IHS Tribal Self-Governance Advisory Committee and Technical Workgroup
Quarterly Meeting
Tuesday, July 18, 2017
Wednesday, July 19, 2017

Embassy Suites Washington DC - DC Convention Center
900-10th Street NW
Washington, DC 20001
Phone: (202) 739-2001

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   - IHS DTTL: Tribal Consultation on IT Service Catalogue
   - OIT Update (Powerpoint)
   - TSGAC Information Systems Advisory Committee (ISAC) report drafted by Stuart Ferguson
   - ISAC Summary Recommendations and Actions from June 28-29, 2017 Meeting

6. Community Health Aide Program Workgroup Update
   - IHS Community Health Aide Program (CHAP) Expansion Presentation
   - TSGAC Comments on the CHAP Workgroup (April 11, 2017)

7. HHS “Reimagining” Initiative
   - TSGAC Letter Requesting Consultation on HHS “Reimagining” Initiative (June 22, 2017)
8. Patient Protection and Affordable Care Act (ACA) Implementation Update
   - FAMILY CYCLE ANALYSIS: Financial Impact of the Senate Health Plan vs. the Affordable Care Act on AI/AN and Other Families
   - Cumulative Financial Impact of the Senate Health Plan vs. the Affordable Care Act over the Family Cycle of an AI/AN Family
   - Side-by-Side Comparison of Health Plans: House Health Bill and Senate Health Bill in Comparison to Current Law/Affordable Care Act
   - Joint Tribal Organization Letter Regarding the Senate’s Better Care Reconciliation Act of 2017

9. Renewing the National IHS-Veterans Administration (VA) Memorandum of Understanding
   - VA Announcement Regarding Phoenix Roundtable Discussion
   - VA Recent Tribal Consultation Timeline
   - TSGAC Comments on VA Consultation (November 2, 2016)
AGENDA

Tuesday, July 18, 2017 (8:00 am to 5:00 pm)
Meeting of IHS Tribal Self-Governance Advisory Committee (TSGAC) and Technical Workgroup with RADM Michael D. Weahkee, Acting Director, IHS

8:00 am  Tribal Caucus
Facilitated by: Marilynn “Lynn” Malerba, Chief, Mohegan Tribe, and Chairwoman, Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC)

Legislative Update
• Senate version of ACA Repeal and Replace
• Special Diabetes Program for Indians
• Restoring Accountability in the IHS of 2017 (S 1250 & HR 2662)

9:00 am  Meeting Called to Order
Welcome
Invocation
Roll Call
Introductions – All Participants & Invited Guests

9:15 am  TSGAC Opening Remarks
Marilynn “Lynn” Malerba, Chief, Mohegan Tribe, and Chairwoman, IHS TSGAC
RADM Michael D. Weahkee, Acting Director, IHS

9:40 am  TSGAC Committee Business
• Approval of Meeting Summary (March 2017)
• Joint TSGAC and Direct Service Tribes Advisory Committee Meeting, October 23, 2017 at the Health and Human Services Building in DC
• 2017 Tribal Strategy Session Agenda

10:00 am  Office of Tribal Self-Governance Update
Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, IHS
• Outcomes of the April Agency Lead Negotiator Meeting

10:30 am  Break
10:45 am  **Office of Environmental Health and Engineering**  
Gary Hartz, Director, Office of Environmental Health and Engineering, IHS  
Chuck Grim, DDS, Chairman, Facilities Appropriations Advisory Board, IHS  
- Request for Access to Sanitation Tracking and Reporting System (STARS)  
- FAAB Meeting Update

11:15 am  **Office of Resource Access and Partnerships Update**  
Carol Chicharello, Acting Director, Division of Business Office Enhancement, Office of Resource Access and Partnerships  
- Pharmacy Benefit Manager Issues  
- Timeliness of payment for Purchased/Referred Care

12:00 pm  **TSGAC Members’ Executive Session with Acting IHS Director**

1:30 pm  **Joint Discussion on Restoring Accountability in the Indian Health Service Act of 2017**  
Jacqueline Bisille, Policy Advisor, Senator John Hoeven, Chairman, U.S. Senate Committee on Indian Affairs  
Kim Moxley, Policy Advisor, Office of the Vice Chairman, U.S. Senate Committee on Indian Affairs  
Ken Degenfelder, Republican Legislative Staff, Indian, Insular and Alaska Native Affairs Subcommittee, House Natural Resources Committee  
Matt Hittle, Legislative Director, Office of Representative Kristi Noem  
Rudy Soto, Legislative Assistant, Office of Representative Norma J. Torres

2:30 pm  **Office of Information Technology Update (OIT)**  
CAPT Mark Rives, DSc, Director, Office of Information Technology, IHS  
Randall Hughes, Tribal Liaison, OIT, IHS  
- Veteran Affairs Migration to Cerner and Impact on the Resource and Patient Management System (RPMS) Updates  
- Futures plans for RPMS

3:00 pm  **Community Health Aide Program Workgroup Update**  
Dr. Chris Halliday, D.D.S., M.P.H., RADM (ret.), USPHS, Deputy Director, Division of Oral Health, OCPS (DHAT Lead)  
Georgianna Old Elk, Public Health Advisor, Community Health Representative Lead, OCPS (CHA Lead)  
Minette Wilson, Public Health Advisor, Division of Behavioral Health, OCPS (BHA Lead)  
- Workgroup Charter  
- Tribal participation  
- Future workgroup plans

3:30 pm  **HHS “Reimagining” Initiative**  
Marilynn “Lynn” Malerba, Chief, Mohegan Tribe, and Chairwoman, IHS TSGAC  
RADM Michael D. Weahkee, Acting Director, IHS  
RADM Kevin Meeks, Acting Deputy Director of Field Operations, IHS (Invited)
4:15 pm  **Patient Protection and Affordable Care Act (ACA) Implementation Update**  
_Cyndi Ferguson, Self-Governance Specialist/Policy Analyst, SENSE Incorporated_  
_Doneg McDonough, Consultant, TSGAC_  
- Outreach and Education Project Update (Tribal Sponsorship Fast Track Took)  
- Timeline of Potential Administration and Congressional Action on ACA Repeal/Replace Legislation  
- Administration and Congressional ACA Related Actions in 2017 and 2018  

4:45 pm  **Preparation for Discussion with Acting IHS Director**  

5:00 pm  **Recess until July 19, 2017**
Wednesday, July 19, 2017 (8:30 am – 12:45 pm)
Meeting of IHS Tribal Self-Governance Advisory Committee (TSGAC) and Technical Workgroup with RADM Michael D. Weahkee, Acting Director, IHS

8:30 am  Welcome and Introductions
Marilynn “Lynn” Malerba, Chief, Mohegan Tribe, and Chairwoman, IHS TSGAC
RADM Michael D. Weahkee, Acting Director and Principal Deputy Director, IHS
RADM Chris Buchanan, Deputy Director, IHS (Invited)

8:45 am  Indian Health Service Budget Update
- IHS Fiscal Year (FY) 2017 Funding and Continuing Resolution
- President’s FY 2018 Budget Request
- FY 2019 National Budget Formulation Evaluation
Ann Church, Acting Chief Financial Officer, IHS
Melanie Fourkiller, Policy Analyst, Choctaw Nation and TSGAC Tribal Technical Workgroup Co-Chair

9:30 am  Joint TSGAC and Acting IHS Director Discussion
- Scheduling CSC Face-to-Face Meeting
- LNF Point of Contact and Follow Up
- TSGAC Request to Delay Catastrophic Health Emergency Fund Rule

11:15 am  Closing Remarks
Marilynn “Lynn” Malerba, Chief, Mohegan Tribe, and Chairwoman, IHS TSGAC
RADM Michael D. Weahkee, Acting Director, IHS

11:30 am  Lunch

12:15 pm  TSGAC Technical Workgroup Working Session

12:45 pm  Adjourn TSGAC Meeting
## 2017 Self-Governance National Calendar

<table>
<thead>
<tr>
<th>Date</th>
<th>Meeting</th>
<th>Location</th>
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<tbody>
<tr>
<td>July 18-19</td>
<td>IHS TSGAC Quarterly Meeting</td>
<td>Embassy Suites – DC Convention Center</td>
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<tr>
<td>July 19-20</td>
<td>DOI SGAC Quarterly Meeting</td>
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<td>July 24-27</td>
<td>Tribal Interior Budget Council</td>
<td>Flagstaff, AZ</td>
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<td>August 8-9</td>
<td>CDC Summer 2017 Tribal Advisory Committee Meeting</td>
<td>Sulphur, OK</td>
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<td>September 6-7</td>
<td>Tribal Self-Governance Strategy Session</td>
<td>Uncasville, CT</td>
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<td>September 12-13</td>
<td>NCAI Impact Days</td>
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<td>September 25-29</td>
<td>NIHB Annual Consumer Conference</td>
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<td>October 15-20</td>
<td>NCAI Annual Convention &amp; Marketplace</td>
<td>Milwaukee, WI</td>
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<td>IHS TSGAC Quarterly Meeting</td>
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<td>October 25-26</td>
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<td>November 7-9</td>
<td>Tribal Interior Budget Council</td>
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<tr>
<td>AREA</td>
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## TSGAC TECHNICAL WORKGROUP

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<tr>
<th>AREA</th>
<th>MEMBER (name/title/organization)</th>
<th>STATUS</th>
<th>CONTACT INFORMATION</th>
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<tr>
<td>Phoenix</td>
<td>VACANT</td>
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<tbody>
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<td>Area Rep</td>
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### OTHER RESOURCES

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<tr>
<th>MEMBER (name/title)</th>
<th>ORGANIZATION</th>
<th>CONTACT INFORMATION</th>
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</table>
| Caitrin Shuy        | National Indian Health Board | P: 202-507-4085  
Email: cshuy@nihb.org |
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P.O. Box 1734, McAlester, OK 74501  
Telephone (918) 302-0252 ~ Facsimile (918) 423-7639 ~ Website: [www.tribalselfgov.org](http://www.tribalselfgov.org)
Meeting Summary

Tuesday, March 28, 2017 (8:00 am to 4:30 pm)

Meeting of Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC) and Technical Workgroup with RADM Chris Buchanan, Acting IHS Director

Tribal Caucus
Facilitated by: Marilynn “Lynn” Malerba, Chief, Mohegan Tribe, and Chairwoman, Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC)

Meeting Called to Order

Welcome
Invocation:
Roll Call:
Alaska: Jaylene Peterson-Nyren, Executive Director, Kenaitze Indian Tribe
Albuquerque: Raymond Loretto, DVM, Governor, Pueblo of Jemez
Bemidji: Jane Rohl, Tribal Council Secretary, Grand Traverse Band of Ottawa & Chippewa Indians
Billings: Calvin Jilot, Council Member, Chippewa Creek Tribe
California: Ryan Jackson, Chairman, Hoopa Valley Tribe
Great Plains: Vacant
Nashville: Marilynn “Lynn” Malerba, Chief, Mohegan Tribe of Connecticut (TSGAC Chair)
Navajo: Nathaniel Brown, Honorable Delegate of the 23rd Navajo Nation Council
Oklahoma 1: Kasie Nichols, Proxy for John Barrett Jr., Chairman, Citizen Potawatomi Nation
Oklahoma 2: Mickey Peercy, Proxy for Gary Batton, Chief, Choctaw Nation
Phoenix: Lindsey Manning, Chairman, Shoshone-Paiute Tribes of the Duck Valley
Portland: W. Ron Allen, Chairman/CEO, Jamestown S’Klallam Tribe
Tucson: Daniel L.A. Preston III, Councilman, Tohono O’odham Nation

Introductions – All Participants & Invited Guests

TSGAC Opening Remarks
Marilynn “Lynn” Malerba, Chief, Mohegan Tribe, and Chairwoman, IHS TSGAC
- Appreciates all the Technical Workgroup’s hard work to prepare for these Quarterly Meetings.

RADM Chris Buchanan, Acting Director, IHS
- Appreciates these meetings, especially since there are new things to be learned every time we meet.
• Though there are many Acting positions currently, everyone is still working hard and are dedicated to the IHS mission and serving American Indians and Alaska Natives (AI/AN).

• Priorities Update
  o People:
    ▪ Continuing work regarding recruitment and retention.
    ▪ The Office of Management and Budget (OMB) gave some Federal hiring freeze exemptions for IHS, but there are still other areas, such as billers and coders, that we need to stress for an exemption.
  o Partnerships:
    ▪ Very important to build, strengthen, and sustain a collaborative effort.
  o Quality:
    ▪ Ensuring IHS is performing at a high level is an ongoing effort. Providing quality services is paramount and having sufficient resources can only help with that.
  ▪ Personnel Updates
    • Johnathan Merrell: Acting Deputy Director for Quality Health Care
    • Dr. Nicole Laurie: Senior Advisor to the Acting Director
  ▪ Government Accountability Office (GAO) Report
    • IHS, Bureau of Indian Affairs (BIA), and Bureau of Indian Education (BIE) were identified as high-risk.
    • Specifically noted the importance of the IHS Quality Framework.
    • Recommended IHS use a new method for allocating Purchased/Referred Care (PRC).
    • Administration will follow up and try to fully understand the issues outlined in the report.
  o Resources:
    ▪ Developing a budget that addresses the needs of all Tribes and ensuring we have the needed resources for service is a large undertaking.
    ▪ Will host a budget 101 webinar to go over IHS appropriations in early April.

• HHS Secretary Price has identified mental health, childhood obesity, and the opioid crisis as his top priorities.

• Contract Support Costs (CSC)
  o The CSC workgroup has been an important part of the work that has gone into CSC.
  o As of March 15, 2017, IHS has extended 1,472 settlement offers to Tribes and 1,357 settlements, totaling $830.4 million, have been finalized.

• Budget Update
  o In early March, a summary proposal to finalize the Fiscal Year (FY) 2017 budget was sent to Congress, which they are expected to take up in the coming weeks.
  o The FY 2018 Presidential Budget Blueprint has been published. It explicitly recognizes sovereignty and self-determination and identifies IHS as a top priority.
  o Both of those documents are available at www.whitehouse.gov.

• Recent Visits and Upcoming Events
  o Looking forward to working with Tribal leaders in the IHS Albuquerque Area during the upcoming Area Annual Tribal Consultation.
  o In early April, Tribal Consultation will occur in the IHS California Area where Acting Director Buchanan will be hosting a listening session and providing updates on mental health, Youth Area Treatment Centers, and Urban Indian Health Programs.
  o Visited Choctaw Nation for a grand opening of their new Regional Medical Clinic, a Joint Venture project, which is the first Tribal clinic in the country to offer an ambulatory surgical facility.

Approved July 18, 2017
Visited the Riverside San Bernardino County Indian Health Inc., the San Diego American Indian Health Center, the Indian Health Council Inc. Rincon Clinic, and the Desert Sage Wellness Center in California, which was an eye opening experience and Acting Director Buchanan’s first time visiting Indian health care facilities in the area.

TSGAC Committee Business

- Approval of Meeting Summary (January 2017)
  - Jamestown S’Klallam Tribe made a motion to approve the January 2017 Meeting Summary.
  - Sac and Fox Nation seconded the motion.
  - The motion passed without objection.

- TSGAC Committee Members Approval
  - Oklahoma Alternate Delegate: Kay Rhoads, Principal Chief, Sac and Fox Nation
    - Jamestown S’Klallam Tribe made a motion to approve the Oklahoma Alternate Delegate nomination.
    - Mohegan Tribe of Connecticut seconded the motion.
    - The motion passed without objection.
  - Bemidji Area Primary Delegate: Jane Rohl, Tribal Council Secretary, Grand Traverse Band of Ottawa & Chippewa Indians
    - Jamestown S’Klallam Tribe made a motion to approve the Bemidji Primary Delegate nomination.
    - Mohegan Tribe of Connecticut seconded the motion.
    - The motion passed without objection.

- IHS Information Systems Advisory Committee (ISAC) Member Nomination and Approval
  - No current nominations. Tribal leaders are encouraged to submit a name to serve as the TSGAC representative.

- National Institutes of Health Tribal Advisory Committee
  - Looking for an alternate representative to serve with Chief Malerba on the Committee, which meets in-person twice a year with monthly conference calls.
  - As it is a new committee, currently there is not much decision making and efforts are focused on education.

Office of Tribal Self-Governance (OTSG) Update

Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, IHS

- Partnerships are very important.
- Agency Lead Negotiator (ALN) Recommendations
  - Appreciates the recommendations provided and will be moving forward on some of those. Specifically, they will be looking to set up a meeting and formal process for passing on historical knowledge. Max Tahsuda, retired Oklahoma City Area ALN, also shared his knowledge and experiences during the last ALN call.
  - OTSG will be hosting a joint meeting with IHS Executive Officers and ALNs during the Annual Conference to discuss various operational issues from the past year.
- Began the year with pre-negotiation meetings in Alaska and are currently participating in several negotiations. No new Self-Governance Tribes yet, but expect a few by the Annual Conference.
- OTSG recognizes the need to update the Programs, Services, Functions, and Activities (PSFA) Manual, as there have been many changes in programs since the current 2002 version was implemented. They will be moving forward with that process and welcome any comments or discussions.
- Currently working on the next cycle of Planning and Negotiation Cooperative Agreement Grants and hope to have an announcement by the Annual Conference. Additionally, OTSG has seen
several Tribes who engaged in the Planning and Negotiation Cooperative Agreement Grants, are moving towards entering into Self-Governance.

- Tribal Comment: With the current application deadline, many Tribes are entering negotiations very late in the year, which causes issues with providing funding for certain things.
  - Response: Looking at addressing the issue through the front end with applications, (i.e., when those are made available) as well as considering a future transition to a two-year cycle.

- Tribal Comment: Can you elaborate on the operational issues you mentioned for discussion at the Annual Conference joint meeting?
  - Response: Annually, a meeting is held to look at any issues that came up during the past year’s operations, such as issues with negotiations and payments to Tribes, with this year’s meeting focusing on finance. It is typically a closed meeting and gives IHS officials an opportunity to come together to discuss those identified topics.

- Acting Director Buchanan will be testifying in the Senate Committee on Indian Affairs (SCIA) oversight hearing on “Diabetes within Native American Children.”
  - Tribal Comment: Will you be including the Tribal requests for permanent reauthorization of the Special Diabetes Program for Indians (SDPI) and a $50 million increase in reoccurring funding in your testimony?
    - Response: I can mention the Tribes priority separately from IHS’s priority.

- Tribal Comment: Will you be updating the PSFA Manual and the Office of Information Technology (OIT) Service Catalog at the same time and how will that work out for data and technology shares?
  - Response: Ideally, the process for updating these documents would all coincide, and we will need to meet and develop a work plan to be addressed.

- IHS Insurance Status of Active Users Data
  - A request for this information was included in an August 2016 TSGAC letter, which IHS initially responded to, and it was identified as an issue in the IHS update letter to TSGAC.
  - Ran a new report and will be distributing it; however, there were limitations due to how much information could be shared legally.
  - Tribal Comment: Why is there a difference between the data coming from the Centers for Medicare & Medicaid Services (CMS) and the data coming from IHS?
    - Response: Will follow up with the Public Health Office.

Break

Veterans Affairs (VA) and Indian Health Service (IHS) Memorandum of Understanding (MOU)
Stephanie Birdwell, Director, Office of Tribal Government Relations, Department of Veterans Affairs
Terry Bentley, VA Tribal Government Relations Specialist, Pacific District
Mary Culley, VA Tribal Government Relations Specialist, Continental, Midwest and Southeast Districts
Peter Vicaire, VA Tribal Government Relations Specialist, Midwest, Continental and North Atlantic Districts
Homana Pawiki, VA Tribal Government Relations Specialist, Continental District
Clay Ward, VA Office of Tribal Government Relations Program Analyst (DC)

- VA Office of Tribal Governmental Relations (OTGR) Personnel and Operations Overview
  - Established in 2011, OTGR is in the VA Office of Public and Intergovernmental Affairs and serves as a staff office to the Secretary.
  - OTGR is not a part of the Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), or the National Cemetery Administration, and has three primary goals, which are: (1) Facilitating the Tribal Consultation Policy; (2) Engaging in activities
that promote economic sustainability for veterans living in Indian Country; and (3) Increasing access to care and benefits.

- **National Update:**
  - 2016 Tribal Consultations
    - Three consultations were held throughout the year regarding: (1) Identifying the Priorities for Serving Veterans in Indian Country; (2) Accreditation of Tribal Veterans Service Offices (VSO); and (3) Proposed Consolidation of non-VA Care into a more standardized system under the Veterans Access, Choice, and Accountability (Choice) Act.
    - The 2016 Tribal Consultation report is in the final stages and should be released soon. The report identified five priorities, which include: (1) Access to Health Care; (2) Addressing Housing for Homelessness; (3) Treatment for Post-Traumatic Stress Disorder (PTSD) and Mental Health; (4) Understanding Benefits including Benefits for Families; and (5) Transportation. Overall, the VA noted a theme in comments that additional VA understanding and familiarity of Tribal Nations and culture is necessary. Additionally, a breakdown of consultation priorities will be included in the report.
  - VA/IHS/Tribal Health Program (THP) Reimbursement Agreement Program
    - This program is part of a Congressional mandate for the VA to consolidate ways care in the community is purchased and, in December, the National Reimbursement Agreement was extended through June 2019.
    - Currently, there are 100 THP agreements, resulting in $51 million in reimbursements impacting 7,941 unique Veterans, which have also been extended until June 30, 2019 without significant change.
  - 500 Housing and Urban Development-VA Supportive Housing (HUD-VASH) Homeless Vouchers have been released to Indian Country, totaling approximately $5.9 million distributed to 26 grantees.
  - Title 38 part 14
    - Regulation identifying the entities eligible for recognition as Veterans Services Organizations, which was recently amended to specifically identify Tribes or Tribal Veterans Affairs Departments as eligible entities.
    - The VA collects data for the Geographic Distribution Index, which provides a breakdown of VA funding being distributed to each county in the United States and shows how valuable and beneficial having a local VSO is for helping Veterans with health care benefits.

- **Pacific District Update**
  - Tribal Veterans Representative (TVR) training will be held May 9-11, 2017.
  - Veteran Summits will be held on June 14-16, 2017 Lewiston, Idaho and June 23-24, 2017 in Reno, Nevada.

- **Continental District Update**
  - Veterans Training Summits scheduled for May 22-23, 2017 in Ohkay Owingeh, New Mexico and July 1-2, 2017 at the Dine College in Tsaile, Arizona.
  - CMS IHS/Tribal/Urban (I/T/U) Training in April during the Gathering of Nations Powwow and will include presenters from VHA and VBA.
  - The goal is to help Veterans get the benefits and programs they need, because these are earned benefits that Veterans have already put in their time for.

- **Midwest and Southeast District Update**
  - Working with Tribes to address homelessness and its effects on Veteran’s health by asking Tribes to develop a cultural component for the programs used to reach out to homeless populations.
The publicity and transportation Tribes provide are a critical component of getting Veterans to Intertribal Stand Down events.

VA is giving presentation on how to get a Veteran signed up and started, followed with a presentation for behavioral clinicians on how to treat traumatic brain damage and PTSD at the Southern Plains Health Association Conference.

The Mississippi Band of Choctaw Indians is in joint-collaboration with the area VA office to develop a VA treatment center within their health and wellness center.

- **Continental, Midwest, and Southeast District Update**
  - For 24 years, States were illegally taxing Native American Veterans and legislation was introduced to fix this in the past, but it didn’t go anywhere. Currently working with Tribes on new legislation that will completely fix the issue.
  - If you have any issues you would like included in the National Congress of American Indians (NCAI) Veterans Agenda, contact Peter Vicaire.
  - Having a quality VSO is very important, because they help make sure Veterans are getting the services they need as well as getting any back pay or issues resolved.
  - The District Office publishes a newsletter regarding Native Veterans and are happy to add anyone who is interested in Native Veterans’ issues to the mailing list.

- **Tribal Comment:** The ability to partner with the VA to provide services to Native Veterans is extremely important, especially since the VA will be getting budget increases and IHS is looking at budget cuts.

- **Tribal Comment:** There is concern when the language of program policy only references Tribal organizations and not Tribes themselves, as sovereign nations. Wampanoag Tribe of Gay Head (Aquinnah) have struggled with establishing a Tribal Service Officer and have received a lot of push back regarding funding not being set aside for that. Has there been any thought to setting funding aside specifically for Tribal VSOs? Additionally, are there any provisions for scholarships to travel to the trainings being held and what financial support systems will you be implementing with the increase in funding the VA is expected to receive? Finally, relative to the Tribal Veterans Health Care Enhancement Act (S.304), IHS shouldn’t be required to pay for services the VA provides to Native Veterans.

- **Response:** Yes, Tribes are sovereigns. Title 38 part 14 doesn’t automatically grant recognition to government entities of any kind. For a government organization to be recognized, they must have a stand-alone VSO whose sole purpose is to serve Veterans. The funding for Service Officers comes from Veterans’ organizations or state governments, because the VA doesn’t currently provide any funding for that; however, you could request that a portion of appropriations is set aside. Unfortunately, there aren’t funds available to sponsor travel and scholarships for training summits, which is why they try to host them at the most local level.

  - **Tribal Comment:** We would disagree that IHS should be mandated to pay for VA co-pays, because the VA has a trust responsibility to those Native Veterans as well as a much larger budget to provide services to them.

  - **Response:** We will have to check with the Office of General Counsel (OGC), but the VA doesn’t charge IHS, rather they charge it to the individual Veteran, because the VA is required by law to assess co-pays depending on how services provided are connected to a Veteran’s service; however, you could push for a legislative fix.

  - **Tribal Comment:** That is the purpose behind our comments. S.304 is a proposed fix to current legislation, but it shouldn’t be fixed to mandate IHS pay the co-pays, it should be fixed so that the VA covers those. You need to take back the message that the VA has a responsibility to Native Veterans and they can’t push that responsibility onto another agency.
Tribal Comment: We are requesting that the VA support and request that legislative change during their budget cycle, which agencies are allowed to do.
  - Response: Will have to follow up with OGC.
Tribal Comment: The sentiment of Indian Country also needs to be included as part of the testimony when the S.304 goes in front of the Committee tomorrow. With these pieces of legislation and language, they try to treat everyone the same no matter what; however, we are different than everyone else and it is a Federal Trust Responsibility that AI/ANs have already paid the price for, especially when it comes to Native Veterans.
Tribal Comment: Legislatively, we are already the payor of last resort so you need to access what your responsibility is in regard to the existing statute.
  - Tribal Comment: We understand the importance of addressing these issues, because AI/ANs serve in the military at a higher rate than anyone else. We would also ask that you remind VA Secretary Shulkin we have provided specific recommendations in several different letters and request he provide more of a response than the one response we have received thus far.
Tribal Comment: Tribes have concerns about the intention to consolidate agreements under the Choice Act. We believe our current agreements are superior to the Choice Act, because they are procurement type agreements, rather than just reimbursement agreements. Additionally, we believe that many provisions within the Choice Act, such as the pre-approval process, will actually hinder the provision of care to Veterans. As such, what is the process for IHS and Tribes to get involved in development of what the future agreement is going to be?
    - Response: The VA budget for purchasing care in the community is $9 billion dollars and they have only reimbursed IHS and THPs $55 million over a 4-year period. OTGR tries to share the message that this is very important funding for THPs When looking at IHS and Tribes, you are working with a sovereign entity, so we believe that Tribal reimbursement agreements should be held harmless; however, we don’t know if VHA will do that. There is also an option for Tribes to engage with the VA as a business entity or vendor to provide services to all Veterans in the area, which should then have discussions regarding what terms should govern that business relationship, whether it be the existing Tribal reimbursement agreement or a separate one under the CHOICE Act. VHA has expressed interest in continuing with consultation; however, the dates for such are not yet known. The VA is expected to participate in consultation for the future MOU and continue consultation regarding consolidation.
  - Tribal Comment: Choctaw Nation has both agreements, because they are providing care to both Native and Non-Native Veterans. This is working for them, but other Tribes may want to explore other options.
    - Response: If you aren’t already engaging with the VA in some way, you really should begin those conversations, as there are many resources available to help Tribal economies and Veterans in Tribal communities.
  - In northern Arizona, they have been able to set up programs that go beyond the reimbursement agreement to provide services and bring in more Veterans. We encourage you to really engage in partnership with the VA so you can do these different things until there is an overarching law.

Office of Information Technology (OIT)
CAPT Mark Rives, Chief Information Officer and Director, OIT, IHS
Randall Hughes, Tribal Liaison, OIT, IHS
LCDR Andrea Scott, Deputy Chief Information Officer and Deputy Director, OIT, IHS
  - Although there have been improvements, Health Information Technology (IT) is still struggling to keep up with an ever-changing technology market. Patients will soon be asking IT to provide more services than ever before.
IHS TSGAC & Technical Workgroup Quarterly Meeting  
March 28-29, 2017 – Summary

- IHS is the only federal health care system to be multi-year winners of the Surescripts White Coat of Quality Award.

- Updates on Goals and Current Initiatives:
  - Strengthen IHS Health IT community, and we have done so by restarting the Health IT Conference, conducting training, and awarding a new Resources and Patient Management System (RPMS) support contract.
  - Improved communications through letters sent by the Acting Director, newsletters, and reestablishment of their Clinical Advisory Committee.

- Tribal Comment: What type of collaboration is taking place to bridge and improve the communications between the VA and IHS?
  - Response: OIT does participate in the Federal Health Information Exchange and has shared data with the VA in some regions; however, the VA did a regional roll out, rather than a national roll out, so some of their regions are farther ahead than others. A lot of times, many of the issues are due to lack of education on one side or the other in particular facilities, which OIT is happy to work with Tribes on.

- Tribal Comment: Chickasaw Nation has a lot of IT issues, which they would like to discuss soon. Many of these issues revolve around Meaningful Use, old technology, lack of integration and patient engagement, and revenue generation. Because these issues have a major impact on health care delivery, it would be good to see a simple IHS IT plan identifying all of these issues and when and how they will be addressed. Overall, it is important that IHS help keep Tribes in the RPMS system if that is the system IHS will continue using.
  - Response: Protests to the changes in the contract structure that were implemented when the previous contracts supporting RPMS naturally came to an end has been one of the biggest things that has paused development efforts. Those issues have now been resolved; however, it resulted in a loss of about a year’s worth of software development. A new contract has been awarded, they have scheduled development work, and will be publishing a timeline of when that work will take place on the OIT website. There are other issues with development due to difficulty finding RPMS people and the experience of the system at the local level being dependent on who’s supporting it and their level of RPMS knowledge, which they hope to address now that regular RPMS training classes have been restarted. OIT has also had conversations with the VA, although it is unknown what they are planning to do with their system, and will be requesting ISAC form a workgroup to address what the future of IHS EHR. Need to keep in mind that RPMS was developed before the emphasis on revenue generation, and its strengths are in population health. RPMS does have weakness that need to be addressed, but perhaps we need to explore other options, such as alternative payment methods, that focus on patients’ and population health, rather than following the health care industry and being a business of medicine.
    - Tribal Comment: The problem is that everyone must supplement funding from IHS with billing. There needs to be better data about population health and third-party reimbursement has evolved into a way to provide for that, which leads to competing priorities. It’s also important that we aren’t duplicating efforts when it comes to reporting.

- Service Catalog Announcement and Consultation
  - The catalog has been reviewed and approved internally. There will be a Dear Tribal Leader Letter (DTLL) listing the webinars and consultation that will take place, information for which is currently available on the IHS website.

- Currently, there are 404 sites using RPMS.
• The process for requesting data from the National Data Warehouse (NDW) and the National Patient Information Reporting System (NPIRS) is published on www.ihs.gov and will be provided via email.
  o Tribal Comment: Previously Tribes could request specific reports, such as workload, and requests have had to go through the Institutional Review Boards (IRB). Is that something new and how much time does it add to the process?
    ▪ Response: Requesting workload reports doesn’t come from NPIRS, rather it comes from the usual process of requesting support from the Area Office, which hasn’t been changed. That is for requesting specific data from the NDW.
  o Tribal Comment: Do you collaborate and share information with the Tribes that have developed RPMS system improvements that work well?
    ▪ Response: They have done some collaboration and do value Tribal partnerships. It has been mentioned that OIT needs to improve how they collaborate and share information, which they would like ISAC to look into the best ways for doing so.
• The information shared by OIT will be published on the website and they will send out a PowerPoint that goes into detail regarding the updates that are scheduled for RPMS.

TSGAC Members’ Executive Session with Acting IHS Director

Office of Environmental Health and Engineering (OEHE)
Gary Hartz, Director, Office of Environmental Health and Engineering, IHS

• Joint Venture Project Update
  o Many of the project agreements signed over the last 8 years have been completed or are in progress to complete, which has provided approximately $900 million and 1.7 million square feet for facilities.
  o Tribes have advocated for reopening the solicitation; however, that is still on hold until they see what happens with the FY 2018 budget.
  o Joint Venture Project Construction Template Updates
    ▪ Lease agreements are still required due to regulations within the law; however, they are working on a template that will streamline the process and allow for concurrent signing of the lease agreement and joint venture agreement (JVA).
    ▪ Tribal Comment: It’s not the lease agreements that are the problem, rather it’s the things that are required to be included in the template for construction. Many Tribes don’t understand the construction process and template and have to hire outside consultants to complete it. It needs to be a simpler process that Tribes can actually use, which they have been continually asking about.
      • Response: They are working on updating the Health System Planning guides to a web-based system, which will make it more accessible and user friendly.
  o Tribal Comment: Choctaw Nation sent a letter recommending that IHS change how they solicit and choose joint venture projects so that it doesn’t create a list that never gets completed, the highest priority projects always get funding, and Tribes can reapply if they aren’t granted a project.
    ▪ Response: They have tried sticking to a 3-year cycle, which means the next solicitation would be in FY 2018; however, the next steps for solicitation will depend on how the budget affects the 6 projects currently in the queue.
  o Tribal Comment: What is the dollar amount, minus Cherokee Nation, for the employment packages of the remaining projects in the queue?
    ▪ Response: For the remaining 6 that haven’t been notified to proceed it’s approximately $70 - $75 million total.
Tribal Comment: Tribes have the authority to design and redesign programs how they see fit, so why do we have to use the current planning and design template, which is for Federal facilities, when it requires special justification for needed design elements, such as outpatient surgery in an outpatient facility, that aren’t included in the template and result in double the work for Tribes? Tribes have said this for several years and there has never been meaningful discussion around it. There has to be a way for IHS to accept a design for a facility that the Tribe is going to build and equip without it being required to model a Federal facility.

- Response: Yes, Tribes can redesign programs and deviate from the Federal standard, but it still has to be looked at from a Federal perspective, because they have to staff the facility based on how the Secretary would have staffed it. At that point, it just comes down the details of what the will and won't allow, which is where agreements have to be reached; however, they believe that the overall process will get easier once it transitions to a web-based program.

Tribal Comment: Is there a timeline for the transition to a web-based program?

- Response: At the end of January it was 60% complete and they’re hoping to start initial testing by the end of the fiscal year.

- Sanitation Facilities Construction (SFC) Fund Distribution Methodology

- Within the facilities appropriation there are line item appropriations for maintenance and improvement, health care facility construction, sanitation facilities construction, the facilities program’s Federal and Tribal staffing and operation, and equipment.

- Appropriations language for those line items has stated that resources need to be distributed based on workload and need.

- Base budgets have been established where Tribes have indicated they want them through the Environmental Health Support account; however, to stay consistent with Congress, resources from that account have been set aside to address workload adjustments. Is the Tribal request that there needs to be more base funding for sanitation facilities delivery from this account?

- Tribal Comment: Tribes have identified that a more dependable way of funding needs to be established for the operation of this program. Citizen Potawatomi Nation and for other Tribes in the Oklahoma City Area have had ongoing issues regarding funding priorities they have identified. Although these funding priorities are a major need for them, it doesn’t seem to rise as a need for consideration at the national level.

- Response: The $99 million for sanitation facilities is distributed to two accounts, 40% for new and like-new, non- HUD housing needs and 60% for existing community and housing needs. The Indian Health Care Improvement Act (IHCIA) specifies a process for determining deficiency and project prioritization. Current total need is $3.4 billion with a feasible project list totaling $1.7 billion. They receive all of those projects, then look at the percentage of total Area need compared to percentage of national need and distribute funding based on those percentages.

- Tribal Comment: Choctaw Nation expressed concerns with the way deficiency is calculated and how Indian and non-Indian communities are defined. First, the Draft guidance refers communities with less than 50% Indian homes as non-Indian and automatically treats them as a lower deficiency level, which is not the case. Therefore, they request that those references be removed.

- Response: Meeting in Oklahoma was beneficial for understanding these issues. Until they started looking at historical data, they believed deficiencies were the same. Many things are already happening to address it, such as GAO visits, and, they commit to reviewing, addressing, and fixing those inconsistencies, which are common across Indian Country.
- Tribal Comment: Since it is a daft guidance how soon will you be able to clarify that issue and will you issue a memo or supplemental draft guidance until the final version is issued?
  - Response: Hoping to finish before the end of the fiscal year and will have to check one providing a supplemental document, but they should be able to do that.
    - Tribal Comment: Are you in agreement about opening the Sanitation Deficiency System (SDS) system so Tribes can see all the data? As a way of improving accountability and transparency, those imputing data should be able to see the entire system and how things are being ranked.
      - Response: Some of that data is already available; however, there are concerns with opening up the system due to some very high levels of need in certain areas and discussions with other Tribes need to take place first.
      - Tribal Comment: There are Tribal representatives from across the country in attendance; however, we will follow up in writing. An offline discussion would be beneficial to discuss any sensitivities that exist.
- Small Ambulatory Health Center Grants
  - Resources were included in the President’s budget request for FY 2017. The Senate marked it up and included a request for $10 million; however, the outcome of that request has yet to be seen.
  - Addition of staffing has been discussed. At the last Facilities Appropriation Advisory Board meeting it was determined that staffing is included in the revised methodology for health care facilities construction; however, current discussion has been focused on the budget request.
- Table 4F Development and Full Implementation of Title V
  - Recognize that not everyone is understanding this and are willing to distribute information about how you track Tribal shares from headquarters to the Tribes.
  - Tribal Comment: Every year Tribes need to be able to track their shares and how they are being implemented. Regarding implementation of Title V, we are referring to stable base budgets, which haven’t been implemented in OEHE, and it is an issue Tribes have continually asked about. OEHE isn’t exempted and previous processes of distribution don’t preclude transitioning to stable base budgets.
    - Response: The understanding is that most of that is already in the Facilities Support Account already.
    - Tribal Comment: The issue is that it is recalculated every year and hasn’t been implemented in other line items.
      - Response: Not recalculated for Tribes that have taken it as base budgets, which means you are already receiving it as a reoccurring amount. It has been implemented in the Environmental Health Support Account, except for $5 million, which is distributed based on workload to account for annual changes and stay consistent with Congress’s direction to do so. Of the $73 million appropriated, approximately $67 million is distributed out, with Tribes who have taken base budgets receiving it as such.
    - Tribal Comment: That is not our understanding so further discussions are needed. A presentation focusing on a walkthrough of that should be given at our next meeting.
      - Response: The delay of appropriations has caused many issues regarding Tribal shares and further discussion would be beneficial.

Contract Support Costs Update (CSC)
Lia C. Carpeneti, Associate, Sonosky, Chambers, Sachse, Miller, Monkman & Flannery, LLP

Approved July 18, 2017
**Geoff Strommer, Partner, Hobbs, Dean, Strauss, and Walker**  
**Melanie Fourkiller, Policy Analyst, Choctaw Nation and TSGAC Tribal Technical Workgroup Co-Chair**

- **CSC Appropriations**
  - IHS originally estimated the amount needed was $800 million, which about $82-$96 million too high. This overestimate is extremely concerning because the funding cannot be used for other IHS programs and was scored against the budget, upsetting Congressional appropriators. There are people working to fix this issue and get that funding reallocated; however, the chances of reallocation this late in the appropriations process are very slim.
  - Currently there isn’t a cap in the appropriation language for CSC; however, Congress could decide they are no longer comfortable with that language and get rid of it, especially with these overestimations and the message it sends about IHS’s ability to manage funding. Moving forward, IHS and Tribes need to work together in developing future CSC calculation methodologies to prevent this from happening again.
  - Tribal Comment: Do you know the difference between the overestimate calculations IHS made and those others outside IHS have made?
    - Response: Outside calculations show about $96-$97 million and IHS calculations estimate about $82 million.

- **CSC Litigation**
  - Tribes hold the view they are entitled to CSC for health programs that are funded with third-party revenue; however, IHS disagrees. In October in the Sage litigation, a New Mexico district court sided in favor of a tribe and ruled that IHS had to pay CSC for those programs. This currently only applies to that one Tribe and IHS has indicated that they will appeal the decision. In light of this, the recommendation is that Tribes be cautious about closing out their 2014 CSC claims.

- Due to the many changes made in the new CSC policy, the CSC workgroup requested more rigorous training be developed to assist Tribes; however, we don’t currently know the status of that request. Additionally, the workgroup agreed to reconvene, which has yet to happen, and work on reaching agreements for each of the backup calculation tabs that were previously deferred. As such, when will the workgroup reconvene to do that work?
  - IHS Response: IHS is working to implement trainings around the new CSC policy, which they hope to do before the end of the fiscal year. However, to address the immediate request for training, they are in the process of filming training segments that will be accessible online and are trying to have ready by the Annual Conference in April. In regards to a CSC workgroup meeting, templates were provided to the workgroup previously, which they would like to receive comments on so they can determine which parts of the template need to be addressed and how much time needs to be scheduled.
  - Tribal Comment: Can we schedule a workgroup call or a webinar to kick off that process and determine if a meeting is needed?
    - Response: Yes, we can work with you to determine what would be the best date for a call.
  - Tribal Comment: Additionally, there is time set aside at the Annual Conference for CSC training so will there be someone available to provide that?
    - Response: We can have more discussions regarding that.

- IHS Response: The reason the CSC estimation is $800 million is due to the budget proposing CSC be appropriated as specific, mandatory funds. As a result IHS had to ensure they would have enough authority to cover CSC if the need was greater than they expected; however, if the indefinite, discretionary appropriation of CSC continues, there will need to be more precise estimations. Complications also arise from the number of CSC claims that are still open, which establishes the start point of estimated need for the next year. Additionally, an expectation that

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several larger Tribes would be joining Self-Governance and the ability of Tribes to renegotiate their Direct CSC were factors in the process.

**Indian Health Service Budget Update**

*Elizabeth Fowler, Deputy Director for Management Operations, IHS*

- IHS FY 2017 Funding and Continuing Resolution (CR)
  - The House and Senate have been working on IHS appropriations provisions; however, IHS is not aware of the details of those provisions.
- President’s FY 2018 Budget Blueprint
  - A brief description of IHS is listed under the Department of Health and Human Services (HHS); however, it doesn’t give enough information to determine how it will translate to a full budget request. The full Presidential Budget Request is expected to be released mid-May.
  - Tribal Comment: The description of IHS as a safety net is very problematic and negates to acknowledge the Trust Responsibility. Therefore, we encourage you to emphasize in your budget request how important IHS is and that it needs to be funded to fulfill that responsibility.
    - Response: We agree. The development of the Blueprint was done on a high level, which didn’t allow for operating division participation opportunities.
- Area Budget Formulation Pilot Project
  - This was an initial idea to address Area needs not reaching the national level; however, the workgroup has decided to forgo further work on this particular process and encourage recommendations on other ways to address the issue be submitted, especially during the evaluation meeting at the Annual Conference.

**Patient Protection and Affordable Care Act (ACA) Implementation Update**

*Cyndi Ferguson, Self-Governance Specialist/Policy Analyst, SENSE Incorporated
Doneg McDonough, Consultant, TSGAC*

- Outreach and Education Project Update
  - Health Care Reform Website Overview
    - Updated continuously so that all information is up-to-date and available. The latest information, such as analysis and timelines, is located under the 2017 Actions Tab.
    - List of all scheduled webinars is available as well as recordings of and supplemental documents from past webinars.
    - There is also a Q & A page where you can submit any general questions and includes a Frequently Asked Questions section.
    - Other Resources page lists different letters and documents that have been developed in relation to the ACA.
    - Finally, there is a success stories page where you can read and print stories coming from several different Tribes.
- Timeline of Potential Administration and Congressional Action on ACA Repeal/Replace Legislation
  - Although the House Bill was withdrawn, we need to stay vigilant of other actions taking place such as the budget and proposals to raise the Federal debt limit that would require an equal amount of funding be placed into savings.
  - Due to rising litigation regarding cost-sharing provisions, we must continue advocating the importance of those provisions and that republicans will have to be proactive in order to protect them.
If they can put the Reinsurance Program, which offsets the costs associated with high risk people, into place before June 2017, it will help to stabilize the marketplace and bring insurers back in.

**Employer Mandate**

- Currently, no employer has paid the mandate, because the Federal government didn’t bill employers. Unknown if the new Administrations will start billing employers, which means it’s a liability for Tribes and advocacy for exemption must continue.
- Tribal Comment: The fact that you would be required to pay the employer mandate penalty, even if all your employees receive health care through IHS, would be a huge burden.

- Administration and Congressional ACA Related Actions in 2017 and 2018
- Moving Forward
  - We expect HHS Secretary Price to be granting State waivers regarding provision requirements.
  - Keep in mind there are 16 States with Federally Recognized Tribes that chose not to expand Medicaid and are standing between a Federal entitlement and people receiving care. We don’t need to request funding for this because it already exists under Federal law, it just needs to be implemented.
  - Tribes should continue any plans for establishing Tribal Premium Sponsorship. Even if the House Bill passed, there would be two and a half years before tax credits and cost-sharing ended.
  - An enrollment kit for Tribes interested in Premium Sponsorship has been developed, which includes everything that needs to be considered on a Tribal level and a fast track that provides information on the program, model documents, and analysis which will be available online soon.

- Tribal Comment: We need to think about how the Administration will readdress this, what our priorities are for strengthening it, and what kind of policy and legislation recommendations we want to make.
- Tribal Comment: Although the House Bill was pulled from the floor, the President signed an Executive Order (EO) that ordered HHS to minimize the burdens of the ACA. This directed HHS Secretary Price, to the extent of the law, to waive or defer provision with large economic burdens. We need to keep this EO and the effects it will have on program revenue in mind.

**2017 Self-Governance Annual Consultation Conference Discussion**

- Registration closes on April 1, 2017. If you are unsure about your registration, you can ask Tami. She can also tell you if you have a hotel room for the conference.
- Still looking for sponsors.
- Looking for moderators and notetakers. It’s very important to have notes from the sessions, especially because they are used often by those who can’t attend in person. Please let us know if you would be willing to serve in this capacity.

**Preparation for Discussion with Acting IHS Director**

- Melanie Fourkiller, TSGAC Tribal Technical Workgroup Co-Chair, reviewed items of discussion identified in Tribal Caucus. Talking points for tomorrow’s meeting will be provided in the morning.

**Recess until March 29, 2017**
Wednesday, March 29, 2017 (8:30 am – 12:45 pm)
Meeting of IHS Tribal Self-Governance Advisory Committee (TSGAC) and Technical Workgroup
with RADM Chris Buchanan Acting IHS Director

Invocation: Kay Rhoads, Principal Chief, Sac and Fox Nation

Welcome and Introductions
Marilynn “Lynn” Malerba, Chief, Mohegan Tribe, and Chairwoman, IHS TSGAC
RADM Chris Buchanan, Acting Director, IHS

Congressional and Legislative Office Update
June Tracy, Director, Congressional and Legislative Office, IHS

- Since it’s the beginning of the 115th Congressional session, activity is just getting started.
- H.R. 235 – Indian Health Service Advance Appropriations Act
  - Bill reintroduced by Congressman Young that would give authorization to provide advanced funding for IHS operations. IHS testified to Congress when this bill was previously introduced; however, no additional specific committee hearings have occurred.
- There are a few specific interest bills, such as Land Transfer Bills in Alaska and State of Virginia Federal Recognition Bills.
- H.R. 981 – Indian Health Service Hiring Freeze Exemption Act
  - Bill introduced by Congresswoman Torres that proposes to exempt IHS positions from the Presidential Memorandum regarding the Federal Hiring Freeze.
- S. 465 – Independent Outside Audit of the Indian Health Service Act
  - Bill introduced by Senator Rounds that proposes an extensive audit of IHS, which arises from the circumstances in the Great Plains Area and the interests of specific offices on the Hill for more information on agency budgets and operational issues.
- S. 304 – Tribal Veterans Health Care Enhancement Act
  - Bill introduced by Senator Thune authorizing use of PRC dollars to pay for services provided to Native Veterans using VA facilities. SCIA is holding a hearing on this bill today and they expect it to be marked up and favorably reported. Originally introduced and marked up in the last Congress, but no final action was taken before the end of the Congressional session.
- SCIA is holding an oversight hearing on the Special Diabetes Program for Indians (SDPI).
  - Purpose it to put the valuable work of the SDPI on record. IHS Acting Director Buchanan will be testifying along with Tribal witnesses. They hope to highlight the major accomplishments that have been achieved thus far.
- Tribal Comment: When there is going to be a Congressional inquiry or hearing, it would be nice if IHS would communicate that information so Tribes can advocate around those critical issues.
  - Response: It’s always good that we all work with the same information and have consistent messaging. IHS Acting Director Buchanan agrees that communication is important.
- Tribal Comment: Can updates from Ms. Tracy and her office be made a regular part our quarterly meetings?
  - Response: Yes

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• Tribal Comment: Can you explain more about S. 304, Senator Thune’s bill? Is it good or bad and what kind of impact will it have?
  o Response: The purpose is to make it easier for Native Veterans to receive the care they need. It will have an impact because it requires IHS to use PRC dollars for those services. However, that impact will vary depending on how widely the programs are used.
• Tribal Comment: Since IHS is the payer of last resort, why wouldn’t the VA be the ones to cover the cost, especially since the VA’s budget is exempt from sequestration and continues to grow with the population? As a committee, we need to look at the language and decide how to address it.
  o Tribal Comment: It makes sense to remove restrictions on that funding. Perhaps it should be language where IHS initially pays for the services, ensuring Veterans receive them, with the VA then reimbursing IHS for the funding paid out.
  o Tribal Comment: PRC has already been an issue within the current IHS-VA MOU and clarification is needed to ensure Veterans are receiving needed care.

**Joint TSGAC and Acting IHS Director Discussion**

• Returning Funds to Treasury
  o Tribal Comment: We appreciate the IHS update letter and the information that has already provided; however, we need further discussion on how we can avoid returning funds in the future and what is needed for Tribes to help facilitate those efforts and what you think caused the spike this past year, which seems to be out of the norm. Additionally, we need to put the percentage of funding being returned into perspective and discuss the comparison to funding amounts being returned by other agencies.
    ▪ Response: Not returning significant amounts of funding. It’s a complicated process that is specific to the appropriations law. Most funding is appropriated as one year funds that they then have 5 years to use. The $3.8 million returned this past year comes from closing out FY 2011 funds and is 0.14% of the total IHS budget for that fiscal year and approximately 0.002% of the current overall IHS operation budget, which includes third-party collections and the like. Funds usually returned are in relation to contracts or services purchased that year, which weren’t used in their entirety, and are not funds from the service unit level.
  o Tribal Comment: When you go to Congress with this information will it say that x amount of money was returned for x reason and are funds from x level of service? It’s important to make sure the facts and situation aren’t getting misrepresented.
    ▪ Response: Yes, that is how we believe it will be handled. Additionally, we are taking other actions to continue improvement, such as implementing the Hyperion Accounting System.
  o Tribal Comment: Are funds being returned restricted to a specific thing? If so, is there a way to review those policies so the language is less restrictive and allows them to be redistributed? Additionally, are the DTLLs being distributed to the people heading up these issues? It’s important that the right people have all the information so these issues can be addressed.
    ▪ Response: We agree and are working to improve communications.
  o Tribal Comment: Can you outline the fluctuations in the budget a little more?
    ▪ Response: From 2006 to 2011 there appears to be a gradual incline, which could be from appropriations increases as well as purchases and contracts.

• S. 465 – Independent Outside Audit of the Indian Health Service Act
  o Tribal Comment: We understand this is driven by Great Plains Tribes. No one should have to deal with the issues in care they are dealing with and we support those issues being addressed; however, we have major concerns with an extensive audit. Overall we
would recommend: 1) the audit have more time to occur; 2) that work with Congress to hold them accountable for fully funding IHS continues; and 3) that IHS be proactive in responding to Congress. As such, does Congress feel they aren’t getting the information needed and that IHS isn’t being responsive to their requests?

- Response: The IHS Great Plains Area is a very challenging issue. The challenges they face didn’t happen overnight and are long standing issues. Agree IHS needs to be proactive and take the opportunity to tell their story. IHS can do better at responding to the GAO and continue working on improving communication.

- Tribal Comment: If an audit is done, it will likely be performed by an outside person who isn’t familiar with Tribal issues or communities. In addition, the cost to perform the audit will likely come out of the HHS budget, which will probably then be filtered down to IHS. As they begin to outline this process can you provide details of what they are planning, especially around how and when it will be funded?

- Response: Yes, we can and it would be a good topic for our IHS monthly update calls.

- Tribal Comment: Have you not received a request to provide this information? You say you would provide it, so does that mean you haven’t provided it yet?

- Response: Correct, I would respond with the information, but have not been asked for it yet.

- Tribal Comment: Can you explain what the process is for responding to Congressional requests? It sounds like you are being responsive; however, there is a running idea in Congress that IHS isn’t responsive. Therefore, it seems that there is a disconnect somewhere between you and Congress that isn’t allowing that information to go through.

- Response: We work very closely with the department to provide this information and some requests don’t have to go through OMB. Currently we don’t have any records showing requests regarding the Great Plains and as such, we encourage any requests that are made to the Area office be passed on to headquarters. When we do receive a request, the information is provided to them in a very timely manner, especially when it is information such as user numbers. Sometimes it can be more difficult to provide information due to the way questions are asked.

- Tribal Comment: A great way to be proactive in providing this information is to provide these update letters to the SCIA. You can also use the monthly update calls to address some of the hot topics.

- Response: Increasing our communication and providing information before it is requested is something we can improve on to be proactive. In the Great Plains, we are already having monthly update calls with Congressional staffers so that we can provide that information.

- Tribal Comment: We appreciate efforts to respond to Congressional requests and understand it can get difficult when you ask for more information and clarification. We also understand that sometimes things come from a specific Tribe or facility and it’s important that all of us, including Direct Service, Urban, and our other organizations, work together to improve things and reinforce the nuances of these issues.

- Tribal Comment: The United South and Eastern Tribes, Inc. (USET) isn’t looking at returning funds in isolation. We can see that there is a target on IHS, which was prevalent in Department of the Interior Secretary Zinke’s confirmation hearing. We don’t take a position that there aren’t efficiencies to be achieved within IHS; however, we are unsure if the detractors of IHS have the same end goal of Tribes, which is a better IHS, and want to emphasize that you have to be proactive in providing information and preventing an unwanted stigma from being established.

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• GAO High Risk Report Recommendations
  o Tribal Comment: In terms of quality care, are all Tribes using the Improving Patient Care (IPC) Program?
    ▪ Response: IPC is a model for improvement and there is one in each of the 12 IHS Areas. In terms of an overall dashboard that provides quality metrics, we are in the process of development. In the GAO report, there is reference to standards, such as wait time standards, which we are working on developing. Those would only apply to direct service facilities, however.
  o Tribal Comment: Providing information on action plans and what has already been done is another area to be proactive. In addition to providing information to Congress, such as this letter about the funds being returned, if you can provide those progress reports to Tribes, we can then provide those to Congress as well.
    ▪ Response: We would love for you to do that and will work to get those reports to you.
• Contract Support Costs (CSC) Workgroup Meeting
  o Tribal Comment: How do we get to better budgeting and prediction for CSC so that we can avoid the gross overestimation that has occurred and how can the CSC Workgroup engage on these issues?
    ▪ Response: The first step would be setting another workgroup meeting. Currently we are working on developing a webinar that will cover these topics and provide the information Tribes need.
  o Tribal Comment: Would it be possible to do this in a series of webinars that can address the fact that not all Tribes have the same level of knowledge regarding CSC calculation?
    ▪ Response: Yes, we can probably accommodate that request and perhaps add it to our monthly update calls.
  o Tribal Comment: Are you having the conversation with Congress regarding the restrictive language and the possibility to reappropriate the funding at the end of the year if you have already fully funded CSC? IHS funding is currently one year funding, so does that mean that CSC is also only one year funding?
    ▪ Response: Yes, currently CSC is one year funding, but it is an indefinite appropriation, which allows us to go to Congress and make a request if we need more; however, calculation of CSC is a difficult process because of all the factors involved.
  o Tribal Comment: The main issue is how much discretion you have with funding and for how long. We should try to preserve it at the least, but if we can get to 2 or 3 year status, inclusive of CSC, it would be better. If it is helpful for TSGAC or another organization to send a letter educating Congress on the complexities of the situation, please let us know.
    ▪ Response: That is a good thing to hear. We are looking into work with outside contractors, such as Cliff Wiggins for Level of Need Funded (LNF), and open to workgroups to address those issues. We would appreciate any recommendations you may have about what that should look like.
  o Tribal Comment: We understand there is some restriction on how IHS can reprogram and utilize funding. Are those policies administrative or statutory in nature? Additionally, if Tribes were to make a request for more flexibility, who would we make it to and what form should it take?
    ▪ Response: There is language around reprogramming; however, we will need to get back to you with the exact information.
  o Tribal Comment: Has Congress provided guidance regarding what would be an acceptable deviation rate from the forecasted amount? If not, that needs to be
addressed so you don’t continue to receive feedback even though it’s improving. Also, is there a way to include Actuaries in the complex forecasting model process?
  
  ▪ Response: No, there isn’t an established number regarding deviation; however, all those topics sound like great items for the CSC workgroup.

- We would like to have a combined meeting of DSTAC, TSGAC, and Urban Programs.

- IHS Headquarters and Area Assessments
  
  o Tribal Comment: We don’t disagree that some of these assessments are necessary, but we request that they be applied fairly across IHS Areas; are for things that benefit Tribes, rather than the Agency’s social media and email security; and are recalculated on a monthly basis for Inter-Governmental Personnel Acts (IPAs) and Memorandums of Agreement (MOAs).
  
  ▪ Response: I would need to get more familiar with how this is done and what is being assessed in different Areas. I will follow up with you on that.

- Level of Need Funded (LNF)
  
  o Tribal Comment: We appreciate the effort you have put in so far and are happy to hear that you are reaching out to Cliff Wiggins. Are you looking to include Health Economists in this conversation? We recommend that there is a Tribal workgroup established.
  
  o Tribal Comment: We also respectfully request that the facilities project list is published publicly on the website by May 1, 2017. Doing so will increase transparency and accountability as well as put Tribes at ease regarding how projects are being prioritized.

- VA-IHS MOU Outstanding Issues
  
  o Tribal Comment: We have many concerns with S. 304 and don’t agree that our services should be consolidated, because the VA is assisting in carrying out the trust responsibility. We have made these concerns known and urge you to push back with the VA on these issues and concerns.
  
  ▪ Response: We have heard those concerns and Ben Smith has been tasked to work with the VA on these issues. We have heard that the VA is mandated by legislation to charge co-pays, which does serve as a barrier to care. Perhaps, instead of the current legislation introduced there should be legislation that allows the VA to cover those co-pays.

  o Tribal Comment: We mentioned to the VA that they should include that legislative language change in their budget justification. Perhaps IHS should do the same.
  
  o Tribal Comment: The VA did commit to having someone with authority at the next Committee meeting. However, it’s concerning that they continue to give non-responses to these issues. It’s also very disturbing that the VA, who has a budget that is so much larger, refuses to pay for these services.
  
  ▪ Response: We will reach out to the VA before the next meeting and have that conversation with them.

- Catastrophic Health Emergency Fund (CHEF) Rule
  
  o Tribal Comment: We request that IHS delay issuing a finalized rule until the Redding case is decided.
  
  ▪ Response: That makes sense and we agree.

- Executive Orders Re: Hiring freeze, Regulatory Mandate, and Reorganization
  
  o Tribal Comment: Before the hiring freeze, IHS was already understaffed and there are many people not in provider positions that make sure health care systems run. How is the Administration going to hear that from you and our committee?
  
  ▪ Response: We try to provide that information in the DTLL. With reorganization, some last-minute things were done and we believe Tribal consultation needs to be held before we move forward. For identifying a regulatory person, we have an IHS Division of Regulatory Affairs who will handle that issue.

  ▪ Tribal Comment: Who would be the person in Regulatory Affairs?
• Response: Carl Mitchell is the Director.
  o Tribal Comment: We are very happy to hear your comments on Tribal consultation for reorganization.
    ▪ Response: It goes with what we heard from HHS Secretary Price about patients, people, and partnerships. We understand that partnerships are very important and we have to utilize the work and experience of everyone involved so that we can truly make things better.

• Workforce Issues
  o Tribal Comment: How many positions are actually vacant in IHS?
    ▪ Response: That is a good question and it depends on how you ask the question. Currently, there are about 15,000 employees and 18,000 commissioned officers. As for an exact number, we don't have that answer today.
  o Tribal Comment: It's important to have that number, even if a rough estimate, so that we can include it in our advocacy effort. Something that would be helpful is a breakdown of those vacancies, including what kind of vacancies are present in each Area. We want to be your partner and help you address these issues, but we need that information.
    ▪ Response: Currently doing monthly reports and as of February, overall target number of employees is 17,850 with 3,214 vacancies equaling an 18% overall vacancy rate. Medical Officers is 27%, Nurse Practitioners is 35%, Certified Registered Nurse Anesthetists is 21%, Nurse Midwives is 26%, Dentists is 23%, Pharmacists is 11%, and Physician Assistants is 28%. Information for each Area is also available.
  o Tribal comment: We would like to have that information as well as the turnover rates by category and attrition. It would be valuable for us to see it, especially how the vacancies are distributed by Areas.
    ▪ Response: This is Federal sites only and a position could be filled by a contractor, which wouldn't appear on the Federal vacancy list. The last information was updated in September and is located in the IHS Director speeches, but we will work to get newer information. Will also need to work on including the vacancy rates of Tribal and Urban facilities; however, that may be difficult because it isn't something Tribes are asked to report and Urban Programs are authorized by IHCIA grants, which makes them a little bit different.
  o Tribal Comment: Is there any incentives for people to work in these rural areas? Additionally, are you looking at other positions that aren't considered as important, but play a major role in health care?
  o Tribal Comment: In language of scholarship and loan reimbursement, is it statutory or regulatory and who can modify that language? It’s not user friendly, which causes many people to back away from it and doesn’t cover positions such as those in administration, which you need to include. Additionally, housing continues to be a barrier to bringing health care providers to rural areas.
    ▪ Response: These are widespread issues we are continuing to work on.

• Partnerships
  o Tribal Comment: Are any conversations taking place regarding interagency agreements and Federal funds transfers?
    ▪ Response: Currently, participating in the Executive Council on Quality Care, which works with the Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA). When we see opportunities to utilize other departments who have already addressed some issues, we do what we can to work with them. As far as funding, we don’t have that information right now.
Tribal Comment: There has been a history of IHS not receiving funds from other agencies. Are you saying there hasn’t been a change in that precedence?
  ▪ Response: Not familiar with that issue

Other Questions or Issues:
  o Tribal Comment: Thank you for taking our recommendation and working to repopulate past correspondence on the webpage; however, there are still some missing.
    ▪ Response: We are working on it and letters from 2008-2017 are currently up.

Closing Remarks
RADM Chris Buchanan, Acting Director, IHS
P. Benjamin Smith, Deputy Director for Intergovernmental Affairs, IHS

• We are committed to keeping our promises and are working on improving communications through the update letters, which we will work to have out sooner.
• We were asked to develop an operations report, which will be coming out soon.
• Conducted consultation in 2008 regarding inclusion of the PSFA Handbook it in the IHS manual; however, we learned that wasn’t the way to go because health care technology is constantly changing. How do you think we could update it so that we can provide a set of guidelines for negotiations? Could we open it for a 45-day comment period with some national calls and then have it updated annually? These handbooks have developed on an Area level and we would like to create a similar tool at the national level, because it’s unacceptable for us to be operating under a document from 2002.
  o Tribal Comment: Could we include it as a consultation session at the Annual Conference?
    ▪ Response: Yes, I think we can do that.
  o Tribal Comment: We appreciate your emphasis on Tribal Consultation. You must continue engaging in consultation and we appreciate any you would like to hold.
    ▪ Response: The idea came from this Committee when it was formed in 1996. We needed to have tools and engaging in consultation is the only way to go.
  o Tribal Comment: Since this is the first major update, we recommend that you work with a technical group before publishing a draft for review. For updating annually, that will become a more established process that can be shortened. Additionally, we appreciate that many information items are available on the OTSG website; however, we request that an established document detailing information often requested, such as user population data, be developed and distributed to all Tribes.
• Tribal Comment: It’s important that we stay in an area of transparency and with the conversations we had yesterday with facilities, we aren’t getting that. The push back we have received is a paternalistic viewpoint that is trying to control how Tribal Leaders operate. We need all the information, even if it isn’t desirable, and it’s disrespectful to justify withholding information as a way of “protecting” Tribes. Additionally, if there are people who believe and think that way, perhaps there isn’t a place for them within IHS.
  o Response: We hear your point and will have to review what was said.
• Tribal Comment: Has the vacancy rate always been what it is currently and has there been an analysis on what the issues with recruitment and retention are? If so, what are those issues?
  o Response: We will have to review the information again to provide an answer regarding the vacancy rate. Another area we can improve on is conducting exit interviews to determine why someone chooses to leave after just a few months. I don’t believe there has been a comprehensive review, but that is something we can work on to further improve our proactiveness.

Closing Invocation: Floyd Gomez, Tribal Secretary, Taos Pueblo
Lunch

TSGAC Technical Workgroup Working Session

Adjourn TSGAC Meeting
<table>
<thead>
<tr>
<th>Assignment</th>
<th>Person(s) Responsible</th>
<th>Date Task Originated</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Continue to gather data from all Areas about impact of CR/shutdown. Specific programmatic impact, such as layoffs, closed programs, PRC, bad patient outcomes, etc. Reach out to the Health Directors in each Area.</td>
<td>Terra Branson</td>
<td>July 31, 2014</td>
<td>Ongoing – SGCE requested additional data and stories at the Strategy Session hosted recently</td>
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<td>2. Appropriations “Think Tank” -- Develop ideas/options for potential solutions to CRs (alternatives to Advanced Appropriations, such as an entire year CR with a “true up”, etc)</td>
<td>Carolyn Crowder Brandon Biddle Caitrin Shuy Liz Malerba Lloyd Miller</td>
<td>July 31, 2014</td>
<td>Refer to Budget Formulation workgroup.</td>
</tr>
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<td>4. Develop a concept paper to suggest new ways to measure need that include pieces beyond LNF.</td>
<td>Rhonda Butcher Kasie Nichols Carolyn Crowder Jackie Eagle Donna Swallows Caitrin Shuy Tyson Johnston Jim Roberts Melissa Gower Jennifer Cooper</td>
<td>October 7, 2015</td>
<td>A workgroup has been established. TSGAC sent a letter in December requesting POC from IHS to discuss our interests further.</td>
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<tr>
<td>5. Letter to IHS on payor of last resort guidance – request Tribal Consultation prior to issuing anything.</td>
<td>Unassigned</td>
<td>March 2016</td>
<td>CMS TTAG ACA Policy Subcommittee will follow up on the scenarios from IHS/CMS. Hold until ACA Policy Subcommittee gets copies of scenarios</td>
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<td>6. Develop and include in IHS Self-Governance Policy protocols for self-governance negotiations, including but not limited to expectations for information and document sharing and protocol for proper communication with Tribal leadership. Review with TSGAC. (see April 10, 1997 letter to TSGAC from previous IHS Director).</td>
<td>Jennifer Cooper OTSG Mickey Peercy Rhonda Farrimond Melanie Fourkiller Cyndi Ferguson Terra Branson</td>
<td>July 21, 2016</td>
<td>TSGAC sent a letter making recommendations for ALNs. Other issues and recommendations remain regarding Title V implementation.</td>
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<tr>
<td>7.</td>
<td>Develop ideas to implement TSGAC Comments to the SG Congressional Report.</td>
<td>Melanie Fourkiller Carolyn Crowder Tammy Clay SGCE</td>
<td>October 27, 2016</td>
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<td>9.</td>
<td>ALN Transfer of Knowledge Workshop</td>
<td>Jennifer Cooper</td>
<td>January 25, 2017</td>
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<td>10.</td>
<td>Coordination of CMOP Webinar</td>
<td>OTSG</td>
<td>January 25, 2017</td>
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<td>11.</td>
<td>Congratulations and Education Packet for HHS Secretary</td>
<td>Will be assigned as people are confirmed and appointed.</td>
<td>January 25, 2017</td>
</tr>
<tr>
<td>12.</td>
<td>OIT Service Catalog Comments</td>
<td>Melanie Fourkiller Melissa Gower Carolyn Crowder</td>
<td>January 25, 2017</td>
</tr>
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<td>14.</td>
<td>Coordination of two IHS-wide webinars to provide an overview on CSC, specifically changes to the CSC policy.</td>
<td>Roselyn Tso SGCE</td>
<td>March 29, 2017</td>
</tr>
<tr>
<td>15.</td>
<td>Coordinate CSC WG call to review the CSC negotiation templates. Email to the CSC Tribal Team for potential dates and inquire whether the Workgroup desires a regular schedule for meetings. Once input is received, send to Jennifer Cooper and Roselyn Tso.</td>
<td>Roselyn Tso Melanie Fourkiller</td>
<td>March 29, 2017</td>
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<tr>
<td>16.</td>
<td>Send email to OTSG requesting IHS Technical Assistance on identifying a path forward on improving budgetary flexibility for IHS (both reprogramming authority and spending authority).</td>
<td>Terra Branson</td>
<td>March 29, 2017</td>
</tr>
<tr>
<td>17.</td>
<td>Letter from SGCE to Senator Rounds regarding S. 465, including Tribal Consultation, looking at best practices and successes and extending time for the audit. Also include content from</td>
<td>Melanie Fourkiller Terra Branson</td>
<td>March 29, 2017</td>
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<tr>
<td>#</td>
<td>Description</td>
<td>Responsible Party</td>
<td>Date</td>
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<td>18</td>
<td>TSGAC/DSTAC/Urban Joint Meeting Coordination – first option is to invite them and set the meeting for Monday, July 17, 2017 during the next TSGAC Quarterly meeting.</td>
<td>Jeremy Marshall</td>
<td>March 29, 2017</td>
</tr>
<tr>
<td>19</td>
<td>Multi-Organizational Letter (TSGAC, DSTAC, NIHB) to the Acting Director requesting IHS to be proactive in addressing issues in the Great Plains.</td>
<td>Terra Branson</td>
<td>March 29, 2017</td>
</tr>
<tr>
<td>20</td>
<td>Follow up letter from TSGAC to Acting Director asking IHS to defer issuing a regulation on CHEF until pending litigation is over.</td>
<td>Kasie Nichols</td>
<td>March 29, 2017</td>
</tr>
<tr>
<td>21</td>
<td>Letter from TSGAC to VA reiterating our objection to automatically consolidate IHS/Tribal reimbursement agreements into the CHOICE program (hold current agreements harmless); include objection to S. 304 (Thune’s bill) on IHS paying co-pays to VA; reiterate request that VA make a request to Congress (in the Budget Justification or otherwise) for authority to pay/waive co-pays for Native Veterans due to trust relationship; and request the VA head of Intergovernmental Affairs attend the July quarterly meeting.</td>
<td>Jennifer McLaughlin</td>
<td>March 29, 2017</td>
</tr>
<tr>
<td>22</td>
<td>TSGAC letter to Acting Director, IHS on OEHE issues (copy to RADM Meeks, Gary Hartz) (recommendations re: transparency for SDS, consistent use of Deficiency Levels at all Areas/Tribal locations, addressing full implementation of Title V at the next quarterly meeting, specific edits needed/agreed regarding the term “Indian Community” in the draft Guidance on SFC.</td>
<td>Kasie Nichols</td>
<td>March 29, 2017</td>
</tr>
<tr>
<td>24</td>
<td>Letter from SGCE to Senator Thune on S. 304 expressing objection to using IHS funding to pay co-pays to VA; supporting authority for VA to pay/waive co-pays for Native Veterans in general</td>
<td>Cyndi Ferguson</td>
<td>March 29, 2017</td>
</tr>
<tr>
<td>25</td>
<td>Letter from TSGAC to Acting Director following up on previous recommendations regarding LNF providing additional detail (formalized Workgroup with representation from each Area).</td>
<td>Kasie Nichols</td>
<td>March 29, 2017</td>
</tr>
<tr>
<td>26</td>
<td>Follow up on TSGAC request to IHS to post Vacancy/personnel reports/statistics on the IHS website in an easily accessible place.</td>
<td>Jennifer Cooper</td>
<td>March 29, 2017</td>
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<td></td>
<td>Task Description</td>
<td>Responsible Party</td>
<td>Date</td>
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<td>27</td>
<td>Letter from TSGAC to IHS making recommendations on the Loan Repayment Program</td>
<td>Doneg McDonough</td>
<td>March 29, 2017</td>
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<td></td>
<td>(designation/expansion of fields of study, assessing growing fields of need within IHS, etc.)</td>
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<td>28</td>
<td>Work with OTSG staff on updating the 2002 Headquarters PSFA Manual.</td>
<td>Terra Branson Cyndi Ferguson Kasie Nichols Melanie Fourkiller</td>
<td>March 29, 2017</td>
</tr>
</tbody>
</table>
### Summary of IHS Tribal Self-Governance Advisory Committee (TSGAC) Correspondence

**Year: 2015-2017**

**Updated: June 22, 2017**

<table>
<thead>
<tr>
<th>Ref. #</th>
<th>Date Sent/Received</th>
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<th>Action(s) Needed</th>
<th>Response Received</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>6/22/17</td>
<td>The Honorable Thomas E. Price Secretary Department of Health and Human Services</td>
<td>Request for Tribal Consultation on HHS Reimagining Initiative and Invitation to the TSGAC Quarterly Meeting July 18-19, 2017</td>
<td>TSGAC invites the Secretary or a representative from the Department to attend the meeting to provide an update of the process and review future opportunities to formally provide our feedback.</td>
<td></td>
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<tr>
<td>2.</td>
<td>6/8/17</td>
<td>Bradley Crutcher Chairman Fort McDermitt Paiute and Shoshone Tribe</td>
<td>Welcome to Self-Governance and Congratulations</td>
<td>Invite to the next TSGAC meeting scheduled for July 18-19, 2017. As a Self-Governance Tribe in an IHS Area with a TSGAC Alternate delegate vacancy, the Fort McDermitt is eligible to submit a letter of nomination for any elected Tribal official or their appointee to serve as an Alternate delegate and select a technical workgroup member to support their work on behalf of the Area.</td>
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</table>
| 3.    | 6/8/17            | Wilfrid Cleveland  
President  
Ho-Chunk Nation | Welcome to Self-Governance and Congratulations | Invite to the next TSGAC meeting scheduled for July 18-19, 2017.  
As a Self-Governance Tribe in an IHS Area with a TSGAC Alternate delegate vacancy, the Ho-Chunk Nation is eligible to submit a letter of nomination for any elected Tribal official or their appointee to serve as an Alternate delegate and select a technical workgroup member to support their work on behalf of the Area. |                    |
| 4.    | 5/26/17           | Rear Admiral Chris Buchanan  
Acting Director, IHS | CHEF Final Rule | TSGAC Request to Delay Catastrophic Health Emergency Fund Final Rule |                    |
| 5.    | 5/26/17           | Rear Admiral Chris Buchanan  
Acting Director, IHS | Update to Level of Need Funded Data and Workgroup Request | TSGAC request for additional educational training regarding the Indian Health Care Improvement Fund (IHCIF), LNF calculations and plans to update information related to each |                    |
| 6.    | 5/24/17           | Ms. Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services | Medicaid Work Requirements for American Indians and Alaska Natives | TSGAC Comments |                    |
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<tr>
<td>7.</td>
<td>5/18/17</td>
<td>Rear Admiral Chris Buchanan Acting Director, IHS RADM Kevin Meeks Acting Deputy Director of Field Operations</td>
<td>Tribal Participation in the Department of Health and Human Services plan to carry out Executive Order 13781</td>
<td>Request to Schedule a Joint TSGAC/DST Call</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>5/10/17</td>
<td>Rear Admiral Chris Buchanan Acting Director, IHS CAPT Mark T. Rives, USPHS Director and Chief Information Officer Office of Information Technology, IHS</td>
<td>TSGAC Delegate to the Information Systems Advisory Committee (ISAC)</td>
<td>Advancement of A. Stewart Ferguson, PhD, Chief Technology Officer for the Alaska Native Tribal Health Consortium, as the TSGAC delegate for the IHS Information Systems Advisory Committee (ISAC).</td>
<td></td>
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<tr>
<td>9.</td>
<td>5/5/17</td>
<td>Nikki Bratcher Bowman, Acting Director Office of Intergovernmental and External Affairs U.S. Department of Health and Human Services</td>
<td>STAC National At-Large Primary Delegate Nomination</td>
<td>Formal nomination of Jefferson Keel, Lieutenant Governor of the Chickasaw Nation, for the National At-Large Primary Delegate position on the Department of Health and Human Services (HHS) Secretary’s Tribal Advisory Committee (STAC).</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>5/1/17</td>
<td>Department of Health and Human Services</td>
<td>HHS 19th Annual Tribal Budget Consultation Session on the FY 2019 Budget Request</td>
<td>Written TSGAC Testimony Submitted</td>
<td></td>
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<td>11.</td>
<td>4/30/17</td>
<td>Jennifer Cooper Acting Director, OTSG</td>
<td>Self-Governance Health Reform National Outreach and Education Semi-Annual Report</td>
<td>Transmittal of 6-month Report</td>
<td></td>
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<tr>
<td>12.</td>
<td>4/11/17</td>
<td>Rear Admiral Chris Buchanan Acting Director</td>
<td>Formation of the Community Health Aid Program (CHAP) Workgroup</td>
<td>TSGAC Recommendations</td>
<td>Letter received 6/11/17 from RADM Buchanan which states the IHS is currently addressing administrative details to establish the CHAP Workgroup, including selecting participants, defining key issues and determining meeting timelines.</td>
</tr>
<tr>
<td>13.</td>
<td>3/7/17</td>
<td>CMS via regulations.gov</td>
<td>Market Stabilization Proposed Rule (CMS-9929-P)</td>
<td>TSGAC Formal Comments</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>2/27/17</td>
<td>Rear Admiral Chris Buchanan Acting Director Indian Health Service</td>
<td>Self-Governance Negotiations and Create Agency Lead Negotiator Pilot Project</td>
<td>TSGAC Recommendations to Improve Self-Governance Negotiations and Create Agency Lead Negotiator Pilot Project</td>
<td>Letter received 3/24/17 from RADM Buchanan which includes IHS responses to this and several other recent issues raised by TSGAC during the January 2017 meeting.</td>
</tr>
<tr>
<td>15.</td>
<td>1/27/17</td>
<td>Norris Cochran Acting Secretary Department of Health and Human Services Rear Admiral Chris Buchanan Acting Director Indian Health Service</td>
<td>Support for Broad Exemption of Indian Health Service from Federal Hiring Freeze</td>
<td>TSGAC support and request for exemption from the hiring freeze for certain staff and contracted positions at the IHS</td>
<td></td>
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<td>16.</td>
<td>12/16/16</td>
<td>IHS Principal Deputy Director</td>
<td>Identification of Staff for Developing Level of Need Funded Data</td>
<td>TSGAC provided recommendations regarding analysis of the Indian Health Care Improvement Fund (IHCIF) and the Level of Need Funded (LNF)</td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>12/5/16</td>
<td>IHS Principal Deputy Director</td>
<td>Updated Contract Support Cost (CSC) Policy</td>
<td>Thank you letter and request that IHS develop a training and outreach plan for Tribal and Federal employees on the new CSC Policy.</td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>11/8/16</td>
<td>Leonard M. Harjo Chief Seminole Nation of Oklahoma</td>
<td>Congratulations and Welcome to Self-Governance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>11/8/16</td>
<td>John Berrey Chairperson Quapaw Tribe of Oklahoma</td>
<td>Congratulations and Welcome to Self-Governance</td>
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<td>22.</td>
<td>11/4/16</td>
<td>IHS Director via consultation.gov</td>
<td>IHS Headquarter Re-alignment</td>
<td>TSGAC Formal Comments</td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td>11/2/16</td>
<td>Dr. Richard A. Stone Principal Deputy Under Secretary for Health Veterans Administration</td>
<td>Request for the Information about the Veterans Administration’s Co-Payment Policy</td>
<td>TSGAC follow up letter from October meeting and discussion with Dr. Stone</td>
<td></td>
</tr>
<tr>
<td>24.</td>
<td>11/2/16</td>
<td>David J. Shulkin Under Secretary for Health Department of Veterans Affairs</td>
<td>Veteran Affairs’ Proposal to Consolidate Community Care Programs</td>
<td>TSGAC Formal Comments</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>10/31/16</td>
<td>IHS Director via consultation.gov</td>
<td>Catastrophic Health Emergency Fund Proposed Rule (RIN 0905-AC97)</td>
<td>TSGAC Formal Comments</td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>10/31/16</td>
<td>OTSG Acting Director</td>
<td>Self-Governance National Indian Health Outreach and Education</td>
<td>Transition of Final Report for 2015-2016</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>10/28/16</td>
<td>Kitty Marx, CMS</td>
<td>Tribal Technical Advisory Group (TTAG) Appointments</td>
<td>TSGAC Re-appointment of TTAG Reps</td>
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<td>28.</td>
<td>10/28/15</td>
<td>IHS Director via consultation.gov</td>
<td>Purchasing Health Care Coverage (IHS Circular 2016-08)</td>
<td>TSGAC Formal Comments</td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>10/5/16</td>
<td>CMS via regulations.gov</td>
<td>HHS Notice of Benefit and Payment Parameters for 2018 (CMS-9934-P)</td>
<td>TSGAC Formal comments</td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>9/27/16</td>
<td>IHS Principal Deputy Director</td>
<td>FY 2015 Report to Congress on Administration of the Tribal Self-Governance Program</td>
<td>TSGAC comments and request to work with IHS to implement the suggested Tribal changes.</td>
<td></td>
</tr>
<tr>
<td>31.</td>
<td>9/16/16</td>
<td>IHS Principal Deputy Director</td>
<td>IHS Quality Framework Draft</td>
<td>TSGAC Comments on IHS Quality Framework Draft</td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>8/23/16</td>
<td>Dr. Baligh Yehia, MD Assistant Deputy Undersecretary for Health for Community Care Veterans Health Administration U.S. Department of Veterans Affairs</td>
<td>Opportunities for Partnerships between Tribal Health Programs and the Veterans Administration</td>
<td>TSGAC comments on the existing Indian Health Services/Tribal Health Programs-Veterans Administration (IHS/THP-VA) Memorandum of Understanding (MOU) and Choice Act Agreements</td>
<td>VA responded on 1/6/17. VA has suggested renewing all existing THP agreements and the VA-IHS National Reimbursement Agreement through December of 2018.</td>
</tr>
<tr>
<td>33.</td>
<td>8/16/16</td>
<td>HHS Regulations</td>
<td>RIN 0991-AC06: Comments on Proposed Rule; Health and Human Services Grant Regulation: Published on July 13, 2016 (81 Federal</td>
<td>TSGAC formal comments to proposed rule</td>
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<td>34.</td>
<td>7/21/16</td>
<td>Mr. Benjamin Smith, Director, Office of Tribal Self-Governance, IHS</td>
<td>Request for ACA/IHCA National Outreach and Education Funding (FY2017)</td>
<td>TSGAC formal request for funding</td>
<td></td>
</tr>
<tr>
<td>35.</td>
<td>7/14/16</td>
<td>Mr. Michael Fisher Lead Contract Specialist Indian Health Service</td>
<td>Solicitation Number 16-IHS-HQ-SS-0001</td>
<td>TSGAC Formal Comments</td>
<td></td>
</tr>
<tr>
<td>36.</td>
<td>7/8/16</td>
<td>IHS Principal Deputy Director</td>
<td>Request to Make Self-Governance Resources Available Publicly</td>
<td>TSGAC request to make negotiation documents publicly availability on the OTSG website as resources for Self-Governance Tribes.</td>
<td></td>
</tr>
<tr>
<td>37.</td>
<td>6/17/16</td>
<td>Centers for Medicare &amp; Medicaid Services (CMS) Department of Health and Human Services P.O. Box 8011 Baltimore, MD 21244-1850</td>
<td>Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2017 Rates, et al. (CMS-1655-P)</td>
<td>TSGAC Formal Comments</td>
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<td>38.</td>
<td>6/9/16</td>
<td>IHS Principal Deputy Director via <a href="mailto:consultation@ihs.gov">consultation@ihs.gov</a></td>
<td>Proposed IHS Contract Support Costs Policy</td>
<td>TSGAC Formal Comments</td>
<td></td>
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<tr>
<td>39.</td>
<td>5/20/16</td>
<td>Betty Gould, Regulations Officer Indian Health Service, Office of Management Services</td>
<td>Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated With Non-Hospital-Based Care Final Rule (RIN 0917-AA12)</td>
<td>TSGAC Formal Comments</td>
<td></td>
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<tr>
<td>40.</td>
<td>5/13/16</td>
<td>Treasury</td>
<td>TSGAC Formal Request for Targeted Partial Administrative Relief from Employer Shared Responsibility Provisions</td>
<td>Summary of recommendations from 5/9/16 Tribal/Treasury technical meeting re: potential options for implementing targeted partial administrative relief in order to align the ACA’s Employer Shared Responsibility provisions with the Federal government's long-standing “special trust responsibilities and legal obligations” to provide health care services to Tribes and Tribal members, most recently re-stated in the reauthorization of the IHCIA.</td>
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<tr>
<td>41.</td>
<td>5/10/16</td>
<td>IHS Principal Deputy Director</td>
<td>Catastrophic Health Emergency Fund Proposed Rule (RIN 0905-AC97)</td>
<td>TSGAC formal comments on proposed rule</td>
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<td>42.</td>
<td>5/10/16</td>
<td>IHS Principal Deputy Director</td>
<td>TSGAC Comments on SASP Program Funding Distribution</td>
<td>TSGAC input on the Substance Abuse and Suicide Prevention program in preparation for the funding opportunity announcement planned for early June 2016</td>
<td></td>
</tr>
<tr>
<td>43.</td>
<td>5/6/16</td>
<td>Steve Petzinger, OMB Program Examiner</td>
<td>Follow up from March 2016 Tribal Self-Governance Advisory Committee Meeting</td>
<td>Summary of the main issues and actions discussed during TSGAC meeting</td>
<td></td>
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<tr>
<td>44.</td>
<td>5/5/16</td>
<td>CMS</td>
<td>CMS-10458, “Consumer Research Supporting Outreach for Health Insurance Marketplace</td>
<td>TSGAC Formal Comments</td>
<td></td>
</tr>
<tr>
<td>45.</td>
<td>4/24/16</td>
<td>IHS Principal Deputy Director OTSG Director ORAP Acting Director</td>
<td>SG National Outreach and Education on ACA/IHCIA</td>
<td>Transmittal of 6-month Report</td>
<td></td>
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<tr>
<td>46.</td>
<td>4/18/16</td>
<td>The Honorable Sylvia Burwell, HHS Secretary The Honorable Robert A. McDonald, VA Secretary</td>
<td>Reimbursement Agreement between the Indian Health Service and Veterans Affairs</td>
<td>TSGAC request to include PRC services in reimbursement agreements between the IHS/Tribes and the VA, as soon as possible.</td>
<td>VA responded on 1/6/17. VA has suggested renewing all existing THP agreements and the VA-IHS National Reimbursement Agreement through December of 2018.</td>
</tr>
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<td>47.</td>
<td>4/18/16</td>
<td>Mary Smith, IHS Principal Deputy Director</td>
<td>CHEF Proposed Rule 42 CFR Part 136 - RIN 0905AC97, Catastrophic Health Emergency Fund, File Code 0905AC97</td>
<td>Request to Withdraw Proposed Rule, conduct Tribal Consultation and then reissue the rule.</td>
<td>IHS issued a Dear Tribal Leader Letter on June 1st stating stated that it will engage in additional consultation before moving forward with the rule.</td>
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<td>48.</td>
<td>4/18/16</td>
<td>Mary Smith, IHS Principal Deputy Director</td>
<td>Recommendations for Health Care Facilities</td>
<td>TSGAC Recommendations</td>
<td>7/23/2016 – Response letter received from IHS. The letter outlines IHS specific responses to each TSGAC recommendation.</td>
</tr>
<tr>
<td>49.</td>
<td>4/11/16</td>
<td>Thomas West Kathryn Johnson Treasury Department</td>
<td>Excise Tax on Certain Employer-Sponsored Health Benefits</td>
<td>TSGAC Follow up comments from March 2016 quarterly meeting.</td>
<td></td>
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<td>50.</td>
<td>4/5/16</td>
<td>Sylvia Matthews Burwell, Secretary, Andy Slavitt Acting Administrator, Centers for Medicare and Medicaid Services</td>
<td>Oklahoma Section 1115 Waiver Amendment Request</td>
<td>TSGAC Formal Comments</td>
<td></td>
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<tr>
<td>51.</td>
<td>3/29/16</td>
<td>Mary Smith, IHS Principal Deputy Director</td>
<td>Request for Service Unit Data on Health Insurance Status and 2016 Appropriation</td>
<td>TSGAC formal request for two sets of data: 1) Health insurance status of Active Users, by Service Unit (all Service Units) 2) IHS appropriation, by Service Unit (all Service Units)</td>
<td>August 26, 2016. IHS provided the following data sets back to the TSGAC: 1) health insurance status of active Users by Service Unit; and 2) IHS appropriation by Service Unit. May 17, 2017. Due to HIPPA restrictions, IHS is unable to provide data in smaller cell counts. The information previously provided includes as much detail as legally allowed.</td>
</tr>
<tr>
<td>52.</td>
<td>2/29/16</td>
<td>Office of Management and Budget Office of Information and Regulatory Affairs Attn: CMS Desk Officer</td>
<td>CMS–10519, Agency Information Collection Activities: Submission for OMB Review</td>
<td>TSGAC Formal Comments</td>
<td></td>
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<td>53.</td>
<td>2/19/16</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Comments on CMS-9936-N; Waivers for State Innovation</td>
<td>TSGAC Formal Comments</td>
<td></td>
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<td>54.</td>
<td>2/2/16</td>
<td>Dr. Debra Houry, MD, MPH Director, National Center for Injury Prevention and Control Centers for Disease Control and Prevention</td>
<td>CDC Proposed 2016 Guideline for Prescribing Opioids for Chronic Pain; Docket CDC-2015-0112</td>
<td>Support for USET Comments on the Proposed Guidelines</td>
<td>3/1/16 - Response received from CDC. Acknowledged the TSGAC comments. CDC expects the final Guideline to help primary care providers offer safer, more effective care for patients with chronic pain and help reduce misuse, abuse and overdoses from opioids.</td>
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<td>55.</td>
<td>1/15/16</td>
<td>Center for Consumer Information and Insurance Oversight, CMS, HHS</td>
<td>Comments on Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces</td>
<td>TSGAC Comments on Draft Letter</td>
<td></td>
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<td>56.</td>
<td>1/13/16</td>
<td>Mr. Thomas West Tax Legislative Counsel Office of Economic Policy Department of Treasury</td>
<td>Invited to Jan 27-28, 2016 TSGAC Meeting</td>
<td>Continue discussion on Permanent Administrative Relief from Affordable Care Act's Employer Mandate on Tribes for Tribal Member Employees</td>
<td>Response Received January 14, 2016. Mr. West and others are unavailable, but continue to work on this issue as it is related to Tribes.</td>
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<td>58.</td>
<td>12/21/15</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>CMS-9937-P, Notice of Benefit and Payment Parameters for 2017</td>
<td>TSGAC Official Comments on Proposed Regulation</td>
<td></td>
</tr>
<tr>
<td>59.</td>
<td>11/17/15</td>
<td>Kitty Marx</td>
<td>TSGAC comments</td>
<td>Support for 100 Percent FMAP Proposal</td>
<td></td>
</tr>
<tr>
<td>60.</td>
<td>11/10/15</td>
<td>Mr. Robert McSwain Principal Deputy Director, IHS</td>
<td>Payment of Settlements to Civil Service Employees</td>
<td>TSGAC requests that IHS provide an accounting to all Tribes of all payments made by IHS into the employee settlement fund by IHS Service Unit location, as well as the number of employees participating in settlement payments at each location.</td>
<td></td>
</tr>
<tr>
<td>62.</td>
<td>11/3/15</td>
<td>Mr. Robert McSwain Ms. Mary Smith IHS</td>
<td>Interpretation of Duplication Provision in 25 U.S.C. § 450j-1(a)(3)</td>
<td>TSGAC respectfully urges IHS to restore its prior position that funding for contract support costs will only be considered duplicative to the extent amounts for those items have been transferred in the Secretarial amount.</td>
<td>Response received from Mr. McSwain on 12/4/15. Due to pending litigation, the IHS letter provides a general response to the issues outlined in the TSGAC original correspondence of 11/3/15.</td>
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<td>63.</td>
<td>11/3/15</td>
<td>Honorable Sylvia M. Burwell, Secretary Department of Health and Human Services</td>
<td>Final Rule related to expand the Medicare-Like Rate</td>
<td>TSGAC requests that HHS expedite the review and publication of the Final Rule related to expand the Medicare-Like Rate, entitled “Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated With Non-Hospital-Based Care,” 79 Fed. Reg. 72160, originally published on December 5, 2014.</td>
<td></td>
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<td>64.</td>
<td>10/27/15</td>
<td>Honorable Robert A. McDonald Secretary of Veterans Affairs</td>
<td>Comments on Veterans Access, Choice and Accountability Act of 2014 (Choice Act)</td>
<td>Comments on the Secretary of Veterans Affairs’ (VA) pending report to Congress concerning the consolidation of “all non-Department provider programs” pursuant to the Veterans Access, Choice and Accountability Act of 2014 (Choice Act).</td>
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<td>65.</td>
<td>10/26/15</td>
<td>Dr. Elaine Buckberg Deputy Assistant Secretary for Policy Office of Economic Policy Department of Treasury</td>
<td>Request for Permanent Administrative Relief from Affordable Care Act’s Employer Mandate on Tribes for Tribal Member Employees</td>
<td>TSGAC provided a set of preferred options for addressing Tribal concerns pertaining to the imposition of the ACA’s employer coverage and reporting requirements as they pertain to Tribal member employees.</td>
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<td>66.</td>
<td>10/23/15</td>
<td>Dr. Elaine Buckberg Deputy Assistant Secretary for Policy Office of Economic Policy Department of Treasury</td>
<td>Request for Extension of Transition Relief from the Employer Mandate</td>
<td>TSGAC requested an extension of transition relief in implementation of the employer mandate from January 1, 2015 until at least January 1, 2016 and preferably to January 1, 2017.</td>
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| 67.   | 10/21/15            | Dr. Elaine Buckberg  
Deputy Assistant Secretary for Policy  
Office of Economic Policy  
Department of Treasury | Excise Tax on Certain Employer-Sponsored Health Benefits | Tribal leaders interpret Section 4980I as not applying to Tribal government thereby interpreting this to mean that the excise tax does not apply to Tribal government plans. The legal analysis for this position is provided in TSGAC’s comments to the IRS on Notice 2015-16, submitted on May 15, 2015 (attached) to letter and again in further comments submitted on October 14, 2015 (also attached to letter). | |
| 68.   | 10/16/15            | Mr. Robert G. McSwain  
Mr. Ben Smith  
| 69.   | 10/14/15            | Internal Revenue Service  
P.O. Box 7604  
Ben Franklin Station, Room 5203  
| 70.   | 10/13/15            | CDR Mark Rives  
Chief Information Officer and Director  
Office of Information Technology  
Indian Health Service  
The Reyes Building  
801 Thompson Avenue  
Rockville MD, 20852 | TSGAC Representative to ISAC | Appointment of Jessica Burger. | |
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<td>71.</td>
<td>9/30/15</td>
<td>Mr. Jeff Wu</td>
<td>Response to Request for Tribal Consultation on Referrals for Limited Cost-Sharing Variation Plans</td>
<td>TSGAC comments and recommendations.</td>
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<td></td>
<td></td>
<td>Deputy Director</td>
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<td></td>
<td></td>
<td>Center for Consumer Information and Insurance Oversight Centers for Medicare and Medicaid Services</td>
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<td>72.</td>
<td>8/28/15</td>
<td>Mr. Robert G. McSwain, Principal Deputy Director Indian Health Service</td>
<td>Fiscal Year 2014 Report to Congress on the Administration of the Tribal Self-Governance Program</td>
<td>TSGAC input on report in response to IHS request for comments.</td>
<td></td>
</tr>
<tr>
<td>73.</td>
<td>8/4/15</td>
<td>Dr. Elaine Buckberg, Deputy Assistant Secretary for Policy Office of Economic Policy Department of Treasury</td>
<td>Exemption of Tribes from the ACA Employer Mandate</td>
<td>Invitation to October 2015 TSGAC Quarterly meeting to discuss topic.</td>
<td>Confirmed attendance for Oct 7, 2015 at 10:30 am. Pre-briefing scheduled for Oct 2.</td>
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<td>74.</td>
<td>8/4/15</td>
<td>Mr. Robert G. McSwain, Principal Deputy Director Indian Health Service</td>
<td>Quality Reporting Measures</td>
<td>Request that IHS conduct an analysis and comparison of the GPRA and Clinical Quality Management approaches.</td>
<td>Response received from Mr. McSwain on October 5, 2015. Mr. McSwain notified the TSGAC regarding implementation of a major change beginning in FY2016 on GPRA clinical performance measures. The IHS is prepared to implement the Integrated Data Collection System Date Mart (IDCS DM), a new reporting mechanism within the National Data Warehouse. 3/30/16 – Letter received from IHS which includes a comparative analysis of GPRA/GPRAMA Performance Reporting and CMS Clinical Quality Management requirements. This letter and analysis was distributed to the TSGAC and discussed during the 3/30/16</td>
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<td>75.</td>
<td>8/4/15</td>
<td>Centers for Medicare and Medicaid Services Department of Health and Human Services Attn: CMS-10561</td>
<td>Comments on CMS-10561, ECP Data Collection to Support Qualified Health Plan (QHP) Certification for PY 2017</td>
<td>TSGAC Official Comments</td>
<td>TSGAC meeting.</td>
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<td>76.</td>
<td>7/28/15</td>
<td>Geoffrey M. Standing Bear Principal Chief Osage Nation</td>
<td>Welcome to Self-Governance</td>
<td></td>
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<td>77.</td>
<td>7/27/15</td>
<td>Mr. Robert G. McSwain, Principal Deputy Director Indian Health Service</td>
<td>Multi-Purpose Agreement (MPA) and Joinder Agreement &amp; ISAC Presentation</td>
<td>Address Tribal comments on MPA; and follow up with OIT to host Webinar regarding ISAC.</td>
<td></td>
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<td>78.</td>
<td>7/27/15</td>
<td>Centers for Medicare and Medicaid Services</td>
<td>Comments on CMS-2390-P, “Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability: Proposed Rules</td>
<td>TSGAC provided a series of substantive comments (26 pages); along with accompanying attachments. The TSGAC comments mirror the model template developed by a team of health care experts from the MMPC/NIH.</td>
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| 79.   | 7/10/15           | Carolina Manzano  
Chief Executive Officer  
Southern Indian Health Council, Inc. | Welcome to Self-Governance | | |
| 80.   | 7/10/15           | Vincent Armenta  
Tribal Chairman  
Santa Ynez Band of Chumash Indians | Welcome to Self-Governance | | |
| 81.   | 7/10/15           | Dan Courtney  
Chairman  
Cow Creek Band of Umpqua Tribe of Indians | Welcome to Self-Governance | | |
| 82.   | 6/29/15           | Mr. Robert G. McSwain,  
Acting Director  
Indian Health Service | Determination of Contract Support Cost Requirements | TSGAC comments in response to IHS’s position that the amount of contract support costs (CSC) owed under its contracts and compacts with Tribes and Tribal organizations under the Indian Self-Determination Act (ISDA) is determined based on “incurred costs.” | |
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<tr>
<td>83.</td>
<td>6/12/15</td>
<td>Mr. P. Benjamin Smith, Director, Office of Tribal Self-Governance, Indian Health Service</td>
<td>Tribal Leadership Priorities for “Self-Governance National Indian Health Outreach and Education”</td>
<td>The TSGAC reaffirms the commitment to empower Tribal communities with the knowledge and tools needed to successfully manage and implement the Patient Protection and Affordable Care Act/Indian Health Care Improvement Act (ACA/IHCIA) provisions concerning health care insurance coverage options to improve the quality and access to care for Tribal citizens and Indian communities. TSGAC urges OTSG to amend the Agreement to renew and fund the “Self-Governance National Indian Health Outreach and Education” contract for FY2016</td>
<td></td>
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<td>84.</td>
<td>6/9/15</td>
<td>Mr. Robert G. McSwain, Acting Director Indian Health Service</td>
<td>Payment of IHS Employee Settlements.</td>
<td>TSGAC provided comments to the May 22, 2015 IHS Dear Tribal Leader Letter (DTLL) on the Payment of Employee Settlements. For the current settlement described in the DTLL, and for any future settlements, the TSGAC strongly urges the IHS to reject the flawed plan to cut health care services and consider one or both alternatives proposed.</td>
<td>IHS Deputy Director provided a response back to Tribal Leaders on July 29, 2015. The letter addresses three questions about the settlement that have been raised frequently in various forums since then.</td>
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<td>85.</td>
<td>5/15/15</td>
<td>Internal Revenue Service</td>
<td>Notice 2015-16 on Section 4980I — Excise Tax on High Cost Employer-Sponsored Health Coverage</td>
<td>TSGAC Comments in Request to Notice from IRS.</td>
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<td>86.</td>
<td>4/27/15</td>
<td>Mr. Robert G. McSwain, Acting Director Indian Health Service</td>
<td>Healing our Spirits Worldwide Gathering</td>
<td>Request of IHS support in this effort and the participation of P. Ben Smith, Director, Office of Tribal Self-Governance (OTSG).</td>
<td>IHS Responded on August 29, 2015 to the TSGAC and stated that Mr. Smith is confirmed to attend and participate in the HOSW gathering.</td>
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<td>87.</td>
<td>4/23/15</td>
<td>Mr. Robert G. McSwain, Acting Director Indian Health Service</td>
<td>Detail of OTSG Deputy Director</td>
<td>TSGAC request to Director to re-evaluate the detail and assign other staff to OUIHP as soon as practicable.</td>
<td>IHS Responded on August 29, 2015 to the TSGAC and stated that OTSG Deputy Director has officially returned to her position as of 7/27/15.</td>
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<td>88.</td>
<td>4/21/15</td>
<td>Mr. Robert G. McSwain, Acting Director Indian Health Service</td>
<td>Special Diabetes Program for Indians (SDPI)</td>
<td>TSGAC comments in response to the DTLL request for comments/consultation on the SDPI programs.</td>
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<td>90.</td>
<td>4/8/15</td>
<td>Mr. Robert G. McSwain, Acting Director Indian Health Service</td>
<td>Payment of Contract Support Costs for MSPI and DVPI funding</td>
<td>Request that the agency review this issue and that, as committed during 3/24/15 TSGAC meeting, provide a final decision to Tribes on the eligibility of MSPI/DVPI for additional</td>
<td>A Dear Tribal Leader was sent out from IHS Acting Director McSwain on 6/22/15 with an update on how the IHS will move forward with MSPI and DVPI over the next five years. Response received from IHS Acting Director McSwain on 5/18/15. Letter stated the IHS is not required to</td>
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<td>91.</td>
<td>4/8/15</td>
<td>Mr. Robert G. McSwain, Acting Director Indian Health Service</td>
<td>Thank you on Rates of CSC Settlement and Claim Resolutions</td>
<td>Continue timely resolution of outstanding claims and consistent full funding of CSC.</td>
<td>provide additional funds beyond what is included in the project budgets.</td>
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<td>92.</td>
<td>4/3/15</td>
<td>Mr. Gregory E. Demske, Chief Counsel to the Inspector General Ms. Melinda Golub, Senior Counsel Mr. Amitava “Jay” Mazumdar, Senior Counsel Office of Counsel to the Inspector General</td>
<td>Thank you for participating in the Tribal Self-Governance Advisory Committee Quarterly Meeting, March 24, 2015</td>
<td>Further dialogue to occur during the Thursday, April 30th Breakout Session A7, <em>Pursuing and Reinvesting Third Party Revenue</em>, at the upcoming 2015 Annual Tribal Self-Governance Consultation Conference in Reno, NV.</td>
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<td>93.</td>
<td>2/26/15</td>
<td>The Honorable Derek Kilmer</td>
<td>Self-Governance Tribes 2015 Appropriations Requests for the Bureau of Indian Affairs</td>
<td>Joint letter from TSGAC/SGAC</td>
<td></td>
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<td>94.</td>
<td>2/10/15</td>
<td>The Honorable Derek Kilmer</td>
<td>Self-Governance Tribes 2015 Appropriations Requests for Indian Health Service</td>
<td>Joint letter from TSGAC/SGAC</td>
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<td>95.</td>
<td>2/9/15</td>
<td>Chief Marilyn Malerba, Chairwoman TSGAC</td>
<td>Agency response to information requested QHPs to IHCPs in specific regions</td>
<td>CMS staff are available to address specific QHP problems and provide further assistance in the process</td>
<td>Response from Marilyn Tavenner, CMMS 2/2/15 to letter dated 12/19/14</td>
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<td>96.</td>
<td>1/31/15</td>
<td>Chief Marilyn Malerba, Chairwoman TSGAC</td>
<td>Agency response to the ongoing and unprecedented international Ebola crisis</td>
<td></td>
<td>Response from Dr. Y. Roubideaux, IHS Director, 1/31/15 to letter dated 10-17-14</td>
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<td>97.</td>
<td>2/5/15</td>
<td>IHS Director, Dr. Y. Roubideaux</td>
<td>Mandatory Appropriations for Contract Support Coasts</td>
<td>Appreciated partnership and looking forward to working to advance long-term solutions for funding CSC</td>
<td></td>
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<td>98.</td>
<td>2/4/15</td>
<td>Betty Gould, Regulations Officer, IHS and Carl Harper, Director ORAP, IHS Submit via regulations.gov</td>
<td>Comments on IHS Proposed Rule entitles “Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated with Non-Hospital-Base Care</td>
<td>Being able to engage in Tribal Consultation on the proposal</td>
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<td>99.</td>
<td>1/20/15</td>
<td>Chief Marilyn Malerba, Chairwoman TSGAC</td>
<td>Concerns regarding procedural consistency and information sharing during CSC negotiations on Disputed claims</td>
<td></td>
<td>Response from Dr. Y. Roubideaux, IHS Director, 1/20/15 to letter dated 12-2-14</td>
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<td>100.</td>
<td>1/14/15</td>
<td>Ms Tracy Parker Warren Office of Public and Intergovernmental Affairs OTGR(075F)-VA</td>
<td>Comments Submitted Response to Notice of TC: Sec 102 © of the Veterans Access, Choice and Accountability Act of 2014</td>
<td>Urge the Reports enter into agreements for reimbursement also current agreements be used and expanded where possible to speed up implementation to eligible veterans</td>
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<td>101.</td>
<td>1/12/15</td>
<td>CCIIO-CMS-DHHS</td>
<td>Comments on Draft 2016 Letter to Issuers in the Federally-Facilitated Marketplace</td>
<td>We are available to discuss any of the recommendations contained in the correspondence and attachment on CMS-9944-P</td>
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<td>102.</td>
<td>1/8/15</td>
<td>IHS Director, Dr. Y. Roubideaux</td>
<td>2015 TGSAC Quarterly Meetings and Tribal Self-Governance Annual Conference Information</td>
<td>Adjustment to your schedule due to changes for the January Qtly meetings</td>
<td>Response from Dr. Y.Roubideaux, IHS Director, 1/15/15 re: She will be in attendance Jan 28 also attendance at March Mtg on the 24th</td>
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Dear Tribal Leader:

Annually, the Indian Health Service (IHS) conducts an update on Maintenance & Improvement (M&I) and Equipment funding allocations, program enhancements, and space needs in the health care facilities.

The IHS Office of Environmental Health and Engineering (OEHE) uses the Healthcare Facilities Data System (HFDS) to automate functions related to Agency-wide facility condition assessments, engineering data systems, and maintenance. These functions include: M&I; Equipment; real property and lease inventory; Federal Real Property Council information; Environmental, Self-Governance, Energy Management, and Stewardship (Historic Preservation); and asset management. The Facilities Engineering Deficiency System (FEDS), a subset of the HFDS database, enables oversight of deficiencies/repair needs data, including the Backlog of Essential Maintenance, Alteration, and Repair (BEMAR) and unmet space needs of both Federal and Tribal buildings.

During the January meeting of the IHS Facilities Appropriation Advisory Board (FAAB), the FAAB recommended that the IHS require all Federal sites and encourage all Tribal sites to update the FEDS database by September 1. Providing updated information that includes both Tribal and Federal facilities data is essential to identifying unmet needs throughout Indian Country.

Data from this update is important for supporting any proposed infrastructure investments. Should facility funding opportunities arise, Tribes and the IHS will be well-positioned with up-to-date and accurate data to justify the need across Indian Country and be ready to respond with "shovel ready" M&I projects.

I encourage you to join us in updating the FEDS information by the September 1 deadline. Please work with your local Area Facilities staff to update facility data. Area Facilities Program staff will be contacting tribally operated, M&I-eligible facilities within each Area directly to provide technical assistance. These facilities will be provided with a spreadsheet that lists existing FEDS deficiencies data for staff to update, edit, and/or expand. The updated spreadsheet will be added to Area FEDS data for transmission to IHS Headquarters.
Area Facilities Program staff will be your local point of contact to answer questions, provide technical support, coordination, and ensure Tribal facility data is incorporated into the IHS FEDS.

Mr. Kevin D’Amanda, Director, Division of Facilities Operations (DFO), IHS, is also available if you need further information. Mr. D’Amanda can be reached by telephone at (301) 443-4562 or by e-mail at Kevin.damanda@ihs.gov.

Sincerely,

/Michael D. Weahkee/
RADM Michael D. Weahkee, MBA, MHSA
Assistant Surgeon General, U.S. Public Health Service
Acting Director
H. R. 2662

To amend the Indian Health Care Improvement Act to improve the recruitment and retention of employees in the Indian Health Service, restore accountability in the Indian Health Service, improve health services, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 25, 2017

Mrs. Noem (for herself, Mr. Bishop of Utah, Mr. Mullin, Mrs. McMorris Rodgers, and Mr. Cole) introduced the following bill; which was referred to the Committee on Natural Resources, and in addition to the Committees on Energy and Commerce, Ways and Means, and Oversight and Government Reform, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Indian Health Care Improvement Act to improve the recruitment and retention of employees in the Indian Health Service, restore accountability in the Indian Health Service, improve health services, and for other purposes.

1 Be it enacted by the Senate and House of Representa-
2 tives of the United States of America in Congress assembled,
3 SECTION 1. SHORT TITLE.
4 This Act may be cited as the “Restoring Account-
5 ability in the Indian Health Service Act of 2017”.
SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

Sec. 1. Short title.
Sec. 2. Table of contents.

TITLE I—INDIAN HEALTH SERVICE IMPROVEMENTS

Sec. 101. Incentives for recruitment and retention.
Sec. 102. Medical credentialing system.
Sec. 103. Liability protections for health professional volunteers at Indian Health Service.
Sec. 104. Clarification regarding eligibility for Indian Health Service loan repayment program.
Sec. 105. Improvements in hiring practices.
Sec. 106. Removal or demotion of Indian Health Service employees based on performance or misconduct.
Sec. 107. Standards to improve timeliness of care.
Sec. 108. Tribal culture and history.
Sec. 109. Staffing demonstration project.
Sec. 110. Rule establishing tribal consultation policy.

TITLE II—EMPLOYEE PROTECTIONS

Sec. 201. Right of Federal employees to petition Congress.

TITLE III—REPORTS

Sec. 301. Definitions.
Sec. 302. Reports by the Secretary of Health and Human Services.
Sec. 303. Reports by the Comptroller General.
Sec. 304. Inspector General reports.
Sec. 305. Transparency in CMS surveys.

TITLE IV—TECHNICAL AMENDMENTS

Sec. 401. Technical amendments.

TITLE I—INDIAN HEALTH SERVICE IMPROVEMENTS

SEC. 101. INCENTIVES FOR RECRUITMENT AND RETENTION.

Title I of the Indian Health Care Improvement Act (25 U.S.C. 1611 et seq.) is amended by adding at the end the following:
SEC. 125. INCENTIVES FOR RECRUITMENT AND RETENTION.

(a) Parity in Pay.—The Secretary shall establish a pay system for physicians, dentists, nurses, and other health care professionals employed by the Service that provides pay that, to the maximum extent practicable, is comparable to the pay provided to physicians, dentists, nurses, and other health care professionals, respectively, under subchapters III and IV of chapter 74 of title 38, United States Code.

(b) Relocation Costs.—The Secretary may provide to an employee of the Service reimbursement for any relocation costs the employee incurs if—

(1) the employee relocates to a Service area experiencing a high level of need for employees, as determined by the Secretary; and

(2) the employee is filling a position that would otherwise be difficult to fill, as determined by the Secretary, in the absence of an incentive.

(c) Housing Vouchers.—

(1) In general.—Subject to paragraph (2), not later than 1 year after the date of enactment of the Restoring Accountability in the Indian Health Service Act of 2017, the Secretary may establish a program to provide tenant-based rental assistance to an employee of the Service who—
“(A) agrees to serve for not less than 1 year at a Service unit designated by the Administrator of the Health Resources and Services Administration as a health professional shortage area, as defined in section 332(a) of the Public Health Service Act (42 U.S.C. 254e(a)); and

“(B) is a critical employee, as determined by the Secretary.

“(2) SUNSET.—Any program established by the Secretary under paragraph (1) shall terminate on the date that is 3 years after the date on which any such program is established.

“(d) ADMINISTRATION.—

“(1) OPM GUIDELINES.—The Secretary shall carry out this section in accordance with any guidelines of the Office of Personnel Management relating to the recruitment and retention of employees, including section 575.109 of title 5, Code of Federal Regulations (as in effect on the date of enactment of the Restoring Accountability in the Indian Health Service Act of 2017).

“(2) SERVICE AGREEMENTS.—The Secretary may only provide reimbursement for any relocation
costs under subsection (b) or any other benefit under subsection (c) to—

"(A) a full-time employee who agrees to serve for not less than 1 year in the Service, beginning on the date of the agreement; or

"(B) a part-time employee who agrees to serve for not less than 2 years in the service beginning on the date of the agreement.”.

SEC. 102. MEDICAL CREDENTIALING SYSTEM.

Title I of the Indian Health Care Improvement Act (25 U.S.C. 1611 et seq.), as amended by section 101, is further amended by adding at the end the following:

"SEC. 126. MEDICAL CREDENTIALING SYSTEM.

(a) IN GENERAL.—By not later than 1 year after the date of enactment of the Restoring Accountability in the Indian Health Service Act of 2017, the Secretary, acting through the Service and in accordance with the requirements described in subsection (b), shall develop and implement a Service-wide centralized credentialing system (referred to in this section as the ‘credentialing system’) to credential licensed health professionals who seek to provide health care services at any Service unit.

(b) REQUIREMENTS.—In developing the credentialing system under subsection (a), the Secretary shall ensure the following:
“(1) Credentialing procedures shall be uniform throughout the Service.

“(2) With respect to each licensed health professional who successfully completes the credentialing procedures of the credentialing system, the Secretary shall authorize each such professional to provide health care services at any Service unit.

“(c) Consultation.—In developing the credentialing system under subsection (a), the Secretary shall consult with Indian tribes and may also consult with any public or private association of medical providers, any government agency, or other relevant expert, as determined by the Secretary.

“(d) Application.—A licensed health care professional may not provide health care services at any Service unit, unless such professional successfully completes the credentialing procedures of the credentialing system developed under subsection (a).

“(e) Regulations.—The Secretary may prescribe such regulations as may be necessary to carry out the provisions of this section.

“(f) Rule of Construction.—This section may not be construed to inhibit the authority of an Indian tribe to enter into or maintain a compact or contract under the
Section 224 of the Public Health Service Act (42 U.S.C. 233) is amended by adding at the end the following:

“(r) Certain Indian Health Service Volunteers Deemed Public Health Service Employees.—

“(1) In general.—For purposes of this section, a health professional volunteer at a Service unit shall, in providing a health service to an individual, be deemed to be an employee of the Public Health Service for a calendar year that begins during a fiscal year for which a transfer was made under paragraph (4)(C). The preceding sentence is subject to the provisions of this subsection.

“(2) Conditions.—In providing a health service to an individual, a health care practitioner shall, for purposes of this subsection, be considered to be a health professional volunteer at a Service unit if all of the following conditions are met:
“(A) The service is provided to the individual at the facilities of a Service unit, or through offsite programs or events carried out by the Service unit.

“(B) The Service unit is sponsoring the health care practitioner pursuant to paragraph (3)(C).

“(C) The health care practitioner does not receive any compensation for the service from the individual, the Service unit, or any third-party payer (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program), except that the health care practitioner may receive repayment from the Service unit for reasonable expenses incurred by the health care practitioner in the provision of the service to the individual.

“(D) Before the service is provided, the health care practitioner or the Service unit posts a clear and conspicuous notice at the site where the service is provided of the extent to which the legal liability of the health care practitioner is limited under this subsection.
“(E) At the time the service is provided, the health care practitioner is licensed or certified in accordance with applicable law regarding the provision of the service.

“(3) APPLICABILITY.—Subsection (g) (other than paragraphs (3) and (5)) and subsections (h), (i), and (l) apply to a health care practitioner at a Service unit for purposes of this subsection to the same extent and in the same manner as such subsections apply to an officer, governing board member, employee, or contractor of an entity described in subsection (g)(4), subject to paragraph (4) and subject to the following subparagraphs:

“(A) Each reference to an entity in subsections (g), (h), (i), and (l) shall be considered to be a reference to a Service unit.

“(B) The first sentence of paragraph (1) applies in lieu of the first sentence of subsection (g)(1)(A).

“(C) With respect to a Service unit, a health care practitioner is not a health professional volunteer at the Service unit unless the Service unit sponsors the health care practitioner. For purposes of this subsection, the
Service unit shall be considered to be sponsoring the health care practitioner if—

“(i) with respect to the health care practitioner, the Service unit submits to the Secretary an application meeting the requirements of subsection (g)(1)(D); and

“(ii) the Secretary, pursuant to subsection (g)(1)(E), determines that the health care practitioner is deemed to be an employee of the Public Health Service.

“(D) In the case of a health care practitioner who is determined by the Secretary pursuant to this subsection and subsection (g)(1)(E) to be a health professional volunteer, this subsection applies to the health care practitioner (with respect to services performed on behalf of the Service unit sponsoring the health care practitioner pursuant to subparagraph (C)) for any cause of action arising from an act or omission of the health care practitioner occurring on or after the date on which the Secretary makes that determination.

“(E) Subsection (g)(1)(F) applies to a health care practitioner for purposes of this subsection only to the extent that, in providing
health services to an individual, each of the conditions described in paragraph (2) is met.

“(4) FUNDING.—

“(A) IN GENERAL.—Amounts in the fund established under subsection (k)(2) shall be available for transfer under subparagraph (C) for purposes of carrying out this subsection.

“(B) ANNUAL ESTIMATES.—

“(i) IN GENERAL.—Not later than May 1 of each fiscal year, the Attorney General, in consultation with the Secretary, shall submit to Congress a report providing an estimate of the amount of claims (together with related fees and expenses of witnesses) that, by reason of the acts or omissions of health professional volunteers, will be paid pursuant to this section during the calendar year that begins in the following fiscal year.

“(ii) APPLICABILITY.—Subsection (k)(1)(B) applies to the estimate under clause (i) relating to health professional volunteers to the same extent and in the same manner as that subsection applies to the estimate under that subsection relating
to officers, governing board members, employees, and contractors of entities described in subsection (g)(4).

"(C) TRANSFERS.—Not later than December 31 of each fiscal year, the Secretary shall transfer from the fund under subsection (k)(2) to the appropriate accounts in the Treasury an amount equal to the estimate made under subparagraph (B) for the calendar year beginning in that fiscal year, subject to the extent of amounts in the fund.

"(5) DEFINITION OF SERVICE UNIT.—In this subsection, the term ‘Service unit’ has the meaning given the term in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

"(6) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to inhibit the authority of an Indian tribe to enter into or maintain a compact or contract under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304 et seq.).

"(7) EFFECTIVE DATES.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), this subsection shall take effect on October 1, 2019.
“(B) REGULATIONS, APPLICATIONS, AND REPORTS.—Effective on the date of the enactment of the Restoring Accountability in the Indian Health Service Act of 2017, the Secretary may—

“(i) prescribe regulations for carrying out this subsection; and

“(ii) accept and consider applications submitted under paragraph (3)(C)(i).”.

SEC. 104. CLARIFICATION REGARDING ELIGIBILITY FOR INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM.

Section 108 of the Indian Health Care Improvement Act (25 U.S.C. 1616a) is amended—

(1) by amending subparagraph (B) of subsection (b)(1) to read as follows:

“(B) have—

“(i)(I) a degree in a health profession; and

“(II) a license to practice a health profession in a State; or

“(ii)(I) a degree in business administration with an emphasis in health care management (as defined by the Secretary),
health administration, hospital administration, or public health; and

“(II) a license or certification to practice in the field of business administration, health administration, hospital administration, or public health in a State, if the Secretary determines such license or certification necessary for the Indian health program to which the individual will be assigned;”;

(2) by amending clause (iii) of subsection (f)(1)(B) to read as follows:

“(iii) to serve for a time period (referred to in this section as the ‘period of obligated service’) equal to—

“(I) 2 years or such longer period as the individual may agree to serve in the full-time practice of such individual’s profession in an Indian health program to which the individual may be assigned by the Secretary; or

“(II) 4 years or such longer period as the individual may agree to serve in the half-time practice of such
individual’s profession in an Indian health program to which the individual may be assigned by the Secretary;”; and

(3) in subsection (g)(2)—

(A) by redesignating subparagraph (B) as subparagraph (C); and

(B) in subparagraph (A)—

(i) by striking the first sentence of the matter preceding clause (i) and inserting the following: “In the case of an individual who contracts to serve a period of obligated service under subsection (f)(1)(B)(iii)(I), for each year of such obligated service, the Secretary may pay up to $35,000 (or an amount equal to the amount specified in section 338B(g)(2)(A) of the Public Health Service Act (42 U.S.C. 254l–1(g)(2)(A))) on behalf of the individual for loans described in paragraph (1). In the case of an individual who contracts to serve a period of obligated service under subsection (f)(1)(B)(iii)(II), for each year of such obligated service, the Secretary may pay up to $17,500 on behalf of
the individual for loans described in para-
graph (1)”; and

(ii) by striking “In making a deter-
mination” and inserting the following:

“(B) In making a determination under this
paragraph”.

SEC. 105. IMPROVEMENTS IN HIRING PRACTICES.

(a) IN GENERAL.—Title VI of the Indian Health
Care Improvement Act (25 U.S.C. 1661 et seq.) is amend-
ed by adding at the end the following:

“SEC. 605. IMPROVEMENTS IN HIRING PRACTICES.

“(a) DIRECT HIRE AUTHORITY.—The Secretary may
appoint, without regard to subchapter I of chapter 33 of
title 5, United States Code (other than sections 3303 and
3328 of such title), a candidate directly to a position with-
in the Service for which the candidate meets the job de-
scription of the Office of Personnel Management.

“(b) TRIBAL NOTIFICATION.—Before appointing,
hiring, promoting, transferring, or reassigning a candidate
to a Senior Executive Service position or the position of
a manager at an Area office or Service unit, the Secretary
shall provide notice to each Indian tribe located within the
defined geographic area of such Area office or Service
unit, as the case may be, of the content of an inclusion
in an employment record under section 606(j).”.

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(b) IN GENERAL.—Subsection (e) of section 2 of the
Act of December 15, 1979 (25 U.S.C. 5117) is amended
by adding the following:

“(3) IHS WAIVERS.—The Secretary of Health
and Human Services shall seek from each Indian
tribe concerned, a waiver of Indian preference laws
for a personnel action that is with respect to—

“(A) an Indian Health Service unit in
which 20 percent or more of the positions in the
Service unit are not filled by a full-time em-
ployee of the Indian Health Service for a period
of 6 months or longer; or

“(B) a former employee of the Indian
Health Service or a formal tribal employee who
was removed from such former employment
within, or demoted for performance or mis-
conduct that occurred during, the 5-year period
the date of such personnel action.”.

SEC. 106. REMOVAL OR DEMOTION OF INDIAN HEALTH
SERVICE EMPLOYEES BASED ON PERFORM-
ANCE OR MISCONDUCT.

Title VI of the Indian Health Care Improvement Act
(25 U.S.C. 1661 et seq.), as amended by section 105, is
further amended by adding at the end the following:
"SEC. 606. REMOVAL OR DEMOTION OF SERVICE EMPLOYEES BASED ON PERFORMANCE OR MISCONDUCT.

"(a) DEFINITIONS.—In this section and section 607:

"(1) EMPLOYEE.—The term ‘employee’ has the meaning given the term in section 2105 of title 5, United States Code.

"(2) MANAGER.—

"(A) IN GENERAL.—The term ‘manager’ has the meaning given the term ‘management official’ in section 7103(a) of title 5, United States Code.

"(B) INCLUSIONS.—The term ‘manager’ includes, as employed at any facility of the Service—

"(i) a chief executive officer;

"(ii) a chief medical officer; and

"(iii) a department director.

"(3) MISCONDUCT.—The term ‘misconduct’ means neglect of duty, malfeasance, or failure to accept a directed reassignment or to accompany a position in a transfer of function.

"(4) PERSONNEL ACTION.—The term ‘personnel action’ means a removal, transfer, or reduction in grade under subsection (b)(2).
“(5) SECRETARY.—The term ‘Secretary’ means the Secretary of Health and Human Services, acting through the Director of the Service.

“(6) SENIOR EXECUTIVE.—The term ‘senior executive’ means a career appointee (as that term is defined in section 3132(a) of title 5, United States Code).

“(7) SENIOR EXECUTIVE SERVICE POSITION.—The term ‘Senior Executive Service position’ has the meaning given the term in section 3132(a) of title 5, United States Code.

“(8) SUPERVISOR.—The term ‘supervisor’ has the meaning given the term in section 7103(a) of title 5, United States Code.

“(b) REMOVAL BASED ON PERFORMANCE OR MISCONDUCT.—

“(1) IN GENERAL.—Subject to paragraph (4), the Secretary may remove an employee of the Service from the position the employee occupies if the Secretary determines the performance or misconduct of the employee warrants removal.

“(2) ACTION.—If the Secretary removes an employee under paragraph (1), the Secretary may—
“(A) remove the employee from the civil service (as defined in section 2101 of title 5, United States Code);

“(B) in the case of an individual described in paragraph (3), transfer the individual from the Senior Executive Service position to a General Schedule position at any grade of the General Schedule for which the individual is qualified and that the Secretary determines is appropriate; or

“(C) in the case of a manager or supervisor, reduce the grade of the manager or supervisor to any other grade for which the individual is qualified and that the Secretary determines is appropriate.

“(3) INDIVIDUAL DESCRIBED.—An individual referred to in paragraph (2)(B) is a senior executive that—

“(A) previously occupied a permanent position within the competitive service (as that term is defined in section 2102 of title 5, United States Code); or

“(B) previously occupied a permanent position within the excepted service (as that term is
defined in section 2103 of title 5, United States
Code).

“(4) DUE PROCESS.—Before an employee may
be subject to a personnel action, the Secretary shall
provide to the employee—

“(A) not less than 10 days before the per-
sonnel action, written notice of the proposed
personnel action; and

“(B) an opportunity and reasonable time
to answer orally or in writing.

“(e) PAY OF CERTAIN INDIVIDUALS.—

“(1) IN GENERAL.—Notwithstanding any other
provision of law, including the requirements of sec-
tion 3594 of title 5, United States Code, any indi-
vidual transferred to a General Schedule position
under subsection (b)(2)(B) or subject to a reduction
in grade under subsection (b)(2)(C) shall, beginning
on the date of the transfer, receive the annual rate
of pay applicable to the position.

“(2) REQUIREMENTS.—

“(A) IN GENERAL.—An individual trans-
ferred to a General Schedule position under
subsection (b)(2)(B) or subject to a reduction
in grade under subsection (b)(2)(C)—
“(i) may not be placed on administra-
tive leave or any other category of paid
leave during the period during which an
appeal (if any) under subsection (e)(2)(A)
is ongoing; and
“(ii) may only receive pay if the indi-
vidual—
“(I) reports for duty; and
“(II) performs a primary duty or
an alternative primary duty, as each
term is described in section 551.104
of title 5, Code of Federal Regulations
(or a successor regulation).
“(B) FAILURE TO REPORT.—If an indi-
vidual transferred to a General Schedule posi-
ton under subsection (b)(2)(B) or subject to a
reduction in grade under subsection (b)(2)(C)
does not report for duty, pursuant to subsection
(f)(3)(B), the individual shall not receive any
increase in rate of pay or other benefit.
“(d) NOTICE TO CONGRESS.—Not later than 30 days
after the date on which the Secretary takes a personnel
action, the Secretary shall submit, in writing, a notice of
the personnel action and the reason for the personnel ac-
tion to—
“(1) the Committee on Indian Affairs of the Senate;

“(2) the Committee on Health, Education, Labor, and Pensions of the Senate;

“(3) the Committee on Natural Resources of the House of Representatives;

“(4) the Committee on Energy and Commerce of the House of Representatives; and

“(5) the Inspector General of the Department.

“(e) PROCEDURE.—

“(1) INAPPLICABILITY.—The procedures under chapters 43 and 75 of title 5, United States Code, shall not apply to a personnel action.

“(2) APPEAL.—

“(A) IN GENERAL.—Subject to subparagraph (B) and subsection (f), an employee subject to a personnel action may appeal the personnel action to the Merit Systems Protection Board under section 7701 of title 5, United States Code.

“(B) LIMITATION.—An appeal under subparagraph (A) may only be made if the appeal is made not later than 7 days after the date of the personnel action.
“(f) EXPEDITED REVIEW BY ADMINISTRATIVE LAW JUDGE.—

“(1) IN GENERAL.—

“(A) REFERRAL.—On receipt of an appeal under subsection (c)(2)(A), the Merit Systems Protection Board shall refer the appeal to an administrative law judge pursuant to section 7701(b)(1) of title 5, United States Code.

“(B) EXPEDITION.—The administrative law judge to whom an appeal is referred under subparagraph (A) shall—

“(i) expedite the appeal under section 7701(b)(1) of title 5, United States Code; and

“(ii) issue a decision in each case not later than 21 days after the date of the appeal.

“(2) FINALITY.—Notwithstanding any other provision of law, including section 7703 of title 5, United States Code, the decision of an administrative law judge under paragraph (1) shall be final and shall not be subject to any further administrative appeal.

“(3) FAILURE TO ISSUE DECISION.—
“(A) IN GENERAL.—In any case in which an administrative law judge fails to issue a decision in accordance with the 21-day requirement described in paragraph (1)(B)(ii), the personnel action shall be treated as final.

“(B) TRANSPARENCY.—In any case in which a personnel action is treated as final under subparagraph (A), the Merit Systems Protection Board shall, not later than 14 days after the date on which the personnel action becomes final, submit a letter explaining the reasons why a decision was not issued in accordance with the 21-day requirement described in paragraph (1)(B)(ii) to—

“(i) the Committee on Indian Affairs of the Senate;

“(ii) the Committee on Health, Education, Labor, and Pensions of the Senate;

“(iii) the Committee on Natural Resources of the House of Representatives;

and

“(iv) the Committee on Energy and Commerce of the House of Representatives.
“(4) RESTRICTION.—The Merit Systems Protection Board or an administrative law judge may not stay any personnel action.

“(5) CESSATION OF PAY INCREASES AND BENEFITS.—During the period beginning on the date on which an employee appeals a removal from the civil service under subsection (e)(2)(A) and ending on the date on which the removal becomes final, the employee may not receive any—

“(A) increase in rate of pay; or

“(B) award, bonus, incentive, allowance, differential, student loan repayment, special payment, or other benefit.

“(6) ASSISTANCE.—To the maximum extent practicable, the Secretary shall provide such information and assistance as may be necessary to ensure an appeal under this subsection is expedited to—

“(A) the Merit Systems Protection Board; and

“(B) any administrative law judge to whom an appeal under this section is referred.

“(g) EMPLOYMENT RECORD TRANSPARENCY.—The Secretary shall ensure that the employment records for any employee subject to a personnel action, regardless of whether that personnel action is final, include—
“(1) a notation that the employee was subject
to a personnel action; and
“(2) a description of the disposition or status of
the personnel action or any appeal of the personnel
action under this section.
“(h) RELATION TO TITLE 5, UNITED STATES
CODE.—
“(1) ADDITIONAL AUTHORITY.—The personnel
action authorities provided to the Secretary under
this section are in addition to the authorities pro-
vided under chapters 43 and 75 of title 5, United
States Code.
“(2) REMOVAL OF SENIOR EXECUTIVES.—Sec-
section 3592(b)(1) of title 5, United States Code, shall
not apply to a personnel action.”.

SEC. 107. STANDARDS TO IMPROVE TIMELINESS OF CARE.
Title IV of the Indian Health Care Improvement Act
(25 U.S.C. 1641 et seq.) is amended by adding at the end
the following:

“SEC. 412. STANDARDS TO IMPROVE TIMELINESS OF CARE.
“(a) IN GENERAL.—Not later than 180 days after
the date of enactment of the Restoring Accountability in
the Indian Health Service Act of 2017, the Secretary, act-
ing through the Service, shall—
“(1) establish, by regulation, standards to measure the timeliness of the provision of health care services in Service facilities; and
“(2) provide such standards to each Service unit.
“(b) DATA COLLECTION.—The Secretary, acting through the Service, shall develop a process for each Service unit to submit to the Secretary data with respect to the standards established under subsection (a)(1).”.

SEC. 108. TRIBAL CULTURE AND HISTORY.
Section 113 of the Indian Health Care Improvement Act (25 U.S.C. 1616f) is amended—

(1) in subsection (a)—

(A) by striking “a program” and inserting “an annual mandatory training program”; and

(B) by striking “appropriate employees of the Service” and inserting “employees of the Service, locum tenens medical providers, and other contracted employees who work at Service hospitals or other Service units and whose employment requires regular direct patient access”; and

(2) by adding at the end the following:

“(c) Notwithstanding any other provision of law, be-
storing Accountability in the Indian Health Service Act of 2017, each employee or provider described in subsection (a) who enters into a contract with the Service on or after the date of such implementation shall, as a condition of employment, annually participate in and complete such training program. For purposes of the preceding sentence, participation in such training program may not be considered complete for the year involved until the individual satisfies each requirement, including testing, if applicable, of the training program for such year, as specified by the Secretary.”.

SEC. 109. STAFFING DEMONSTRATION PROJECT.

Title VIII of the Indian Health Care Improvement Act (25 U.S.C. 1671 et seq.) is amended by adding at the end the following:

"SEC. 833. STAFFING DEMONSTRATION PROJECT.

“(a) IN GENERAL.—The Secretary, acting through the Service, shall establish a demonstration project that authorizes the Service to provide federally managed Service units with additional staffing resources with the goal that the resources become self-sustaining.

“(b) SELECTION.—In selecting Service units for participation, the Secretary shall consider whether a Service unit services an Indian tribe that—

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“(1) has utilized or contributed substantial tribal funds to construct a health facility used by the Service or identified in the master plan for the Service unit;

“(2) is located in a State or States with Medicaid reimbursements plans or policies that will increase the likelihood that the staffing resources provided will be self-sustaining; and

“(3) is operating a health facility described in paragraph (1) under historical staffing ratios that have not been equalized or updated by the Service or any other Service program to reflect current staffing needs.

“(e) DURATION.—Staffing resources provided to a Service unit under this section shall be for a duration that the Secretary, in consultation with the applicable Indian tribe, determines appropriate, except that each staffing position provided shall be for a period of not less than 3 fiscal years.

“(d) REPORT.—Not later than 5 years after the Secretary ends the demonstration project under this section, the Secretary shall prepare and submit a report to the Committee on Indian Affairs and the Committee on Health, Education, Labor, and Pensions of the Senate, and the Committee on Natural Resources and the Com-
mittee on Energy and Commerce of the House of Rep-
resentatives, regarding the project, including—

“(1) whether the staffing resources resulted in
additional revenue for the Service unit sufficient to
maintain the staff on a permanent basis;

“(2) the levels to which the staffing resources
reduced the unmet staffing need for the Service unit;

and

“(3) whether the demonstration project could
be deployed to reduce unmet staffing needs through-
out the Service.”.

SEC. 110. RULE ESTABLISHING TRIBAL CONSULTATION
POLICY.

Title VIII of the Indian Health Care Improvement
Act (25 U.S.C. 1671 et seq.), as amended by section 109,
is further amended by adding at the end the following:

“SEC. 834. RULE ESTABLISHING TRIBAL CONSULTATION
POLICY.

“(a) IN GENERAL.—Not later than 1 year after the
date of enactment of the Restoring Accountability in the
Indian Health Service Act of 2017, the Secretary shall es-
tablish, through the negotiated rulemaking process de-
scribed in subsection (b), a rule establishing a tribal con-
sultation policy for the Service.
“(b) NEGOTIATED RULEMAKING.—Before publishing
a proposed rule described in subsection (a), the Secretary
shall follow the provisions of subchapter III of chapter 5
of title 5, United States Code (commonly known as the
‘Negotiated Rulemaking Act of 1990’).

“(c) CONTENTS OF TRIBAL CONSULTATION POL-
ICY.—The policy established under the rule described in
subsection (a) shall—

“(1) update, and replace, the tribal consultation
policy established under Circular No. 2006–01 of the
Service, or any successor policy; and

“(2) include the following:

“(A) A process for determining when the
Service will notify Indian tribes, and a descrip-
tion of how the Indian tribes should be notified.

“(B) A determination of what actions or
agency decisions by the Service will trigger a re-
requirement for meaningful consultation with In-
dian tribes.

“(C) A determination of what actions con-
stitute meaningful consultation with Indian
tribes.”.
TITLE II—EMPLOYEE PROTECTIONS

SEC. 201. RIGHT OF FEDERAL EMPLOYEES TO PETITION CONGRESS.

(a) ADVERSE ACTION FOR VIOLATION OF RIGHT TO PETITION CONGRESS.—Section 7211 of title 5, United States Code, is amended—

(1) by striking "The right of" and inserting "(a) IN GENERAL.—The right of"; and

(2) by adding at the end the following new subsection:

"(b) ADVERSE ACTION.—An employee who interferes with or denies a right protected under subsection (a) shall be subject to any adverse action described in paragraphs (1) through (5) of section 7512, in accordance with the procedure described in section 7513 and any other applicable procedure."

(b) ELECTRONIC NOTIFICATION OF RIGHT OF EMPLOYEES OF INDIAN HEALTH SERVICE.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as the "Secretary"), acting through the Director of the Indian Health Service, shall, in accordance with paragraphs (2) through (6), provide to each employee of the Indian Health Service, and electroni-
cally post, a memorandum providing notice of the
right to petition Congress under section 7211 of title
5, United States Code.

(2) CONTENTS.—The memorandum described
in paragraph (1) shall include the following state-
ment: “It is a violation of section 7211 of title 5,
United States Code, for any Federal agency or em-
ployee to require a Federal employee to seek ap-
proval, guidance, or any other form of input prior to
contacting Congress with information, even if that
information is in relation to the job responsibilities
of the employee. A Federal employee found to have
interfered with or denied the right of another Fed-
eral employee under such section shall be subject to
an adverse action described in paragraphs (1)
through (5) of section 7512 of title 5, United States
Code, including a suspension for more than 14 days
without pay.”.

(3) SUBMISSION.—Not later than 30 days after
the date of enactment of this Act, the Secretary
shall submit the memorandum described in para-
graph (1) to the Inspector General of the Depart-
ment of Health and Human Services (referred to in
this subsection as the “Inspector General”) for ap-
proval.
(4) APPROVAL OR DISAPPROVAL.—Not later than 30 days after the submission of the memorandum under paragraph (3), or a revised memorandum under paragraph (6), the Inspector General shall approve or disapprove the memorandum or revised memorandum, as the case may be.

(5) NOTICE.—In the case of an approval under paragraph (4), not later than 30 days after such approval, the Secretary shall—

(A) provide to each employee of the Indian Health Service an electronic copy of the approved memorandum; and

(B) post such memorandum in a clear and conspicuous place on the website of the Indian Health Service for a period not less than 120 days.

(6) REVISED MEMORANDUM.—In the case of a disapproval under paragraph (4), not later than 15 days after such disapproval, the Secretary shall submit a revised memorandum to the Inspector General for approval under paragraph (4).

SEC. 202. FISCAL ACCOUNTABILITY.

Title VI of the Indian Health Care Improvement Act (25 U.S.C. 1661 et seq.), as amended by sections 105 and 106 is further amended by adding at the end the following:
“SEC. 607. FISCAL ACCOUNTABILITY.

“(a) MANAGEMENT OF FUNDS.—

“(1) IN GENERAL.—If the Secretary fails to submit the professional housing plan under section 301(a) of the Restoring Accountability in the Indian Health Service Act of 2017 or the staffing plan under section 301(b) of that Act, the Secretary may not receive, obligate, transfer, or expend any amounts for a salary increase or bonus of an individual described in paragraph (2) until the professional housing plan or staffing plan, as the case may be, is submitted.

“(2) INDIVIDUAL DESCRIBED.—An individual described in this paragraph is an individual employed in a position in the Service that is a position—

“(A) described under sections 5312 through 5316 of title 5, United States Code;

“(B) placed in level IV or V of the Executive Schedule under section 5317 of title 5, United States Code;

“(C) as a limited term appointee, limited emergency appointee, or noncareer appointee in the Senior Executive Service, as defined under paragraphs (5), (6), and (7), respectively, of

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section 3132(a) of title 5, United States Code;

or

(D) under section 213.3301 or 213.3302
of title 5, Code of Federal Regulations.

(b) PRIORITY OF PATIENT CARE.—

(1) IN GENERAL.—The Secretary shall use
amounts available to the Indian Health Service that
are not obligated or expended, including base budget
funding and third party collections, during the fiscal
year for which the amounts are made available, and
that remain available, only to support patient care
by using such funds for the costs of—

(A) essential medical equipment;

(B) purchased or referred care; or

(C) staffing.

(2) SPECIAL RULE.—In using amounts under
paragraph (1), the Secretary shall ensure that, in
any case where the amounts were originally made
available for a particular Service unit, such amounts
are used to benefit Indians served by that Service
unit.

(3) RESTRICTIONS.—The Secretary may not
use amounts described in paragraph (1)—

(A) to remodel or interior decorate any
Area office; or

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“(B) to increase the rate of pay of any employee of an Area office.
“(c) SPENDING REPORTS.—Not later than 90 days after the end of each quarter of a fiscal year, the Secretary shall submit a report describing the authorizations, expenditures, outlays, transfers, reprogramming, and obligations of each level of the Service, including the headquarters, each Area office, each Service unit, and each health clinic or facility, to—
“(1) each Indian tribe;
“(2) in the Senate—
“(A) the Committee on Indian Affairs;
“(B) the Committee on Health, Education, Labor, and Pensions;
“(C) the Committee on Appropriations;
and
“(D) the Committee on the Budget; and
“(3) in the House of Representatives—
“(A) the Committee on Natural Resources;
“(B) the Committee on Energy and Commerce;
“(C) the Committee on Appropriations;
and
“(D) the Committee on the Budget.
“(d) STATUS REPORTS.—
“(1) IN GENERAL.—Subject to paragraph (2), not later than 180 days after the end of each fiscal year, the Secretary shall provide to each entity described in paragraphs (1) through (3) of subsection (e) a report describing the safety, billing, certification, credential, and compliance statuses of each facility managed, operated, or otherwise supported by the Service.

“(2) UPDATES.—With respect to any change of a status described in paragraph (1), the Secretary shall immediately provide to each entity described in paragraphs (1) through (3) of subsection (e) an update describing such change.

“(e) RULE OF CONSTRUCTION.—This section may not be construed to inhibit the authority of an Indian tribe to enter into or maintain a compact or contract under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 5304 et seq.).”

**TITLE III—REPORTS**

**SEC. 301. DEFINITIONS.**

In this title:

(1) **SECRETARY.**—The term “Secretary” means the Secretary of Health and Human Services.

(2) **SERVICE.**—The term “Service” means the Indian Health Service.
(3) SERVICE UNIT.—The term "Service unit" has the meaning given the term in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

SEC. 302. REPORTS BY THE SECRETARY OF HEALTH AND HUMAN SERVICES.

(a) IHS PROFESSIONAL HOUSING PLAN.—Not later than 90 days after the date of enactment of this Act, the Secretary shall develop, make publicly available, and submit to Congress and the Comptroller General of the United States a written plan to address the professional housing needs of employees of the Service that comports with the practices and recommendations of the Government Accountability Office relating to professional housing.

(b) PLAN RELATING TO IHS STAFFING NEEDS.—Not later than 90 days after the date of the enactment of this Act, the Secretary shall develop, make publicly available, and submit to Congress and the Comptroller General of the United States a written plan to address staffing needs in the Service that comports with the practices of the Government Accountability Office relating to workforce planning.

(c) INDIAN HEALTH CARE IMPROVEMENT ACT REPORT.—Not later than 1 year after the date of enactment

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of this Act, and each year thereafter for a period of 5 years, the Secretary shall develop, make publicly available, and submit to Congress a report on the data submitted under section 412(b) of the Indian Health Care Improvement Act, as amended by section 107.

SEC. 303. REPORTS BY THE COMPTROLLER GENERAL.

(a) IHS HOUSING NEEDS REPORT.—

(1) IN GENERAL.—Not later than 1 year after the date on which the Comptroller General of the United States receives the professional housing plan under section 302(a), the Comptroller General shall develop and submit to Congress a report on the professional housing needs of employees of the Service.

(2) CONTENTS.—The report required under paragraph (1) shall include the following:

(A) An evaluation of any existing, as of the date of the report, assessments and projections for the professional housing needs of employees of the Service, including discussion and conclusion as to whether existing assessments and projections accurately reflect the professional housing needs of employees of the Service.

(B) An assessment of the professional housing needs of employees of the Service for each Service area (as defined in section 4 of the
Indian Health Care Improvement Act (25 U.S.C. 1603)).

(C) An assessment of the professional housing plan developed by the Secretary under section 302(a).

(b) IHS Staffing Needs Report.—

(1) In General.—Not later than 1 year after the date on which the Comptroller General receives the report under section 302(b) of this Act, the Comptroller General shall prepare and submit to Congress a report on the staffing needs of the Service.

(2) Contents.—The report required under paragraph (1) shall include the following:

(A) A description of the number and type of full-time positions needed at each facility of the Service and the amount of funds necessary to maintain such positions.

(B) An assessment of the use of independent contractors, including the number of independent contractors hired to fill vacant full-time positions and amounts spent on independent contractors who provide health care services.
(C) An assessment of the staffing plan developed by the Secretary under section 302(b).

(c) WHISTLEBLOWER PROTECTIONS REPORT.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Comptroller General shall develop and submit to Congress a report on the efficacy of existing protections for whistleblowers in the Service.

(2) CONTENTS.—The report required under paragraph (1) shall include the following:

(A) A discussion and conclusion as to whether the Service has taken proper steps to prevent retaliation against whistleblowers.

(B) If applicable, any recommendations for changes to the policy of the Service with respect to whistleblowers.

(C) A discussion and conclusion as to whether the official email accounts of employees of the Service are appropriately monitored.

SEC. 304. INSPECTOR GENERAL REPORTS.

(a) PATIENT CARE REPORTS.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, and every 2 years thereafter, the Inspector General of the Department of Health and Human Services shall develop and
submit to Congress and the Service a report on patient harm events occurring in Service units and deferrals and denials of care of patients of the Service.

2. CONTENTS.—The report required under paragraph (1) shall include the following:

   (A) An evaluation of the number and kind of events that contribute to patient deaths in a Service unit and recommendations regarding reducing the number of patient deaths.

   (B) An evaluation of the Service’s tracking and reporting of, and response to, patient harm events and recommendations regarding how to improve such tracking, reporting, and response.

   (C) The effects of deferrals and denials of care on patients of the Service, including patient outcomes, and recommendations regarding how to reduce deferrals and denials of care.

(b) REPORTING SYSTEMS AUDIT.—Not later than 2 years after the date of enactment of this Act, the Inspector General shall—

   (1) conduct an audit of reporting systems of the Service, as of the date of enactment of this Act; and

   (2) provide to the Service recommendations and technical assistance regarding implementation of im-
proven reporting systems, procedures, standards, and protocols.

SEC. 305. TRANSPARENCY IN CMS SURVEYS.

Section 1880 of the Social Security Act (42 U.S.C. 1395qq) is amended by adding at the end the following:

"(g)(1) Not less frequently than once every 2 years, the Administrator of the Centers for Medicare & Medicaid Services shall conduct surveys to assess the compliance of each hospital or skilled nursing facility of the Indian Health Service with—

"(A) section 1867; and

"(B) conditions of participation in the program under this title.

"(2) Each survey completed under this subsection shall be posted on the Internet website of the Centers for Medicare & Medicaid Services. Such posting shall comply with the Federal regulations concerning the privacy of individually identifiable health information promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996."

TITLE IV—TECHNICAL AMENDMENTS

SEC. 401. TECHNICAL AMENDMENTS.

The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) is amended—
(1) by striking "contract health service" each place such term appears (regardless of casing and typeface and including in the headings) and inserting "purchased/referred care" (with appropriate casing and typeface); and

(2) by striking "contract health services" each place such term appears (regardless of casing and typeface and including in the headings) and inserting "purchased/referred care" (with appropriate casing and typeface).
On behalf of the Self-Governance Communication & Education Tribal Consortium (SGCETC), I am pleased to provide the following written testimony regarding House bill 2662 (H.R. 2662), Restoring Accountability in the Indian Health Service Act of 2017. SGCETC appreciates the time, attention and effort this Committee and others have devoted to improving the quality and access to health care for all American Indians and Alaska Natives (AI/ANs). While we agree that legislation offers new opportunities for IHS, Self-Governance Tribes cannot support the legislation as introduced.

Today, 352 Federally-recognized Tribes and Tribal Organizations exercise Self-Governance authority to operate and manage health programs previously managed by the Indian Health Service (IHS), while many more continue to evaluate their opportunities. As Tribes assume greater authority over the delivery of health care in their communities, legislation like H.R. 2662 is increasingly important to us as we seek to gain more autonomy in the management and delivery of health care programs in partnership with the IHS. This collaboration has proven successful and has improved the Indian health system that existed prior to the passage of the Indian Self-Determination and Education Assistance Act (ISDEAA).

Over the last decade, this Committee, in partnership with Tribes, has passed several pieces of legislation that provided opportunities to modernize IHS, support self-determination, and permanently reauthorize the Indian Health Care Improvement Act (IHCIA). Similarly, shared efforts and continued partnerships will be required to successfully correct the health care quality challenges that IHS faces.

We would be remiss without first reiterating that the agency is chronically underfunded, and receives a fixed amount of appropriations each year to provide health care for 2.2 million AI/AN people, a per capita spending level that is the lowest of any healthcare system. AI/AN have the right to have quality health care services, but without proper resources put behind these intentions, it is unlikely to be fully successful. We appreciate Congress expanding health programs in the Indian Health Care Improvement Act to increase access to health care services in Tribal communities, but more is needed to both appropriately fund these initiatives and further incorporate new and innovative
ways to modernize IHS health delivery. Without funding to address the information technology gap, to treat critically diagnosed patients with specialized care, and improve the facilities to maintain accreditation and accommodate the diverse cultural health needs of native people, IHS will remain an outdated system that is locked in a “time capsule” and unable to achieve its mission of “raising the health status of AI/AN to the highest possible level.”

We offer the following recommendations for the Committee to consider and hope that additional Tribal input will improve the legislation to make meaningful progress toward modernization of the IHS.

**General Recommendations**

This legislation offers many solutions to some of IHS' leading challenges, including provider recruitment and retention and filling shortages, improving quality care and increasing Tribal engagement and culture in the system. While we have some specific comments below to provide additional insight and to identify potential unintended consequences of certain provisions, we also recommend that specific legislation be considered to advance the Federal policy that has proven to improve quality, increase access to care for Tribal citizens and reduce the Federal bureaucracy – Self-Governance.

Self-Governance is the most successful partnership between the Federal and Tribal governments to ever exist. H.R. 2662 does articulate protections for Tribes to assume programs, services, functions, and activities at any time. However, it does not encourage or create additional opportunities for Tribes to assume these responsibilities. We hope that in future legislation, the Committee will consider legislation to expand Self-Governance and assure Tribal rights to assume management of their health care.

Additionally, Self-Governance Tribes note that the legislation does not authorize additional appropriations to support the new initiatives. We strongly believe that overlooking the funding necessary to properly implement the proposed programs will likely result in diminished returns on the Committee’s efforts. In fact, even though IHCIA was permanently reauthorized seven years ago, more than 20 provisions remain unfunded and therefore unimplemented. As this legislation moves forward, we recommend and offer any support to Senators who can seek additional appropriations for IHS to improve the quality and access to care for all AI/ANs.

**Creating Parity between IHS and Veterans Health Administration**

Many of the programs which stand to remain unimplemented are those that seek to address IHS’ provider shortage and vacancies. Self-Governance Tribes were heartened by the efforts this legislation makes to bring parity between the Veterans Health Administration (VHA) and IHS in provider compensation and personnel policy, to expand the IHS Loan Repayment Program, and to create demonstration projects to employ successful recruitment and retention strategies. However, some of the proposals do not recognize the challenges that exist in Indian Country. For instance, the housing voucher program included in Section 101 is limited to three years and does not
acknowledge that the real challenge in Tribal communities is that there is a housing shortage. Recognizing that appropriations for IHS-constructed provider housing are far below need, granting IHS authority and flexibility to explore innovative means for addressing housing shortages would be extremely helpful. At a minimum, we ask that the Committee considers extending the termination date for this program as well as authorizing appropriations so that IHS and Tribes can properly support such a voucher program.

Similar to VHA, this legislation also provides IHS additional flexibility to take personnel actions or to remove employees when necessary. Self-Governance Tribes agree that additional authority to manage employee performance is essential to improving quality of care over time. These practices also more closely mirror private industry standards for personnel management.

**Addressing Provider and Administrator Vacancies**

This legislation responds to long-standing Tribal requests to modify IHS authorities to increase qualified providers and health administrators through expansion of the IHS Loan Repayment Program in Section 104. Self-Governance Tribes support the increased flexibility in eligibility for the Loan Repayment Program, as it is an important tool for recruitment and retention. We recommend that this section be expanded further to provide the IHS with flexibility to repay student loans for shortages of providers in geographic areas with chronic vacancies as long as the provider agrees to serve at least 4 years in that location.

Though we appreciate the efforts to better include Tribal leadership in important hiring decisions, we are concerned that the legislation may have inadvertently included too many positions for Tribal notification. The legislation includes the “position of a manager at an Area office or Service unit” under the Tribal notification requirement in Section 105(a). Self-Governance Tribes are concerned that this could be interpreted quite broadly and that a “too” general interpretation of this language could include an overwhelming number of positions at the local and area levels – creating significant administrative burdens for IHS Human Resources staff. This may lead to unintended consequences, including further delays in the hiring process for critical day-to-day program management and vacancy rate increases. The highest-level managers should have Tribal support; however, program level management decisions should be left to the Senior Executive Service (SES) positions and service unit Chief Executive Officers (CEOs) so as not to interfere with their autonomy, accountability and ability to fill vacancies at the earliest opportunity.

With regard to the waiver of Indian Preference in hiring in Section 105(b), we are unclear of the intention to allow waivers in order to consider former employees that have been removed from employment or demoted for performance or misconduct. This would seem to be at odds with our collective goals to provide quality health care services.

H.R. 2662 offers a few solutions to improve the Service’s ability to hire employees, including centralization of medical credentialing and direct hire authority. Self-
Governance Tribes know all too well that an efficient hiring process will increase quality and access to care. We fully support shared credentialing throughout the IHS-operated facilities as proposed in Section 102, allowing IHS to efficiently deploy and assign providers to facilities as needed. A centralized medical credentialing process has been initiated by the IHS through Tribal Consultation under a Quality Framework, and is currently being implemented. We support full implementation of the Framework, and while IHS has created a small staff to implement the Framework by reallocating existing resources, implementation would be expedited and enhanced by appropriately funding this effort through additional appropriations. We further recommend that the Committee protect current and future Self-Governance Tribes’ rights to choose to operate their own credentialing systems or leverage the efficiency of a centralized credentialing system and quality standards administered by IHS.

Another opportunity the bill offers IHS is the Staffing Demonstration Project included in Section 109. Self-Governance Tribes know the value that demonstration projects can create in Indian Country. Demonstration projects often establish best practices and scalability of a program. However, the proposed project seems over-limiting in that it only includes Federally-operated sites with significant third-party resources. Staffing shortages are a challenge for all rural health care systems. Self-Governance Tribes recommend that access should be broad enough to include Tribes who are managing their health services and wish to exercise their right to participate. The provisions should address cases when Tribes wish to exercise their Self-Governance authority during the demonstration project. Self-Governance Tribes also recommend that an option be available to Tribal Health Programs to extend the liability protections for health professional volunteers under Section 103.

The legislation does not address one common recommendation Tribes previously made to this Committee to improve recruitment and retention of providers. The loan repayment program has proven to be the IHS’s best recruitment and retention tool to ensure an adequate health workforce to serve in the many remote IHS locations. Self-Governance Tribes recommend that the Committee include a provision that would provide the IHS loan repayment program the same tax free status enjoyed by those who receive National Health Service Corps (NHSC) loan repayments. Under the IHS and NHSC programs, health care professionals provide needed care and services to underserved populations. However, the IHS uses a large portion of its resources to pay the taxes that are assessed on its loan recipients. Currently, the Service is spending 29.7 percent of its Health Professions’ account for taxes. Making the IHS loan repayments tax free would save the agency $7.21 million, funding an additional 232 awards. Changing the tax status of the IHS loans to make them tax free would enable the agency to fill two-thirds or more of the loan repayment requests without increasing the IHS Health Professions’ account.

Improving Timeliness of Care
Self-Governance Tribes recognize that access to care can be partially measured by evaluating patient wait times. We appreciate the efforts by the proposed legislation in Section 107 to require measurement and accountability for patient wait times. The
Improving Patient Care (IPC) initiative, which began in 2008, provides a good foundation for measuring wait times as well as other measures, and we would recommend the IHS implement IPC in all of its facilities. However, additional time may be necessary to develop the rule. One hundred and eighty days would likely not allow for the proper development of a policy and required Tribal consultation. We would recommend additional time to develop a new set of standards. Further we hope the Committee will consider requiring Consultation prior to implementation and that data collected be available to impacted Tribes on a regular basis.

Establishing a Formal Tribal Consultation Policy
In the Department of Health and Human Services, IHS has set the gold standard for government-to-government consultation. The IHS policy has undergone many revisions and continues to be updated as the relationship between Tribes and IHS changes. Tribes have been an active partner with the IHS in the development and subsequent changes of the IHS Tribal Consultation Policy. If a negotiated rule is required as described in Section 110, it may unnecessarily limit future Tribal engagement or restrict the flexibility the agency requires to serve the best interest of Tribes. Generally, Self-Governance Tribes agree there is always room to improve implementation of the IHS Tribal Consultation Policy, but we are unsure that development of a rule will create the enforcement and results the Committee is seeking.

Fiscal Accountability
While Self-Governance Tribes are supportive of the Committee’s effort to ensure that valuable resources are committed to improving patient care, we believe this is a provision that needs additional consideration before passage. The current language in Section 202 is significantly more restrictive than current regulations and could inadvertently impact both the ability of the IHS to meet its obligations to provide care, as well as current and future Self-Governance opportunities.

Specifically, narrowing the use of unobligated funds may negatively impact the ability of IHS and Tribes to meet accreditation standards and requirements in the future such as technology requirements, which may include additional spending categories other than those included in this Section. The language also does not take into account specific appropriations for Facilities and Contract Support Costs, which are limited to those appropriations accounts, and much of this funding is intentionally available until expended. These provisions would also seem to limit IHS’ ability to pay funds to a Tribe under a Title I or Title V contract that were collected associated with a Program, Service, Function or Activity that is being assumed for operation by a Tribe. These provisions could also complicate IHS service delivery when there are delays in the appropriations process. Finally, the Section should be clarified to apply only to the IHS directly-operated program.

With regard to the reporting requirements of Section 202, it appears as though the fiscal year reporting required under this section would also include Title I and Title V contracts and funding agreements. Under current law, IHS would not have the ability to obtain
information to accurately report the requested information, because the fiscal data is reported by Tribes under their required audits.

In closing, SGCETC would like to thank the Committee for the opportunity to submit testimony and feedback. We look forward to working with you to improve the quality and access to care at IHS. If you have any questions or wish to discuss our recommendations in greater detail, please contact Terra Branson, Self-Governance Communication and Education (SGCE) Director, at terrab@tribalselfgov.org.
Dear Tribal and Urban Indian Organization Leader:

I am writing to announce two Indian Health Service (IHS) listening sessions related to the Resource and Patient Management System (RPMS) Electronic Health Record (EHR). As a first step and in accordance with IHS policies on Tribal Consultation and Conferring with Urban Indian Organizations, the IHS will seek input and recommendations from American Indian and Alaska Native Tribes and Tribal Organizations, as well as, Urban Indian Organizations, through listening sessions on how best to modernize and improve our EHR.

The IHS has made significant advances in health information technology as a result of our partnership with the U.S. Department of Veterans Affairs (VA). Earlier this month, the VA announced plans to modernize their EHR, the Veterans Information System and Technical Architecture (VistA). While not immediate, this change will impact the IHS RPMS EHR. To best prepare for upcoming changes, we will continue to work with the VA and take necessary steps to modernize our EHR platform by working closely with Tribal and Urban partners.

Since 1984, the IHS has relied on RPMS as our health information solution. The RPMS is a government-developed health information system comprised of over 80 integrated software applications. The RPMS is VistA at its core, sharing much of the same infrastructure and some clinical applications with the VA. Over time however, the RPMS has evolved, adding many improvements, functions, and interface capabilities that do not exist in VistA. For example, many VA applications, including laboratory and pharmacy, have been extensively modified to meet IHS requirements.

Additionally, the IHS has developed numerous applications independently of the VA to address IHS-specific mission and business needs, such as patient- and population-based clinical, practice management, and financially oriented administrative processes. Information about the IHS RPMS may be found at: https://www.ihs.gov/rpms/. Information about the VA’s EHR selection is available at the following Web site: https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2914.

The IHS will host two listening sessions via teleconference to engage our Tribal and Urban partners and stakeholders. The session time, dates, and conference line information are listed below, and will also be posted on the IHS Calendar of Events on the IHS Web site at: https://www.ihs.gov/ihscalendar/.

Listening

- Thursday, July 6, 2017 from 2:00 - 3:00 p.m. (Eastern)
- Monday, July 10, 2017 from 2:00 - 3:00 p.m. (Eastern)
Conference Call Details

- Conference Call: (888) 916-0647
- Participant Passcode: 7693138

As we conduct these listening sessions, I also invite you to provide input or feedback in writing. The comment deadline is August 25, 2017.

Please provide your written comments and recommendations as indicated below:

**TRIBAL LEADERS**
- By E-MAIL: at consultation@ihs.gov
  Subject line: RPMS CONSULTATION

**URBAN INDIAN ORGANIZATION LEADERS**
- By E-MAIL: at urbanconfer@ihs.gov
  Subject line: RPMS URBAN CONFER

By POSTAL MAIL

RADM Michael D. Weahkee
Acting Director
Indian Health Service
5600 Fishers Lane
Mail stop: 08E86
Rockville, MD 20857
ATTN: RPMS CONSULTATION

RADM Michael D. Weahkee
Acting Director
Indian Health Service
5600 Fishers Lane
Mail stop: 08E86
Rockville, MD 20857
ATTN: RPMS URBAN CONFER

I look forward to your views and comments. If you have any questions, please contact Captain Mark Rives, Chief Information Officer, and Director, Office of Information Technology, IHS, by telephone at (301) 443-2019 or by e-mail at mark.rives@ihs.gov.

Sincerely,

/Michael D. Weahkee/
RADM Michael D. Weahkee, MBA, MHSA
Assistant Surgeon General, U.S. Public Health Service
Acting Director
Dear Tribal and Urban Indian Organization Leader:

I am writing to initiate a 45-day Tribal Consultation and Urban Confer on a draft Indian Health Service (IHS) Headquarters Information Technology (IT) Service Catalog. The IT Service Catalog will serve as a tool for Indian Self-Determination and Education Assistance Act (ISDEAA) negotiations by describing the current programs, services, functions, and activities (PSFAs) carried out by Headquarters Office of Information Technology (OIT). In addition, it will provide information on how to access OIT support services.

The recommendation to develop an IT Service Catalog came from the IHS Information Systems Advisory Committee (ISAC). This committee was established to guide the development of a co-owned and co-managed Indian health information infrastructure and information systems. The ISAC reviewed and approved the draft IT Service Catalog at their Semi-Annual Meeting on August 10-11, 2016. An electronic copy of the draft Service Catalog is available on-line at: https://www.ihs.gov/oit/service-catalog/.

The IHS OIT aims to provide secure and reliable IT in innovative ways to improve health care delivery and quality, enhance access to care, reduce medical errors, and modernize administrative functions. As a next step, the IHS has launched a 45-day Tribal Consultation and Urban Confer.

Table 1.1 below illustrates a functional change in OIT categories as a result of the draft IT Service Catalog. Since 2002 and currently in use, the OIT functions fall into four functional areas. The draft IT Service Catalog consolidates and simplifies major functions into three major support options by delineating improvements in interoperability, along with greater interdependence among our systems.

<table>
<thead>
<tr>
<th>Current OIT Major Function Service Categories to date (in effect since 2002)</th>
<th>New Functional Service Categories as described in Draft IT Service Catalog</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Database Services</td>
<td>National Patient Information Reporting System (NPIRS)</td>
</tr>
<tr>
<td>Telecommunications Management Services</td>
<td>Infrastructure, Office Automation &amp; Telecommunications (IOAT)</td>
</tr>
<tr>
<td>Software Development and Maintenance Service</td>
<td>Resources &amp; Patient Management System (RPMS)</td>
</tr>
<tr>
<td>System Support/Training Services</td>
<td></td>
</tr>
</tbody>
</table>

Table 1.1 OIT Functional Services Category Comparison Chart.

As part of the 45-day Tribal Consultation and Urban Confer, the IHS will host national webinars on the draft IT Service Catalog scheduled over the next two months. For dates and times, please visit the IHS OIT Web site at the following address: https://www.ihs.gov/oit/service-catalog/.
I look forward to your input on this draft IT Service Catalog. Please provide your comments and recommendations by e-mail at consultation@ihs.gov or urbanconf@ihs.gov. You may also provide comments by postal mail to the address indicated below. The comment deadline is August 4, 2017.

RADM Michael D. Weahkee  
Acting Director  
Indian Health Service  
5600 Fishers Lane, Mail Stop 08E86  
Rockville, MD 20857

Thank you for your support and partnership. I look forward to your comments and recommendations.

Sincerely,

/Michael D. Weahkee/

RADM Michael D. Weahkee, MBA, MHSA  
Assistant Surgeon General, U.S. Public Health Service  
Acting Director
IHS Office of Information Technology
Update

Tribal Self Governance Advisory Committee Meeting

July 18, 2017

CAPT Mark Rives, D.Sc.
Chief Information Officer
Indian Health Service

TSGAC Requested Update

• Veteran Affairs Migration to Cerner and Impact on the Resource and Patient Management System (RPMS)

• Futures plans for RPMS

• CyberSecurity Update
HIT Systems in the IHS

- Tools for:
  - support of patient care
  - managerial oversight
  - agency performance reporting

- Living systems impacted by changes in:
  - hardware
  - software
  - licensing
  - security vulnerabilities
  - legislation/regulation
  - stakeholders requests
  - program initiatives
  - Etc.

- Must be regularly re-examined
  - Part of due diligence
  - Part of normal business process

Veteran Affairs Migration to Cerner
and Impact on the Resource and Patient Management System (RPMS)

- May 2017 – VA announced move from VistA to DOD MHS Genesis platform

- Impact on IHS:
  - IHS uses code developed by the VA
  - RPMS depends on VistA
  - Large number of software components affected
  - Unknown amount of funding required to continue code development provided by VA

- Timeline:
  - VA plans are still under development and funding from Congress has been requested
  - Transition would occur over 8-10 years
  - VistA would continue to be supported for several years
Understanding VA adoption of DOD MHS Genesis

- Scope of VA acquisition and replacement is “anything clinical” and “as is”
- “As is” means VA will adapt to the system, rather than adapt the system
- Adopting the entire MHS Genesis (EHR) system means
  - Same solution, instance, security ATO, protocols
  - VA adopts DOD clinical flow paths
  - VA uses DOD EHR templates
  - No customization, only configuration
    - There will not be a “VA version” of the CERNER HER
    - Customization adds to cost
    - VA only has to add what they do differently from DOD (e.g. long term care)
  - MHS patient record will transition to the VA patient record (active duty to retired)
- MHS includes the CERNER dental solution and the revenue cycle functions
- No information yet on plans for imaging solution
- Estimated cost ranges from $19B to $35B

IHS Actions

- May 2017 - Chartered ISAC Workgroup
  - Examine EHR and health IT platforms
  - Draft options for long term plan for IHS electronic health record
- July 3 and 10 - Held Listening Sessions
  - Learn from Tribal partners who use COTS solutions
  - Describe costs, pros, cons, lessons learned, impacts on quality and access
- On-going - Develop RFI
  - What should and should not be included in a COTS solution?
- ISAC meeting
  - Chicago – June 2017 and Tent: Sept 2017, TBD
  - Recommendations forthcoming
- Engagement
  - HHS
  - VA
Futures plans

• Support for RPMS will continue for immediate future
  • VA continuing support through transition
• Enhancements for data interoperability are needed
  • For current initiatives
  • For future patient record accessibility
• Must address “day to day” updates to RPMS
  • User requests
  • Maintain and improve functionality
• Long term
  • VA software focus will shift to archiving the system

Update: Cyber-security

• Two major recent worldwide attacks
  • May 2017 - WannaCry Attack
  • June 2017 - Petya & Not-Petya
  • IHS was not infected
• Response & Issues
  • Monitoring and patching of 50,000 devices
  • Issues with patching biomedical devices
  • Patching is key
• Seeking ways to enhance interaction with tribal partners during security incidents
  • Communication and information sharing
Questions?

Mark.Rives@ihs.gov
301-443-2019
**NAME OF WORKGROUP** *(please check which Committee this report will be for)*

- Technical Workgroup
- HHS Secretary’s Tribal Advisory Committee (STAC)
- Budget Formulation Workgroup
- Facilities Appropriation Advisory Board (FAAB)
- Tribal Leaders Diabetes Committee (TLDC)
- HHS Tribal Consultation Advisory Workgroup
- AL/AN Health Research Advisory Group
- Information Systems Advisory Committee (ISAC)
- Contract Support Costs (CSC) Workgroup
- Health Promotion/Disease Prevention Policy Group
- CDC Tribal Consultation Advisory Committee (TCAC)
- Tribal Technical Advisory Group (CMS-TTAG)
- Self-Governance Health Care Reform

**DATE OF MEETINGS**  
June 28-29, 2017

**COMMITTEE REPRESENTATIVE:**

Name: Stewart Ferguson  
Title: Chief Technology Officer  
E-mail: sferguson@anthc.org

**AGENDA ITEM**  
**SUMMARY/HIGHLIGHTS** *(Committee action should be noted in this section)*

**Adopting a COTS (Commercial Off-The-Shelf) EHR solution to replace RPMS**

1. The ISAC was unanimous in recommending that IHS pursue a COTS solution for the future IHS HIT system. This means replacing the Resource and Patient Management System (RPMS) with one or more commercial EHR offerings in the coming years.
2. The ISAC recommended the IHS identify funding or avenues of funding to support an immediate and detailed un-biased analysis of COTS solutions to replace the IHS RPMS.
3. In May 2017, the ISAC established the IHS HITS Modernization Workgroup to assist the Agency with long term strategies to modernize and improve the HITS solution used in Indian health care hospitals and facilities. The workgroup has a deadline to report to the IHS Principal Deputy Director of August 13, 2017. At the ISAC meeting, this workgroup was re-purposed to work on executive level action and business plans for IHS moving to a COTS system, and a vision for IHS services for a COTS EHR system. Part of this effort will be to provide input to an RFI for gathering more information about COTS solutions.
4. ISAC discussed the Veterans Affairs (VA) recent announcement of their selection of a Cerner software product as their long-term solution. This greatly affects the current IHS HIT system, as the core of the IHS Resource and Patient Management System (RPMS) is the VA’s homegrown software. Without it, development, modernization, and enhancement of the RPMS and Electronic Health Record (EHR) is questionable.
5. The IHS CIO provided a summary of the VA decision to negotiate with Cerner to adopt the DoD implementation. VA shared determination and findings with IHS that allowed the VA to leapfrog purchasing process and not do an extensive RFQ process. IHS is exploring options to participate with the VA in the Cerner solution.
6. ISAC noted that any COTS solution would also require IHS to complete an infrastructure analysis and upgrade, as the DoD found their infrastructure was lacking for a COTS solution.
7. IHS is currently conducting listening sessions with partners to get feedback on a COTS solution.

**RPMS Development**

1. IHS has decided NOT to make RPMS compatible for Meaningful Use (MU) Stage 3 until ISAC make this a priority. This means all sites relying on RPMS will need a waiver or will have to forego seeking MU Stage 3 incentive payments, if they participate in the MU program.
2. IHS has awarded a single contract for all future RPMS development, replacing four previous contracts. The contracting process generated some delays in software
development, but IHS staff expects this to improve the quality and timeliness of releases.
3. IHS is investing in a new cloud based development and testing environment, and migrating towards agile development processes. This is a large undertaking but it was unclear if this was reviewed and approved by ISAC, and whether this is fiscally prudent should IHS move towards a COTS system.
4. IHS has also let a contract for RPMS training and documentation support. This also will improve software quality assurance through Independent Verification and Validation (IV&V) and standardized training methodologies.
5. ISAC unanimously recommended that IHS prioritize upgrading the development of Clinical Quality Measures (CQMs). These fell off the development roadmap for RPMS and now raise risks for organizations that rely on RPMS and the CQMs for regulatory reporting. CQMs will be upgraded sufficient to meet the needs of Medicare’s Quality Payment Program (QPP).
6. IHS is working on a solution for Electronic Prescribing of Controlled Substances (EPCS). This is expected to be generally available to RPMS sites in mid to late 2018.

Other IHS Technology Changes
1. IHS is developing and deploying a single credentialing software solution (“MD Staff”). This is currently being tested in four areas and limited to Federal facilities, but is expected to be available to others by end of 2017. It is unclear if this system will be able to import or export to other systems currently in use.
2. IHS is piloting a number of dashboard and communication initiatives to strengthen communications. This includes a dashboard on RPMS development, product that will allow improve
3. IHS is moving towards enterprise contracts for IT hardware to reduce pricing and standardize hardware offerings.
4. IHS plans to support UDS reporting for urban sites, and is creating an Urban Program Data Mart.

Service Catalog
1. IHS continues to work on the “long overdue” service catalog that details the IT services being provided by IHS. The current draft (version 1) is being shared for feedback. The goal is to replace buyback description of services, but pricing for services is not yet included in the service catalog. It is unclear when IHS plans to provide pricing information.

ISAC Charter
1. The ISAC Charter has not been updated in years, is vague on certain issues (e.g. assigning non-permanent members, approvals required for membership), and needs a review of the permanent membership. The IHS CIO will lead a workgroup on revising the charter.

Staff
1. IHS has worked on HR innovations that include the ability to have a single announcement work across the system so individuals do not have to fill out multiple applications.
2. Keith Longie will lead an effort to review the human capital management plan for ISAC.

Security
1. In light of the recent “Wanna Cry” attacks, IHS continues to evaluate their security. IHS has made significant efforts to harden and secure 50,000 end-point devices. Security continues to be a top priority for IHS.

RECOMMENDED TSGAC ACTION
1. TSGAC needs to be very actively involved in the discussion of a COTS EHR solution. It will require strong leadership and support from tribal organizations if we want to be successful in exploring a COTS replacement for RPMS. The topic of replacing RPMS with a COTS solution needs serious consideration, as many tribal organizations have taken this route at their own cost and reaped the benefits. However, it appears there is reluctance, resistance, and lack of knowledge within IHS staff to full explore and understand this option.
2. TSGAC needs to advocate now, more than ever, for all major IT development efforts to be carefully reviewed by ISAC. Investments in software development, architectural changes, cloud based platforms, and new processes need to be carefully considered when RPMS may be sunsetted in lieu of a COTS solution. It is especially important to be prudent with choices as the VA migrates away from VISTA and that development stream is reduced in coming years to IHS.
3. TSGAC may want to provide feedback on the new charter for ISAC. It is important that tribal representation remain strong on this committee, and that tribal representatives are active and provide critical feedback to IHS going forward. I volunteered to serve on this workgroup
4. TSGAC needs to advocate for funding for IHS IT. Migration to a COTS product will require significant new funding. Even staying with RPMS needs more funding as RPMS development lags that of COTS products (e.g. RPMS will not meet Meaningful Use Stage 3, CQM are out of date, and EPCS solutions will not be available for a year).
DATE: July 11, 2017
TO: Principal Deputy Director
FROM: Information Systems Advisory Committee Co-Chairs
SUBJECT: Information Systems Advisory Committee June 28-29, 2017 Semi-Annual Meeting Recommendations and Actions

ISSUE
We are submitting the Indian Health Service (IHS) Information Systems Advisory Committee (ISAC) recommendations and actions resulting from the ISAC semi-annual meeting held on June 28-29, 2017 at the Department of Health and Human Services Regional Office in Chicago, Illinois, for your consideration (see attached).

DISCUSSION
The ISAC primarily focused on the modernization of the IHS Health Information Technology (HIT) system at our semi-annual meeting. The Veterans Affairs (VA) recently announced their selection of a Commercial-Off-The-Shelf (COTS) software product as their long-term solution. This greatly impacts the current IHS HIT system, as the core of the IHS Resource and Patient Management System (RPMS) is the VA’s homegrown software. Without it, development, modernization, and enhancement of the RPMS and Electronic Health Record (EHR) is questionable. The ISAC is therefore recommending the IHS also pursue a COTS solution for the future IHS HIT system moving forward. This will require the IHS to conduct thorough needs, alternatives, and risk analyses, identify funding, and proactively consult with Tribal and Urban partners. A modernized EHR system will allow IHS/Tribal/Urban clinicians and patients to share current and future healthcare information for continuity of care and improved treatment, supporting the mission and goals of IHS, so they might be fully achieved.

Respectfully Submitted,

Donnie Parish     Lindsay King
ISAC Tribal Co-Chair     ISAC Federal Co-Chair
Chief Information Officer     Director, Office of Tribal Self-Determination
Cherokee Nation     Oklahoma Area IHS

Attachment:
ISAC Semi-Annual Meeting Recommendations and Actions

Cc: ISAC Committee
IHS Chief Medical Officer
IHS Chief Information Officer
The Indian Health Service (IHS) Information Systems Advisory Committee (ISAC) is submitting the following recommendations and actions from the June 2017 ISAC Semi-Annual Meeting to the IHS Principal Deputy Director:

**RECOMMENDATIONS**

The ISAC approved the following recommendations during their meeting:

1. **Health Information Technology System (HITS) Modernization.** The ISAC recommends the IHS pursue a Commercial-Off-The-Shelf (COTS) solution for the future IHS HITS moving forward.

2. **HITS Modernization Funding.** The ISAC recommends the IHS identify funding or avenues of funding to support an immediate and detailed un-biased analysis of COTS solutions to replace the IHS Resource and Patient Management System (RPMS).

3. **ISAC HITS Modernization Workgroup.** In May 2017, the ISAC established the IHS HITS Modernization Workgroup to assist the Agency with long term strategies to modernize and improve the HITS solution used in Indian health care hospitals and facilities. The workgroup has a deadline to report to the IHS Principal Deputy Director of August 13, 2017.

   A. **Repurpose ISAC HITS Workgroup.** The ISAC recommends re-purposing the workgroup to work on executive level action and business plans for IHS moving to a COTS system.

   B. **Action Plan.** The Action Plan will include:

      (1) An IHS-sponsored or funded third party analysis of COTS Electronic Health Records (EHR).

      (2) An IHS-sponsored or funded third party needs analysis of the existing RPMS/EHR to inventory required components.

      (3) Develop a survey or other vehicle for data collection that will go to all IHS, Tribal, and Urban health care organization participants so further requirements can be gathered.

      (4) Develop and release a Request for Information.
(5) Pursue a full and open competition for a core set of capabilities for EHR modernization. A competitive process will allow IHS to consider commercial alternatives that may offer reduced cost, technical risk, and access to increased capability and future growth in capability by leveraging ongoing advancements in the commercial marketplace.

(6) Continue near-term coordinated efforts to develop EHR data interoperability, especially in support of quality initiatives, such as Electronic Clinical Quality Measures (eCQM), Government Performance and Results Act (GPRA), and the Comprehensive Primary Care (CPC). This near-term goal shall be pursued as a first priority separately from the longer-term goal of HITS modernization.

C. Business Plan. The workgroup will also develop a preliminary Business Plan for review and implementation of a COTS EHR solution(s). The workgroup will propose a vision (or model) for the future state of IHS services in support of a COTS EHR system, including but not limited to deployment support, operational support, analysis of new solutions, data and analytics services, etc.

4. Office of Information Technology (OIT) Service Catalog. The ISAC supports the OIT efforts to develop and finalize the OIT Service Catalog.

A. The ISAC recommends transparency in associated Tribal Leader Letters, Tribal Listening sessions, and webinars and involvement of IHS Area Agency Lead Negotiators and Contract Proposal Liaison Officers.

B. The ISAC recommends inclusion of financial transparency in the OIT Service Catalog.

C. Further, the ISAC recognizes the importance of and recommends OIT staff participation in Tribal negotiations.

5. Electronic Clinical Quality Measure (eCQM) Reporting. The ISAC recommends that the IHS seek out a COTS solution or work to restore functionality in the current electronic health record to enable reporting of clinical quality measures to meet the requirements of clinical quality payment programs. This will include elevating the ISAC and OIT priorities for updating the eCQM logic in 2014 RPMS EHR as follows:

A. Update the eCQM to the most current logic in RPMS (e.g. from 2014 logic →2015 logic →2016 logic).

B. Configure the Quality Reporting Document Architecture 1 (QRDA 1) so it is in xml format.

C. As recommended in 1.C.6 above, continue near-term coordinated efforts to develop EHR data interoperability, especially in support of quality initiatives, such as eCQM, GPRA and CPC.
6. ISAC Information Sharing. The ISAC recommends the IHS develop an information portal that all ISAC members, whether on the IHS network or not, can access for ISAC information sharing. This portal will allow for greater collaboration with Tribal and Urban entities, including the ability to speak with Tribal and Urban Leaders in a digital format.

**Actions**

1. Office of Information Technology Fiscal Year (FY) 2018-2020 Human Capital Management Plan (HCMP). The ISAC supports the next iteration of the IHS Human Capital Work Plan and is establishing a workgroup chaired by Keith Longie, ISAC member and Bemidji Area Director, to develop the Work Plan. The workgroup will provide ISAC with a report on the Work Plan at the next semi-annual ISAC meeting. This iteration of the work plan is to include recommendations of expanding OIT’s organizational structure to the Areas and sites, so that there may be a more centralized management structure in place.

2. ISAC Charter. The ISAC is revising their charter, which will be submitted for the IHS Director or designee’s approval when completed. This includes the following activities:

   A. The IHS Chief Information Officer will lead a workgroup to update the ISAC charter on behalf of the ISAC. The CIO will report back to the ISAC with the proposed changes.

   B. The revised charter will include authorization for the IHS Chief Information Officer to approve new ISAC members to expedite membership appointments. The ability to appoint members at this level in the IHS is similar to other chartered IHS committees.

   C. The revised charter will include a permanent seat for a Direct Service and Contracting Tribes Advisory Committee representative.

   D. The IHS Chief Information Officer will contact the National Indian Health Board to verify their participation on ISAC as they have not sent a representative in several years.

3. ISAC Information Technology (IT) Priorities. The ISAC is revising their IT Priorities to include health information system modernization. The revised priorities are forthcoming.
IHS Community Health Aide Program (CHAP) Expansion
TSGAC 3rd Quarterly Meeting

July 18, 2017
Overview

- Background
- IHS Aide Program Updates
- Next Steps
- Recommendations
- Discussion
Background

• Timeline
• Alaska Native Tribal Health Consortium (ANTHC) CHAP vs. IHS CHAP
• Behavioral Health Aide (BHA)
• Community Health Representative (CHR)
• Dental Health Aide Therapist (DHAT)
National Timeline

1968
- Community Health Aide Program Begins

1968
- CHAP is established in Alaska
- IHCA is amended to authorize CHAP

1998
- CHAP adds DHAT within the CHAPCB (AK)

1998
- The Community Health Aide Certification Board (CHAPCB) is established

2007
- First group of BHA's certified under CHAPCB (AK)

2008
- BHA Program is added to CHAPCB (AK)

2009
- DTTL initiates draft policy to expand CHAP in lower 48

2016
- Tribal consultation for IHS Policy on CHAP Expansion

2017
IHS Internal Timeline

- **6/2016**: DTTL initiates consultation on draft CHAP in lower 48.
- **10/2016**: Tribal consultation for IHS Policy on CHAP Expansion.
- **1/2017**: Report of Tribal Consultation on CHAP.
- **3/2017**: OCPS Director met with CMO & DDIGA on next steps.
- **4/2017**: OCPS Director met with Division Directors to develop plan and appoint lead.
- **4/2017**: Chief of Staff directs OCPS to take lead and move forward.
- **5/2017**: Leads are appointed for each Aide program under the expansion.
## CHAP Expansion Framework

<table>
<thead>
<tr>
<th>Phase I: Assessment</th>
<th>What does the system currently look like?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase II: Design</td>
<td>What will the program look like?</td>
</tr>
<tr>
<td>Phase III: Implementation</td>
<td>How do we roll it out?</td>
</tr>
<tr>
<td>Phase IV: Evaluation</td>
<td>How well is the program performing?</td>
</tr>
</tbody>
</table>
ANTHC CHAP vs. IHS CHAP

Alaska CHAP

- Alaska Community Health Aide Program (CHAP)
  - Behavioral Health Aide
  - Community Health Aide
  - Dental Health Aide

IHS National CHAP (proposed)

- IHS Community Health Aide Program (CHAP)
  - Behavioral Health Aide
  - Community Health Representative
  - Dental Health Aide
Behavioral Health Aide

• Tiered-Practice Level
• Certification through Tribal Colleges & Universities (TCU’s)
• Centers for Medicare and Medicaid Services (CMS) Reimbursement
• Explore Regional Certification
Community Health Representative

• Background
  – Established in 1968 by Congress
  – Majority of paraprofessionals within the lower 48 are CHR’S
  – Come from our local communities & immediate surrounding areas.
  – Current workforce in Indian Country is 1,400 representing more than 250 tribes in 12 service areas.

• Future Direction:
  – Adapt existing CHR model to mirror the CHAP model (Alaska)
  – Various tiers of paraprofessional services
  – Goal to establish billable services
Dental Health Aide

- Tiered Model
  - DHA I
  - DHA II
  - DHA III
  - DHAT

- IHCIA & DHAT

- Certification

- Training Programs
Next Steps

• Charter Development
• Stakeholder Engagement
• Workgroup Formation
Contacts

• Dr. Chris Halliday (OCPS/DOH)
  – Dental Health Aide Therapy Program
  – Christopher.Halliday@ihs.gov

• Georgianna Old Elk (OCPS/DBH)
  – Community Health Representative Program
  – Georgianna.OldElk@ihs.gov

• Minette Wilson (OCPS/DBH)
  – Behavioral Health Aide Program
  – Minette.Wilson@ihs.gov
Discussion
April 11, 2017

RADM Chris Buchanan
Acting Director
Indian Health Service
Office of the Director
5600 Fishers Lane
Mail Stop: 08E53
Rockville, MD 20857

RE: TSGAC Recommendations for the Formation of the Community Health Aid Program (CHAP) Workgroup

Dear Acting Director Buchanan:

I write on behalf of the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC) to provide the following recommendations regarding the future establishment of the Community Health Aid Program (CHAP) Workgroup. We appreciate the opportunity to weigh in prior to the development of the Workgroup and look forward to the opportunity to assist the IHS as it works to implement the Program.

TSGAC is pleased IHS worked collaboratively and efficiently with Tribes to collect comments and summarize the results prior to establishing a plan. We are supportive of the workplan to draft the CHAP expansion policy and implementation plan for IHS. However, we wish to share the following recommendations with regard to the formulation and scope of work for the National CHAP Workgroup:

- **Include a Self-Governance representative.** Though generally Self-Governance Tribes are not required to follow IHS written policy, many Tribes treat IHS policy as a starting point or guideline in the initial development of their own programs. Additionally, many Self-Governance Tribes are interested or currently using similar models to expand access to services in Tribal communities. Still other Tribes may wish to proceed with passing their own authorizing laws and establishing licensing initiatives as sovereign governments. For these reasons, we respectfully request that Self-Governance have a representative on the Workgroup and will provide recommended names.

- **Ensure each IHS Area has Tribal representation on the Workgroup.** In the January 4, 2017 Dear Tribal Leader Letter, IHS lists “IHS Area Leadership” as part of the group to comprise the Workgroup. TSGAC interpreted this to mean IHS Area Office Leadership and would like to further recommend that among the suggested experts, that each IHS Area have a Tribal representative.
• **Focus on creating a baseline that protects the integrity of the program while allowing for maximum flexibility and implementation across the country.** Much of CHAP’s success hinges on the needed flexibility to implement it in multiple states across the country. For that reason, we ask that the Workgroup develop models which meet the needs of every state and area with a program, which may include the option to have licensing standards and boards in each Area.

• **Consider existing programs that may be impacted by CHAP.** As noted previously in Tribal comments, CHAP already exists in Alaska and other states have implemented parts of the CHAP program. The Workgroup should thoroughly understand if and how any new policy will impact current programs across the country, and be mindful to avoid negative impacts to successful programs.

• **Create an evaluation plan.** As with any new program, Tribes and other stakeholders will want to evaluate the success of the program in expanding access to and quality of care. The Workgroup should consider how best to evaluate Program outcomes and encourage sites to collectively and regularly report those outcomes to Tribes.

• **Create a mechanism for continual evaluation and evolution.** Over time, the CHAP program in Alaska has gone through many changes and improvements to meet the current population health needs. In addition to evaluating the program, there must be a set mechanism at either the Area level or the National level (or both) to allow for the evolution and improvement of the program. This mirrors current practice of the Community Health Aide Program Certification Board in Alaska and should be replicated.

As always, TSGAC appreciates the ongoing IHS effort to improve access and quality of care for American Indians and Alaska Natives. We look forward to the announcement to establish the Workgroup and accept nominations as well as receiving regular updates from the Workgroup. If you have any questions or concerns regarding the recommendations from above please contact me at lmalerba@moheganmail.com. Thank you.

Sincerely,

[Signature]

Chief Lynn Malerba, Mohegan Tribe of Connecticut
Chairwoman, IHS TSGAC

cc: Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, IHS TSGAC Members and Technical Workgroup
June 22, 2017

The Honorable Thomas E. Price
Secretary
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

RE: Request for Tribal Consultation on HHS Reimagining Initiative and Invitation to the TSGAC Quarterly Meeting July 18-19, 2017

Dear Secretary Price,

On behalf of the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC), I write to request that the Department of Health and Human Services (HHS) conduct Tribal Consultation prior to submitting recommendations to the Office of Management and Budget pursuant to Executive Order 13781, Comprehensive Plan for Reorganizing the Executive Branch.

TSGAC believes that any efforts to reorganize, streamline, or create efficiencies require Tribal Consultation under the HHS Tribal Consultation Policy, most recently revised in 2010. The Department’s Tribal Consultation Policy states that, “Before any action is taken that will significantly affect Indian Tribes it is the HHS policy that…consultation with Indian Tribes will occur.” The policy further states that actions that may “have substantial direct effects on one or more Indian Tribes” or impact “on the relationship between the Federal Government and Indian Tribes” require Tribal Consultation. Therefore, we believe that Tribal Consultation on this initiative is necessary.

Self-Governance is an excellent and proven means to downsize federal bureaucracy and ensure resources reach the local level. As such, we recognize that reorganization can be very beneficial and do not categorically oppose efforts to do so; however, the purpose of any reorganization should be to improve quality of care, access to care, and the efficiency in which resources are provided to Tribal citizens. TSGAC is willing and prepared to assist HHS staff and others throughout this process and request open access to the ideas and suggestions that are developed prior to finalization. Proper Tribal Consultation and active participation and engagement throughout this process will undoubtedly impact the success and outcomes of your recommendations to the Office of Management and Budget Director. We hope to learn how your office is planning to engage in Tribal consultation, as required by the HHS Tribal Consultation Policy, prior to any implementation or submission to the Office of Management and Budget.

Additionally, TSGAC is hosting our regular quarterly meeting July 18-19, 2017 in Washington, DC, where we have set aside time to discuss this initiative. We invite you or a representative from the Department to attend the meeting to provide an update of the process and review future opportunities to formally provide our feedback.
We look forward to your partnership on this issue and hope that you are able to attend the upcoming TSGAC meeting. Please contact and coordinate additional arrangements for the proposed meeting with Terra Branson, Director of Self-Governance Communication & Education Tribal Consortium at terrab@tribalselfgov.org or (918) 302-0252. Thank you.

Sincerely,

Marilynn “Lynn” Malerba
Chief, The Mohegan Tribe of Connecticut
Chairwoman, Tribal Self-Governance Advisory Committee

cc: Chester Antone, Councilman, Tohono O’odham Nation and Chair, HHS Secretary’s Tribal Advisory Committee
Nicolas Barton, Chairman, Direct Service and Contracting Tribes Advisory Committee, IHS
RADM Michael Weahkee, Acting Director, IHS
RADM Kevin Meeks, Acting Deputy Director of Field Operations, IHS
Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, IHS
This brief examines the financial impact the health insurance legislation recently introduced in the Senate (Senate bill) would have on American Indians and Alaska Natives (AI/ANs) who meet the definition of Indian under the Affordable Care Act (ACA), as compared to coverage under current law, including the ACA. In addition, this brief provides a similar set of analyses of the impact of the Senate bill versus the ACA for others who do not meet the definition of Indian. As such, this brief provides two sets of analyses, and within each set of analyses, health insurance-related costs are presented for families with varying household income levels at different points along a continuum of “family cycle stages.”

In summary, beginning in 2020, low- to middle-income AI/AN families meeting the ACA definition of Indian would have significantly higher net health insurance-related costs under the Senate bill than they would under the ACA at every family cycle stage, with the difference in net costs continuing to grow larger with each successive stage. As shown in the analysis below, this would result from the termination of comprehensive Indian-specific cost-sharing protections and significantly lower federal subsidies for health insurance premiums. And termination of the ACA Medicaid expansion would result in the lowest-income individuals having to enroll in private health plans with deductibles of approximately $6,100 per person per year.

Background

The ACA includes a number of provisions designed to make comprehensive health insurance more accessible to low- to middle-income individuals, with a number of protections specific to AI/ANs. Under the ACA, for instance, AI/ANs who meet the definition of Indian qualify for comprehensive cost-sharing protections (regardless of household income), meaning they pay no deductibles, co-insurance, or copayments when receiving essential health benefits (EHBs). These Indian-specific cost-sharing protections were designed and provided in recognition of the federal trust responsibility to AI/ANs and Indian Tribes. The ACA also includes general cost-sharing protections for individuals who do not meet the definition of Indian, have a household income up to 250% of the federal poverty level (FPL), and enroll in silver-level coverage. In addition, the ACA generally provides premium tax credits (PTCs) for individuals with a household income between 100% and 400% of the federal poverty level (FPL), with the amount of the PTCs adjusted to reflect differences in the cost of health insurance premiums based on age and geographic area.

The Senate bill, released on June 22, 2017, would repeal the Indian-specific cost-sharing protections, as well as the general cost-sharing protections, provided under the ACA. In addition, the Senate bill would substantially reduce the value of the PTCs designed to help low- to middle-income AI/ANs and other individuals purchase health insurance on the individual market. Like the ACA, the Senate bill would adjust
the amount of PTCs to reflect differences in the cost of health insurance premiums based on a local reference plan when calculating the value of the tax credits. However, rather than use the second-lowest-cost silver plan, which has an actuarial value (AV) of 70%, the Senate bill would base PTCs on the “applicable median cost benchmark plan,” which has an AV of 58%, a modification that would result in decreased PTCs for individuals across almost all age and income groups.

Apart from the change in the reference plan, the Senate bill would revise the ACA “applicable percentage” schedule, which determines the percentage of household income Marketplace enrollees must contribute when calculating the value of PTCs, to provide more financial assistance for younger enrollees and less for older enrollees; the ACA adjusts the applicable percentage by income but not by age (see table below). The Senate bill also would change the ACA income eligibility threshold for PTCs to between 0% and 350% FPL, leaving many middle-income individuals ineligible for PTCs. In addition, the Senate bill would repeal the Indian-specific cost-sharing protections, as well as the general cost-sharing protections, provided under the ACA.

### Comparison of Applicable Percentage Contribution, by Age and Income Level:

**Affordable Care Act (ACA) vs. Senate Plan**

<table>
<thead>
<tr>
<th>Household Income (as % of FPL)</th>
<th>ACA (2017)</th>
<th>Senate Plan (2020)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Ages</td>
<td>Age 0-29</td>
</tr>
<tr>
<td></td>
<td>Low End</td>
<td>High End</td>
</tr>
<tr>
<td></td>
<td>of Range</td>
<td>of Range</td>
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<tr>
<td>0% to 100%</td>
<td>2.04%</td>
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<td>100 to 133%</td>
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<td>133% to 150%</td>
<td>3.06%</td>
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</tr>
<tr>
<td>150% to 200%</td>
<td>4.08%</td>
<td>4.00%</td>
</tr>
<tr>
<td>200% to 250%</td>
<td>6.43%</td>
<td>4.30%</td>
</tr>
<tr>
<td>250% to 300%</td>
<td>8.21%</td>
<td>4.30%</td>
</tr>
<tr>
<td>300% to 350%</td>
<td>9.69%</td>
<td>4.30%</td>
</tr>
<tr>
<td>350% to 400%</td>
<td>9.69%</td>
<td>4.30%</td>
</tr>
</tbody>
</table>

**Household Income (as % of FPL)**

**Stage 1 (Attachment A):** 2-person family consisting of two 22-year-old adults;

**Stage 2 (Attachment B):** 4-person family consisting of two 32-year-old adults and two 2-year-old children;

**Stage 3 (Attachment C):** 4-person family consisting of two 50-year-old adults and two 20-year-old children; and

**Stage 4 (Attachment D):** 2-person family consisting of two 60-year-old adults.

As the analysis shows, low- to moderate-income AI/AN families meeting the ACA definition of Indian would have significantly higher net health insurance-related costs under the Senate bill than they would under the ACA at every family cycle stage, with the difference in net costs continuing to grow larger with each successive stage. For example, at Stage 2 (see Attachment B), an AI/AN family with household income at 300% FPL ($72,900) would have net health insurance-related costs of $3,465 under the ACA, compared with an average of $8,921 under the Senate bill, a difference of $5,421; the disparity would increase to $12,266
for an AI/AN family with the same household income at Stage 3 (see Attachment C). In addition, families with incomes between 350% and 400% FPL would fare markedly worse under the Senate bill than they would under current law, as the Senate bill does not provide PTCs beyond 350% FPL.

**Family Cycle Analysis 2: Families in the General Population**

Analysis 2, Stages 1 - 4 illustrate the estimated financial impact of the Senate bill versus the ACA for families in the general population (i.e. not meeting the ACA definition of Indian) with varying household income levels at different points along the same continuum of family cycle stages used in Analysis 1 (Attachments E, F, G, and H).

The analysis, similar to Analysis 1, indicates that low- to moderate-income families in the general population would have higher net health insurance-related costs under the Senate bill than they would under the ACA. These higher net costs are particularly true for families with lower incomes and older enrollees. In addition, as was the case under Analysis 1, families with incomes between 350% and 400% FPL would fare markedly worse under the Senate bill than they would under current law. Under the Senate bill, though, AI/ANs would incur a much greater increase in costs than the general population, as the general population is not eligible for—and would not lose—the comprehensive Indian-specific cost-sharing protections provided under the ACA.

**Impact of Termination of Medicaid Expansion**

As shown in the attachments, the lowest-income individuals would experience a dramatic increase in financial obligations under the Senate bill versus current law. Under the ACA Medicaid expansion, low-income AI/ANs have no health insurance premiums and no out-of-pocket costs. Under the Senate bill, in contrast, low-income AI/ANs would have to contribute 2% to 2.5% of their household income toward the premium for a health plan with substantial enrollee out-of-pocket costs. (The federal government would cover the remainder of the premium.)

Using the example shown in the attachments (see Attachments A and D), a family of two with income at 100% FPL would have to contribute $320 for the year toward the premium for a health plan that covers 58% of average health care costs, with the family liable for the remainder of the costs. The deductible for this health plan is $6,100 per individual and $12,200 per family. Plan enrollees must meet the deductible (with enrollees covering the cost) before the health plan begins making payments for services. And total enrollee out-of-pocket costs could reach as high as $14,300. Again, this compares with current law, under which the Medicaid expansion-eligible AI/AN population has no premiums, no deductibles, and no out-of-pocket costs.

For a middle- or higher-income family, these out-of-pocket costs would prove challenging. Lower-income families are likely to be overwhelmed by these costs, resulting in the shift of (uncompensated) costs to health care providers, forcing the family into bankruptcy, and/or serving as a major deterrent to accessing needed health care services.

**Conclusion**

Based on the above analyses, the Senate health bill would have a devastating effect on the ability of AI/ANs to access affordable health insurance coverage, with the most vulnerable populations hit especially hard. The Senate health bill would strip away comprehensive Indian-specific cost-sharing protections provided under the ACA, making AI/ANs (or Tribes on their behalf) liable for thousands of dollars in
additional out-of-pocket health care costs each year, as well as significantly reduce the current level of federal subsidies for health insurance premiums available to lower- and middle-income individuals. In addition, the Senate health bill would effectively terminate the ACA Medicaid expansion, resulting in the loss of comprehensive health insurance coverage for 237,497 AI/ANs who have already enrolled through the expansion and blocking hundreds of thousands more of the potential for future enrollment. Ultimately, the Senate health bill would impose a massive financial burden on middle-income and higher-income AI/AN families (or Tribes on their behalf) that opt to purchase health insurance in the individual market, while making health care costs unmanageable—and coverage largely unusable—for those with lower incomes.

1 This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.
2 The analyses are based on health insurance-related costs for AI/AN and non-AI/AN families in Big Horn County, Montana.
3 The ACA eliminates cost-sharing for Marketplace enrollees who meet the ACA definition of Indian (i.e., member of an Indian tribe or shareholder in an Alaska Native regional or village corporation). Under sections 1402(d)(1) and (2) of the ACA, Indians can enroll in either a zero or limited cost-sharing plan, depending on their income level, and receive comprehensive cost-sharing protections (e.g., no deductibles, coinsurance or copayments).
4 These protections require health insurance issuers to reduce cost-sharing in their standard silver plans, which have an actuarial value (AV) of 70%, to meet a higher AV: 94% for individuals up to 150% FPL, 87% for those from 151-200% FPL, and 73% for those from 201-250% FPL.
5 Actuarial value represents the percentage of average health care costs covered by a health plan; the enrollee covers remainder of the health care costs in the form of out-of-pocket costs.
6 Analysis 1 is based on enrollment in bronze-level coverage, which provides the lowest premiums and highest level of federal financial assistance for individuals who meet the ACA definition of Indian.
7 It is important to note that, for this analysis, the premiums under the Senate bill were not adjusted to account for an allowable 5:1 age rating (versus 3:1 under current law), a change that would raise the premiums for older enrollees and reduce the premiums for younger enrollees. In addition, a conservative estimate of the average value of the cost-sharing protections is shown; the average benefit likely is greater.
8 It is important to note that, under the Senate bill, net health-insurance related costs for adults in the 0-138% FPL income band in Medicaid expansion states would increase significantly. Although the Senate bill would retain the option under the ACA to expand Medicaid eligibility to 138% FPL, the enhanced (90% plus) federal funding is eliminated. In this analysis, the state is assumed to terminate the ACA Medicaid expansion when the enhanced funding terminates.
9 If higher than average costs are incurred, AI/ANs enrolled in a bronze plan under the Senate bill are liable for out-of-pocket costs of at least $12,200, and a total of $17,997 when combined with the net cost of the health insurance premiums.
10 Analysis 2 is based on enrollment in silver-level coverage, which provides general cost-sharing protections for individuals who do not meet the ACA definition of Indian and has less cost-sharing than bronze-level coverage.
11 The Senate bill would end the enhanced federal matching rate (of 90%) for the Medicaid expansion population. Given that few states expanded Medicaid eligibility up to 138% FPL prior to the availability of the enhanced federal matching rate, it is assumed that most states would terminate their Medicaid expansions if the heightened rate of 90% reverts to the standard rate (averaging 55%). Prior to the availability of the enhanced federal matching rate in 2014, only six states—California, Colorado, Connecticut, Minnesota, New Jersey, and Washington—and the District of Columbia expanded their Medicaid programs.
12 Under the Montana Medicaid expansion, for non-AI/AN populations, the state received a waiver allowing it to charge premiums at levels not more than 2% of household income to individuals with income greater than 50% FPL, with total cost-sharing (including premiums) for a household subject to a quarterly aggregate cap of 5% of household income.
**Attachment A: Analysis 1, Stage 1**

### Comparison of Health Insurance-Related Costs (Individual Market), by Family Cycle Stage and Income Level: Affordable Care Act (ACA) vs. Senate Plan

**Stage 1: 2-Person AI/AN Family in Big Horn County, MT; 2017**

Two 22-year-olds: all meet ACA definition of Indian; bronze plan enrollment

<table>
<thead>
<tr>
<th>HH Income (% FPL)</th>
<th>ACA Premiums</th>
<th>ACA Premium Tax Credits</th>
<th>ACA Average OOP Costs</th>
<th>ACA Net Costs</th>
<th>Senate Plan Premiums</th>
<th>Senate Plan Premium Tax Credits</th>
<th>Senate Plan Average OOP Costs</th>
<th>Senate Plan Deductible</th>
<th>ACA Net Costs Difference Under Senate Plan</th>
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<tr>
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<td>$0</td>
<td>$2,310</td>
<td>$12,200</td>
<td>$9,864 +$2,310 =+$12,200</td>
</tr>
</tbody>
</table>

1. The Senate plan is based on discussion draft released on June 22, 2017.
2. In Montana, Medicaid covers all adults up to 138% FPL, and CHIP covers children ages 0-18 up to 266% FPL.
3. Premiums are for Blue Cross Blue Shield Basic 103 in 2017, with all family members enrolling in the plan. The plan has an annual deductible of $6,100 per individual/$12,200 per family and an OOP maximum of $7,150 per individual/$14,300 per family. The premiums across the "family cycle stages" were not adjusted under the Senate plan to account for an allowable 5:1 age rating (versus 3:1 under current law).
4. The premium tax credits (PTCs) shown for the ACA are generated by HealthCare.gov and capped at the amount of the total plan premium.
5. As under the ACA, the Senate plan would base the value of PTCs on a reference plan. However, rather than using the second-lowest-cost silver plan, which has an actuarial value (AV) of 70%, the Senate bill would use the "applicable median cost benchmark plan," which has an AV of 58%, as the reference plan (the lowest AV allowed for a bronze plan under the ACA). All available bronze plans in Big Horn County, MT, in 2017 have an AV of 60%; the PTCs shown for the Senate plan are calculated using the premium for one of these plans.
6. The Senate plan would revise the ACA "applicable percentage" schedule, which determines the percentage of household income Marketplace enrollees must contribute when calculating PTCs, to provide more financial assistance for younger enrollees and less for older enrollees; the PTCs shown for the Senate plan reflect this change. The ACA does not adjust the applicable percentage by age.
7. The ACA eliminates cost-sharing for Marketplace enrollees who meet the ACA definition of Indian (i.e., member of an Indian tribe or shareholder in an Alaska Native regional or village corporation). Estimated average out-of-pocket costs shown are derived from average payments made in 2016 by HHS to Marketplace health plans in Montana to compensate for cost-sharing protections provided for policies with at least one AI/AN enrollee. A conservative estimate of the average value of the cost-sharing protections is shown; the average benefit likely is greater. Figures are adjusted across family cycle stages to reflect changes in the number of enrollees and age of household members.
8. Average OOP" figure is based on the family incurring average OOP costs; "Full Deductible" figure is based on the family having to pay the full deductible, after which coverage under the Marketplace plan begins.
9. In this income band, figures for the ACA are based on the implementation of the ACA Medicaid expansion, which allows states to extend eligibility to all adults up to 138% FPL (Montana implemented the expansion in January 2016); figures for the Senate plan assume the termination of the Medicaid expansion, as the proposal would phase out the enhanced federal matching rate for the expansion population, likely making the expansion unaffordable to continue.
### Comparison of Health Insurance-Related Costs (Individual Market), by Family Cycle Stage and Income Level: Affordable Care Act (ACA) vs. Senate Plan

**Stage 2: 4-Person AI/AN Family in Big Horn County, MT; 2017**

Two 32-year-olds and two 2-year-olds; all meet ACA definition of Indian; bronze plan enrollment

<table>
<thead>
<tr>
<th>HH Income (% FPL)</th>
<th>ACA</th>
<th>Senate Plan</th>
<th>Net Costs Difference Under Senate Plan</th>
</tr>
</thead>
<tbody>
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<td></td>
<td>(a)</td>
<td>(b)</td>
<td>(c)</td>
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<tr>
<td></td>
<td>Premiums²</td>
<td>Premium Tax Credits³</td>
<td>Average OOP Costs⁷</td>
</tr>
<tr>
<td>100% ($24,300)</td>
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<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>133% ($32,319)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>150% ($36,450)</td>
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<td>150% ($36,450)</td>
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<td>200% ($48,600)</td>
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<td>250% ($56,700)</td>
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<td>500% ($121,500)</td>
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<td>$0</td>
<td>$0</td>
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</tbody>
</table>

1 The Senate plan is based on discussion draft released on June 22, 2017.
2 In Montana, Medicaid covers all adults up to 138% FPL, and CHIP covers children ages 0-18 up to 266% FPL.
3 Premiums for Blue Cross Blue Shield Basic 103 in 2017, with all family members enrolling in the plan. The plan has an annual deductible of $6,100 per individual/$12,200 per family and an OOP maximum of $7,150 per individual/$14,300 per family. The premiums across the "family cycle stages" were not adjusted under the Senate plan to account for an allowable 5:1 age rating (versus 3:1 under current law).
4 The premium tax credits (PTCs) shown for the ACA are generated by HealthCare.gov and capped at the amount of the total plan premium.
5 As under the ACA, the Senate plan would base the value of PTCs on a reference plan. However, rather than using the second-lowest-cost silver plan, which has an actuarial value (AV) of 70%, the Senate bill would use the "applicable median cost benchmark plan," which has an AV of 58%, as the reference plan (the lowest AV allowed for a bronze plan under the ACA). All available bronze plans in Big Horn County, MT, in 2017 have an AV of 60%; the PTCs shown for the Senate plan are calculated using the premium for one of these plans.
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7 The ACA eliminates cost-sharing for Marketplace enrollees who meet the ACA definition of Indian (i.e., member of an Indian tribe or shareholder in an Alaska Native regional or village corporation). Estimated average out-of-pocket costs shown are derived from average payments made in 2016 by HHS to Marketplace health plans in Montana to compensate for cost-sharing protections provided for policies with at least one AI/AN enrollee. A conservative estimate of the average value of the cost-sharing protections is shown; the average benefit likely is greater. Figures are adjusted across family cycle stages to reflect changes in the number of enrollees and age of household members.
8 "Average OOP" figure is based on the family incurring average OOP costs; "Full Deductible" figure is based on the family having to pay the full deductible, after which coverage under the Marketplace plan begins.
9 In this income band, figures for the ACA are based on the implementation of the ACA Medicaid expansion, which allows states to extend eligibility to all adults up to 138% FPL (Montana implemented the expansion in January 2016); figures for the Senate plan assume the termination of the Medicaid expansion, as the proposal would phase out the enhanced federal matching rate for the expansion population, likely making the expansion unaffordable to continue.
Comparison of Health Insurance-Related Costs (Individual Market), by Family Cycle Stage and Income Level: Affordable Care Act (ACA) vs. Senate Plan

Stage 3: 4-Person AI/AN Family in Big Horn County, MT; 2017

Two 50-year-olds and two 20-year-olds; all meet ACA definition of Indian; bronze plan enrollment

<table>
<thead>
<tr>
<th>HH Income (% FPL)</th>
<th>ACA Premiums</th>
<th>ACA Premium Tax Credits</th>
<th>ACA Average OOP Costs</th>
<th>ACA Net Costs</th>
<th>Senate Plan Premiums</th>
<th>Senate Plan Premium Tax Credits</th>
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<tr>
<td>150% ($36,450)</td>
<td>$18,287</td>
<td>$18,287</td>
<td>$0</td>
<td>$0</td>
<td>$18,287</td>
<td>$16,829</td>
<td>$6,930</td>
<td>$12,200</td>
<td>$8,388 + $13,658</td>
</tr>
<tr>
<td>200% ($48,600)</td>
<td>$18,287</td>
<td>$18,287</td>
<td>$0</td>
<td>$0</td>
<td>$18,287</td>
<td>$14,739</td>
<td>$6,930</td>
<td>$12,200</td>
<td>$10,478 + $15,748</td>
</tr>
<tr>
<td>250% ($50,750)</td>
<td>$18,287</td>
<td>$18,045</td>
<td>$0</td>
<td>$2,319</td>
<td>$18,287</td>
<td>$12,820</td>
<td>$6,930</td>
<td>$12,200</td>
<td>$12,398 + $17,668</td>
</tr>
<tr>
<td>300% ($52,900)</td>
<td>$18,287</td>
<td>$15,969</td>
<td>$0</td>
<td>$3,219</td>
<td>$18,287</td>
<td>$10,633</td>
<td>$6,930</td>
<td>$12,200</td>
<td>$14,585 + $19,855</td>
</tr>
<tr>
<td>350% ($58,050)</td>
<td>$18,287</td>
<td>$14,791</td>
<td>$0</td>
<td>$3,496</td>
<td>$18,287</td>
<td>$4,849</td>
<td>$6,930</td>
<td>$12,200</td>
<td>$20,368 + $25,638</td>
</tr>
<tr>
<td>351% ($58,051)</td>
<td>$18,287</td>
<td>$14,791</td>
<td>$0</td>
<td>$3,496</td>
<td>$18,287</td>
<td>$0</td>
<td>$6,930</td>
<td>$12,200</td>
<td>$25,217 + $30,487</td>
</tr>
<tr>
<td>500% ($121,500)</td>
<td>$18,287</td>
<td>$0</td>
<td>$0</td>
<td>$18,287</td>
<td>$18,287</td>
<td>$6,930</td>
<td>$12,200</td>
<td>$25,217 + $30,487</td>
<td></td>
</tr>
</tbody>
</table>

1 The Senate plan is based on discussion draft released on June 22, 2017.
2 In Montana, Medicaid covers all adults up to 138% FPL, and CHIP covers children ages 0-18 up to 266% FPL.
3 Premium is for Blue Cross Blue Shield Basic 103 in 2017, with all family members enrolling in the plan. The plan has an annual deductible of $6,100 per individual/$12,200 per family and an OOP maximum of $7,150 per individual/$14,300 per family. The premiums across the "family cycle stages" were not adjusted under the Senate plan to account for an allowable 5:1 age rating (versus 3:1 under current law).
4 The premium tax credits (PTCs) shown for the ACA are generated by HealthCare.gov and capped at the amount of the total plan premium.
5 As under the ACA, the Senate plan would base the value of PTCs on a reference plan. However, rather than using the second-lowest-cost silver plan, which has an actuarial value (AV) of 70%, the Senate bill would use the "applicable median cost benchmark plan," which has an AV of 58%, as the reference plan (the lowest AV allowed for a bronze plan under the ACA). All available bronze plans in Big Horn County, MT, in 2017 have an AV of 60%; the PTCs shown for the Senate plan are calculated using the premium for one of these plans.
6 The Senate plan would revise the ACA “applicable percentage” schedule, which determines the percentage of household income Marketplace enrollees must contribute when calculating PTCs, to provide more financial assistance for younger enrollees and less for older enrollees; the PTCs shown for the Senate plan reflect this change. The ACA does not adjust the applicable percentage by age.
7 The ACA eliminates cost-sharing for Marketplace enrollees who meet the ACA definition of Indian (i.e., member of an Indian tribe or shareholder in an Alaska Native regional or village corporation). Estimated average out-of-pocket costs shown are derived from average payments made in 2016 by HHS to Marketplace health plans in Montana to compensate for cost-sharing protections provided for policies with at least one AI/AN enrollee. A conservative estimate of the average value of the cost-sharing protections is shown; the average benefit likely is greater. Figures are adjusted across family cycle stages to reflect changes in the number of enrollees and age of household members.
8 "Average OOP"figure is based on the family incurring average OOP costs; "Full Deductible"figure is based on the family having to pay the full deductible, after which coverage under the Marketplace plan begins.
9 In this income band, figures for the ACA are based on the implementation of the ACA Medicaid expansion, which allows states to extend eligibility to all adults up to 138% FPL (Montana implemented the expansion in January 2016); figures for the Senate plan assume the termination of the Medicaid expansion, as the proposal would phase out the enhanced federal matching rate for the expansion population, likely making the expansion unaffordable to continue.
### Attachment D: Analysis 1, Stage 4

#### Comparison of Health Insurance-Related Costs (Individual Market), by Family Cycle Stage and Income Level: Affordable Care Act (ACA) vs. Senate Plan

<table>
<thead>
<tr>
<th>HH Income (% FPL)</th>
<th>ACA</th>
<th>Senate Plan</th>
<th>Net Costs Difference Under Senate Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(a)</td>
<td>(b)</td>
<td>(c)</td>
</tr>
<tr>
<td>100% ($16,020)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>133% ($21,307)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>150% ($24,030)</td>
<td>$20,500</td>
<td>$20,500</td>
<td>$0</td>
</tr>
<tr>
<td>200% ($32,040)</td>
<td>$20,500</td>
<td>$20,500</td>
<td>$0</td>
</tr>
<tr>
<td>250% ($40,050)</td>
<td>$20,500</td>
<td>$20,500</td>
<td>$0</td>
</tr>
<tr>
<td>300% ($48,060)</td>
<td>$20,500</td>
<td>$20,500</td>
<td>$0</td>
</tr>
<tr>
<td>350% ($56,070)</td>
<td>$20,500</td>
<td>$20,387</td>
<td>$0</td>
</tr>
<tr>
<td>351% ($56,071)</td>
<td>$20,500</td>
<td>$20,387</td>
<td>$0</td>
</tr>
<tr>
<td>500% ($80,100)</td>
<td>$20,500</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

1. The Senate plan is based on discussion draft released on June 22, 2017.
2. In Montana, Medicaid covers all adults up to 138% FPL, and CHIP covers children ages 0-18 up to 266% FPL.
3. Premiums for Blue Cross Blue Shield Basic 103 in 2017, with all family members enrolling in the plan. The plan has an annual deductible of $6,100 per individual/$12,200 per family and an OOP maximum of $7,150 per individual/$14,300 per family. The premiums across the "family cycle stages" were not adjusted under the Senate plan to account for an allowable 5:1 age rating (versus 3:1 under current law).
4. The premium tax credits (PTCs) shown for the ACA are generated by HealthCare.gov and capped at the amount of the total plan premium.
5. As under the ACA, the Senate plan would base the value of PTCs on a reference plan. However, rather than using the second-lowest-cost silver plan, which has an actuarial value (AV) of 70%, the Senate bill would use the "applicable median cost benchmark plan," which has an AV of 58%, as the reference plan (the lowest AV allowed for a bronze plan under the ACA). All available bronze plans in Big Horn County, MT, in 2017 have an AV of 60%; the PTCs shown for the Senate plan are calculated using the premium for one of these plans.
6. The Senate plan would revise the ACA “applicable percentage” schedule, which determines the percentage of household income Marketplace enrollees must contribute when calculating PTCs, to provide more financial assistance for younger enrollees and less for older enrollees; the PTCs shown for the Senate plan reflect this change. The ACA does not adjust the applicable percentage by age.
7. The ACA eliminates cost-sharing for Marketplace enrollees who meet the ACA definition of Indian (i.e., member of an Indian tribe or shareholder in an Alaska Native regional or village corporation). Estimated average out-of-pocket costs shown are derived from average payments made in 2016 by HHS to Marketplace health plans in Montana to compensate for cost-sharing protections provided for policies with at least one AI/AN enrollee. A conservative estimate of the average value of the cost-sharing protections is shown; the average benefit likely is greater. Figures are adjusted across family cycle stages to reflect changes in the number of enrollees and age of household members.
8. Average OOP"figure is based on the family incurring average OOP costs; "Full Deductible" figure is based on the family having to pay the full deductible, after which coverage under the Marketplace plan begins.
9. In this income band, figures for the ACA are based on the implementation of the ACA Medicaid expansion, which allows states to extend eligibility to all adults up to 138% FPL (Montana implemented the expansion in January 2016); figures for the Senate plan assume the termination of the Medicaid expansion, as the proposal would phase out the enhanced federal matching rate for the expansion population, likely making the expansion unaffordable to continue.
### Attachment E: Analysis 2, Stage 1

#### Comparison of Health Insurance-Related Costs (Individual Market), by Family Cycle Stage and Income Level:

**Adequate Care Act (ACA) vs. Senate Plan**

**Stage 1: 2-Person Family in Big Horn County, MT; 2017**

<table>
<thead>
<tr>
<th>HH Income (% FPL)</th>
<th>ACA</th>
<th>Senate Plan</th>
<th>Difference Under Senate Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 ($16,020)</td>
<td>(a)</td>
<td>(e)</td>
<td>+$4,096</td>
</tr>
<tr>
<td>$0 ($21,307)</td>
<td>(b)</td>
<td>(f)</td>
<td>+$4,308</td>
</tr>
<tr>
<td>$8,596 ($32,040)</td>
<td>(c)</td>
<td>(g)</td>
<td>+$2,513</td>
</tr>
<tr>
<td>$1,063 ($40,050)</td>
<td>(d)</td>
<td>(h)</td>
<td>+$5567</td>
</tr>
<tr>
<td>$1,625 ($48,060)</td>
<td></td>
<td></td>
<td>-$630</td>
</tr>
<tr>
<td>$3,080 ($56,070)</td>
<td></td>
<td></td>
<td>+$115</td>
</tr>
<tr>
<td>$4,280 ($56,071)</td>
<td></td>
<td></td>
<td>+$4,080</td>
</tr>
<tr>
<td>$11,329 ($80,100)</td>
<td></td>
<td></td>
<td>+$0</td>
</tr>
</tbody>
</table>

1. The Senate plan is based on discussion draft released on June 22, 2017.
2. In Montana, Medicaid covers all adults up to 138% FPL, and CHIP covers children ages 0-18 up to 266% FPL.
3. Premium is for Blue Cross Blue Shield Solution 102 in 2017, with all family members enrolling in the plan. The plan has an annual deductible of $3,350 per individual/$6,700 per family and an OOP maximum of $5,600 per individual/$11,200 per family. The premiums across the “family cycle stages” were not adjusted under the Senate plan to account for an allowable 5:1 age rating (versus 3:1 under current law).
4. The premium tax credits (PTCs) shown for the ACA are generated by HealthCare.gov and capped at the amount of the total plan premium.
5. As under the ACA, the Senate plan would base the value of PTCs on a reference plan. However, rather than using the second-lowest-cost silver plan, which has an actuarial value (AV) of 70%, the Senate bill would use the “applicable median cost benchmark plan,” which has an AV of 58%, as the reference plan (the lowest AV allowed for a bronze plan under the ACA). All available bronze plans in Big Horn County, MT, in 2017 have an AV of 60%; the PTCs shown for the Senate plan are calculated using the premium for one of these plans.
6. The premium tax credits (PTCs) shown for the ACA are generated by HealthCare.gov and capped at the amount of the total plan premium.
7. As under the ACA, the Senate plan would base the value of PTCs on a reference plan. However, rather than using the second-lowest-cost silver plan, which has an actuarial value (AV) of 70%, the Senate bill would use the “applicable median cost benchmark plan,” which has an AV of 58%, as the reference plan (the lowest AV allowed for a bronze plan under the ACA). All available bronze plans in Big Horn County, MT, in 2017 have an AV of 60%; the PTCs shown for the Senate plan are calculated using the premium for one of these plans.
8. Estimated average out-of-pocket costs shown are derived from average payments made in 2016 by HHS to Marketplace health plans in Montana to compensate for cost-sharing protections provided for policies with at least one AI/AN enrollee. For silver-level coverage, the ACA provides general (partial) cost-sharing protections up to 250% FPL. These protections require health insurance issuers to reduce cost-sharing in their standard silver plans, which have an actuarial value (AV) of 70%, to meet a higher AV: 94% for individuals and families up to 150% FPL, 87% for those from 151-200% FPL, and 73% for those from 201-250% FPL. A conservative estimate of the average value of the cost-sharing protections is shown; the average benefit likely is greater. Figures are adjusted across family cycle stages to reflect changes in the number of enrollees and age of household members.
9. In this income band, figures for the ACA are based on the implementation of the ACA Medicaid expansion, which allows states to extend eligibility to all adults up to 138% FPL (Montana implemented the expansion in January 2016); figures for the Senate plan assume the termination of the Medicaid expansion, as the proposal would phase out the enhanced federal matching rate for the expansion population, likely making the expansion unaffordable to continue.
## Attachment F: Analysis 2, Stage 2

### Comparison of Health Insurance-Related Costs (Individual Market), by Family Cycle Stage and Income Level:

<table>
<thead>
<tr>
<th>HH Income (% FPL)</th>
<th>ACA</th>
<th>Senate Plan</th>
<th>Net Costs Difference Under Senate Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(a)</td>
<td>(b)</td>
<td>(c)</td>
</tr>
<tr>
<td>100% ($24,300)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>133% ($32,319)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>150% ($36,450)</td>
<td>11,352</td>
<td>9,767</td>
<td>693</td>
</tr>
<tr>
<td>200% ($48,600)</td>
<td>11,352</td>
<td>8,130</td>
<td>1,502</td>
</tr>
<tr>
<td>250% ($60,750)</td>
<td>11,352</td>
<td>6,267</td>
<td>3,119</td>
</tr>
<tr>
<td>300% ($72,900)</td>
<td>17,446</td>
<td>10,232</td>
<td>3,465</td>
</tr>
<tr>
<td>350% ($85,050)</td>
<td>17,446</td>
<td>9,054</td>
<td>3,465</td>
</tr>
<tr>
<td>351% ($85,051)</td>
<td>17,446</td>
<td>9,054</td>
<td>3,465</td>
</tr>
<tr>
<td>500% ($121,500)</td>
<td>17,446</td>
<td>0</td>
<td>3,465</td>
</tr>
</tbody>
</table>

1. The Senate plan is based on discussion draft released on June 22, 2017.
2. In Montana, Medicaid covers all adults up to 138% FPL, and CHIP covers children ages 0-18 up to 266% FPL.
3. Premium is for Blue Cross Blue Shield Solution 102 in 2017, with all family members enrolling in the plan. The plan has an annual deductible of $3,350 per individual/$6,700 per family and an OOP maximum of $5,600 per individual/$11,200 per family. The premiums across the “family cycle stages” were not adjusted under the Senate plan to account for an allowable 5:1 age rating (versus 3:1 under current law).
4. The premium tax credits (PTCs) shown for the ACA are generated by HealthCare.gov and capped at the amount of the total plan premium.
5. As under the ACA, the Senate plan would base the value of PTCs on a reference plan. However, rather than using the second-lowest-cost silver plan, which has an actuarial value (AV) of 70%, the Senate bill would use the “applicable median cost benchmark plan,” which has an AV of 58%, as the reference plan (the lowest AV allowed for a bronze plan under the ACA). All available bronze plans in Big Horn County, MT, in 2017 have an AV of 60%; the PTCs shown for the Senate plan are calculated using the premium for one of these plans.
6. The Senate plan would revise the ACA “applicable percentage” schedule, which determines the percentage of household income Marketplace enrollees must contribute when calculating PTCs, to provide more financial assistance for younger enrollees and less for older enrollees; the PTCs shown for the Senate plan reflect this change. The ACA does not adjust the applicable percentage by age.
7. Estimated average out-of-pocket costs shown are derived from average payments made in 2016 by HHS to Marketplace health plans in Montana to compensate for cost-sharing protections provided for policies with at least one A/A/N enrollee. For silver-level coverage, the ACA provides general (partial) cost-sharing protections up to 250% FPL. These protections require health insurance issuers to reduce cost-sharing in their standard silver plans, which have an actuarial value (AV) of 70%, to meet a higher AV: 94% for individuals and families up to 150% FPL, 87% for those from 151-200% FPL, and 73% for those from 201-250% FPL. A conservative estimate of the average value of the cost-sharing protections is shown; the average benefit likely is greater. Figures are adjusted across family cycle stages to reflect changes in the number of enrollees and age of household members.
8. In this income band, figures for the ACA are based on the implementation of the ACA Medicaid expansion, which allows states to extend eligibility to all adults up to 138% FPL (Montana implemented the expansion in January 2016); figures for the Senate plan assume the termination of the Medicaid expansion, as the proposal would phase out the enhanced federal matching rate for the expansion population, likely making the expansion unaffordable to continue.
## Attachment G: Analysis 2, Stage 3

### Comparison of Health Insurance-Related Costs (Individual Market), by Family Cycle Stage and Income Level:

**Affordable Care Act (ACA) vs. Senate Plan**

**Stage 3: 4-Person Family in Big Horn County, MT; 2017**

Two 50-year-olds and two 20-year-olds; none meets ACA definition of Indian; silver plan enrollment

<table>
<thead>
<tr>
<th>HH Income (% FPL)</th>
<th>ACA</th>
<th>Senate Plan</th>
<th>Net Costs Difference Under Senate Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(a)</td>
<td>(b)</td>
<td>(c)</td>
</tr>
<tr>
<td>100% ($24,300)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>133% ($32,319)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>150% ($36,450)</td>
<td>$23,232</td>
<td>$1,040</td>
<td>$2,726</td>
</tr>
<tr>
<td>200% ($48,600)</td>
<td>$23,232</td>
<td>$2,572</td>
<td>$5,577</td>
</tr>
<tr>
<td>250% ($60,750)</td>
<td>$23,232</td>
<td>$4,678</td>
<td>$9,065</td>
</tr>
<tr>
<td>300% ($72,900)</td>
<td>$23,232</td>
<td>$5,198</td>
<td>$12,461</td>
</tr>
<tr>
<td>350% ($85,050)</td>
<td>$23,232</td>
<td>$5,198</td>
<td>$13,639</td>
</tr>
<tr>
<td>351% ($85,051)</td>
<td>$23,232</td>
<td>$5,198</td>
<td>$13,639</td>
</tr>
<tr>
<td>500% ($121,500)</td>
<td>$23,232</td>
<td>$5,198</td>
<td>$28,430</td>
</tr>
</tbody>
</table>

### Notes:

1. The Senate plan is based on discussion draft released on June 22, 2017.
2. In Montana, Medicaid covers all adults up to 138% FPL, and CHIP covers children ages 0-18 up to 266% FPL.
3. Premium is for Blue Cross Blue Shield Solution 102 in 2017, with all family members enrolling in the plan. The plan has an annual deductible of $3,350 per individual/$6,700 per family and an OOP maximum of $5,600 per individual/$11,200 per family. The premiums across the “family cycle stages” were not adjusted under the Senate plan to account for an allowable 5:1 age rating (versus 3:1 under current law).
4. The premium tax credits (PTCs) shown for the ACA are generated by HealthCare.gov and capped at the amount of the total plan premium.
5. As under the ACA, the Senate plan would base the value of PTCs on a reference plan. However, rather than using the second-lowest-cost silver plan, which has an actuarial value (AV) of 70%, the Senate bill would use the “applicable median cost benchmark plan,” which has an AV of 58%, as the reference plan (the lowest AV allowed for a bronze plan under the ACA). All available bronze plans in Big Horn County, MT, in 2017 have an AV of 60%; the PTCs shown for the Senate plan are calculated using the premium for one of these plans.
6. The Senate plan would revise the ACA “applicable percentage” schedule, which determines the percentage of household income Marketplace enrollees must contribute when calculating PTCs, to provide more financial assistance for younger enrollees and less for older enrollees; the PTCs shown for the Senate plan reflect this change. The ACA does not adjust the applicable percentage by age.
7. Estimated average out-of-pocket costs shown are derived from average payments made in 2016 by HHS to Marketplace health plans in Montana to compensate for cost-sharing protections provided for policies with at least one A/A enrollee. For silver-level coverage, the ACA provides general (partial) cost-sharing protections up to 250% FPL. These protections require health insurance issuers to reduce cost-sharing in their standard silver plans, which have an actuarial value (AV) of 70%, to meet a higher AV: 94% for individuals and families up to 150% FPL, 87% for those from 151-200% FPL, and 73% for those from 201-250% FPL. A conservative estimate of the average value of the cost-sharing protections is shown; the average benefit likely is greater. Figures are adjusted across family cycle stages to reflect changes in the number of enrollees and age of household members.
8. In this income band, figures for the ACA are based on the implementation of the ACA Medicaid expansion, which allows states to extend eligibility to all adults up to 138% FPL (Montana implemented the expansion in January 2016); figures for the Senate plan assume the termination of the Medicaid expansion, as the proposal would phase out the enhanced federal matching rate for the expansion population, likely making the expansion unaffordable to continue.
Comparison of Health Insurance-Related Costs (Individual Market), by Family Cycle Stage and Income Level:

Affordable Care Act (ACA) vs. Senate Plan

Stage 4: 2-Person Family in Big Horn County, MT; 2017

Two 60-year-olds; none meets ACA definition of Indian; silver plan enrollment

<table>
<thead>
<tr>
<th>HH Income (% FPL)</th>
<th>ACA Premiums</th>
<th>ACA Premium Tax Credits</th>
<th>ACA Average OOP Costs</th>
<th>ACA Net Costs</th>
<th>Senate Plan Premiums</th>
<th>Senate Premium Tax Credits</th>
<th>Senate Average OOP Costs</th>
<th>Senate Net Costs</th>
<th>Difference Under Senate Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% ($16,020)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$26,044</td>
<td>$20,180</td>
<td>$5,198</td>
<td>$11,061</td>
<td>+$11,061</td>
</tr>
<tr>
<td>133% ($21,307)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$26,044</td>
<td>$19,968</td>
<td>$5,198</td>
<td>$11,274</td>
<td>+$11,274</td>
</tr>
<tr>
<td>150% ($24,030)</td>
<td>$26,044</td>
<td>$24,840</td>
<td>$1,040</td>
<td>$2,244</td>
<td>$26,044</td>
<td>$19,539</td>
<td>$5,198</td>
<td>$11,702</td>
<td>+$9,459</td>
</tr>
<tr>
<td>200% ($32,040)</td>
<td>$26,044</td>
<td>$23,760</td>
<td>$2,252</td>
<td>$4,536</td>
<td>$26,044</td>
<td>$17,841</td>
<td>$5,198</td>
<td>$13,400</td>
<td>+$8,864</td>
</tr>
<tr>
<td>250% ($40,050)</td>
<td>$26,044</td>
<td>$22,532</td>
<td>$4,678</td>
<td>$8,190</td>
<td>$26,044</td>
<td>$16,495</td>
<td>$5,198</td>
<td>$14,746</td>
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<tr>
<td>300% ($48,060)</td>
<td>$26,044</td>
<td>$21,163</td>
<td>$5,198</td>
<td>$10,078</td>
<td>$26,044</td>
<td>$14,973</td>
<td>$5,198</td>
<td>$16,268</td>
<td>+$6,190</td>
</tr>
<tr>
<td>350% ($56,070)</td>
<td>$26,044</td>
<td>$20,387</td>
<td>$5,198</td>
<td>$10,854</td>
<td>$26,044</td>
<td>$11,417</td>
<td>$5,198</td>
<td>$19,824</td>
<td>+$8,970</td>
</tr>
<tr>
<td>351% ($56,071)</td>
<td>$26,044</td>
<td>$20,387</td>
<td>$5,198</td>
<td>$10,854</td>
<td>$26,044</td>
<td>$0</td>
<td>$5,198</td>
<td>$20,387</td>
<td>+$20,387</td>
</tr>
<tr>
<td>500% ($80,100)</td>
<td>$26,044</td>
<td>$0</td>
<td>$5,198</td>
<td>$31,241</td>
<td>$26,044</td>
<td>$0</td>
<td>$5,198</td>
<td>$31,241</td>
<td>+$0</td>
</tr>
</tbody>
</table>

1 The Senate plan is based on discussion draft released on June 22, 2017.
2 In Montana, Medicaid covers all adults up to 138% FPL, and CHIP covers children ages 0-18 up to 266% FPL.
3 Premium is for Blue Cross Blue Shield Solution 102 in 2017, with all family members enrolling in the plan. The plan has an annual deductible of $3,350 per individual/$6,700 per family and an OOP maximum of $5,600 per individual/$11,200 per family. The premiums across the “family cycle stages” were not adjusted under the Senate plan to account for an allowable 5:1 age rating (versus 3:1 under current law).
4 The premium tax credits (PTCs) shown for the ACA are generated by HealthCare.gov and capped at the amount of the total plan premium.
5 As under the ACA, the Senate plan would base the value of PTCs on a reference plan. However, rather than using the second-lowest-cost silver plan, which has an actuarial value (AV) of 70%, the Senate bill would use the “applicable median cost benchmark plan,” which has an AV of 58%, as the reference plan (the lowest AV allowed for a bronze plan under the ACA). All available bronze plans in Big Horn County, MT, in 2017 have an AV of 60%; the PTCs shown for the Senate plan are calculated using the premium for one of these plans.
6 The Senate plan would revise the ACA “applicable percentage” schedule, which determines the percentage of household income Marketplace enrollees must contribute when calculating PTCs, to provide more financial assistance for younger enrollees and less for older enrollees; the PTCs shown for the Senate plan reflect this change. The ACA does not adjust the applicable percentage by age.
7 Estimated average out-of-pocket costs shown are derived from average payments made in 2016 by HHS to Marketplace health plans in Montana to compensate for cost-sharing protections provided for policies with at least one A/A/N enrollee. For silver-level coverage, the ACA provides general (partial) cost-sharing protections up to 250% FPL. These protections require health insurance issuers to reduce cost-sharing in their standard silver plans, which have an actuarial value (AV) of 70%, to meet a higher AV: 94% for individuals and families up to 150% FPL, 87% for those from 151-200% FPL, and 73% for those from 201-250% FPL. A conservative estimate of the average value of the cost-sharing protections is shown; the average benefit likely is greater. Figures are adjusted across family cycle stages to reflect changes in the number of enrollees and age of household members.
8 In this income band, figures for the ACA are based on the implementation of the ACA Medicaid expansion, which allows states to extend eligibility to all adults up to 138% FPL (Montana implemented the expansion in January 2016). Figures for the Senate plan assume the termination of the Medicaid expansion, as the proposal would phase out the enhanced federal matching rate for the expansion population, likely making the expansion unaffordable to continue.
This brief examines the cumulative financial impact that health insurance legislation recently introduced in the Senate (Senate bill) would have over a “family cycle” on American Indians and Alaska Natives (AI/ANs) who meet the definition of Indian under the Affordable Care Act (ACA), as compared with current law, including the ACA.¹

The analysis indicates that, for one moderate-income AI/AN family with average health care costs (or for the family’s Tribe if the Tribe finances health care for Tribal members), there would be a cumulative negative financial impact of $323,654 over the family cycle if the Senate bill were enacted, versus current law. And the cumulative negative financial impact could total as much as $633,424 over the family cycle if the family were assumed to have chronic health care expenditures up to the full amount of the deductible annually. Ultimately, the Senate bill would result in (a) an increase in required contributions for health insurance premiums and OOP costs for health plan enrollees, (b) a loss of revenues (and increased uncompensated care) for Indian health care providers, and (c) additional demands on the Indian health system Purchased/Referred Care program.²

Background

The ACA includes a number of provisions designed to make comprehensive health insurance more accessible to low- to middle-income individuals, with a number of protections specific to AI/ANs. Under the ACA, for instance, AI/ANs who meet the definition of Indian qualify for comprehensive cost-sharing protections (regardless of household income), meaning they pay no deductibles, co-insurance, or copayments when receiving essential health benefits (EHBs).³ These Indian-specific protections were designed for and provided in the ACA in recognition of the federal trust responsibility to AI/ANs and Indian Tribes.

The Senate bill, released on June 22, 2017, would repeal the Indian-specific cost-sharing protections, as well as the general cost-sharing protections, provided under the ACA. In addition, the Senate bill would substantially reduce the value of premium tax credits (PTCs) designed to help low- to middle-income AI/ANs and other individuals purchase health insurance on the individual market. The Senate bill also would phase out the Medicaid expansion program that provides comprehensive health insurance coverage to individuals and families with household income under 138% of the federal poverty level (FPL), with the federal government funding more than 90% of the total costs.
The data presented in the attached tables represent the cumulative financial impact of the Senate bill over a family cycle for an AI/AN family with an annual income of $48,600. A “family cycle” consists of various stages at different points along a continuum as a family matures over time. The family cycle example presented is for a two-adult, two-child AI/AN household, beginning with 22-year-old newlywed adults and tracking them as they become parents, raise their children, and finally retire at age 65. These data are drawn in part from a companion analysis that details the financial impact of the Senate bill on AI/AN families with varying household income levels at different points along a continuum of family cycle stages.

**Findings**

Two tables are attached that present estimated net health insurance-related costs under the Senate bill versus current law for the example family. The tables indicate the net health plan premium paid (after consideration of available PTCs). However, each table incorporates a different assumption pertaining to the OOP health care costs of plan enrollees, as follows:

- Table A assumes plan enrollees will have “average” OOP costs;
- Table B assumes plan enrollees will pay the “full deductible” amount annually.

The financial impact of enactment of the Senate bill is estimated to be as follows:

- Assuming “average” OOP costs, a single AI/AN family (and/or a Tribe on their behalf) would pay out (and/or lose in revenues) an additional **$323,654** over the family cycle if the Senate bill were enacted, versus current law.
- Assuming payment of the “full deductible” amount annually, a single AI/AN family (and/or a Tribe on their behalf) would pay out (and/or lose in revenues) an additional **$633,424** over the family cycle if the Senate bill were enacted, versus current law.

The magnitude of this financial impact on an AI/AN family demonstrates the tremendous strain the Senate bill, if enacted, would place on the ability of AI/AN families to meet basic necessities, as well as prevent them from accumulating savings for a home purchase, college tuition, or retirement needs. Likewise, to the extent that Tribes redirect Tribal funds to meet the newly-unfunded health care costs, the Senate bill could seriously hamper the ability of Tribes to meet these health care needs as well as other critical Tribal priorities.

Two additional points are important to consider in reviewing these findings.

- The cumulative cost differential under the Senate bill could be even higher than shown here for two reasons:
  - First, the cumulative cost differential could be even higher if a family has chronic health care needs and, as a result, reaches the annual OOP costs maximum ($7,150 per individual and $14,250 per family) each year.
Second, the cumulative cost differential could be even higher if a family has a higher or lower income level. In fact, for families at most other income levels shown in the companion analysis, the cumulative cost differential would be higher than shown here.

- A moderate-income family (or a Tribe on their behalf) could incur most of or the entire cumulative cost differential under the Senate bill over the family cycle ($323,654 or $633,424, depending on the assumption of OOP costs) before the health plan pays any medical claims under the coverage.

- This could occur because the value of the PTCs under the Senate bill is tied to a health plan that will have a large deductible (at least $6,100 per individual and $12,200 per family), with enrollee OOP costs needing to reach this level before the plan begins covering health care services.\(^7\)

- In addition, the Senate bill would eliminate the comprehensive Indian-specific cost-sharing protections that protect AI/ANs from paying the deductible, a provision included in the ACA to satisfy more fully the federal trust responsibility to AI/ANs. (The Senate bill also would eliminate the cost-sharing protections for the general population.)

**Conclusion**

If enacted, the Senate bill would impose a tremendous financial burden on AI/AN families (or Tribes on their behalf). Rather than more fully fulfilling the federal trust responsibility, the Senate bill would impose on AI/AN families significantly higher net health insurance-related costs than they have under current law at every family cycle stage, with the difference in net costs continuing to grow larger with each successive stage. For an AI/AN family with earnings of $48,600 per year and average OOP health care costs, the increased financial burden imposed by the Senate bill would total $323,654 over the period analyzed. This higher burden results from Senate bill provisions that would terminate the comprehensive Indian-specific cost-sharing protections, significantly lower federal subsidies for health insurance premiums, and phase out the ACA Medicaid expansion.

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1. This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.
2. The Purchased/Referred Care program finances health care services at non-Indian health care providers when services at not readily available within the Indian health care system.
3. The ACA eliminates cost-sharing for Marketplace enrollees who meet the ACA definition of Indian (i.e., member of an Indian tribe or shareholder in an Alaska Native regional or village corporation). Under sections 1402(d)(1) and (2) of the ACA, Indians can enroll in either a zero or limited cost-sharing plan, depending on their income level, and receive comprehensive cost-sharing protections (e.g., no deductibles, coinsurance or copayments).
4. The analyses are based on health insurance-related costs for AI/AN families in Big Horn County, Montana.
5. See “Family Cycle Analysis: Financial Impact of the Senate Health Plan vs. the Affordable Care Act on AI/AN and Other Families,” June 29, 2017.
6. In practice, the out-of-pocket (OOP) costs would result in a combination of (a) increased enrollee OOP costs; (b) foregone revenue by Indian health care providers, and (c) increased PRC payments.
7. Under current law, some preventive services are fully covered by the health plan before the deductible is reached. This provision might remain in effect if the Senate bill were enacted.
Side-by-Side Comparison of Health Plans:
House Health Bill and Senate Health Bill in Comparison
to Current Law / Affordable Care Act¹

June 28, 2017

This brief examines key elements of the health plan under consideration by the U.S. Senate
(Senate Plan; released June 22, 2017 and amended June 26, 2017), as well as the health bill
passed by the House of Representatives (House Plan; passed May 4, 2017), to current law,
inclusive of the Patient Protection and Affordable Care Act (Affordable Care Act, or ACA).

Analysis of Select Provisions of Senate Bill, House Bill, and ACA

In the attached matrix, a side-by-side comparison of the Senate Plan, the House Plan, and current
law / the Affordable Care Act is provided on a number of key elements.

Congressional Budget Office Analysis

A detailed analysis of the financial and coverage impact on the Senate bill is found at:


Attachment

- Side-by-side matrix comparing Senate Plan, House Plan, and current law / ACA

¹ This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.
<table>
<thead>
<tr>
<th>Proposal</th>
<th>Affordable Care Act (ACA)</th>
<th>American Health Care Act (AHCA)</th>
<th>Better Care Reconciliation Act (BCRA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bill Number (if applicable)</td>
<td>(Current; enacted in 2010; Public Law 111–148)</td>
<td>H.R. 1628</td>
<td>Substitute for H.R. 1628</td>
</tr>
<tr>
<td>Date Introduced</td>
<td>5/4/2017 final version</td>
<td>6/22/2017 discussion draft, with 6/25/2017 revision</td>
<td></td>
</tr>
<tr>
<td>Main Sponsor(s)</td>
<td>Speaker Paul Ryan, House E&amp;C/W&amp;M/Rules Committees</td>
<td>Majority Leader Mitch McConnell</td>
<td></td>
</tr>
<tr>
<td>Latest Action</td>
<td>Passed by full House on 5/4/2017</td>
<td>Released on 6/22/2017</td>
<td></td>
</tr>
</tbody>
</table>

### Indian-Specific Provisions in Marketplace

<table>
<thead>
<tr>
<th>Cost-Sharing Protections</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>--For members of an Indian tribe or shareholders in an Alaska Native regional or village corporation, eligibility for either a zero or limited cost-sharing Marketplace plan, depending on income level (under both plan variations, AI/AN enrollees have no cost-sharing when receiving health care services).</td>
<td>-- Eliminates Indian-specific cost-sharing protections (as of January 1, 2020).</td>
<td>-- For 2018 and 2019, funds current (ACA) cost-sharing protections.</td>
</tr>
<tr>
<td>-- Ability for AI/ANs to enroll in bronze plan and still receive cost-sharing protections.</td>
<td>-- Eliminates cost-sharing protections for general population (as of January 1, 2020).</td>
<td>--Beginning in 2020, eliminates Indian-specific cost-sharing protections</td>
</tr>
<tr>
<td>-- Ban on Marketplace plans reducing payments to Indian health care providers by the amount of any cost-sharing that AI/AN enrollees would have otherwise owed for health care services.</td>
<td>--Beginning in 2020, eliminates general cost-sharing protections</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M-SEPs</th>
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</thead>
<tbody>
<tr>
<td>-- Monthly special enrollment periods (M-SEPs) for AI/ANs and their dependents.</td>
<td>-- M-SEPs for AI/ANs are not repealed and continue to be effective for coverage secured through a Marketplace.</td>
<td>--Retains M-SEPs for AI/ANs; Senate bill was revised to add, beginning in 2019, a 6-month delay in enrollment for individuals lacking creditable coverage for 63 days or more. The provision does not delay effective date of M-SEP for IHS-eligible persons as a “medical care program of the Indian Health Service or of a tribal organization” is considered creditable coverage.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Provisions</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>--AI/AN exemption from individual shared responsibility payments (individual mandate).</td>
<td>--Repeals individual mandate (retroactive to January 1, 2016)</td>
<td>--Repeals individual mandate retroactive to January 1, 2016</td>
</tr>
<tr>
<td>--Expansion and permanent reauthorization of the Indian Health Care Improvement Act (IHICIA).</td>
<td>--Makes no changes to the IHICIA</td>
<td>--Repeals employer coverage mandate retroactive to January 1, 2016. (Retains requirement for 2015; employer reporting requirements retained.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>--Makes no changes to the IHICIA</td>
</tr>
<tr>
<td>Proposal</td>
<td>Affordable Care Act (ACA)</td>
<td>American Health Care Act (AHCA) [REVISED analysis of bill as of 5/4/2017]</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Premium Tax Credits (PTCs)</td>
<td>-- Households income-based, advanceable, refundable PTCs for individuals and families with incomes of 100-400% FPL, with amounts adjusted for geographic differences in cost of health insurance premiums.</td>
<td>-- In 2019 transition period, ACA’s PTCs adjusted to modify caps on the household income percentage contribution: 4.3% ≤ 30 yrs; 5.9% ≤ 40 yrs; 8.35% ≤ 50 yrs; 10.5% ≤ 59 yrs; 11.5% &gt;69 yrs. (Higher net premiums for 50+ lower net premiums for some enrollees ≤50.)</td>
</tr>
<tr>
<td>In the Affordable Care Act (ACA)</td>
<td>-- Not eligible for PTCs if eligible for other public insurance programs, or employer-sponsored coverage that meets affordability, coverage, and AV standards. IHS eligibility not considered “coverage.” (See attachment for comparison of impact of ACA and AHCA PTCs for households at various income levels.)</td>
<td>-- Not eligible for PTCs if eligible for other public insurance programs, or employer-sponsored coverage (no affordability or coverage standards for employer coverage). -- Repeal ACA’s PTCs at end of 2019.</td>
</tr>
<tr>
<td></td>
<td>-- Starting in 2020, new, advanceable, refundable, age-adjusted tax credits, with amounts initially set at following levels (2020): $2,000 for 0-29; $2,500 for 30-39; $3,000 for 40-49; $3,500 for 50-59; $4,000 for 60+; $14,000 per family max tax credits. Overall value of tax credits drops by 40% (ACA to AHCA).</td>
<td>-- Starting in 2020, new, advanceable, refundable, age-adjusted tax credits, with amounts initially set at following levels (2020): $2,000 for 0-29 year-olds; $2,500 for 30-39; $3,000 for 40-49; $3,500 for 50-59; $4,000 for 60+; $14,000 per family max tax credits. Overall value of tax credits drops by 40% (ACA to AHCA).</td>
</tr>
<tr>
<td>Cost-Sharing Protections</td>
<td>-- 100% cost-sharing protections for members of an Indian tribe or shareholders in an Alaska Native regional or village corporation. -- Reduced out-of-pocket costs for individuals / families under 250% FPL in Marketplace coverage.</td>
<td>-- Retains out-of-pocket maximums per individual and family. -- Repeals Indian-specific and general cost-sharing protections completely, beginning in 2020.</td>
</tr>
<tr>
<td>Repayment of Excess Payments</td>
<td>-- Limits repayment of excess premium tax credits advanced, based on income of tax filer</td>
<td>-- Requires 100% repayment of any excess premium tax credits advanced (effective for 2018 and 2019)</td>
</tr>
<tr>
<td>Health Savings Accounts (HSAs)</td>
<td>-- Permitted (HSA contribution of approx. $3,350 [self-only coverage] and $6,750 [family coverage]).</td>
<td>-- Allowable HSA tax-deductible contribution increased to amount of deductible/out-of-pocket maximum (approx. $6,750 [single coverage]; $13,500 [family coverage]). -- Allows deposit of excess PTCs (in excess of premium costs) into HSA. -- Other provisions to promote the use of HSAs.</td>
</tr>
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<td>----------------------------------------------------------------------------</td>
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<tr>
<td><strong>Market Stability Mechanisms</strong></td>
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<tr>
<td>3 R's</td>
<td>-- Establishes a “Patient and State Stability Fund” (Fund), which includes a default federal reinsurance program (“Market Stabilization”) for issuers, with $100 billion in funding over 2018-2026</td>
<td>-- Establishes a state stability and innovation program (funded through CHIP), with short-term and long-term components</td>
</tr>
<tr>
<td></td>
<td>-- As part of the Fund, allows funding for a range of purposes</td>
<td>Short-Term Program</td>
</tr>
<tr>
<td></td>
<td>-- Allows states to use the Fund for reducing the cost of health insurance in the individual and small group markets for individuals with high costs due to the low population density of their state</td>
<td>For 2018-2020, appropriates $50 billion to CMS to allocate to fund health care arrangements “to address coverage and access disruption and respond to urgent health care needs within States,” with payments made directly to health insurance issuers</td>
</tr>
<tr>
<td></td>
<td>-- Allows states to use the Fund for maternity and newborn care and for prevention, treatment, or recovery support services for individuals with mental illness or substance abuse disorders</td>
<td>Long-Term Program</td>
</tr>
<tr>
<td></td>
<td>-- Appropriates $15 billion for the Fund in 2020 for maternity, mental health, and substance abuse disorder purposes</td>
<td>For 2019-2026, appropriates $62 billion for states to provide financial assistance to help high-risk individuals obtain individual market coverage, stabilize insurance markets, pay health care providers for services, or provide assistance to reduce out-of-pocket costs in the individual market (requires use of at least $5 billion for insurance market stabilization over the 2019-2021 period)</td>
</tr>
<tr>
<td></td>
<td>-- As part of the Fund, establishes a Federal Invisible Risk Sharing Program (FIRSP), administered by HHS, to provide payments to health insurance issuers with respect to claims for eligible high-cost individuals for the purpose of lowering individual market premiums</td>
<td>Requires states to apply for funding once, with applications deemed approved for future years</td>
</tr>
<tr>
<td></td>
<td>-- Makes available $15 billion in funding for FIRSP over 2018-2026</td>
<td>-- Allows CMS to determine the formula for allocating the funding</td>
</tr>
<tr>
<td></td>
<td>-- Beginning in 2020, allows states to take over operation of FIRSP</td>
<td>-- Requires states to spend any funding received within 3 years</td>
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<tr>
<td></td>
<td></td>
<td>-- Beginning in 2022, requires states to provide matching contributions to obtain funding, ranging from 7% in 2022 to 35% in 2026</td>
</tr>
<tr>
<td><strong>State Run High Risk Pools</strong></td>
<td>-- Establishes a temporary high-risk pool program, which operated until 2014, for individuals who have pre-existing medical conditions and cannot obtain health insurance in the individual market</td>
<td>State-Run High Risk Pools</td>
</tr>
<tr>
<td></td>
<td>-- Required HHS to administer the program directly or through contracts with states or non-profit private entities that operate qualified high-risk pools</td>
<td>-- Appropriated $5 billion in funding for the program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-- Appropriated $5 billion in funding for the program</td>
</tr>
<tr>
<td><strong>Coverage Rules</strong></td>
<td>-- Requires individuals to secure health insurance coverage or make a payment to federal government (exemption from requirement for AI/ANs).</td>
<td>Individual coverage requirement technically retained (because of “reconciliation” restrictions) but penalties for not securing coverage repealed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Individual coverage requirement technically retained (because of “reconciliation” restrictions) but penalties for not securing coverage repealed, retroactive to January 1, 2016.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health plan required “to increase monthly premium rate” by 30% for persons with a break in coverage of more than 63 days. IHS eligibility considered &quot;creditable coverage&quot; for purposes of not being subject to non-continuous coverage (30%) penalty.</td>
</tr>
<tr>
<td><strong>State Insurance Market Operations</strong></td>
<td>-- Health plan offerings standardized with actuarial values (AVs) set by metal level to facilitate plan comparisons.</td>
<td>-- Requirement for plans to be offered by specified actuarial value (metal level) repealed as of December 31, 2019.</td>
</tr>
<tr>
<td></td>
<td>-- Maximum out-pocket amounts established.</td>
<td>-- Maximum out-of-pocket limits retained.</td>
</tr>
<tr>
<td></td>
<td>-- Requirement for each state to establish a Marketplace that allows individuals to: Learn about their health insurance options; compare health plans based on costs, standardized benefits (EHBs), and other important features; obtain information on insurance affordability programs designed to help individuals with low-to-moderate incomes pay for coverage; select a health plan and enroll in coverage.</td>
<td>-- Requirement for a state-by-state Marketplace not repealed.</td>
</tr>
<tr>
<td></td>
<td>-- Permits catastrophic plans for all enrollees (with PTCs).</td>
<td>-- Permits catastrophic plans for all enrollees (with PTCs).</td>
</tr>
<tr>
<td></td>
<td>-- Permits catastrophic plans (AV = 55%) for &lt; 30 year olds (no PTCs).</td>
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*CURRENT LAW VS. HOUSE BILL (ACHA; H.R. 1628) AND SENATE BILL (BCRA; H.R. 1628)*

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**Health Care Proposal Tracking - 2017-06-28a Comparison-format**

June 28, 2017

3 of 7
|----------------------------------------------|------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------|
| **ESI Excise Tax/Tax Exclusion Cap**         | -- Beginning in 2020, 40% tax (Cadillac tax) imposed on cost of employer-sponsored insurance (ESI) exceeding the following amounts, with amounts adjusted annually for CPI.  
-- For individuals, $10,200 times health cost adjustment percentage  
-- For families, $27,500 times health cost adjustment percentage  
-- Delays the ACA Cadillac tax until 2026. | -- Delays the ACA Cadillac tax until 2026.                                           | -- Delays the ACA Cadillac tax until 2026.                                           |
| **Employer Mandate**                         | Employers required to offer insurance to full-time (FT) employees and pay a portion of premium if employee enrolls, or make an annual per FT employee payment (approx. $2,000) to federal government.  
-- Repeal of employer mandate penalties retroactive to January 1, 2016.  
(Coverage requirements technically staying in effect.)  
-- Employer reporting requirements remain in effect. | Repeal of employer mandate penalties retroactive to January 1, 2016.  
(Coverage requirements technically staying in effect.)  
-- Employer reporting requirements remain in effect. | Repeal of employer mandate penalties retroactive to January 1, 2016.  
(Coverage requirements technically staying in effect.)  
-- Employer reporting requirements remain in effect. |
| **Net Investment Income Tax**                | 3.8% tax on individuals, estates, and trusts that have certain investment income exceeding certain thresholds.  
| **Additional Medicare Tax**                  | 0.9% tax on wages and self-employment income that exceeds the following thresholds:  
-- $250,000 for married taxpayers filing jointly;  
-- $125,000 for married taxpayers filing separately;  
-- $200,000 for all other taxpayers.  
Repeal of tax effective for years after 2022.                                                | Repeal of tax effective for years after 2022.                                        | Repeal of tax effective for years after 2022.                                        |
| **Health Insurance Provider Fee**            | Fee on each covered entity engaged in the business of providing health insurance for U.S. health risks (moratorium instituted for 2017).  
Repeal of fee effective for years after 2016.                                                | Repeal of fee effective for years after 2016.                                         | Repeal of fee effective for years after 2016.                                         |
| **Medical Device Excise Tax**                | 2.3% tax on manufacturers and importers for sales of certain medical devices (moratorium instituted for 2016 and 2017).  
| **Excise Tax on Tanning Services**           | 10% tax on indoor UV tanning services.                                                    | Repeal of tax effective for years after 2016.                                         | Repeal of tax effective for years after 2016.                                         |
### Proposal

<table>
<thead>
<tr>
<th>Affordable Care Act (ACA)</th>
<th>American Health Care Act (AHCA) [REVISED analysis of bill as of 5/4/2017]</th>
<th>Better Care Reconciliation Act (BCRA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Market Rules/Protections</strong></td>
<td><strong>Insurance Market Regulations</strong></td>
<td><strong>Waivers (Section 1332)</strong></td>
</tr>
<tr>
<td>-- Ban on annual and lifetime coverage limits;</td>
<td>-- Bans on pre-existing condition exclusions; health status underwriting;</td>
<td>-- Retains ACA ban on pre-existing condition exclusions, health status underwriting,</td>
</tr>
<tr>
<td>-- Ban on rescissions (withdrawal of coverage);</td>
<td>life-time and annual coverage limits; coverage for adult children to age 26;</td>
<td>life-time and annual coverage limits; coverage for adult children to age 26; EHB</td>
</tr>
<tr>
<td>-- Required coverage of preventive services;</td>
<td>essential health benefit (EHB) requirements (although likely to be</td>
<td>requirements, and other ACA consumer protections (but under revised Section 1332</td>
</tr>
<tr>
<td>-- Dependent coverage through age 26;</td>
<td>modified by regulation); and other ACA consumer protections.</td>
<td>waivers can waive many ACA requirements)</td>
</tr>
<tr>
<td>-- Required Summary of Benefits and Coverage;</td>
<td>-- Penalty equal to 30% of the premium required for 12 months for enrollees</td>
<td>-- Includes no penalty for failing to maintain continuous coverage (the House bill does</td>
</tr>
<tr>
<td>-- Required internal claims/appeals/external review;</td>
<td>who do not maintain continuous coverage (individuals eligible for HHS services</td>
<td>include a penalty)</td>
</tr>
<tr>
<td>-- Ban on pre-existing condition exclusions;</td>
<td>exempt from penalty).</td>
<td>-- Increases allowable age rating of premiums to 5:1 (from 3:1 under the ACA)</td>
</tr>
<tr>
<td>-- Ban on discriminatory premium rates;</td>
<td>-- Repeals plan actuarial value and metal level requirements.</td>
<td>-- Beginning in 2019, ends ACA medical loss ratio (MLR) requirements and allows states to</td>
</tr>
<tr>
<td>-- Guaranteed availability/renewability of coverage;</td>
<td>-- Essential health benefits (EHBs) determined / regulated by states.</td>
<td>determine MLR and any rebates that health insurance issuers would have to pay to</td>
</tr>
<tr>
<td>-- Ban on discrimination based on health status;</td>
<td>-- Increases allowable age rating of premiums to 5:1 (from 3:1).</td>
<td>consumers for failing to meet those requirements</td>
</tr>
<tr>
<td>-- Non-discrimination in health care;</td>
<td>-- Verification requirement for enrollment during SEPs.</td>
<td>-- Senate bill revised to add, beginning 2019, a 6-month delay in enrollment for individuals</td>
</tr>
<tr>
<td>-- Ban on excessive waiting periods;</td>
<td>-- Option to continue offering ACA Marketplace plans outside of Marketplace.</td>
<td>lacking creditable coverage for 63 days or more. The provision does not delay effective</td>
</tr>
<tr>
<td>--Required coverage of mental health services/parity</td>
<td></td>
<td>date of M-SEP for IHS-eligible persons as a &quot;medical care program of the Indian Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Service or of a tribal organization&quot; is considered creditable coverage.</td>
</tr>
</tbody>
</table>

#### Coverage of Reproductive Services

<table>
<thead>
<tr>
<th><strong>Health Care Proposal Tracking - 2017-06-28a Comparison-format</strong></th>
<th><strong>June 28, 2017</strong></th>
<th><strong>5 of 7</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Permits states to enter into cross-state compacts.</strong></td>
<td><strong>-- Ban on use of federal funding to pay for abortions (with certain exceptions).</strong></td>
<td><strong>-- Allows small businesses to form “small business health plans,” fully insured plans</strong></td>
</tr>
<tr>
<td><strong>-- No changes made (due to “reconciliation” restrictions).</strong></td>
<td><strong>-- Bans Medicaid funding for Planned Parenthood (for 1 year)</strong></td>
<td><strong>offered by health insurance issuers to small businesses through association sponsors</strong></td>
</tr>
<tr>
<td><strong>-- Extends ERISA preemption of state insurance regulations to small business health plans</strong></td>
<td></td>
<td><strong>(association health plans)</strong></td>
</tr>
<tr>
<td><strong>-- Pre-empts any state laws that would preclude health insurance issuers from offering</strong></td>
<td><strong>-- Allows small businesses to form “small business health plans,” fully insured plans</strong></td>
<td><strong>coverage related to small business health plans</strong></td>
</tr>
<tr>
<td></td>
<td><strong>offered by health insurance issuers to small businesses through association sponsors</strong></td>
<td><strong>(association health plans)</strong></td>
</tr>
<tr>
<td><strong>-- Extends ERISA preemption of state insurance regulations to small business health plans</strong></td>
<td></td>
<td><strong>-- Allows small businesses to form “small business health plans,” fully insured plans</strong></td>
</tr>
<tr>
<td></td>
<td><strong>offered by health insurance issuers to small businesses through association sponsors</strong></td>
<td><strong>(association health plans)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>-- Extends ERISA preemption of state insurance regulations to small business health plans</strong></td>
<td><strong>-- Allows small businesses to form “small business health plans,” fully insured plans</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>offered by health insurance issuers to small businesses through association sponsors</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>(association health plans)</strong></td>
</tr>
</tbody>
</table>
### Medicaid Program Changes

**Base Medicaid Program**

- Eligibility requirements.
  - Health care benefit package requirements.
  - Consumer protections, including under managed care plans.
  - Retroactive program eligibility of up to 3 months from date of application.

**Medicaid Expansion (to 138% FPL)**

- Optional Medicaid expansion under which states can extend eligibility to all non-elderly residents with incomes up to 138% FPL.
- Availability of federal financial assistance covering 100% of Medicaid spending on health care services for the expansion population through 2016, with the rate gradually decreasing to a fixed level of 90% in 2020.

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA’s Medicaid Expansion (to 138% FPL)</td>
<td>-- No ACA Medicaid expansion option for current non-expansion states after 2017.</td>
<td>-- Technically retains the ACA Medicaid expansion option but eliminates the enhanced FMAP (90% +) for the expansion population</td>
<td>-- For states that expanded Medicaid by March 1, 2017, begins to phase out the enhanced FMAP for the expansion population in 2020, decreasing the rate annually over the 2021-2023 period and providing the standard rate in subsequent years [rate remains at 90% in 2020 and subsequent years under the ACA]</td>
</tr>
<tr>
<td></td>
<td>-- No enhanced FMAP available for states adopting the Medicaid expansion after March 1, 2017.</td>
<td></td>
<td>-- For states that expanded Medicaid outside of the ACA “Medicaid expansion” authority, provides 80% FMAP for the expansion population over the 2017-2023 period and the standard rate in subsequent years</td>
</tr>
<tr>
<td></td>
<td>-- In current Medicaid expansion states, enhanced FMAP (90% in 2020) retained for individuals enrolled under the expansion prior to 2020, for as long as they retain coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- For states expanding Medicaid outside of ACA’s “Medicaid expansion” authority, 80% FMAP in 2017 and each subsequent year (versus standard FMAP rate).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Per capita cap / allotment on federal financial assistance for Medicaid spending on health care services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Spending for A/ANs at I/Ts not subject to per capita cap</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- A/AN enrollees (and spending at non-I/T providers) included in applicable section 1903A category.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Repeal of Essential Health Benefits (EHBs) requirement for benchmark plans.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>-- For non-expansion states, repeal of Medicaid DSH allotment reductions and provides increased federal assistance for safety net providers.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>-- Repeal of 3-month retroactive eligibility (limit to month of enrollment) and other provisions to reduce Medicaid costs (such as update allowable home equity limits).</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>-- Require states to conduct income eligibility redeterminations at least every six months.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>-- Remove an ACA option enabling states to enroll uninsured adults in Medicaid immediately if they need acute medical care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Eligibility requirements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Health care benefit package requirements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Consumer protections, including under managed care plans.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>-- Numerous other provisions.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>BLOCK GRANT</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Option for states to receive a 10-year block grant, beginning in FY 2020.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Requirement for states to file 10-year plan with HHS [deemed approved unless HHS finds the plan either “incomplete” or “actuarially unsound” within 30 days).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Initial block grant amount determined using the same base year calculation as for the per capita allotment, with amount adjusted annually by CPI-U [similar potential concern as with regard to how A/ANs are counted for purposes of determining per capita cap and block grant allotments].</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Requirement for states to audit block grant spending to ensure use on health care [and “make available” results to HHS].</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Any unspent block grant funding retained by states.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Federal/state spending ratio under block grant based on CHIP levels, meaning a state could reduce state-funding below FMAP proportions and rely on federal block grant funding as a greater share of total program funding.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eligibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Option 1: Must cover children (up to 100% FPL), newborns (for one year), and pregnant women (up to 50% FPL).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Option 2: Must cover pregnant women (up to 50% FPL).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Inclusion of others as eligible populations at state discretion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Block grant excludes disabled, elderly, and adults covered under Medicaid expansion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benefit Package</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Elimination of current health services coverage requirements, with the exception of providing certain broad benefit categories: hospital care; surgical care and treatment; medical care and treatment; obstetrical and prenatal care and treatment; prescribed drugs, medicines, and prosthetic devices; other medical supplies and services; and health care for children under 18 (no EPSDT requirement).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Elimination of current cost-sharing protections / requirements [appears to eliminate existing Indian-specific cost-sharing protections].</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-- Elimination of current service delivery protections / requirements.</td>
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<td></td>
</tr>
<tr>
<td>Block Grant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-- Requires states to conduct income eligibility redeterminations at least every six months.</td>
<td></td>
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<tr>
<td>-- Allows states to impose work requirements on certain Medicaid beneficiaries.</td>
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<tr>
<td>-- Imposes new restrictions on the ability of states to finance Medicaid through provider taxes</td>
<td></td>
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</tr>
</tbody>
</table>

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Health Care Proposal Tracking - 2017-06-28a Comparison-format

June 28, 2017

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CURRENT LAW VS. HOUSE BILL (ACHA; H.R. 1628) AND SENATE BILL (BCRA; H.R. 1628)

<table>
<thead>
<tr>
<th>Proposal</th>
<th>Affordable Care Act (ACA)</th>
<th>American Health Care Act (AHCA)</th>
<th>Better Care Reconciliation Act (BCRA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AI/AN provisions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-- Cost-sharing prohibited for AI/AN.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-- Mandatory managed care enrollment prohibited for AI/AN.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-- 100% FMAP for services to AI/ANs by IHS and Tribal providers.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-- Tribal consultation requirements.</td>
<td></td>
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</tr>
<tr>
<td><strong>Medicare</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Program Changes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-- Phase-out of the Part D coverage gap.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-- Increased financial assistance for individuals in the Part D coverage gap.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-- Elimination of copays for certain preventive services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-- Changes in payment rates.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-- Provisions designed to improve efficiency/quality program integrity.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>American Health Care Act (AHCA)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(REVISED analysis of bill as of 5/4/2017)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Provisions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-- Under per capita allotment, increase in inflation factor for elderly enrollees from CPI-U Medical to CPI-U Medical plus 1 percentage point.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-- New York State provision: Per capita allotment reduced by the amount raised from cities/counties, except funds raised in New York City.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-- Beginning October 1, 2017, option for states to institute a work requirement for non-disabled, non-elderly, non-pregnant adults as a condition of receiving coverage (does not include an exception for the work requirement for students, except in limited circumstances).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Better Care Reconciliation Act (BCRA)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(REVISED analysis of bill as of 5/4/2017)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Provisions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-- Retains phase-out of the Part D coverage gap</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-- Repeals ACA taxes dedicated to funding Part A Trust Fund</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-- Other TBD.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes and Recommended Articles:

1. Health cost adjustment percentage equals 100% plus the excess (if any) of the percentage over 15% by which the per employee cost for providing coverage under the BC BS standard benefit option under FEHBP for plan year 2018 (determined by using the benefit package for such coverage in 2010) exceeds such cost for plan year 2010.

---

Other provisions:

- Cost-sharing prohibited for AI/AN.
- Mandatory managed care enrollment prohibited for AI/AN.
- 100% FMAP for services to AI/ANs by IHS and Tribal providers.
- Tribal consultation requirements.
- Phase-out of the Part D coverage gap.
- Increased financial assistance for individuals in the Part D coverage gap.
- Elimination of copays for certain preventive services.
- Changes in payment rates.
- Provisions designed to improve efficiency/quality program integrity.

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Notes and Recommended Articles:

1. Health cost adjustment percentage equals 100% plus the excess (if any) of the percentage over 15% by which the per employee cost for providing coverage under the BC BS standard benefit option under FEHBP for plan year 2018 (determined by using the benefit package for such coverage in 2010) exceeds such cost for plan year 2010.

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Other provisions:

- Cost-sharing prohibited for AI/AN.
- Mandatory managed care enrollment prohibited for AI/AN.
- 100% FMAP for services to AI/ANs by IHS and Tribal providers.
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Notes and Recommended Articles:

1. Health cost adjustment percentage equals 100% plus the excess (if any) of the percentage over 15% by which the per employee cost for providing coverage under the BC BS standard benefit option under FEHBP for plan year 2018 (determined by using the benefit package for such coverage in 2010) exceeds such cost for plan year 2010.
Applicable Percentages, Thresholds, and Payments:
Indexing Adjustments Related to Certain Affordable Care Act Provisions
for 2015-2018

Revised June 6, 2017

This brief seeks to provide guidance to Tribes on indexing adjustments associated with the Patient Protection and Affordable Care Act (ACA) provisions for calculating the amount of premium tax credit (PTCs), determining whether individuals qualify for an income-based exemption from the shared responsibility payment, determining whether employer-sponsored health insurance is considered affordable, determining the amount of any shared responsibility payment owed by individuals or employers, and establishing the maximum out-of-pocket amounts for individuals and families.

Applicable Percentage Contribution (for Premium Tax Credit Calculations)
Under ACA, individuals who have an income between 100 percent and 400 percent of the federal poverty level (FPL) and meet other requirements can obtain PTCs to help pay for Marketplace coverage. Section 36B of the Internal Revenue Code (Code) (as added by ACA) set the required household income

<table>
<thead>
<tr>
<th>Household Income (as % FPL)</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low End of Range</td>
<td>Top End of Range</td>
<td>Low End of Range</td>
<td>Top End of Range</td>
<td>Low End of Range</td>
<td>Top End of Range</td>
</tr>
<tr>
<td>&lt; 133%</td>
<td>2.0</td>
<td>2.0</td>
<td>2.01</td>
<td>(+0.5)</td>
<td>2.01</td>
</tr>
<tr>
<td>133%-150%</td>
<td>3.0</td>
<td>4.0</td>
<td>3.02</td>
<td>(+0.7)</td>
<td>4.02</td>
</tr>
<tr>
<td>150%-200%</td>
<td>4.0</td>
<td>6.3</td>
<td>4.02</td>
<td>(+0.5)</td>
<td>6.34</td>
</tr>
<tr>
<td>200%-250%</td>
<td>6.3</td>
<td>8.05</td>
<td>6.34</td>
<td>(+0.6)</td>
<td>8.10</td>
</tr>
<tr>
<td>250%-300%</td>
<td>8.05</td>
<td>9.5</td>
<td>8.10</td>
<td>(+0.6)</td>
<td>9.56</td>
</tr>
<tr>
<td>300%-400%</td>
<td>9.5</td>
<td>9.5</td>
<td>9.56</td>
<td>(+0.6)</td>
<td>9.56</td>
</tr>
</tbody>
</table>


1 This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.
contribution percentages for 2014 and authorized IRS to adjust these percentages annually to reflect the excess of the rate of premium growth for the preceding calendar year\(^1\) over the rate of income growth for the preceding calendar year.\(^2\) The applicable percentage contribution amounts for each calendar year/coverage year are shown in Table 1 above.

**Repayment of Overpayments**

The Marketplace determines eligibility for PTC, and the amount of any PTC, based on the information that individuals applying for coverage provide about their expected household income and family size for the year. Individuals who receive advance PTC payments over the coverage year must reconcile these payments with the amount of PTC for which they qualify based on their actual income for the year reported on their federal tax return.\(^3\) If individuals receive advance PTC payments that are less than the amount of PTC for which they qualify based on their actual income, they will receive the difference as a reduction in their tax bill or an increase in their refund. However, if individuals receive advance PTC payments that exceed the PTC for which they ultimately qualify based on their actual income, they will have to repay the excess amount, subject to certain limits (see Table 2 below).

**Table 2: Premium Tax Credit Repayment Limits for 2014 Through 2017**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Single</td>
<td>Other</td>
<td>Single</td>
<td>Other</td>
</tr>
<tr>
<td>0%-200% FPL</td>
<td>$300</td>
<td>$600</td>
<td>$300</td>
<td>$600</td>
</tr>
<tr>
<td>201%-300% FPL</td>
<td>$750</td>
<td>$1,500</td>
<td>$750</td>
<td>$1,500</td>
</tr>
<tr>
<td>301%-400% FPL</td>
<td>$1,250</td>
<td>$2,500</td>
<td>$1,250</td>
<td>$2,500</td>
</tr>
<tr>
<td>401%+ FPL</td>
<td>No Limit</td>
<td>No Limit</td>
<td>No Limit</td>
<td>No Limit</td>
</tr>
</tbody>
</table>


**Income-Based Exemption from Shared Responsibility Payment Penalty for No Coverage**

A. **Affordability Percentage (Required Contribution Percentage for Affordability Determinations)**

Starting in 2014, § 5000A of the Code (as added by ACA), requires individuals of all ages to make a shared responsibility payment when filing their federal income tax return if they do not have qualifying health insurance (minimum essential coverage) for each month or do not qualify for an exemption. American Indians and Alaska Natives are able to file for an exemption from this payment on their federal income tax forms. Other individuals and families who cannot afford coverage because their premiums would exceed a certain percentage of household income, i.e. the affordability percentage, qualify for an income-based exemption. Section § 5000A of the Code set the affordability percentage at 8 percent for 2014 and authorized HHS to adjust this percentage annually to reflect the excess of the rate of premium growth between the preceding calendar year and 2013 (premium adjustment percentage) over the rate of income growth for that period.\(^4\) The affordability percentages are shown, by calendar year (CY), in Table 3 below.

**Table 3: Affordability Percentage for CY 2014 Through CY 2018**

<table>
<thead>
<tr>
<th>Affordability Percentage</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8.0</td>
<td>8.05</td>
<td>8.13</td>
<td>8.16</td>
<td>8.05</td>
</tr>
</tbody>
</table>

Source: CMS, CMS-9949-F, CMS-9944-F, CMS-9937-F, and CMS-9934-F.
B. Federal Income Tax Filing Threshold

In addition to the income-based exemption discussed above, individuals who do not have gross income that meets the minimum threshold for having to file a federal income tax return qualify for an exemption from the shared responsibility payment, provided that no one can claim these individuals as a dependent. IRS determines the tax filing threshold annually.

Table 4: Federal Income Tax Filing Threshold for 2014 Through 2017 (Ages 0-64)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$10,000</td>
<td>$10,150</td>
<td>$10,300</td>
<td>$10,350</td>
</tr>
<tr>
<td>Head of Household</td>
<td>$11,500</td>
<td>$13,050</td>
<td>$13,250</td>
<td>$13,350</td>
</tr>
<tr>
<td>Married Filing Jointly</td>
<td>$20,000</td>
<td>$20,300</td>
<td>$20,600</td>
<td>$20,700</td>
</tr>
<tr>
<td>Married Filing Separately</td>
<td>$3,900</td>
<td>$3,950</td>
<td>$4,000</td>
<td>$4,050</td>
</tr>
<tr>
<td>Qualifying Widower w/Dependent</td>
<td>$16,100</td>
<td>$16,350</td>
<td>$16,600</td>
<td>$16,650</td>
</tr>
</tbody>
</table>


Shared Responsibility Payment Penalty for No Coverage

Individuals who neither have qualifying health insurance (minimum essential coverage) for each month nor qualify for an exemption must make a “shared responsibility payment.” In general, the amount of the annual payment equals the greater of: (1) a percentage of household income, with a cap at the national average premium for the bronze plan available through the Marketplace that provides coverage for the

Table 5: Individual Shared Responsibility Annual Payment Amounts for 2014 Through 2017

<table>
<thead>
<tr>
<th>Household (HH) pays greater of:</th>
<th>Formula</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage Amount</td>
<td>Specified % of HH income above tax filing threshold</td>
<td>1%</td>
<td>2%</td>
<td>2.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>With amount not exceeding:</td>
<td>$2,448 per person</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$12,240 per HH of 5+</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flat Amount</td>
<td>Specified per person $ figure</td>
<td>$95 per adult $47.50 per child</td>
<td>$325 per adult $162.50 per child</td>
<td>$695 per adult $347.50 per child</td>
<td>$695 per adult $347.50 per child</td>
</tr>
<tr>
<td>With amount not exceeding:</td>
<td>$285 per HH</td>
<td>$975 per HH</td>
<td>$2,085 per HH</td>
<td>$2,085 per HH</td>
<td></td>
</tr>
</tbody>
</table>

applicable family size involved, or (2) a flat dollar amount, with a maximum flat amount per family of three times the adult amount (see Table 5 above). Federal regulations set the percentages of household income used to determine the percentage amount at 1.0% in 2014, 2.0% in 2015, and 2.5% in 2016 and subsequent years. For 2014, 2015, and 2016, federal regulations set the flat amount per adult at $95, $325, and $695, respectively, and for 2017 and subsequent years $695 plus cost-of-living adjustments. Federal regulations set the flat amount per child at half the amount per adult.

Annual Limitations on Cost-Sharing

ACA established maximum annual limitations on cost-sharing for individual (self-only) and family (non-self-only) health insurance coverage. In May 2013, IRS set these limitations at $6,350 and $12,700, respectively, for plan year (PY) 2014.6 For plan years after 2014, 45 CFR 156.130(a)(2) granted HHS the authority to adjust the limitation on cost-sharing; cost sharing for self-only coverage cannot exceed the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage,7 and for family coverage, the limit is twice the dollar limit for individual coverage.8 HHS issued regulations updating the limitations on cost-sharing for PY 2015 in 2014,9 for PY 2016 in 2015,10 PY 2017 in 2016,11 and PY 2018 in 201612 (see Table 6 below).

Table 6: Annual Limitations on Cost-Sharing for PY 2014 Through PY 2018

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ind.</td>
<td>$6,350</td>
<td>$6,600</td>
<td>$6,850</td>
<td>$7,150</td>
<td>$7,350</td>
</tr>
<tr>
<td>Family</td>
<td>$12,700</td>
<td>$13,200</td>
<td>$13,700</td>
<td>$14,300</td>
<td>$14,700</td>
</tr>
</tbody>
</table>


Required Contribution Percentage (for Calculating Affordability of Employer Offer of Coverage)

Under section 4980H of the Code, as added by ACA, applicable large employers (ALEs)—those with at least a certain number of employees (generally 50 full-time employees or a combination of full-time and part-time employees equivalent to 50 full-time employees)—might have to make a shared responsibility payment if they do not offer affordable health insurance to their full-time employees.13 The required contribution percentage, i.e. the percentage of household income an employee must contribute for self-only coverage, is used to determine whether employer-sponsored insurance is considered affordable.14 Section § 36B of the Code set the affordability percentage at 9.5 percent for 2014 and authorized IRS to adjust this percentage annually to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year. In 2014, IRS released guidance updating the required contribution percentages for CY 201515 and CY 201616 (see Table 7 below).

Table 7: Required Contribution Percentage for CY 2014 Through CY 2018

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Contribution %</td>
<td>9.5</td>
<td>9.56</td>
<td>9.66</td>
<td>9.69</td>
<td>9.56</td>
</tr>
</tbody>
</table>


Employer Shared Responsibility Payments

ALEs subject to a shared responsibility payment will have to make one of two types of payment, but not both. The first type of payment applies if, for any month in 2016 and subsequent years, an ALE does not
offer minimum essential coverage to at least 95 percent of its full-time employees (and their dependents) and if at least one full-time employee receives a premium tax credit for purchasing health insurance through the Marketplace. In this case, the ALE must make an annual payment of $2,160 (for 2016; calculated at 1/12th per applicable month) for each full-time employee (without regard to whether each employee received a premium tax credit), after excluding the first 30 full-time employees from the calculation. Since 2015, IRS has indexed this figure annually.\(^1\) In 2014 and 2015, there were transition rules that lessened the requirements on employers.

Even if an ALE offers minimum essential coverage to a sufficient number of full-time employees (and their dependents) to avoid liability for the first type of shared responsibility payment, the ALE generally still will have to make the second type of payment for each full-time employee (if any) who receives a premium tax credit for purchasing health insurance through the Marketplace. In this case, the ALE must make an annual payment of $3,240 (for 2016; calculated at 1/12th per applicable month) for each full-time employee who received a premium tax credit or cost-sharing assistance. Since 2015, IRS has indexed this figure annually.\(^2\)

Table 8: Applicable Payment Amount (Employer Shared Responsibility) for CY 2014 Through CY 2017

<table>
<thead>
<tr>
<th>Type of Payment</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Type</td>
<td>$2,000</td>
<td>2,080</td>
<td>$2,160</td>
<td>$2,270 (est.)</td>
</tr>
<tr>
<td>2nd Type</td>
<td>$3,000</td>
<td>3,120</td>
<td>$3,240</td>
<td>$3,400 (est.)</td>
</tr>
</tbody>
</table>

Source: IRS, Notice 2015-87.

The determination of “affordability” of the employer offer of coverage applies to the full-time employee, as well as to any family member who also is offered coverage by the employer, whether or not the employer makes a contribution for the premiums of the employee’s family member(s).


As required by section 4980H of the Code, IRS will increase this figure by an amount equal to the product of the figure and the premium adjustment percentage for the calendar year.

Ibid.
June 27, 2017

The Honorable Mitch McConnell
S-230 The Capitol
Washington, D.C. 20510

RE: Tribal Priorities in Senate Healthcare Reform Legislation

Dear Senator McConnell:

On behalf of the National Indian Health Board (NIHB), the National Congress of American Indians (NCAI), National Council on Urban Indian Health (NCUIH), Self-Governance Communication and Education (SGCE), and the Tribal Nations of the United States we serve, we write to convey and explain our strong and united opposition to the Senate’s Better Care Reconciliation Act of 2017 (BCRA) in its current form.

While the legislation mirrors several provisions of the House bill that are of critical importance to Indian Country, we have grave concerns about other aspects of the BCRA that make it impossible for us to support the legislation in its current form. Specifically, we cannot support legislation that would gut the Medicaid program or eliminate cost-sharing protections for American Indians and Alaska Natives (AI/ANs). Most importantly, we request that the legislation:

1) Maintain Medicaid funding based on need, rather than capping it according to a complicated per capita allocation formula or through capped block grants.
2) Continue Medicaid Expansion, and at the very least, continue Medicaid Expansion for AI/ANs
3) Protect AI/ANs from barriers to care that are inconsistent with the federal trust responsibility, such as work requirements under Medicaid
4) Retain cost-sharing protections at Section 1402 of the Patient Protection and Affordable Care Act (ACA); and
5) Maintain funding for preventative services, including the Prevention and Public Health Fund and women’s health services.

As you know, the federal government has a trust responsibility, agreed to long ago and reaffirmed many times by all three branches of government, to provide healthcare to Tribes and their members. Both Medicaid and IHS funding are part of the fulfillment of the trust responsibility.
However, the federal government has not done its part to live up to the responsibility to provide adequate health services to AI/ANs. IHS funding is discretionary and is appropriated every year and distributed to IHS and Tribal facilities across the country. But IHS appropriations have been about 50% of need for decades, and Medicaid revenue is essential to help fill the gap. When demand for services is higher than the funds available, services must be prioritized and rationed. As a result of this chronic underfunding, historical trauma, and a federal-state centric public health system, AI/ANs suffer from a wide array of health conditions at levels shockingly higher than other Americans. Nationally, AI/ANs live 4.5 years less than other Americans, but in some states life expectancy is 20 years less. This is not surprising given that in 2016, the IHS per capita expenditures for patient health services were just $2,834, compared to $9,990 per person for health care spending nationally. The Senate should pass reform legislation only if it does not reduce access to care for AI/ANs, or further strain the already stretched resources of Indian Health Service, Tribally-operated, and urban Indian health programs (collectively called the “I/T/U”).

Medicaid
Cuts to the Medicaid program outlined in the BCRA are especially troubling. Under a block grant per-capita system, States will experience a dramatic reduction in federal funding for their Medicaid programs. Most will have to either reduce eligibility for the program or reduce or eliminate benefits that are essential to many AI/ANs. Medicaid is a crucial program for the federal government in honoring its trust responsibility to provide healthcare to AI/ANs. Because healthcare services are guaranteed for AI/ANs, cuts in Medicaid only shift cost over to the IHS, which is already drastically underfunded. Put simply, without supplemental Medicaid resources, the Indian health system will not survive.

AI/ANs are a uniquely vulnerable population and uniquely situated in the Medicaid program. Unlike other Medicaid enrollees, because of the federal trust responsibility, AI/ANs have access to limited IHS services to fall back on at no cost to them. As a result, Medicaid enrollment and utilization incentives are completely different for AI/ANs in Medicaid. Medicaid conditions of eligibility designed to ensure that beneficiaries have “personal investment” do not work when mandatory in Indian country. Instead of participating in these programs, many AI/ANs will simply choose not to enroll in Medicaid and fall back on the underfunded IHS instead. This will deprive Tribal and urban programs of vital Medicaid revenue and strain limited IHS resources to the breaking point.

Medicaid is a crucial program for the federal government to fulfill the trust responsibility. Over 40 years ago, Congress permanently authorized the IHS and Tribal facilities to bill Medicaid for services provided to Medicaid-eligible AI/ANs to supplement inadequate IHS funding and as part of the federal trust responsibility. At the same time, because Congress recognized that “…it would be unfair and inequitable to burden a State Medicaid program with costs which normally would have been borne by the Indian Health Service,”1 it ensured that States would not have to bear any such costs, by providing that States would be reimbursed at 100 percent Federal Medical Assistance Percentage (FMAP) for services received through IHS and Tribal facilities.

---

1 Senate Report 94-133, Indian Health Care Improvement Act
The Senate Finance Committee, which has primary legislative responsibility for the Medicare and Medicaid programs, adopted a similar reimbursement provision as a part of H.R. 3153, the Social Security Amendments of 1973. In its report on the legislation, the Finance Committee justified the 100 percent FMAP by noting:

"...that with respect to matters relating to Indians, the Federal Government has traditionally assumed major responsibility. The Committee wishes to assure that a State's election to participate in the Medicaid program will not result in a lessening of Federal support of health care services for this population group, or that the effect of Medicaid coverage be to shift to States a financial burden previously borne by the Federal Government."

In light of this legislative history, Tribes are pleased to see the 100 percent FMAP preserved in the BCRA. As the Senate considers this proposed legislation, please ensure that this remains in place. In addition, because the federal trust responsibility also follows AI/ANs off of reservations, 100 percent FMAP should also be extended to services provided through urban Indian health programs (UIHPs).

With regard to Medicaid, we respectfully request that the Senate:

1) **Continue to Fund Medicaid Based on Need without Caps**

   Medicaid is an important tool through which the federal government uses to fulfill its trust responsibility to provide for Indian health care.

   The cuts proposed by Sections 133 and 134 of the BCRA would be devastating to Tribal and urban health programs. BCRA would make cuts to Medicaid that are even higher than those proposed by the House of Representatives. BCRA’s caps are tied to a lower inflation factor beginning in 2025 that would result in even higher cuts to State Medicaid plans.

   We were encouraged to see that BCRA contains provisions that would prevent the cost of care provided to AI/ANs from counting against either a per capita cap or a block grant. However, we request that urban Indian health programs be included in the exemption as well. Faced with the cuts proposed in Sections 133 and 134 of the bill, most States will be forced to make cuts to eligibility and/or services in future years. This will affect all providers and recipients, including Tribal/urban providers and AI/AN patients. This will lead to significant cuts in Medicaid revenues for I/T/Us, and will threaten our ability to provide healthcare services to our people. The Indian healthcare delivery system will not succeed if faced with the cuts proposed in BCRA.

   To the extent that the Senate bill maintains such dramatic caps, it should work with Tribes to develop a mechanism to exempt reimbursements for services received through IHS/Tribal/Urban facilities from any State-imposed limitations on eligibility or services that may result from these caps. Such reimbursements would be covered by 100 percent FMAP and therefore will not affect State budgets.
We also request language be added to the bill that requires States with one or more Indian Tribes or Tribal health providers to engage in Tribal consultation on a regular and ongoing basis, and prior to the submission of any Medicaid or CHIP State Plan Amendment, waiver applications, demonstration projects or extensions that may impact them as Medicaid providers or their Tribal members as Medicaid recipients.

2) Preserve Medicaid Expansion

Medicaid Expansion has increased access to care and provided critical third-party revenues to the Indian health system. The uninsured rate for Native Americans has fallen nationally from 24.2% to 15.7% since the enactment of the Affordable Care Act, due in large part to Medicaid Expansion. This has resulted in health care services to AI/AN people who might not have normally received care. It has also resulted in saved revenues to the Medicaid program through preventing more complex and chronic health conditions and saved the Medicaid program money. Medicaid Expansion has increased Medicaid revenues at IHS/Tribal/Urban health programs that are being reinvested back into both the Indian and the larger national health care system.

The BCRA would roll back federal funding Medicaid Expansion by 2024. The Senate should preserve Medicaid Expansion as an option for States on a permanent basis. While BCRA contains important provisions designed to equalize funding between Expansion and non-Expansion States, we are concerned that the funding made available to non-Expansion States is insufficient to match that which has been provided to Expansion States. At the very least, Expansion should be retained for the AI/AN population under a special Medicaid optional eligibility category for State Plans in recognition of the federal trust responsibility.

3) Exempt AI/ANs from Work Requirements

The BCRA would allow the States to impose mandatory work requirements as a condition of Medicaid eligibility, and incentivize States that impose such requirements with a 5 percent increase in FMAP to reimburse them for the administrative costs of implementing such a requirement.

As noted above, mandatory work requirements will not work in Indian country because the incentive structures are completely different. Unlike other Medicaid beneficiaries, AI/ANs have access to IHS services. If work requirements are imposed as a condition of eligibility, many AI/ANs will elect not to enroll in Medicaid. As a result, rather than encouraging job seeking or saving program costs, mandatory work requirements will discourage AI/ANs from enrolling in Medicaid and place pressure on the already underfunded IHS. Further, cash jobs are scarce or non-existent in much of Indian country, making work requirements impossible to meet and job training programs an exercise in futility.
Tribes fully support work programs and employment, but we believe such programs should be voluntary so as not to provide a barrier to access Medicaid for our members. Again, this is consistent with over 40 years of Medicaid policy for Indian Country. To the extent it considers imposing work requirements, the Senate should exempt AI/ANs from any work requirements.

**Marketplace**

We also ask that the Senate amend the BCRA to maintain cost sharing protections for AI/ANs. These protections were included for AI/ANs in fulfillment of Congress and the United States federal trust responsibility to provide health care to Indians. Section 208 of the BCRA would repeal the cost-sharing subsidy program established by Section 1402 of the ACA. However, Section 1402(d) of the ACA also includes important and critical cost sharing protections for AI/ANs who have incomes at or below 300 percent of the federal poverty level, or who are referred for care through the IHS Purchased/Referred Care (PRC) program. These cost-sharing protections incentivize AI/ANs to sign up for health insurance and also make it affordable. Eliminating them would create a disincentive for AI/AN to sign up for insurance, since they already have access to IHS services. This would result in less third party reimbursements for the Indian health system and have a destabilizing effect on the system’s ability to provide health care to AI/AN people. Dollar-for-dollar, leveraging cost sharing protections for AI/ANs and thereby encouraging insurance coverage is a very efficient means of moving the needle forward in meeting the federal trust responsibility for health care resources.

**Prevention Services**

We are also deeply concerned by the proposed reduction of prevention services in the legislation. The elimination of the Prevention and Public Health Fund will cripple Tribes’ efforts to support public health initiatives. Many Tribal health programs rely on PPHF directed funding to keep their public health systems operational. Unlike states, Tribes must piece together a patchwork of funds, some of which are derived from the PPHF, to administer basic prevention services. Additionally, the reduction in funding for women’s health services around the country will have major impacts on Tribal members, especially those who do not have direct access to services on or near their reservation. The Senate should restore cuts to the preventative services in the legislation.

Tribes support the inclusion of state funding to address the opioid crisis. However, states do not often pass these funds to Tribes. Drug-related deaths among AI/ANs is almost twice that of the general population. To address this problem, Tribes should either receive direct federal funding to address the opioid crisis, or states should be required to engage in state-Tribal consultation on the use of funds appropriated for the states.

In conclusion, the undersigned organizations must oppose the BCRA in its current form. We could support the legislation only if needs-based funding for Medicaid is preserved, Medicaid Expansion is continued, and the other changes outlined above are made to the bill before passage. In fulfillment of the trust responsibility, current exemptions for AI/ANs from health insurance
premiums, co-pays, and cost sharing must be preserved, and Medicaid-eligible AI/ANs must be allowed access to the program without further requirements attached to ensure additional burden is not placed on very limited IHS appropriations. Tribes across the country are eager to come to the table to discuss how shortcomings in the current healthcare system can be addressed, without wreaking immeasurable harm on our health programs and the people we serve.

If you have any questions please do not hesitate to contact NIHB’s Executive Director Stacy A. Bohlen at sbohlen@nihb.org or (202) 507-4070.

Sincerely,

Vinton Hawley
Chairperson
National Indian Health Board

Brian Cladoosby
President
National Congress of American Indians

Ashley Tuomi
President
National Council on Urban Indian Health

W. Ron Allen
Board Chairman
Self-Governance Communication & Education Tribal Consortium

Cc:
Senator, John Cornyn, Majority Whip
Senator John Thune, Republican Conference Chairman
Senator Orrin Hatch, Chairman, Senate Finance Committee
Senator Mike Enzi, Chairman, Senate Budget Committee
Senator Lamar Alexander, Chairman, Senate Health, Education, Labor and Pensions Committee
Senator John Hoeven, Chairman Senate Committee on Indian Affairs
Better Care Reconciliation Act of 2017  
Issue for American Indian and Alaska Natives  
Section 208. Repeal of Cost-Sharing Subsidy

SECTION AT ISSUE: Section 208 of the Better Care Reconciliation Act (BCRA) would repeal the cost-sharing subsidy program, which is at Section 1402 in the Patient Protection and Affordable Care Act (ACA). This is of great concern for American Indian and Alaska Natives (AI/ANs), as Section 1402(d) includes critical cost sharing protections for AI/ANs that have incomes at or below 300% of the federal poverty level. These cost-sharing protections make health insurance affordable for AI/AN people. Eliminating them would also have a destabilizing effect on the tribal health system that is responsible for providing health care to most AI/AN people. For the reasons explained in this paper, Congress should continue the cost-sharing protections for AI/ANs by amending Section 208 of the BCRA to continue the cost-sharing protections for AI/ANs contained in section 1402(d) of the ACA. These protections were included for AI/ANs in fulfillment of Congress and the United States federal trust responsibility to provide health care to Indians.

JUSTIFICATION FOR CHANGE:

- The objectives of the Indian cost-sharing protections are to: (1) to promote access to affordable insurance for eligible Indians and to overcome the comparatively low health coverage that Indians have in comparison to the general population; and (2) to carry out the unique federal responsibility to provide health care to Indians long recognized in federal law.
- Indian families have disproportionately lower incomes than the general population and spend a higher proportion of their household earnings on necessities such as housing, transportation, utilities, and food, leaving little money for health care costs.
- Eliminating cost-sharing for Indians at or below 300% of federal poverty level aligns with federal statutes the prohibit Indians from being charged cost-sharing for premiums or co-payments in the Medicaid program.
- Because the Indian Health Service (IHS) provides care without cost to Indians, there is already a strong dis-incentive for eligible Indian patients to purchase insurance. The dis-incentive is exacerbated when cost-sharing is imposed on a low-income Indian patient for using insurance.
- Because of inadequate funding (IHS is funded at roughly 50-60% of need), the federally-created Indian health system is unable to provide the full scope of medical care needed by the AI/ANs it serves. Thus, IHS operates a Purchased and Referred Care (PRC) program through which needed care is purchased from public and private providers. But due to inadequate PRC funding, access to outside care is very limited and many patient care needs are delayed or unfilled. Eliminating barriers like cost sharing for Indians to purchase insurance saves federal funding in the PRC program.
- The Indian health care system is unlike any other mainstream health care delivery system. It was created by the federal government specifically to carry out its trust responsibility to provide health care to AI/AN people. In order to fulfill this trust responsibility Congress must enact Indian-specific provisions where necessary to ensure that Indians served by the IHS system can fully utilize their rights under federal health care laws such as the BCRA.

PROPOSED AMENDMENT: We propose amending Section 208 of the BCRA, to exempt the cost-sharing protections for Indians contained in subsection 1402(d) of the ACA from repeal. This would still accomplish Congress’ intent to repeal the overall cost-sharing subsidies, but leave the Indian cost-sharing protections in place. The language below is Section 208, with italic/underlined text the amending language we propose:

Sec. 208. REPEAL OF COST-SHARING SUBSIDY PROGRAM.  
(a) In General. – Subject to subsection (c) Section 1402 of the Patient Protection and Affordable Care Act is repealed.
(b) Effective Date. – The repeal made by subsection (a) shall apply to cost-sharing reductions (and payments to issuers for such reductions) for plan years beginning after December 31, 2019.

(c) Exemption. – Notwithstanding any other provision of law, subsection (d) of Section 1402 of the Patient Protection and Affordable Care Act shall continue to be implemented and payments required under that subsection shall continue to be made.
Better Care Reconciliation Act of 2017:
Issue for American Indians and Alaska Natives
Sec. 131. Optional Work Requirement for Nondisabled, Nonelderly, Nonpregnant Individuals.

SECTION AT ISSUE: Section 131(a) of the Better Care Reconciliation Act of 2017 (BCRA) would amend the Social Security Act at Section 1902 by adding a new section at 1902(oo) to permit states, effective October 1, 2017, to require non-disabled, non-elderly, non-pregnant individuals to satisfy a work requirement as a condition for receipt of Medicaid medical assistance. The provision would define work requirements as an individual’s participation in work activities for a specified period of time as administered by the state. The provision would incorporate, by reference, the definition of work activities as they appear in SSA Section 407(d) under Part A of Title IV (Block Grants to States for TANF).

Incentivizing access to Medicaid will not work for American Indian and Alaska Native people (AI/AN) since they have access to health care from the Indian Health Service (IHS). Work requirements would actually have the opposite effect to hinder access (or block access entirely) to Medicaid. Instead of participating in these programs, many AI/ANs will simply choose not to enroll in Medicaid and rely on the underfunded IHS instead. Tribal governments support full employment for their citizens, but making work requirements a condition of Medicaid eligibility will not encourage them to find work. Many tribal citizens are located in remote rural areas with limited employment opportunities. While some work requirement proposals would create exceptions for individuals who can demonstrate they are looking for work, those proposals require accessing state employment programs. Tribal citizens generally look to their Tribal governments for employment assistance programs, not state programs, and as a result will not be able to demonstrate they are seeking employment through state programs.

Section 131(a) as drafted would result in cost-shifting from the Medicaid program back to the IHS appropriation that has historically been chronically underfunded. The following language exempts AI/ANs that are eligible to receive their Medicaid services through the Indian health system from work requirements. This protection is in fulfillment of Congress and the United States federal trust responsibility to provide health care to Indians.

SEC. 131. OPTIONAL WORK REQUIREMENT FOR NON-DISABLED, NONELDERLY, NONPREGNANT INDIVIDUALS.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as previously amended, is further amended by adding at the end the following new subsection:

(oo) OPTIONAL WORK REQUIREMENT FOR NON-DISABLED, NONELDERLY, NONPREGNANT INDIVIDUALS.—

(1) IN GENERAL.—Beginning October 1, 2017, subject to paragraph (3), a State may elect to condition medical assistance to a nondisabled, nonelderly, nonpregnant individual under this title upon such an individual’s satisfaction of a work requirement (as defined in paragraph (2)).

(2) WORK REQUIREMENT DEFINED.—In this section, the term ‘work requirement’ means, with respect to an individual, the individual’s participation in work activities (as defined in section
(3) REQUIRED EXCEPTIONS.—States administering a work requirement under this subsection may not apply such requirement to—

(A) a woman during pregnancy through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends;

(B) an individual who is under 19 years of age;

(C) an individual who is the only parent or caretaker relative in the family of a child who has not attained 6 years of age or who is the only parent or caretaker of a child with disabilities; or

(D) an individual who is married or a head of household and has not attained 20 years of age and who—

(i) maintains satisfactory attendance at secondary school or the equivalent; or

(ii) participates in education directly related to employment;

(E) an individual eligible to receive health services from the Indian Health Service, an Indian Tribe, a Tribal Organization, or an Urban Indian Organization.

(b) INCREASE IN MATCHING RATE FOR IMPLEMENTATION.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following:

(aa) The Federal matching percentage otherwise applicable under subsection (a) with respect to State administrative expenditures during a calendar quarter for which the State receives payment under such subsection shall, in addition to any other increase to such Federal matching percentage, be increased for such calendar quarter by 5 percentage points with respect to State expenditures attributable to activities carried out by the State (and approved by the Secretary) to implement subsection (oo) of 14 section 1902.
June 16, 2017

Dear Tribal Leader:

On September 28, 2016, the Department of Veterans Affairs (VA) facilitated tribal consultation in Washington, D.C., with a comment period through November 30, 2016, on VA’s community care consolidation effort. VA received many comments from tribes, and as a result, VA is renewing existing reimbursement agreements through June 30, 2019. As reflected in the renewal amendment language, VA and Tribal Health Programs (THPs) are agreeing to work together to ensure VA’s community care program allows for continuation and growth of the unique relationship that THPs have with VA and the Veterans they serve.

I would like to invite tribal leaders (or their representative designees) along with THPs’ leadership to a roundtable discussion on July 12, 2017, from noon to 3:00 PM at Heard Museum, 2301 North Central Avenue, Phoenix, AZ 85004, to discuss how VA and THPs can work together to update the reimbursement agreements in advance of the June 30, 2019 expiration date. VA suggests the following topics as points of discussion:

- Do THPs have any suggestions on how VA can move from the all-inclusive rate payment methodology to more recent industry standard payment methodology (e.g., value based rate structure)?
- Do THPs have quality related standards in place that can be shared with VA and utilized as the basis for developing a value based rate structure?
- Do THPs have any suggestions related to care coordination between VA and THPs?
- Do THPs have any established care coordination procedures that may be utilized as basis for enhancing care coordination between VA and THPs?

If you or a representative plans to attend the roundtable discussion, please RSVP to tribalgovernmentconsultation@va.gov.

For additional information regarding this effort please contact Majed Ibrahim at majed.ibrahim@va.gov.
I look forward to meeting with you and I appreciate your support as we move forward together to enhance and improve the experience for our Veterans.

Sincerely,

Baligh Yehia, M.D., M.P.P., M.Sc
Deputy Under Secretary for Health
for Community Care
Department of Veterans Affairs Tribal Consultation  
VHA Office of Community Care  
Reimbursement Agreements

Recent Events

VA Round Table Discussion

**Lower 48**

- **July 12, 2017** – VA to facilitate a “round table discussion” with tribal leaders in the lower 48 states in Phoenix, AZ at the Heard Museum.

- **June 20, 2017** – Dear Tribal Leader Letter mailed and emailed to elected tribal leaders of 567 federally recognized tribes for the upcoming “round table discussion” in Phoenix, along with supplemental information.

**Alaska**

- **August 2, 2017** – VA to facilitate a “round table discussion” with tribal leaders in Anchorage, Alaska.

- **July 7, 2017** - Dear Tribal Leader Letter mailed and emailed to elected tribal leaders of 567 federally recognized tribes for the upcoming “round table discussion” in Alaska, along with supplemental information.

Tribal Consultation Timeline

- **December 2016** – As a result of feedback from tribal leaders, VA extends the reimbursement agreements with IHS and Tribal Health Programs (THPs) through June 30, 2019, and commits to facilitating further discussion with tribes.

- **September 28, 2016** – VA tribal consultation takes place at the National Museum of the American Indian in Washington, D.C. in conjunction with the Annual White House Tribal Nations Conference.

- **September 12, 2016** – Dear Tribal Leader Letter mailed and emailed to elected tribal leaders of 567 federally recognized tribes, along with supplemental information.
November 2, 2016

David J. Shulkin
Under Secretary for Health
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington DC 20420

RE: TSGAC Comments on Veteran Affairs’ Proposal to Consolidate Community Care Programs

Dear Under Secretary Shulkin:

On behalf of the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC), I am writing to provide comments on the Veteran Affairs’ (VA) Proposal to Consolidate Community Care Programs. Thank you for the ability to consult with the Veteran’s Administration on the very important issue of improving continuity of care and health care access for Veterans. We expect that the VA, as part of the Federal government, will partner with us to provide the best possible health care for people who, not only have treaty rights to health care, but have also fought in every war, beginning with the American Revolution, at higher rates than any other race in this country.

As a Federal health care program, IHS is similar in status to the VA with the exception of three very important points:

1. Only American Indians and Alaska Natives (AI/ANs) have treaty rights for the provision of health care.
2. IHS is severely and chronically underfunded in contrast to every other Federal health care program. While the Veteran’s Health Administration is funded at twice the level per person than IHS, in fact, the budget for 200,000 homeless veterans is equivalent to the total funding for the more than five million eligible individuals for IHS.
3. Unlike other Federal health care programs, IHS is a discretionary line item in the budget, not a mandatory line item. Parity with other programs is lacking, which results in IHS actually providing fewer services each year, because unlike mandatory health programs, IHS funding does not increase with population growth, inflation, or new technology, and is subject to sequestration.

Considering these differences, TSGAC provides the following comments in response to your consultation request, dated September 12, 2016:

**Extend the current VA-IHS/Tribal Health Program (THP) Memorandum of Understanding (MOU) until December 2018, at minimum.**

TSGAC has expressed its concern in previous communication and oral testimony that failure to extend the currently operating MOUs will disrupt care for AI/AN veterans. There are a number of issues that remain for both parties to explore prior to any substantive changes taking place. Therefore, we recommend that VA establish and utilize a short-term Federal-Tribal workgroup to develop recommendations on issues related to the agreements which include, but are not limited to:

- Serving non-native veterans living in our service areas;
- Tribal access to the VA centralized mail order pharmacy;
• Coordination of care with the current Indian health referral system;
• Inclusion of Purchased/Referred Care Program; and,
• Elimination of co-pays for AI/AN veterans.

VA has not provided any compelling evidence to Congress, IHS, nor Tribes to discontinue the current agreements. A breach in the current agreements will be a failure by the Federal government to provide treaty secured care to AI/AN veterans across the Nation.

Do not consolidate the current MOU into the larger Community Care Program or standardize IHS/Tribal Agreements with other contracted care.

In a previous Dear Tribal Leader Letter, dated October 7, 2015 the Veterans Administration requested Tribal consultation on whether IHS and THPs agreements should be included in the core provider network under the Choice Act. VA affirmed our request that IHS and Tribal programs not be considered part of the core provider network or as a non-department provider in the report to Congress, Plan to Consolidate Community Care Programs. IHS and, therefore, THPs are not contractors, procurement sources, or outside, private vendors. As such, we continue to recommend that IHS and THPs be allowed to directly bill and receive reimbursement from the VA without going through an intermediary service, which would add another costly layer of bureaucracy. We are a Federal health care program that implements the treaty obligation for provision of health care to eligible AI/ANs across the United States.

Do not change the agreed upon reimbursement rates.

To date, the reimbursements received and the number of veterans cared for are low in comparison to other care providers. Indeed, from 2012 to 2015 the VA reported that is has provided just $33 million in reimbursements to IHS and THPs – approximately 0.06% of the entire Veterans’ Health budget and 1% of the IHS budget. While there are approximately 140,000 eligible AI/AN veterans, only 6,000 use the VA system for health care. Additionally, 360 Tribes participate in Self-Governance, yet only 89 agreements have been executed with the VA, suggesting there is much more capacity to improve our access to care for veterans especially in remote and rural locations. We do not support or recommend that Tribal agreements be standardized to incorporate Choice Act provisions because the current agreements are successful in providing additional care to AI/ANs and respect the government-to-government relationship. The Choice Act provisions are less desirable for IHS and THP for a number of reasons, including, the Act’s requirement for preapprovals and lower reimbursement rate. Pre-approvals delay care, interrupt continuity of care for Veterans and increase costs, due to the need to travel and the requirement to see additional VA providers for pre-approval.

Additionally, the Choice Act does not pay at the agreed upon Office of Management & Budget (OMB) rate, which is cost based and was included in the initial MOU. Each Federal program that reimburses IHS and Tribes for health care (Medicare and Medicaid) does so at these rates. IHS appropriations are currently at approximately $3,200 per patient, far below VA health resources per patient and national average health spending. TSGAC does not support any reduction in the rate, given the dire circumstances Indian Country faces with regard to physical health and the social determinants of health. Any reduction in reimbursement will only further exacerbate the conditions the Indian Health System faces. We understand that this MOU specifically deals with reimbursement for care and that the other major issues we face are well beyond the scope of the VA. However, we find it necessary to remind the VA that Tribal Nations are struggling to meet basic needs. For example, some of the major issues and lack of basic needs currently facing AI/ANs include:

• Joblessness rates at or above 47%
• 40% of AI/AN living on reservations live in poverty
• 8-24% lack complete plumbing (reservation/Alaska)
• 7.5-33.3% lack a complete kitchen (reservation/Alaska)
• 18.9-17.3% lack a telephone (reservation/Alaska)
• 14.4%-27.2% live in overcrowded conditions (reservation/Alaska)

To suggest that reimbursement rates should be diminished, only further harms our citizens and adds to the struggle of meeting those basic needs by diminishing the amount of health care available in Tribal communities.

Allow current Agreements to extend to services provided to non-Native veterans.
We believe we can and should do better for our veterans in offering care at the most convenient and culturally sensitive locations. We support offering care to non-Native veterans as well, using the current MOU, due to the fact that many of our health care facilities are located in remote, rural areas and would provide more timely access to the veterans living in those areas, where often no other healthcare providers exist. However, the Choice Act is administratively burdensome for Tribal Health Programs to administer, which creates a barrier to care for Veterans. The existing MOU is the least burdensome manner to accomplish timely access to care. Today, some THPs are providing limited services under Choice Act or Community Care Agreements. However, these services are to fill gaps, not to extend greater access or quality to all veterans. It has been and continues to be our position that the VA should honor and fully implement Section 405 (c) of the Indian Health Care Improvement Act (IHCIA) to include services to non-Native veterans. We believe that VA has the authority under IHCIA and that such an extension could continue to provide equal access for all veterans.

Fully implement Section 405 (c) of IHCIA.
To date, the VA-IHS/THPs MOUs have proven to be successful in facilitating patient care and provided the least administratively burdensome for all parties. However, IHCIA Section 405(c) has not been fully implemented. The current national agreement and, by default, nearly all THP agreements do not include reimbursement for Purchased/Referred Care (PRC). Reimbursement for specialty care provided through PRC is essential to ensure that veterans receive the best care possible. Nationally, only one in thirteen visits is an inpatient visit, but veterans often need additional services which cannot be provided directly by an IHS Service Unit or THP. THPs, in particular, work hard to provide a seamless health care experience lack of coordination for specialty care paid by PRC will only exacerbate a veteran’s experience with both systems. In general, failure to include PRC in the initial agreement further rations the amount of health care IHS and THPs can provide to Native veterans and other eligible AI/ANs in the system.

An additional concern which VA should work to find a solution to under this section is reimbursement of care provided by traditional healers. Traditional healers are an essential component of care within many Indian communities and veteran’s choices should not be limited to a certain type of provider.

Provide equal access to the Consolidated Mail Outpatient Pharmacy (CMOP) Program.
Another aspect of the partnership between VA, IHS, and THPs that should be addressed is the ability of all THPs to access CMOP. Tribes who are first entering Self-Governance need flexibility from VA to have access to this Program. It is essential in maintaining current services when IHS transfers pharmacy responsibilities to a Tribe. Access to CMOP would align IHS, Tribal and the VA systems mission by decreasing transportation costs for the fulfillment of prescriptions and wait times to fill a prescription. Extension of this CMOP access would also increase medical compliance.

Discontinue the practice of collecting co-payments from AI/AN Veterans.
Currently, AI/AN’s who present at a VA facility are assessed co-pays. TSGAC has previously expressed our concern that this practice is wrong and does not in align with the trust responsibility to
provide health care to all AI/ANs. IHS and THPs are the payer of last resort (section 2901(b) of the Affordable Care Act) whether or not there is a specific agreement in place for reimbursement. Neither the AI/AN veteran nor the Indian Health System should be responsible for any co-pays.

Specific recommendations the Tribal Self-Governance Advisory Committee have previously provided are contained in the letters noted below for your review and response. If you would like copies, please let me know:

- **August 23, 2016**: Opportunities for Partnership between Tribal Health Programs and the Veterans Administration
- **April 18, 2016**: Reimbursement Agreement between the IHS and VA
- **October 27, 2015**: Comments on the Veterans Access, Choice and Accountability Act of 2014
- **January 14, 2015**: Comments Submitted in Notice of Tribal Consultation: Section 102 (c) of the Veterans Access, Choice and Accountability Act of 2014

In closing, working in partnership with the VA, IHS, and THPs offer more timely and more convenient access to our Nation’s veterans. We support the effort to ensure that all of our veterans receive the best care possible, in recognition of all their sacrifices on our behalf and for this Country.

If you have any questions or wish to discuss these comments further, please contact me at (860) 862-6192 or via email at lmalerba@moheganmail.com. We look forward to your response to this letter and the letters noted above which have yet to be responded to.

Sincerely,

Chief Lynn Malerba, Mohegan Tribe of Connecticut
Chairwoman, IHS TSGAC

cc: TSGAC Members and Technical Workgroup
Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, IHS
Stephanie Birdwell, Director Office of Tribal Government Relations, VA