimed and spent. We got some guidance from CMS as to how we ought to allocate costs and how we ought to keep track of expenditures, and we took the opportunity from that learning experience to make sure

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we sat down with tribes and informed them of what the rules were.

This is our understanding of how you appropriately participate in this kind of a program, and we had some difficult conversations with the tribes. A lot of the paperwork that we were saying was going to be required, a lot of the recordkeeping, a lot of the coding was something that was, especially for smaller tribes, difficult; but they understood the importance of being able to account for the funding and for us to have a pretty clear reporting trail, so did a lot of good work there.

We had our own consultation with the tribes back in June of 2005. Looking here for the -- we a meeting up here in February 2006 with the regional CMS folks. And I'll take pains to say that, as difficult as some of these negotiations were, I felt both the state -- all three of us: The state, the tribes, and regional office folks -- were negotiating very transparently and in good faith, we were sharing information step by step, trying to get reality checks as we went along -- are we on the right path here? Are we doing enough there? And I felt very good about the partnership that we had established amongst the

three parties.

We submitted our final draft back in August 2006 and engaged in a series of Q and A, and we have come

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to a point, I think, Dennis, where we feel as though the proposal we have put forth is a reasonable one and that the additional requirements that are being proposed or suggested by CMS at this stage of the game in our assessment exceeds those that are expected of school districts. It's more onerous than what is being expected of the local health jurisdictions. And I think we, the state, share the tribes' notion that we're now in an area of overkill here, that what we think we're being asked to do with our staffing is not reasonable, particularly when you look at the risk we're talking about (inaudible) and this is, as I said, about $500,000 of federal money we're trying to make sure we keep track of here.

And at this point in time, it pains me to say this, but I think it's fair to say there is a strong feeling that tribes are being discriminated against in this process, that the standards that they're being held accountable to is not a fair one, not an equitable one, it's more restrictive than what other administrative claiming entities are involved with, and I think at this point in time, what we would ask of you is that you accept the proposal that we have put forward and retract any of the additional requirements that have been on the table and been a point of dispute. Approve this and let us move forward in partnership. And I'll pause and ask Brian here

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if he'd like to make a remark.

MR. CLADOOSBY: My name is Brian Cladoosby. I'm the chairman of the Swinomish Tribe, and I thank the creator, Dennis, for giving you traveling mercies. I understand you come to us from Washington D.C. It's quite a trip to make. I know many of us in this room have done it many times, and it's a long trip, and so I thank God that you're able to get here safely -- you and your staff, whoever else came from D.C. with you.

And just to give you a little bit of my background, I've been on the tribal council for 23 years now, and I've been the tribal chair for -- this is my 11th year as the tribal chair of Swinomish. And so just a

little bit of background, there are 29 tribes in the state of Washington, and I'm not sure if you're familiar with how we operate out here, the tribes do, but we work together quite wonderfully on health issues, and it's a testament to those around the room here who have made this issue a top priority.

And you may not know, but there's many different types of tribes: There's small tribes and large tribes, there's rural tribes, there's urban tribes, there's isolated tribes that are -- you know, some are out on the coast, some are up in the mountains. And it's an understatement to say that the status of health on Indian

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reservations is extremely poor. You've seen the statistics. You know what we have to deal with on our reservations. And take, for example, maternal health. The statistics will show that of all the racial groups in the state of Washington -- and I'm talking about new Alaska Native and Native American mothers, the ones that are just experiencing this wonderful experience -- and just a side note, I finally became a grandfather on December 17th. And it's awesome. It's a wonderful experience to be able to hold your granddaughter when she's three years old. Many of you in the room know what I'm talking about.

And so to experience seeing my daughter have the benefit of going through a well-planned and a well-overseen pregnancy and to deliver a healthy baby is an experience I want all tribal members to feel and experience. There is nothing like it in the world. And unfortunately, a lot of these young mothers -- and up in Lummi on Sunday, I spent three hours with my great-great-grandnephew. My wife's grandniece just had a little boy. And you can't explain the experience unless you've been there. And my wife is Lummi, I'm Swinomish, and my grandniece -- to see her there holding her newborn son is just a sight to behold, and to know that that child was one of the few that was able to experience going through this in a good way. Unfortunately, we have a lot

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of mothers that are poor, that are addicted to substance abuse, smoking, drugs, alcohol. They've experienced abuse from a physical standpoint, from a mental standpoint, from a sexual standpoint that we here as men can't understand.

And it is those ones that we need to address to make sure that they get the care that they need. And unfortunately, they are not. And the statistics will show that 36 percent of new American mothers have been diagnosed with a mental health problem, and they are underenrolled in the CMS program. Those are the mothers that we need to look out for and those children. We need to give those children a chance. And I can't thank my creator enough the chance that my grandchild is having.

And I'm here letting you know how compassion I feel about all of our mothers in Indian country. We have such a strong place in our society for our elder mothers, for our mothers. They're just so important. I can't underestimate the importance of them in our culture.

And, you know, this last statement is a problem, and we need you to help us solve it. We're not asking you to be the knight in shining armor, come in and fix all our problems. We want you to be a partner with us. We want you to help us solve these problems. And I can't underestimate the importance of this program and how important it is for us tribes to be able to participate.

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Like I said, some of these tribes are very small tribes, and some of them -- you know, casinos are becoming a good benefit for tribes, but unfortunately, there's a lot of small tribes -- you hear about all the successes, but you don't hear about the small tribes that aren't able to get involved in the gaming and they don't have the staff necessary and the requirements that we want to put on these small tribes is just too onerous, and they're throwing up their hands saying why, you know, why even try.

I've got a couple documents I'm going to have John here bring to you. One of them is the "Improving Health Through Partnerships." And this is a publication of a tribal group representing Washington state tribes. And our very own American Indian Health Commission is relied upon heavily by our tribes to work with our state Medicaid program on issues to improve the Alaska Native and American Indian health programs. And you'll see in that document there -- the other one I gave you is the "American Indian and the Alaska Native Strategic Plan," and this is a publication of CMS that documents -- and this comes from

the publication -- the importance of federal trust and government relationships and sovereignty.

I cannot say that enough. I'll never get tired of saying those. And, you know, it's like when my

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grandchild gets ready to learn the ABCs. I'm not going to tell her once and my children aren't going to tell her once and she's going to get it. And it's the same with these issues that we bring about continually: Federal trust, government-to-government relationships, and sovereignty. Just when we get people like you to understand what that means to us, then you move on and somebody new comes in. So that's why I never get tired of saying those and repeating them and explaining what it means to us.

Also in that publication is the underenrollment in CMS programs of tribal members. And the publication also addresses the impact CMS policies have on Indian health programs in Washington state. And there's two important quotes that I'd like to share with you from this document. It says: "Changes in CMS policies and programs can make a significant difference in Indian health budgets. While they are insignificant to the CMS budgets, Alaska Indians and Native Americans comprise about 1/10th of 1 percent of the total CMS beneficiary population."

So when you look at it in those terms, it is very small, but that small portion to us is very important. I cannot underestimate that.

So every requirement CMS places on MAM (inaudible) tribe will be able to participate in that program, and that is sad, because we are thinking about our

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mothers and our children in the future and we have to do whatever we can as a team to help them.

Washington tribes have been able to accomplish significant strides in improving Indian health by working with the State. As you can see, there's a partnership here, and this partnership is going to include you once you approve this plan, and we're going to make the lives of many tribal members a lot better after today. As a team.

And so we need to extend that type of mutual cooperative relationship with you because it is so integral to Indian health. I want to be sure that all tribes are

able to participate in all CMS programs, including MAM.

So how can we achieve that goal today? Do you agree that this program is an important vehicle not only to improve Indian health status and access to Medicaid services, but to also improve the problem of underenrollment of Indians in CMS programs?

I look at this as a long-term benefit to have healthy tribal communities. We need to break the cycle in Indian country. We need -- we've been in the cycle for a couple generations now where we've had these health disparities. And you might -- may or may not have read "The Quiet Crisis" that came out here recently that shows the disparities in Indian country. And I believe it

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takes two generations to break a cycle, and this is a cycle that we need to break.

There can be a positive impact long-term to health budgets that tribes rely on from the Feds, from the state, from the local, and from their own budget process; and so we need to break that cycle. We need to make sure that we leave this room saying that yes, we can sign this plan, we can agree to it, and we can move forward.

This is the second time in three years that I as a leader have come down here to talk about this very important subject. The last time was with the regional administrator, I believe -- correct me if I'm wrong -- and so this is the second time in three years that we're working on the same issues. Let's get it done and move forward so our mothers and children out there have a fighting chance to succeed like my grandchild and my great-great-grandnephew have. Thank you.

DENNIS SMITH: Anyone else going to speak?

SPEAKER: I have an announcement, everybody. Marilyn Scott was stuck in the traffic behind a wreck and then there was an incident of road rage and the police pulled over five cars, and one of those are hers. So she probably won't make it here, and she wants to give her sincere apologies because she was trying very hard to get here, but, you know, sometimes God puts obstacles in

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front of us for a reason. Thank you.

DENNIS SMITH: Thank you. Hope she gets released soon.

SPEAKER: I would like to add to what Brian said. I need to let you know that our tribes -- a lot of people think we don't pay taxes, but you can check any of my paychecks, and we do pay taxes, and some of our tribes are the biggest employers in our part of the state. I know my tribe is. I believe we employ somewhere around 4,000 people. And that's not only our tribal members that benefit from our employment either; it's the whole -- we have two counties and then the outskirts of our counties is actually seven counties involved in Colville. So I'd like to make that statement.

Another reason why I believe that we deserve to be treated equal as anybody else in this nation is our people serve our country more than anybody in the United States per capita-wise. I could give you an example. My family, there's my dad, my two brothers, myself, my sister. On my wife's family, her dad, three of her brothers, and both of our grandparents. So we need to recognize our people that serve the country.

It was last year that I attended a funeral service in D.C., and it was one of my good friend's sons, another tribal member of the (inaudible) tribe. So I just

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wanted to make that known, that we pay taxes, we serve our country, and that we should be treated just as equal. Thank you.

SPEAKER: Yes, Steve Koots with the Cowlitz Indian Tribe. I think also we're here representing our tribal members, but for those of us who have clinics -- and that's all of the tribes in the room plus many that are not here -- we serve many other tribes from across the United States, so we're not just here on behalf of our own tribal members. In our case, we serve members from over 90 different tribes throughout the United States and from Alaska, and many of them are moving and they're mobile and they're around the country and they live in poor circumstances, and we need to have means and mechanisms and tools to try and engage these people with services to increase their health status and keep their health from declining.

And we see it all the time, and it's a battle we fight constantly every day.

SPEAKER: I would like to add it's 2008 and

you're still -- for a person that's on Medicaid -- oh, my name is William Penn from the Squaxin Island Tribe, and I was just saying it's 2008, and there are still a lot of barriers put in place for a person that's on Medicaid to try to get a service (inaudible) they're at capacity with

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their Medicaid clients, and there's -- we got to look at ways to overcome these kind of obstacles and make it a better deal for the medical providers. (Inaudible) That would allow people to get better health care when they're in the Medicaid system.

DENNIS SMITH: Thank you very much. Again, I want to thank everyone for coming today, thank everyone for inviting me, and looking at your timeline that you've laid out, I feel that I also need to apologize that this is an issue that has gone on longer than I had certainly realized in terms of we want to be good partners also and to be able to solve problems.

I do want to make some just very brief remarks. First, to everyone, that the privilege of embarrassing Doug Porter in front of everyone, to extend my gratitude to Doug for all of his work. He mentioned it, but in a far too modest way about his role that he has served in not only three states, but nationally. And Doug has served on the Medicaid board, on the executive committee, various different capacities, and is truly one of the handful of true Medicaid experts. There are only a few Medicaid experts in the United States or the world, and Doug is one of them and whose counsel I value a great deal. We're very fortunate to have him in Washington and in the region.

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Secondly, I want to say up front that I share the very goal that you so eloquently described, and I firmly believe and have been trying very much to get every woman, every mother, every child, every man who is eligible for Medicaid, to find them, to get them enrolled in the program, to be able to provide the health insurance and the access to health care that they need.

I believe so passionately in that that I'm actually getting sued in another part of the program. Last August I sent out a guidance to the states saying 95 percent of all of your poor Medicaid and SCHIP eligible

children, you should sign them up, you should find them, you have an obligation to go out and find them before you are extending benefits to higher income individuals. That is the goal that we set out, and we're actually being sued for saying you shouldn't be (inaudible) such a goal. But that is exactly the same way that I feel. We should find every single individual who is eligible for the program to give them the access to care that they need.

And I also want to say very much so there is -- I want to assure you the issue is the accountability that I am being held to in Washington to a -- yesterday, right before I flew out, had a meeting with Congressional staff that were pressing us about unapproved drugs that the Medicaid program was allegedly paying for, and the concern

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that was being expressed by Congressional staff -- this was an oversight staff -- that Medicaid was not -- didn't -- the allegation was we didn't have control of our program.

We went back in preparing for the meeting, we did a run on the national drug codes, ADC codes, against our databases, and in one quarter found that we potentially had paid $9,000 inappropriately.

Again, I sympathize with you in terms of the view that you may have that the scrutiny that the program is under, but that scrutiny is there not because it is about the tribes or the tribal organizations, but it is the scrutiny across the entire program. It's not about the tribes. And it is in many respects, as I have again been called on a number of times to justify my stewardship of the Medicaid program, and people do like to tend to say well, it's only X number of dollars. But to put that into context, that's what I was being questioned on yesterday. Being questioned on $9,000, trying to account for that money.

So this is -- we all are accountable. We are all held accountable. And from our perspective, that is only what we are trying to do. Our intent is not to erect barriers. Quite the opposite. We want to tear down those barriers, but -- and we want to support the work that you are doing, the type of work that you are doing, but as

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we do that and support that, we also believe that we need to build in the accountability so that we can get a clean

record that we can account for all of those dollars.

So I do want to hasten to assure you our relationship is extremely important to me personally. It's extremely important to the agency that I serve in, the department and to the administration. And it is my goal, it is my desire that we do get to approval on the state plan amendment to provide the services and the activities that are so important to finding those individuals who are eligible for the program. So that is my desire: To get to approval.

The issues that have played out in Washington, in the state of Washington here in terms of the administrative claim have played out elsewhere as we've dealt with schools. And again, we recently took action on schools because we believe there was not sufficient accountability built into the system. And people could arguably say, well, good things were happening, so why don't you just let us continue doing what we've been doing.

Medicaid was being billed to build schools. I'm all for building schools, but I think that's beyond the role and the capacity of the Medicaid program. We cannot be held for that. We are paying the paying the salaries of

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principals and secretaries to principals and people who have virtually nothing to do with enrolling children or providing services, and -- but that is about the accountability that we have been building into it.

We also have recently come out with a rule on target case management, again out of a reaction because of where there was a lack of accountability in the system again to where Medicaid was being pulled into becoming a financing source with many programs and agencies that were well beyond the mission of the Medicaid program.

So looking at the timeline that you have laid out for your particular plan, I readily see to some extent almost being caught in the current of everything else that has been going on in Medicaid in terms of those accountabilities. So I can appreciate and understand your frustration as you are looking at, say, well, this is just about a simple state plan amendment for a very simple program that we're trying to support, when, in fact, as I said, looking at your time frame, you've been pulled into

the current of other critical issues as well.

I want to move forward. You all have already worked very hard. The tribes have, the state has, the regional office, the consultation with central office. It's my impression we are very close. This discussion isn't about revisiting all the good work that you've

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already done; it's about finding the solutions to the last couple -- finding those last couple of pieces to the puzzle and putting them in place. And I want to -- I will not hold you to any standard that I don't hold anyone else to, but I also can't hold you to a lesser standard. And I don't think that you would -- you're not asking for that and I want to acknowledge that you're not asking for that either.

So it might be helpful as these issues are fresher in other people's mind than they are mine, I go back and forth about them, but perhaps I can ask Judy and Doug and Brian to sort of say where do we think we are now at this point in time, what are the last couple of -- and Barb Richards -- I want to acknowledge her role and her staff out here in all of these issues -- what are the last pieces that we need to find to make this complete so we can get this approved and support the very important work that you are doing. But I can also go back and assure everyone that the accountability on our end is there.

Doug?

MR. PORTER: Take a first shot at it, Dennis, and invite others to fill in the blanks. From the state's perspective, I think we are interested in -- I guess I want to preface this by saying I don't think this has to do with a lack of accountability or less

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accountability. What I'm talking about right now is frequency of accountability. So this is information that we're going to get sooner or later, and the request we've heard from CMS is that we need quarterly monitoring. Quarterly monitoring would be looking at expenditures, average expenditures under the new cost allocation plan that we've been using with tribes that are in this program of between $13,000 and $18,000 for a quarter, for three movements. Tribes have up to a year to submit a claim. And so we think it makes sense to do an annual monitoring,

not a quarterly monitoring. We'll both get the information. We'll all have the information that we all think we need to be accountable. Simply the frequency with which we will be gathering it, so we would ask that that request for quarterly monitoring be withdrawn.

We think that the cost allocation plan has withstood adequate scrutiny. Our methodology we think is sound. We think we have had confirmation from the regional office, and I think there are now unresolved -- the suggestion of additional activity codes that I guess get a more granular accounting of where the activities are occurring, and I have to stop talking about that because I don't understand anymore of that than what I just said, so I'll let somebody else fill in those blanks.

SPEAKER: I'm (Inaudible), Klallam Tribe,

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and I just wanted to talk from Port Gamble's perspective on accountability. And we do do annual audit for the tribe, so we're very accountable. Whatever on our contract that we apply for, we'll send them a single audit. We passed with flying colors. I think a lot of tribes here go through single audits. We're a small tribe, and we make sure our internal controls are in place and people are handling things the right way. We all pretty much have our own MAM coordinators. I have mine here with me today. And anytime any new staff come on, we do the training to make sure they're claiming correctly. So I think as far as accountability, tribes do very well. So just wanted to make that point.

SPEAKER: Chris Locke from American Indian Health Commission. I also think you do the tribal MAM program a great disservice by comparing it to the school-based programs. And I think that part of the problems have also been created because of the requirements and the overreview MAM cost allocation plans have been housed with the same staff who have been overseeing the school programs. They're not alike. They're not alike at all. And I think that this has caused part of the problem.

As (inaudible) said, tribes are used to being extremely accountable to the federal government for a

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variety of different programs. I think Brian and others

have elequently made the point that the MAM program is really important to Washington state tribes because it's the only program available out there that will help provide some funding for enrollment, outreach, and other kinds of activities that are so important to deal with some of the maternal health status problems that Brian alluded to. It's getting those women enrolled. And Indian women face really unusual circumstances to get enrolled and it's difficult to get them enrolled because they feel they're entitled to health care services through the federal government. They don't often understand that, by enrolling in the Medicaid program, that means their tribe will be able to get extra income, they'll be able to get additional services. So the unique issues that Indian women and Indian people in general, elders because of the state recovery issue -- face really require a different kind of outreach that only tribes really can provide because the Indian people trust their tribal staff.

So again, this MAM program is really important to tribes. It's not like schools. It's far more like health departments, but it's not even like health departments.

But another point. We did a quick calculation of what it might cost for the Washington state

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tribes just in the first year to comply with these extra coding requirements that we feel are unnecessary to begin with, but we understand that there's probably about six additional codes that would be required. We estimate it would cost about $80,000 in the first year, and this would include the training that all the tribal staff would need, it includes the extra time that the staff would have to do to segment their time into these additional codes. And again, for a program that provides $500,000 a year, to spend $80,000 for these additional requirements that, again, I think that it's not the same standard. It's a standard in excess of what you're asking other entities that have MAM contracts with the state.

So again, the issues of small tribes are not being like the school districts, but like other kinds of unusual entities. The importance of the MAM program to really get Indian people who we know are underenrolled in the Medicaid program enrolled, just really, again, I think

tribes have made a lot of concessions to the draft MAM program that's on the table now, and we'd like to ask you to just accept this draft as opposed to imposing yet again additional costs to the administration of the program for the tribes.

DENNIS SMITH: So the issues we have are annual instead of quarterly and the additional activities

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codes. Other issues? Judy?

SPEAKER: I'm Judy Wallace, and I review all the claiming plans that come in from any claiming entity that comes in within a state. And because of the unique nature of tribes, we want the tribes to be able to provide outreach and enrollment in the home setting. Most of the other claiming entities -- Chris mentioned schools -- are not allowed to provide outreach and enrollment in a home, only in a school.

And I think that we worked very closely to provide some additional code examples. Right now you have a Code 4, a Code 8 that you capture services -- activities that are provided in a clinic setting in terms of outreach and enrollment. And I think what CMS had asked was that the tribes be able to distinguish that when that was provided in the home setting. In addition, all claiming plans that come into CMS --

DENNIS SMITH: For a second, so the purpose of the additional code is to be able to support and recognize an activity that you are being allowed to do which is in the home, which generally wouldn't be allowed.

MS. LOCKE: I don't think that's true. Someone who knows more about that --

SPEAKER: My name is Todd Slevett. I'd just like to --

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DENNIS SMITH: Just offhand, I'm not certain who else we pay to go door to door for this -- as I said, the schools -- we certainly don't pay schools to go into homes for that activity.

SPEAKER: Again, my name is Todd Slevett. I'm with HRSA. I've been working on the tribal cap. I'm the program manager. And my understanding is that the CMS claiming guide which we've been told to use as the source to develop our cost allocation plan, does not actually have

any information regarding where a Medicaid administrative match activity should take place.

Our understanding is outreach -- it makes sense that you're going to be going out into the community talking to people outside of an office setting to go talk to them about Medicaid.

So I guess my point is we were never under the understanding that these activities would only be taking place in a clinic setting or an office setting. My understanding is that many other states are doing exactly the same thing.

DENNIS SMITH: Again, stipulating for the moment that other states might not be, again, the purpose is simply to be able to distinguish and support the activity that you're actually doing.

MS. WALLACE: In terms of capturing the

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setting in which the activity took place, and we're only talking about outreach and enrollment and referral and the -- you know, we want to move forward in terms of I think Todd and Alan and many of you have been talking with us months back, and that all claiming plans, most of which have come into CMS, are approved in a clinic setting. Because of the unique nature of tribes, we want the tribes to be able to do the outreach and enrollment knowing the rural areas and the fact that they feel more comfortable in that setting.

So our understanding is that the school guide, which we know is sorely out of date and we hope to revise in the future, was created first for school entities, as Dennis mentioned, because of some very clear accountability issues, and we've applied it to other claiming entities moving forward.

We want you to be able to meet all of your goals and visions in terms of enrolling your members in tribes in their home. We're just asking that you report that data.

And my second point is that all claiming plans that come in are asked to capture data and report that to their regional office, so that's not something that we're -- is unique to tribes. Any new plan that's approved has that stipulation.

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SPEAKER: Steve Kootz with the Cowlitz Tribe. In my previous job I worked in public health, and I will tell you a whole lot of outreach, getting people signed up and connected with care, happens outside the office. It happens in the community, it happens in the schools, it happens in the homes, it happens at church gatherings, it happens everywhere, and we were not required to do this.

Secondly, it's not very efficient -- I realize that -- it's not very efficient to drive an hour or more sometimes to go and see somebody in their home to get them signed up, but sometimes you have to do what you have to do. And, you know, we're not getting paid to drive an hour or two hours to go and do that, but sometimes that's what it takes because there's a whole lot of reasons why they don't neatly come in and line up -- in a lot of circumstances -- line up just to sign up for benefits.

SPEAKER: Jennifer LaPoint, Cowlitz Tribe. I just want some clarification, I guess, from the statement you made about why does it really -- what is that data going to be used for that it makes it necessary to collect the data separately. If tribes are the only ones supposedly cleared to do outreach in the home, what is CMS going to use the data for if we are taking the time to ender it separately?

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MS. WALLACE: That's a great question. And the data is reported to the regional offices. When we talked with Alan we said this format could be developed by the state that would address how they'd like to report this information. But it's really just for us to know that activities of Medicaid outreach and enrollment -- how much of the activities are being provided in the home and how many are being provided in the clinic. It doesn't distinguish anything characteristic of a particular Medicaid enrollee; it's just some summary numbers of reporting that information because we're allowing this new from CMS so that, if somebody asks us from an accountability perspective, how much of your outreach and enroamment is being provided in the clinic, how much in a home setting or an other setting, we want to be able to answer those questions across states.

DENNIS SMITH: Let me ask a clarifying

question of Judy, and by all means, you're the expert, not me, on these areas, but does it not also then -- and correct me if I'm wrong -- again, on the accountability side, because the funding is using certified public expenditures on an audit basis, auditors would want it broken out between the clinic to where -- versus in the home setting? Because you need to identify the -- where the -- the funding is going to come from two different

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places, so you want to prevent duplicative billing, and you want to be able to support where the nonfederal share is coming from.

SPEAKER: So the funding -- if we provide service in our clinic versus outreach in the home or at another community location, they come from different funding costs. Is that --

MS. WALLACE: No, not exactly. I think what we're saying is that, if you look at your chart, this reports in terms of how much money has been collected from Medicaid, this is the federal share. The state is putting up the match. And what Dennis was talking about was that we're looking for -- that's referred to as certifying your public expenditures in terms of how the money is being used.

SPEAKER: (Jackie Garner?) One thing, we're talking a lot about accountability and this is a small piece, but as this program evolves, it also advises all of us on our planning. If we don't know where activities take place, then going forward, if we want to do something creative with outreach, we're lacking that information and then typically I have to call the regions and they have to scurry around and try and answer questions like that. But I come from a program background, and in my mind, it's good program -- it's just good program work to know where your

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activities are taking place if you want to think down the road about what might be possible.

SPEAKER: I think what Jennifer's point is is that to spend $80,000 for tribes to come up with information that clearly -- I mean you don't have a purpose for it right now -- to me just seems extraordinary. And if, in fact, this is a standard thing that everybody else across the country has to report these kinds of codes,

perhaps you can make a case, but, you know, I just don't see it here. And again, the smallness of the tribes, the importance of this program to them -- it's baffling to me. It really is.

SPEAKER: Thank you for a second to clarify. I mean I guess to me, from my perspective, I do believe in data and program planning, and my whole job is infrastructure development, and I'm also trying not to be a little bit offended that you think that we don't track that for our own program development, where if we want to change how we do outreach in our community, we do that internally and (inaudible) report to CMS. But I guess I just have a hard time collecting data with no purpose. I don't think you should ever collect information if you don't already know how you're going to use it. And I didn't hear an answer from any of you that you conclusively have any use for it besides collecting it and reporting it to the

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regional office.

SPEAKER: I can maybe offer some -- some reason for the home setting documentation (inaudible) if you need to justify the time spent in a particular area as opposed to a different area, I can see where the home setting would probably require more time, and so if you were saying that we spent this much time doing such and such, it would help to verify your home studies as being reasonable to think that there's probably more time spent doing a home setting as opposed to those who come in and out of the clinic quickly or a phone call to the clinic quickly. That's one reason I can see for some clarification as to where the setting is actually taking place.

SPEAKER: My name is Willie Jones, and I'm the vice chairman for the Lummi Nation, and as I sit here and listen, I listened to some statistics earlier about -- and I can go back and quote like Brian did on several different areas where we're the lowest on the totem pole as far as health is concerned, and we're actually low on the totem pole as far as registration for Medicaid for help in our communities.

And I've been wondering how do we get a plan in Lummi to get our people in to register? I agree with the lady there: It's got to be our plan to do this. And I

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look at some of the reasons why our people don't come in. They're disgusted with the past systems that didn't work. We have a hard time getting them to come in. A lot of them are waiting for the treaty to be served, a guaranteed treaty, and when we debated whether we were even going to take Medicaid, several tribal leaders across this country hesitated because of the impact that might have on our treaty until we were assured that it wasn't going to affect our treaty at all.

And so it needs to be tribal plan and tribal data of how we recruit and get our people in to get them signed up to get help because some of them stay home and be sick because they're sick and tired of the system that don't work and the treaty that's not lived up to. So we have to do outreach, and it's got to be our plan. And we're unique. We're not the same as the state or the national level. The Lummi Tribe is unique, and Shoalwater Bay is unique in its problems.

And so the thing I like about this meeting is that we have the state sitting here and the feds sitting here and the tribes sitting here, but I'd like us to look at the problems and really try to solve the problems here and look at the facts. This is a tribal issue. This is a tribal -- it should be tribal data and a tribal plan working in coordination with both state and feds. We have

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to work that way. So I just needed to state what I was hearing here, and it's really bothering me because I have people at home that won't even come into our office because of the way they've been treated by the state and the federal government. But I like where we're at around a table like this. We've come a long way. And I'd like us to go forward from here. That's all I've got to say.

DENNIS SMITH: And again, I would like to think we're in passionate agreement that we do want you to go into the home because you're saying they won't come to the clinic. We're saying we will support you going into the home. Our request is simply to distinguish when you do that, that there are specific ways of reporting that that's what you did, and we're simply asking you to use that.

If that's burdensome because you have to train your workers to use the codes, again, I would be open

to suggestions on how we can train your workers to use the codes.

SPEAKER: I was glad you said training because that would alleviate some of the money, but then -- we have a very -- we're not a small tribe, but adding things into the program -- I guess I'm not seeing what the report was. Was this the one that was separate? That little one?

MS. WALLACE: No, I think what CMS offered, just so that everyone is on the same page, is that we even took your codes and offered a suggestion to modifying your codes to add -- currently you have a 2A -- you have a Code 2 and a Code 4 in terms of outreach and enrollment. We asked that it be distinguished as an A, B, and C in terms of where that activity took place because we do want to be sensitive to the tribes and we want to make sure that more people are reached in the home, and so that's the reason we went so far as to actually making some suggestions to your plan for modifications that would -- that we thought were very minor.

SPEAKER: Judy, this is Todd Slevett. I'd like to just give a brief summary. We have a little miscommunication in the coding. You're using the codes that you suggested. The tribes understand the suggested changes this way: We currently have Code 1, which is outreach. A is non-Medicaid outreach; B is Medicaid outreach.

What CMS is suggesting is that that B code for Medicaid outreach delineate further into three settings: One, activities in a home setting, activities in an office setting, and activities elsewhere. They also are suggesting that we make that same distinction for Code 2. 2B is eligibility determinations. And we make the distinction that they're happening in either a home, the office, or community setting, and for what's currently Code 9, which is referral coordination monitoring, that we make those same distinctions for the 9B code.

So essentially, it's nine new codes, ways of looking at things. So that's what they're asking us to do in our cost allocation plan.

SPEAKER: I want to mention a couple of

things here and also respond to some of the remarks you opened with --

SPEAKER: Jim, can you introduce yourself. I think we're getting ahead of our transcriber by not introducing ourselves. So just a reminder for her benefit, state your name.

SPEAKER: I'm Jim Roberts with Northwest Portland Area Health Board. I wanted to make mention of one of the opening remarks that Mr. Smith mentioned about scrutiny in his program and the oversight that you're under back in Washington.

I am familiar with some of that that goes on in D.C. and I'm sympathetic with what you have to go through in responding to committees and finance and ways and means and such, but I think certainly the example that you gave about prescription costs in a situation where reimbursements might have not been proper and efficient in the course of that context isn't necessarily representative

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of this particular program and does it some disservice in the sense that the internal controls, the cost allocation plan, and everything that the tribes and states have -- state has worked here to submit to CMS to this point is fully compliant with the regulatory requirements of this program, consistent with the requirements of the school-based guide, and from an accountability standpoint, I think there are a number of internal controls that are built in (inaudible) the billing worksheets and some of the documents that have been developed in concert with CMS staff, the state, and tribes I think provide the accountability matrix that are required in this program and go to the point that Doug Porter mentioned earlier to the point of being overkill.

Also, Chris mentioned that the comparison to what happened in the schools isn't necessarily entirely fair to the tribal health programs. Tribes are completely different than health. Schools have principals and teachers and occasionally one or two nurses or R.N.s that provide services to the schools. Tribes have inside their facility docs, physicians, nurses, dentists, et cetera, et cetera.

So when you're looking at the level of professionals that are carrying out this program, they're

completely different than what's involved in the school
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setting. So that said, I think Todd mentioned the staff or at least the codes, and I think this is one of the things that tribes have always kind of I think had a little rub with CMS in terms of we feel we've had the settings and the internal controls to distinguish between services provided outside of -- in the home that are related to the MAM program, and those are related to the medical-type service. Todd explained the codes. But certainly there's the timesheets is another important one, I think. And I'm not as familiar with some of the technical aspects in carrying out this program, so please, Todd, and other tribal folks that carry out the MAM program, if I'm not correct, please correct me.

And I think the burden of creating more codes provides more technical aspects that need to be carried out or training requirements that cost the tribes more money, so we end up actually spending more money trying to regulate something in terms of the actual benefit back to the program. So I think from that standpoint, it's extremely onerous on the tribes.

But I just wanted to make mention that I do think that the codes are there, at least what I've heard in terms of the technical people that assisted us in developing this program, and I think the training and materials that both the state and the tribes use, I think
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the people carrying out this program at the ground level understand what they can and cannot do.

DENNIS SMITH: Again, let me again backtrack just a little bit in terms of I'm agreeing with your comments to say you're not schools. We agree you're not schools. These are activities that -- these were ideas that we tried to come up with to support what you want to do. We're -- we are trying to -- again, I think that the -- these -- the settings -- you're saying, you are saying what we're doing is unique. You're saying we're not schools. You're saying et cetera, so we're trying to find the balance, we're trying to achieve the balance to recognize that you are -- the activities that you're doing -- I'll say again -- I want to support those activities. We are trying to find a balance.

The codes that we came up with were intended, whether they came out that way or not, but the intent was to say, you told us what you do, what you want to do; so our response back was to say, this is how we could recognize it.

MS. WALLACE: Following up on what Dennis said, we want to be sensitive to capture the setting, whether it's home, clinic, or other, and we would like it if you could come up with a way because we want you to go out to the home to reach all of the unenrolled members of

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the tribes to be able to do that and do it in a very cost effective way so that it's not costing the state or the tribes more money and that the money is being spent for reaching out to more folks because that's what's important, and I think that's where we worked with Todd to -- because we heard what you said and we wanted to be sensitive to the fact that many people are not coming to clinics, that they're scared of clinics, and that you want to go out to the homes more and to the tribes and tribal organizations that are afraid when they hear underinsured or Medicaid and they don't want to be recognized as such.

So I think what we're asking is for you to come up with a way that's cost efficient for you because we didn't see it as -- we were offering suggestions, which is far beyond what CMS would normally do in terms of coming up with code sets to delineate.

So our intent was not to create additional burden; it was to help you to distinguish the setting and to be responsive to the unique nature of the tribes.

SPEAKER: Let me offer my opinion from the State's perspective where there may have been a misunderstanding, I think. We are of the opinion that the proposal that we put before CMS would allow us to claim activities outside the clinic and the office setting; is that correct? What I hear you guys saying, our federal

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partners, is we have an interest in knowing what activities are occurring in the clinic and outside of the clinic in the community. So can we, the State, as we collect information inform -- with the existing codes, can we answer those questions what's happening outside the clinic versus what's happening in the clinic or in the office?

SPEAKER: I don't think we can give specific data with the current structure. The way our cost allocation plan works currently with these codes with outreach eligibility determinations is that the staff is conducting an activity as per the CMS claiming guide where it says if you're informing potential eligible about the Medicaid program and so forth, there's nothing in the claiming guide that we started working on three years ago that said we had to say where that activity is taking place. It was our understanding that as long as we were doing that type of an activity, informing the potentially eligible person about the Medicaid program, that we were meeting the intent of the CMS claiming guide. And again, we started this three years ago.

So we were never under the understanding that we needed to separate where these activities are taking place, and I think that's really what our primary concern here is, is that we started three years ago working under the guide and in full compliance in our mind and the

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tribes' without this information being in the guide. And we were sharing this information with CMS all along the way, and these issues never came up until recently.

DENNIS SMITH: And that's what I appreciate in terms of, as these are done, then you have discussions like this and we've had them on the phone: Okay, outside the clinic. What does that mean? What do you want to do? Well, we want to go into the home. Okay, you want to go into the home. So how do we recognize that? That's again -- that's what -- what the purpose is.

SPEAKER: Again, I don't understand why you need to have it recognized.

SPEAKER: Dennis, Brian Cladoosby of the Swinomish Tribe again. And I think what we're trying to do is we're trying to implement what you're being sued on. We are trying to get out there to reach those people that are below that poverty level that you're concerned with and we're concerned with for whatever reason they don't like to come to a clinic setting, whether it's fear of the tribal government, federal government, all the stuff they have to deal with. So, you know, we're just trying to implement what you want us to do.

DENNIS SMITH: And again, we're in

passionate agreement about that.

MR. CLADOOSBY: We just need to make sure

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that -- scrutiny is important. Everybody has to be scrutinized for what they do. And the tribes, I think, are very familiar with having to do reporting on a big scale. And if you took a snapshot of the tribes and the work they've done in reporting to the federal government and looking at the audits, if you took a little survey of the twenty-nine tribes and picked out a handful of tribes, you'll see that we've done a great job. What we don't want to do is have to do more than what is required, and, you know, we're living under an administration of smaller government, and, you know, I just want to make it very clear that we don't want to be in a position where we're not providing information. We want to provide information. But we want to provide the information that is, you know, equal to what others are doing.

And I need to know from your group, is the concern here that we're going to hire, 40, 50, 100 people and it's going to be a monetary situation that you'll see tribes going out and hiring 40 people to go out and scour the bushes to look for people to sign up? I need to know. I need to hear that. Is it a monetary concern if you start seeing the number of people outside the clinic being signed up in comparison to how much money -- because you said the point -- you know, people out there are using this money to build schools. If you look at how much money the tribes

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are receiving, you know, we're not in that position to build much with the amount of money; so that shouldn't be a concern from your standpoint, I hope. But I do understand that accountability is important.

And is it a -- I need to know. Is it a concern from your staff that they need to know this in relationship to the money that is being provided?

DENNIS SMITH: It's not a concern in regards to -- it's not a concern in relationship to what you are doing is going to increase the amount of money that is claimed. Doing what you're suggesting that you want to do, in my mind, probably does mean there will be increased costs. I'm not objecting to increased costs.

SPEAKER: Can I ask a clarifying question?

Do tribes currently track this broken out by the average eligibility and referral?

SPEAKER: No.

SPEAKER: Do you track it -- so none of the tribes currently are doing this; is that right? It sounds like some are doing different types of reporting, and I'm just trying to figure out how much of a further burden this would be moving from what you may already be doing to --

DENNIS SMITH: To my point though, can I go back to Brian's point, I would also suggest that in a way, it might actually be helpful to you to say -- to come back

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and say, look, our costs did increase. What we are claiming from the federal government did increase, and we can tell you why. We can tell you why it is because we did hire 40 new workers and we increased enrollment, and that was what the goal was. The goal was to get more people enrolled.

So the reporting supports what the outcome is intended to be.

MR. CLADOOSBY: Swinomish receives $120,000 under this program. How much is the total budget that we're talking about here in the state and federal government? It's not a lot. So to manage that amount, we're not -- so, you know, we're not going to hire 40 people to go out there from Swinomish's perspective, and I don't think you're going to see a lot of other tribes doing the same thing based on the amount of money that we receive for this program. So I know it's a concern, but hopefully I can show you that --

SPEAKER: We've got hands going on all the way behind you too.

SPEAKER: I'm Kim Elliott from Shoalwater Bay Indian Tribe. I've been the MAM coordinator. We have 35 staff that does this. We put in for $12,000 for the first quarter. Costs $4,000 in administrative time to get this ready to go. So we're bringing in $8,000. It's

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better than nothing, but you put more codes on, it's going to take more of my staff time. I'm the only one doing this, preparing for getting this into the state.

DENNIS SMITH: Again, I want to keep this in perspective. All we're saying is you went to the home, and

now you have a way to record it.
SPEAKER: That's true.
DENNIS SMITH: That's all it is.
SPEAKER: Mariah Ralston from the Quinault Tribe. I think the fear is you want to collect this data, but you're not really giving us a good reason why. And so that's the fear of what you're going to do with this information.
SPEAKER: Stand up and talk, Ed. Go ahead, Ed.
DENNIS SMITH: Go ahead.
SPEAKER: We just need to know, if that's our concern of all the tribes in the room and across the country, is not the federal government collecting information; it's what are you going to do with it once you have it and what safeguards do we have with your use of this information. That's standard -- I mean every area where the feds are asking for information, tribes are asking those questions: Why do you need it? What are you going to do with it? What safeguards do we have in the

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future? And what do we get out of it?
DENNIS SMITH: The whole idea of a cost allocation plan -- and Doug, jump in here if I say something wrong -- you have -- I mean to some extent, you're almost arguing why do you need any cost allocation plan whatsoever. That's not what we're -- you know, you already can see the need for a cost allocation plan. You have said these are activities that we do, that we want to do, and that is the purpose of the codes, is to say we went to the home. Right now you have no way of expressing that in the way you are saying here are the costs. The federal government is funding the share. There's -- it's being funded in various ways. This is what the money -- this is what the money went to do.
SPEAKER: Can we call to order here a little bit? We've had people's hands up in the back. Could somebody be appointed to start taking names down so Mr. Smith can call on them as they raise their hands?
SPEAKER: I'm going to nominate our host, Barbara, to be the moderator here going forward, but I have a comment and a suggestion. The comment would be, Dennis, that I think if you feel any heat underneath some of the

remarks that are being made here about the codes -- it's my opinion that it's not just about the codes; it's about we thought we had a deal, we -- and I guess I want to say

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this: You said in your opening remarks, "We're very close." We have heard that for at least three years that we're very close, and I think I would -- so that's my comment. The suggestion would be that if this is the sticking point, if you all are okay on the reporting frequency being annually but feel strongly about capturing this information through codes, and if this is it, if this is the deal maker or deal breaker, I would suggest that we take a few minutes to caucus. I'll have the tribes go off and discuss it. The state folks can discuss it. You all can regroup and then reconvene.

However, if there are other issues that have not yet been put on the table, I wouldn't recommend that.

DENNIS SMITH: And that's why I asked also -- I tried to ask all parties, "It's just these two issues; right?" And that was my understanding, was that's all that separates us from -- are the two issues.

SPEAKER: Barbara, do you want to --

BARBARA RICHARDS: Just to make sure, Judy and Treva -- are they the only two remaining issues (inaudible) that we've got on the table?

MS. WALLACE: The quarterly reports, I think I (inaudible) earlier, all claiming (inaudible) are being held to that same standard regardless of the claiming entity. So the other issue is really CMS requesting that

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we distinguish the (inaudible.) That's the issue you're asking to caucus about.

SPEAKER: And let me make sure about the statistical sampling, the 95% caucus interval. As I understand it, that was an issue that might still be in play, and I need to make sure where that is.

MS. WALLACE: I think we got a response from the State on that issue in terms of the statistical validity -- that that had been reviewed with our statistician, Todd, so I think we're --

SPEAKER: For 98%?

SPEAKER: No, we went through this negotiation process probably a few years ago with

(inaudible) and our statistician and a statistician from the Northwest Portland Area Indian Health Board, and they all came to an agreement of what needed to be met in our cost allocation plan in order for it to be approvable, and we are operating under those assumptions.

And I actually found the e-mail from (inaudible) that gives us exactly what we were expected to do under our time study methodology, and we are meeting these expectations. And we haven't heard anything since then that there was any other issues with our time study method.

SPEAKER: This is Treva Womath. When we

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looked at that, didn't we do that based on a 95 percent?

MR. SLEVETT: Yes, and I would offer that that's the last we've ever heard about the time study methodology. We have never received anything from CMS in writing or vice versa regarding our Medicaid administrative match contracts, that there's any other methodology that we needed to have.

SPEAKER: So 98 percent was -- that just surfaced?

MR. SLEVETT: Yeah, we just heard that through a rumor, something to do with SCHIP or something of that nature, but we haven't heard anything officially.

SPEAKER: Yeah, Steve Kootz with the Cowlitz Indian Tribe. Before I ask my question or make my statement, I would like to see people raise their hands in the room who have actually sat down and during the day that you have to do your codes actually done it. So if you can please raise your hands.

Okay. The statement that I wanted to make was we're all sitting in the room, and part of what we're talking about is codes, and let me tell you, when you're trying to train your staff and multiple staff to keep these codes straight, to have your data reproduceable from staff to staff and tribe to tribe, the more variables you put in here, the harder it is to keep all the information

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straight. And so, you know, here we're talking about you want to know is it in the home, is it in the community, is it in the clinic, and it's taken nine codes to get there. It shouldn't have to.

And so it is incredibly -- whether you realize it or not -- and if you haven't had to code your day in 15-minute increments to all of these things, you really ought to do it because we're trying to make it so that it's doable and it's accurate and it makes sense to them because it doesn't make sense in a lot of ways. We're fighting that battle constantly. So that's what I wanted to say.

And the other thing too is it isn't just that people are afraid to come into the clinic. You know what? They come into the clinic and their paperwork isn't complete and it gets rejected and they don't have phones and they've moved three times since they started the paperwork, and so theses activities have to go on in multiple locations just to bring somebody forward because we have -- just like the population but probably in greater terms, we have people that have a lot of things in their lives that make it so, you know, it's pretty hard even just to get to the grocery store and go buy milk let alone fill out all this paperwork. And so you have to bird dog them in multiple locations or you give up and they then don't

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get access to care.

DENNIS SMITH: Yes, sir.

SPEAKER: John Stephens, Swinomish. Before the tribes come to caucus, I need to ask a very specific question. Is CMS saying that the ability of tribes to provide outreach services in the home is not allowed unless the code is provided showing that that service was provided in the home, or is the fact that we state that we're providing it sufficient to meet the requirements? Because if the -- part of the message I'm receiving is that you're attempting to help us in terms of do this in the home, we believe that we can do it; otherwise, if we thought that was a good idea, we would have made the suggestion two years ago.

That's another part of the problem is this process. I asked my chairman if it was all right for me to participate in the tribal workroom. That was three and a half years ago. He said, "How long do you think it will take?" I said, "Maybe six months."

So our tribe is committed a lot of time and resources to attempt to comply with what we think are the

requirements, and my chairman said we only want to meet the requirements at a minimum so that we satisfy the law. We don't need additional reporting burdens placed upon us. We, in our own administrations, can handle prioritization

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and data collection to serve our communities.

So my initial question is: Is it CMS's position that providing outreach in the home is not allowed unless there's a code that shows that the outreach was done in the home?

DENNIS SMITH: Well, I came to solve the problem that is separating us, and I don't want to lay down something that says I'm just unwilling to accept. I was at least under the impression that if we were able to discuss what we were -- ways to meet our mutual interests, we would be able to do that. I didn't come to issue ultimatums. I don't intend to issue ultimatums now. I'm trying to solve a problem that has separated us. So it doesn't do any good for me to say yes, I'm laying down that ultimatum. That's not what I came for. That's not the spirit in which I came. I'm trying to explain to you as to what we are -- our efforts were intended to support what you wanted to do.

SPEAKER: Jim Roberts with Portland Area Health Board. I want to come back to the discussion on the time study for a moment. I don't want to talk about it, but I want to use it as an example of how we've always had this moving target of issues as we've tried to resolve this issue.

I think clearly what's important in this

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timeline is that we began to work on this in June 2005. We're in January 2008. We are almost at three years in working on the issues associated with this plan, and the whole time -- the reason why it's taken so long is we've always had these moving targets of issues.

So it's particularly frustrating to me to hear there might be another 98 percent confidence level.

SPEAKER: We think that's off the table.

SPEAKER: Good, because that involved the collaboration of all three statisticians from the tribal side, the state side, and CMS; and to hear CMS might be talking about something different was problematic. I'm

glad to hear that's off the table.

But, I guess, I think one of the things that -- before we go on to caucus that I think's important for us to understand is that, if we can reach an agreement on the issues that are outstanding right now, can you give us a commitment before you leave this room that you would approve the Washington State MAM plan.

DENNIS SMITH: I came to solve the remaining issues so you will have an approved plan. That's what I came to do. I think --

SPEAKER: I think we would like to go with Doug's suggestion of taking a 10-minute caucus.

SPEAKER: I'm not ready to do that. I'm Jim

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Sherrill, Health & Human Services Director (inaudible) Indian tribe.

I think the follow-up question to John's, then, if you're unwilling to say that the code issue is a deal breaker or not from CMS's point of view and if it's true that you're here to help solve that issue, my position, frankly, is it's solvable by your approving the plan as submitted. That allows us to do what needs to be done. So given that position and if you are, in fact, looking for some middle ground, what is it?

DENNIS SMITH: That's what I --

SPEAKER: From your point of view, what is it?

DENNIS SMITH: My remarks were to, as I said, in my response, I wasn't prepared to issue an ultimatum

SPEAKER: Are you prepared to suggest a middle ground?

DENNIS SMITH: That's what I would hope that the discussion would lead to, is to where we can find a mutually acceptable way to meet our goals, whether we do -- variety of ways of doing that. We go to the codes, we phase it in. We go to the code -- again, I'm not familiar with -- do we need nine codes? Does five suffice? Do we need -- that's the sort of discussion I think that would be

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helpful.

Again, we have two issues: We have the frequency of reporting, and we have the issue of how to

capture the information sufficient to support what you want to do. I think it would be a useful -- I would feel the value of talking with my colleagues for five minutes to regroup to say it's been a great discussion, perhaps I hope we have a better understanding of where we all are, so how do we just now get the problem solved.

As I said, I didn't come in the spirit of issuing ultimatums. I would prefer you not force me to -- into that position. But can we break for five minutes?

SPEAKER: Dennis, I need to excuse myself once again. Thank you for coming out here. I have another meeting. We're dealing with the state on a culvert issue, so we're going to negotiate another issue. As a tribal leader, you know, fish, casinos, culverts, water, transportation, now this issue, and --

DENNIS SMITH: I would always want you on my side.

SPEAKER: Thank you, and I pray the creator gives you traveling mercies as you go back to D.C.

MODERATOR: If we could reconvene here in 10 minutes.

(Recess taken.)

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DENNIS SMITH: Do we have a suggestion? Did someone else want to speak for the tribes? Okay, great, speak.

MR. PORTER: We thought we'd do the -- we went first in the first go-around; we thought we'd offer you the opportunity to make any remarks you might want to make as a result of your get-together; but before we start, we wanted to find out if anybody has a hard timeline. What time does everybody have to walk out the door?

DENNIS SMITH: I have to leave in 10 minutes, but deadlines, in my mind, are a good thing to get focused. We had a couple of suggestions, and, again, as I said, I didn't come in the spirit of ultimatums, but we are two ways on the quarterly and annual reporting, again, if that is something -- if there's some way we can work that out with the state in a way that -- and I'm not certain we can -- that doesn't sort of impact the tribes, we would be open to that.

The second part, again, I do feel very strongly that I want to capture the information of those

types of home visits. However, I'm willing to reduce the number of codes it takes to capture that information if there's a way to -- you already have 21 or 22 codes already; right? You currently report on 22 codes. The suggestion we came up with that was leading you to nine

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more; is that correct? If there's some way to do it in a number less than nine, if we can get it down to three, I thought that that would be some way to achieve the same purpose. So that was my thinking.

MR. PORTER: We had a lot of discussion, Dennis, about this, and a couple points that were made that I want to be able to represent accurately.

First is that it is still difficult to understand what problems are being solved by the additional requirements that CMS is asking for. As I said at the outset, we think that the years we've spent negotiating this agreement have put forth a plan and a cost allocation model that is accountable and that is doable by the tribes. The additional frequency of monitoring or reporting is not something that either the state or the tribes find useful in the management of the program. And the additional codes, while it may be interesting to capture the information, again, is not something that would be useful across the board for tribes. They have different ways of keeping track of how they do what they do out there to enroll folks, and these kinds of codes would be an artificial sort of -- another way to represent that that wouldn't really help them in their management of the program.

And finally -- and this may be news -- but

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local health jurisdictions and schools also do outreach outside of their physical boundaries and are not required to keep track and split these things out. So it still does feel like an unfair additional burden for tribes. And I think what I'm hearing from my colleagues is, if you require these additional complex codes, which I've assured them you are likely to do, of other organizations, then that would not be so unfair; however, it would still be a burden for tribes as it would be for these other jurisdictions as well.

So I think, bottom line, Dennis, as far as

the collection of tribes here are concerned is we think the plan we put forth is one you could approve without these additional requirements. If you are not inclined to do that, then I think the tribes would just as soon wait until you tell us what you will approve and then each individual tribe can make a decision as to whether or not they want to participate in the program.

SPEAKER: That captured, I think, the consensus that we all came to here (inaudible.)

DENNIS SMITH: Let's take them one at a time. The quarterly versus annual report. And folks can jump in here and make sure --

MR. PORTER: Can I say one more thing about that that may help Judy understand where we're coming

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from? My own opinion as a Medicaid director, I don't care so much. We'll report every month if we have to. But what I think I heard from folks in the room here was, since we have a year to submit our claims, to avoid the administrative burden of filling out a report every three months, I'm not going to submit any claims for a year. So my report's very easy: Zero, zero, zero, 13,000, 130,000. There. Is that useful to you, having that kind of quarterly report? And I think that's a serious thought to take into account. Really, what is being gained by that frequency if they have a year to submit claims?

MS. WALLACE: Let me just provide clarification. The State currently provides quarterly reporting of expenditures to CMS and to the regional office. That's ongoing. Every claiming plan that has come into CMS regardless of the claiming entity, that has been a condition of approval -- that the state provides monitoring and reports quarterly. So I'm going to actually turn that around on you, Doug, in terms of what are you going to require working with your team in the tribal organizations and come up with something that meets everybody's -- so it's a win-win situation

MR. PORTER: Again, I will report what I'm required to report whatever expenditures I know about, so I have no problem with that, per se. I'm just suggesting to

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you all, as you deal with these sovereign set of governments on a government-to-government basis, the

reasons you're asking for compliance with certain requirements have got to be more than, well, that's what everybody else does.

So you're hearing from the tribes it would be not useful -- in fact, more of a burden -- administratively to have quarterly reporting. If you require that, then they'll have to figure out how they would respond to that.

Suffice to say, I don't think this is the deal breaker.

MS. WALLACE: I don't either.

DOUG PORTER: I think we're getting down to now that they've trained their staff on how to do this again, to go back out and train them how to do it differently when other jurisdictions are claiming today for the same kinds of activities and not having to use those codes, why should the tribes agree to do that here and now? And if that is a deal breaker for you all, then you should say so and tell us what is required and then, again, instead of collectively having an agreement, each tribe will have to sit down and say is it worth it to me to go through this.

BARBARA RICHARDS: And I think that in the

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spirit of cooperation, that what I've heard today is you all want to go out and provide these services in the home, and we do not want to dictate the actual how you report that information; we just want to know the activities, whether or not they're provided in the home or clinic setting. And again, what we had suggested to the State was really some ways that you could capture that for the same activity, so I think that we would offer that the state, in concert with the tribes, go back and see if there's a way that you could capture outreach, enrollment, and referral and coordination to distinguish whether that activity was provided in the home or clinic for us and which is a way that you could do that to distinguish from an accountability standpoint and every claiming plan that has come in to us is being held to that standard going forward. I can't speak to the history because I probably wasn't here when some of those other plans were approved.

SPEAKER: So are you saying that all the other plans are going to have that same requirement that

you said is being placed on the tribes?
SPEAKER: I will tell you that partly I don't understand what is so unique about the home because when you say "outreach," tell you the truth, outreach means you go out of your office by definition. Outreach happens in cars, it happens in restaurants, happens in libraries,

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happens in community centers, happens in churches, happens in tribal centers, happens at gatherings, I mean it is a huge -- it is a huge thing. So to a certain extent, what you're saying is if home is so important, we need to know why, Number 1, or is it important to know that it happens in a clinic setting or outside of a clinic setting because if home is so important, why isn't it important to know how many times you have to go meet them in their car because they don't want you in their home or you're meeting them out in the woods because they're living out in the woods and oh, by the way, they're moving all the time and they don't really have a home.

So I guess you need to help us understand what is so important about the word "home."

DENNIS SMITH: The logical extension of that argument, though, is to say, well, it doesn't really matter, so just give us the money, and we're not going to do that. And this is a standard we will hold everyone to, whether it's a tribe or a clinic or a school or anything else. I am prepared to, as I said -- we thought we were trying to accommodate the request on how things were broken out. Nine is too many. If you can do it with three, I'm agreeable to doing it with three. If you can do it that way.

SPEAKER: And so what three codes are you

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talking about? Are you talking about clinic, home. What's the third?

MS. WALLACE: I think when the State came to us and asked where were these activities being performed, they said that there may be another, so that was really our attempt to come up with something that was responsive to the State. So if you want to do home and clinic for each of the codes --

MS. SOSA: Do you understand that we have tribes that don't have medical clinics in the state of

Washington so that it would always be not even home, it would be outreach? I'm just not sure if you understand the diverse dynamics here in the state of Washington and what the gentleman was just sharing with you about the diversity of the situations of the families that we're working with. Homes are not necessarily always what they have.

DENNIS SMITH: Which is, I think, why we suggested "other."

SPEAKER: I need clarification. Is there really something about home/not home; or is it really in the clinic/outside the clinic? And then once we get down to that, for example, if that was the approval in the clinic/out of the clinic, then I need more clarification because probably 80 percent of my stuff happens in the parking lot. Is that in the clinic if it's on the premises

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or is it not in the four walls? I mean you just keep getting more and more -- I'm just curious if it's really home or if it's in the clinic or out of the clinic because then you wouldn't need another if everything out of the clinic is out of the clinic.

SPEAKER: There's another way to ask the same question. You said this is going to be a standard. What is the standard that's going to be applied to all other others other than tribes? You just said there's going to be a new standard.

DENNIS SMITH: We want to capture this information whether it is a tribe or anyone else sending folks out to their homes. Again, I --

SPEAKER: Home. You used the word "home," so it's not clinic?

MS. WALLACE: Home, clinic, other.

DENNIS SMITH: If you have a different suggestion, again, we're trying to respond to what you tell us.

SPEAKER: (Inaudible.)

DENNIS SMITH: Pardon?

SPEAKER: We didn't ask for that though.

DENNIS SMITH: You didn't ask for what?

SPEAKER: Home, clinic setting.

DENNIS SMITH: You all told me this morning

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you wanted to send people to people's homes. I'm trying to

capture that.
SPEAKER: Again, this is Jim Sherrill from Cowlitz Tribe. And again, we think we can send people to their homes given approval of the current plan -- the outreach -- if you approve it as sent to you, we will continue to do outreach in homes and community. So the simplest solution from our point of view is to approve the proposed plan.
The alternative that was discussed -- and again, this has got to be placed in the context of individual tribes will make a decision, not us as a collective -- but that if there's any modification to what I previously said, it's two codes: Clinic and other.
SPEAKER: To me, I think it could be actually just one code with the checkoff box: "Clinic" or "other." I don't think you need to add places in here in your application that's going to be dragging it on any further than that.
DENNIS SMITH: Agreed. So do you want to do clinic, community?
SPEAKER: And a home is in a community. And as for the parking lot issue, the way we deal with it with hospitals is if it's part of the legal entity -- I'm sorry, Jackie Garner, CMS -- if it's part of the legal entity,

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then that would be the clinic. If the parking lot is not part of the clinic's legal lease or whatever, then it's community.
DOUG PORTER: I'm only smiling slightly because we're a nonreservation-based tribe, but I can tell you, on a reservation, the clinic doesn't have an entity. The tribe has an entity, and it's the reservation, and they would consider their entity the whole reservation. And I mean I'm just -- you know, the clinic doesn't neatly own sometimes a neat little parcel. It's -- they're part of the broader reservation. But just a comment.
DENNIS SMITH: I am out of time, but if the distinction between clinic, which is a physical place, and the community or other being outside that -- and I think that's a reasonable distinction to make -- I will, again -- I'm prepared to do that now. If you would rather have some additional time to reflect on it, the extent to which, again, whether you say we, you know -- we are anxious to

pass on the honor of being the first to someone else and, you know, because my guess is, as our discussion here, other entities are interested -- they generally are -- in how these things come out, and -- but that's what I'm prepared to do today.

If you would prefer a different or additional discussions, my feelings won't be hurt, that if

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you want to take some additional time to consider.

SPEAKER: I think that probably, realizing you have to you catch a plane, I'm assuming that's why you need to get moving and knowing the traffic out there, you need to make sure you take care of that -- I think probably we can go ahead and quickly caucus afterwards and see if we can come to a decision. And Doug, you can probably relay it to Barbara who can relay it to you and we can probably come up with something fairly quickly or we can't. We'll know one way or another pretty quick.

DOUG PORTER: And if we can't, Dennis, safe to say, the State would still want to work with our federal partners in coming up with what we think would be the most reasonable compromise, and individual tribes could decide whether or not they could make that work. But let's take one last effort to see. You heard from folks clearly that you have in your hand support from the existing proposal.

We'll take one more breakout session to talk about this clinic, non-clinic, or some other more simplistic coding issue, and then we'll get back to Barbara.

SPEAKER: So Dennis, we want to thank you for coming out and having this consultation with us and taking the time, so thanks from all of us.

DENNIS SMITH: My pleasure, and thank you.

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STATE OF WASHINGTON)
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COUNTY OF KING)

I, Mindy L. Suurs, CCR, a duly authorized Notary Public in and for the State of Washington, residing at Bellevue, do hereby certify:

That the foregoing proceedings were taken before me

and thereafter transcribed under my direction;

That I am not a relative, employee, attorney, or counsel of any party to this action or relative or employee of any such attorney or counsel and that I am not financially interested in the said action or the outcome thereof;

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal this 31 day of January, 2008.

_____

Mindy L. Suurs
Notary Public in and for the State
of Washington, residing at Bellevue.