IHS Tribal Self-Governance Advisory Committee and Technical Workgroup Quarterly Meeting

Tuesday January 24, 2018
Wednesday January 25, 2018

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

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IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education
P.O. Box 1734, McAlester, OK 74501
Telephone (918) 302-0252 ~ Facsimile (918) 423-7639 ~ Website: www.Tribalselfgov.org

INDIAN HEALTH SERVICE TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE
AND TECHNICAL WORKGROUP QUARTERLY MEETING
Wednesday, January 24, 2018 (1:00 pm to 5:15 pm)
Thursday, January 25, 2018 (8:30 am to 1:30 pm)

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

AGENDA

Wednesday, January 24, 2018 (1:00 pm to 5:15 pm)
Meeting of IHS Tribal Self-Governance Advisory Committee (TSGAC) and Technical Workgroup with RADM Michael D. Weahkee, Acting Director, IHS

1:00 pm **Tribal Caucus**
Facilitated by: Marilynn "Lynn" Malerba, Chief, Mohegan Tribe, and Chairwoman, Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC)

- Purchased and Referred Care Workgroup Meeting Update and GAO Report
- Recommendations on IHS grant-making with recurring appropriations (approximately $52m), and payment of CSC on these funds
- Status of IHS Director Nomination
- IHS Strategic Plan Workgroup -- DTLL
- Tribal Consultation on Sanitation Deficiency System Guidance -- DTLL
- Level of Need Funded Workgroup and Process – DTLL
- Other Issues

2:00 pm **Meeting Called to Order**
Welcome
Invocation
Roll Call
Introductions – All Participants & Invited Guests

2:15 pm **TSGAC Opening Remarks**
Marilynn "Lynn" Malerba, Chief, Mohegan Tribe, and Chairwoman, IHS TSGAC
RADM Michael D. Weahkee, Acting Director and Principal Deputy Director, IHS (Invited)

2:35 pm **TSGAC Committee Business**

- Approval of Meeting Summary (October, 2017)
- Approval of TSGAC Primary and Alternate Members for Great Plains Area
- Input on agenda topics for next Joint TSGAC/Direct Service Tribes Advisory Committee (DSTAC) Meeting

2:45 pm **Office of Tribal Self-Governance Update**
Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, IHS

- OTSG Staff Update
- Status of TSGAC recommendations regarding Title V implementation (initial TSGAC letter dated 2/27/27)

3:15 pm **Break**

3:30 pm **Legislative Update**
Caitrin Shuy, Director of Congressional Relations, National Indian Health Board (Invited)

- Appropriations
- Special Diabetes Program for Indians
- Children's Health Insurance Program
- Tax Reform Impact on Indian Health
- Restoring Accountability in the IHS of 2017 (S 1250 & HR 2662)
- Legislation Related to Veterans Affairs
- Other Updates

4:00 pm **Indian Health Service Budget Update**
Elizabeth Fowler, Deputy Director for Management Operations, IHS (Invited)

- Fiscal Year 2018 Appropriations
- Fiscal Year 2020 National Budget Formulation

4:20 pm **Office of Resource Access and Partnerships Update**
Terri Schmidt, RN, Acting Director, Office of Resource Access & Partnerships (Invited)

- Cost savings under Medicare Like Rates (MLR) for physician services.
- Pending DTLL to address lack of payment by CVS/Caremark (Pharmacy Benefit Manager (PBM)) claims
- Update on other unpaid PBM and medical claims

4:45 pm **Patient Protection and Affordable Care Act (ACA) Implementation Update**
Cyndi Ferguson, Self-Governance Specialist/Policy Analyst, SENSE, Inc.
Doneg McDonough, Consultant, TSGAC

- Update on Recent Administration and Congressional ACA Related

5:00 pm **Preparation for Discussion with Acting IHS Director**

5:15 pm **Recess until January 25, 2018**

Thursday, January 25, 2018 (8:30 am – 1:30 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 (Invited)

8:45 am **Office of Information Technology Update (OIT)**
CAPT Mark Rives, DSc, Director, Office of Information Technology, IHS (Invited)
Carol Chicharello, Deputy Director, Health Program Improvement and Support, IHS

- *Veteran Affairs' Migration to Cerner and Impact on the Resource and Patient Management System (RPMS) Updates*
- *Future plans for RPMS*
- *Data available to support Tribal Sponsorship Programs (*Request IHS to design an RPMS report)

9:00 am ***Health Resources and Services Administration (HRSA)***
George Sigounas, MS, Ph.D., Administrator, HRSA
Dr. Michael Toedt, Chief Medical Officer, IHS
Benjamin Smith, Deputy Director for Intergovernmental Affairs, IHS

- Health professional shortage areas
- Loan Repayment Program
- Alignment of data requirements with IHS

9:25 am **IHS Strategic Plan Update and TSGAC Input**
Marilynn "Lynn" Malerba, Chief, Mohegan Tribe, and Chairwoman, IHS TSGAC
RADM Michael D. Weahkee, Acting Director and Principal Deputy Director, IHS
Francis Frazier, Director, Office of Public Health Support, IHS

10:00 am **Joint TSGAC and Acting IHS Director Discussion**

- Catastrophic Health Emergency Fund (CHEF) Proposed Rule and Policy
- Permanent OTSG Director Selection Status
- VA Partnership Strategy – potential separate meeting
- Update on Quality Programs
- Level of Need Funded Workgroup
- Contract Support Costs Policy Template Finalization
- Other follow-up items from TSGAC October 31, 2017 Letter

11:55 am **Closing Remarks**
Marilynn "Lynn" Malerba, Chief, Mohegan Tribe, and Chairwoman, IHS TSGAC
RADM Michael D. Weahkee, Acting Director and Principal Deputy Director, IHS

12:00 pm **Lunch - TSGAC Members' Executive Session with Acting IHS Director**

12:30 pm **TSGAC Technical Workgroup Working Session**

1:30 pm **Adjourn TSGAC Meeting**

2018 Calendar

Date	Event	Location
January 23-25, 2018	1st Quarterly Meeting	Washington, DC-Embassy Suites DC Convention Center
March 27-29, 2018	2nd Quarterly Meeting	Washington, DC Embassy Suites DC Convention Center
April 22-26, 2018	Tribal Self-Governance Annual Consultation Conference	Albuquerque Convention Center Albuquerque, NM
July 17-19, 2018	3rd Quarterly Meeting	Washington, DC-Embassy Suites DC Convention Center
September 11-12, 2018 (Tentative)	Tribal Self-Governance Strategy Session	Doubletree Downtown St. Paul, Minnesota
October 1-4, 2018	4th Quarterly Meeting	Washington, DC-Embassy Suites DC Convention Center

2019 Proposed Calendar

Date	Event	Location
January 22-24, 2019	1st Quarterly Meeting	Washington, DC-Embassy Suites DC Convention Center
March 26-28, 2019	2nd Quarterly Meeting	Washington, DC-Embassy Suites DC Convention Center
April 21-25, 2019	Tribal Self-Governance Annual Consultation Conference	Grand Traverse Resort and Spa, Traverse City, Michigan
July 16-18, 2019	3rd Quarterly Meeting	Washington, DC-Embassy Suites DC Convention Center
September 10-12, 2019	Tribal Self-Governance Strategy Session	TBD
October 1-3, 2019	4th Quarterly Meeting	Washington, DC-Embassy Suites DC Convention Center

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MEMBERSHIP LIST

(May 19, 2017)

AREA	MEMBER (name/title/organization)	STATUS	CONTACT INFORMATION
Alaska	**Jaylene Peterson-Nyren, Executive Director** Kenaitze Indian Tribe	**Primary**	150 N Willow St. Kenai, AK 99611 P: (907) 335-7200 Email: Jaylene@kenaitze.org
	Gerald "Jerry" Moses, Senior Director Intergovernmental Affairs, Alaska Native Tribal Health Consortium	Alternate	4000 Ambassador Drive, LIGA Department Anchorage, AK 99508 P: (907) 729-1900 Email: gmoses@anthc.org
Albuquerque	**Ruben A. Romero, Governor** Pueblo of Taos	**Primary**	PO Box 1846 Taos, NM 87571 P: 575-758-9593 ~ F: 575-758-4604 Email: governor@taospueblo.com
	Raymond Loretto, DVM, Tribal Council Representative Pueblo of Jemez	Alternate	PO BOX 100 Jemez Pueblo, NM 87024 P: 575-834-7359 ~ F: 575-834-7331 Email: Raymond.loretto.dvm@jemezpueblo.org
Bemidji	**Jane Rhol, Tribal Council Secretary** Grand Traverse Band of Ottawa & Chippewa Indians	**Primary**	2605 N West Bay Shore Drive Peshawbestown, MI 49682-9275 P: (231) 534-7494 Email: jane.rohl@gtbindians.com
	VACANT	Alternate	
Billings	**Beau Mitchell, Council Member** Chippewa Cree Tribe	**Primary**	PO Box 544 Box Elder, MT 59521 Email: beau@cct.rockyboy.org
	Shelly Fyant, Tribal Council Member The Confederated Salish and Kootenai Tribes of the Flathead Nation	Alternate	PO BOX 278 Pablo, MT 59855 P: (406) 275-2700 ~ F: (406) 275-2806 Email:
California	**Ryan Jackson, Council Member** Hoopa Valley Tribe	**Primary**	PO Box 1348 Hoopa, CA 95546 Email: cbfdistrict@gmail.com
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Great Plains	**VACANT**	**Primary**	
	VACANT	Alternate	
Nashville	**Marilynn "Lynn" Malerba, Chief** Mohegan Tribe of Connecticut **TSGAC Chairwoman**	**Primary**	5 Crow Hill Road Uncasville, CT 06382 P: 860-862-6192 ~ F: Email: lmalerba@moheganmail.com

	Casey Cooper, Chief Executive Officer Eastern Band of Cherokee Indians Hospital	Alternate	43 John Crowe Hill Rd. PO Box 666 Cherokee, NC 28719 Email: Casey.Cooper@cherokeehospital.org
Navajo	**Jonathan Nez, Vice President** Navajo Nation	**Primary**	PO BOX 7440 Window Rock, AZ 86515 P: (928) 871-7000 Email: jonmnez@yahoo.com
	Nathaniel Brown, Delegate of the 23rd Navajo Nation Council Navajo Nation	Alternate	PO BOX 3390 Window Rock, AZ 86515 P: (928) 871-6380 Email: nbrown@navajo-nsn.gov
Oklahoma 1	**John Barrett, Jr., Chairman** **Rhonda Butcher, Director** Citizen Potawatomi Nation	**Primary** **Proxy**	1601 S. Gordon Cooper Dr. Shawnee, OK 74801 P: 405-275-3121 x 1157 F:405-275-4658 Email: rbutcher@potawatomi.org
	Kay Rhoads, Principal Chief Sac and Fox Nation	Alternate	920883 Hwy 99 Stroud, OK 74079 P: (918) 968-3526 x 1004 F: (918) 968-1142 Email: chief@sacandfoxnation-nsn.gov
Oklahoma 2	**Jefferson Keel, Lt. Governor** Chickasaw Nation	**Primary**	PO Box 1548 Ada, OK 74821 P: 580-436-7232 ~ F: 580-436-7209 Email: lt.gov@chickasaw.net
	Gary Batton, Chief **Mickey Peercy, Executive Director** Choctaw Nation of Oklahoma	Alternate **Proxy**	PO Box 1210 Durant, OK 74702 P: 580-924-8280 ~ F: 580-920-3138 Email: mpeercy@choctawnation.com
Phoenix	**VACANT**	**Primary**	
	VACANT	Alternate	
Portland	**W. Ron Allen, Tribal Chairman/CEO** Jamestown S'Klallam Tribe **TSGAC Vice-Chairman**	**Primary**	1033 Old Blyn Highway Sequim, WA 98382 P: 360-681-4621 ~ F: 360-681-4643 Email: rallen@jamestowntribe.org
	Tyson Johnston, Vice President Quinault Indian Nation	Alternate	P.O. Box 189 (1214 Aalis Drive) Taholah, WA 98587 P: 360-276-8211 ~ F: 360-276-4191 Email: tjohnston@quinault.org
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	Anthony J. Francisco, Jr., Councilman Tohono O'odham Nation	Alternate	P.O. Box 837 Sells, AZ 85634 P: (520) 383-5260 Email: Anthony.francisco@tonation-nsn.gov

TSGAC TECHNICAL WORKGROUP

AREA	MEMBER (name/title/organization)	STATUS	CONTACT INFORMATION
Alaska	Brandon Biddle Alaska Native Tribal Health Consortium	Tech Rep	4000 Ambassador Drive Anchorage, Alaska 99508 P: 907-729-4687 Email: bbiddle@anthc.org
	Alberta Unok Deputy Director Alaska Native Health Board	Tech Rep	4000 Ambassador Drive Anchorage, Alaska 99508 P: 907-562-6006 Email: aunok@anhb.org
Albuquerque	Shawn Duran Taos Pueblo	Tech Rep	P.O. Box 1846 Taos, N.M. 87571 P: 575.758.8626 ext. 115 Email: SDuran@taospueblo.com
Bemidji	John Mojica Mille Lacs Band of Ojibwe	Tech Rep	43408 Oodena Drive Onamia, MN 56359 P: 320-532-7479 ~ F: 320-532-7505 Email: john.mojica@millelacsband.com
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California	VACANT	Tech Rep	
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	Cyndi Ferguson SENSE Incorporated	Tech Rep	Upshaw Place 1130 -20th Street, NW; Suite 220 Washington, DC 20036 P: (202) 628-1151 ~ F: (603) 754-7625 C: (202) 638-4502 Email: cyndif@senseinc.com
	Doneg McDonough	Tech Rep (Health Reform)	Phone: 202-486-3343 (cell) Fax: 202-499-1384 Email: d.mcdonough@yahoo.com
Great Plains	VACANT	Tech Rep	
Nashville	Dee Sabattus United South and Eastern Tribes, Inc.	Tech Rep	711 Stewarts Pike Ferry, Suite 100 Nashville, TN 37214 Email: dsabattus@usetinc.org
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	Melanie Fourkiller Choctaw Nation **Tribal Technical Co-Chair**	Tech Rep	PO Box 1210 Durant, OK 74702 P: 580-924-8280 ~ F: 580-920-3138 C: 918-453-7338 Email: mfourkiller@choctawnation.com
	Karen Ketcher Cherokee Nation	Tech Rep	PO Box 948 Tahlequah, OK 74465 P: 918-772-4130 Email: karen-ketcher@cherokee.org
	Kasie Nichols Citizen Potawatomi Nation	Tech Rep	1601 S. Gordon Cooper Dr. Shawnee, OK 74801 P: 405.275.3121 ~ F: 405.275.0198 C: 405-474-9126 Email: kasie.nichols@potawatomi.org
Phoenix	VACANT	Tech Rep	
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Tucson	Veronica Geronimo Tohono O'odham Nation	Tech Rep	P.O. Box 837 Sells, AZ 85634 P: (520) 383-5260 Email: veronica.geronimo@tonation-nsn.gov

FEDERAL TECHS

AREA	MEMBER (name/title)	STATUS	CONTACT INFORMATION
HQ	Jennifer Cooper Deputy Director, OTSG **(Federal Tech Co-Chair)**	OTSG Rep	801 Thompson Ave, Suite 240 Rockville, MD 20852 P: 301-443-7821 ~F: 310-443-1050 Jennifer.Cooper@ihs.gov
	Jeremy Marshall Policy Analyst, OTSG	OTSG Rep	801 Thompson Ave, Suite 240 Rockville, MD 20852 P: 301-443-7821 ~F: 310-443-1050 Jeremy.Marshall@ihs.gov
Great Plains	Sandy Nelson (POC) Director, Office of Tribal Programs	Area Rep	115 4th Avenue, SE, Suite 309 Aberdeen, SD 57401 P: 605-226-7276 ~F: 605-226-7541 Sandy.Nelson@ihs.gov
Alaska	Lanie Fox (POC) Director, Office of Tribal Programs	Area Rep	4141 Ambassador Drive, Suite 300 Anchorage, AK 99508-5928 P: 907-729-3677 ~F: 907-729-3678 Lanie.Fox@ihs.gov
California	Travis Coleman IHS Agency Lead Negotiator	Area Rep	650 Capitol Mall, Ste 7-100 Sacramento, CA 95814 P: 916-930-3927 ~F: 916-930-3952 Travis.Coleman@ihs.gov
Nashville	Lindsay King IHS Agency Lead Negotiator	Area Rep	711 Stewarts Ferry Pike Nashville, TN 37214-2634 P: 615- 467-1521 ~F: 615-467-1625 Lindsay.King@ihs.gov
Navajo	Floyd Thompson Executive Officer IHS Agency Lead Negotiator	Area Rep	Hwy 264 (St. Michael, AZ) Window Rock, AZ 86515-9020 P: 928-871-1444 ~F: 928-871-5819 Floyd.Thompson@ihs.gov
	Alva Tom (POC) Director, Indian Self-Determination	Area Rep	Hwy 264 (St. Michael, AZ) Window Rock, AZ 86515-9020 P: 928-871-1444 ~F: 928-871-5819 Alva.Tom@ihs.gov
Oklahoma	Max Tahsuda Director, Tribal Self-Determination IHS Agency Lead Negotiator	Area Rep	701 Market Drive Oklahoma City, OK 73114 P: 405-951-3761 ~F: 405-951-3868 Max.Tahsuda@ihs.gov
Portland	Denise Imholt IHS Agency Lead Negotiator	Area Rep	1414 NW Northrup Street, Suite 800 Portland, OR 97209 P: 503-414-7792 ~F:503-414-7791 Denise.Imholt@ihs.gov
Tucson	Robert L. Price (POC) Public Health Advisor, Office of Tribal Affairs	Area Rep	7900 South J Stock Road Tucson, AZ 85746 P: 520-295-2403 ~F:520-295-2540 Robert.Price@ihs.gov

OTHER RESOURCES		
MEMBER (name/title)	**ORGANIZATION**	**CONTACT INFORMATION**
Caitrin Shuy Director of Congressional Relations	National Indian Health Board	P: 202-507-4085 Email: cshuy@nihb.org
Devin Delrow Director of Federal Relations	National Indian Health Board	P: 202-507-4072 Email: ddelrow@nihb.org

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Technical Workgroup
Assignment Matrix
Updated: October 10, 2017

Technical Workgroup Co-Chairs:
Melanie Fourkiller, Tribal Co-Chair
Jennifer Cooper, Federal Co-Chair

	Assignment	Person(s) Responsible	Date Task Originated	Status
1.	Develop metrics to evaluate effectiveness of MLR after implementation.	Mickey Peercy (PRC Workgroup) Doneg McDonough	April 13, 2015	9/15/17: Include on October Quarterly TSGAC Meeting, Tribal Caucus.
2.	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). 1997 IHS Director Letter [SG Negotiations issue – whether IHS ALNs should accept provisions (at Tribal option) that have been previously negotiated in other Compacts/FAs, to the extent applicable to that Tribe.]	Jennifer Cooper SGCE Mickey Peercy Rhonda Farrimond Melanie Fourkiller Cyndi Ferguson Terra Branson Shawn Duran Alberta Unok	July 21, 2016	Other issues and recommendations remain regarding Title V implementation. 7/20/17: This group agree to review the ALN Handbook and make recommendations moving forward. 9/15/17: Will be included for update on October, 2017 Quarterly Meeting agenda.
3.	Develop TSGAC Comments to the SG Congressional Report.	Melanie Fourkiller Carolyn Crowder SGCE	October 27, 2016	On hold until next report is sent out for Tribal Consultation
4.	Outline of the successes of Self-Governance	Melanie Fourkiller Melissa Gower Terra Branson Jim Roberts Cyndi Ferguson	January 25, 2017	On hold, pending outcome of SGCE Fellow Research 9/15/17: Terra will follow up with contractors to report the status of this.
5.	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	Jennifer McLaughlin	March 29, 2017	Drafted. 7/20/17: Should include a request for additional consultation and meetings regarding recent roundtable discussion questions. 9/15/17: Jennifer will add this, and send another draft of the letter for finalization.

	for Native Veterans due to trust relationship; and request the VA head of Intergovernmental Affairs attend the July quarterly meeting.			
6.	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.	Kasie Nichols	March 29, 2017	Superceded by item #16 and Completed.
7.	Follow up on TSGAC request to IHS to post Vacancy/personnel reports/statistics on the IHS website in an easily accessible place.	Jennifer Cooper	March 29, 2017	Jennifer is confirming that this has been completed.
8.	Letter from TSGAC to IHS making recommendations on the Loan Repayment Program (designation/expansion of fields of study, assessing growing fields of need within IHS, etc.)	Doneg McDonough	March 29, 2017	Completed.
9.	Work with OTSG staff on updating the 2002 Headquarters PSFA Manual.	SGCE Cyndi Ferguson Kasie Nichols Melanie Fourkiller	March 29, 2017	In process. Working Call held October 4, 2017; next working call TBD in November
10.	Letter to IHS Acting Director outlining our concerns regarding IHS utilizing grants to distribute funding.	Jennifer McLaughlin	July 20, 2017	In process.
11.	Send a joint letter from TSGAC and DSTAC to IHS Acting Director and ORAP Acting Director requesting that IHS make the Pharmacy Benefit Manager issues a top priority to resolve.	Melissa Gower SGCE	July 20, 2017	Completed.
12.	Send letter to IHS Acting Director to request that IHS host Tribal Consultation on Sanitation Facilities Construction guidance.	Unassigned-TSGAC will host a call on August 10th at 3:00 EST to discuss this further.	July 20, 2017	Completed.
13.	Send a request and nomination to Benjamin Smith and Human Resources for a TSGAC appointee to participate in the interview process for the OTSG Director position.	SGCE Terra Branson	July 20, 2017	Completed.
14.	Follow up on the request for additional information regarding distribution of the Indian Health Care Improvement Fund.	SGCE	July 20, 2017	Question re: IHS determining how these funds would be spent – CPN
15.	Letter from TSGAC to VA – include new information concerning CARE proposal	Jennifer McLaughlin	October 25, 2017	
16.	Letter from TSGAC to NIH – request for extension to comment period on Biogenetic Research	Karen Ketcher	October 25, 2017	

17.	Letter from TSGAC to IHS regarding LNF – identifying people to participate on Workgroup, and early	Melissa Gower	October 25, 2017	
18.	Letter from TSGAC to Acting Secretary, HHS requesting IHS exemption from SES hiring moratorium. Cite Regulation in	Melanie Fourkiller	October 25, 2017	
19.	Develop comments from TSGAC to the HHS Strategic Plan (this week)	Terra Branson	October 25, 2017	
20.	Develop comments from TSGAC to the IHS Strategic Plan (by October 31)	Melanie Fourkiller	October 25, 2017	
21.	Letter from TSGAC to IHS on CHEF policy	Geoff Strommer, Jim Roberts	October 25, 2017	
22.	Letter from TSGAC to IHS on Grants with recommendations	Kasie Nichols	October 25, 2017	
23.	Letter from SGCE to Congress on Behavioral health/Public Health Block Grant proposal	Jeremy Arnette	October 25, 2017	
24.	Develop testimony from SGCE for Senator Rounds Bill (Audit of IHS)– Hearing November 8	Terra Branson-Research and then assign	October 25, 2017	
25.	Develop SGCE testimony for VA Hearing held Oct 25 – perhaps joint with NIHB	Terra/Melanie/Melissa	October 25, 2017	
26.	Develop legislative language to preserve THP reimbursement agreements with VA for the CARE Act	Catrin Shuy	October 25, 2017	
27.	Letters from TSGAC to Tribes in the Areas with vacancies (3 Areas) to ask them to identify/nominate	Terra Branson	October 25, 2017	
28.	Overall Letter from TSGAC to IHS as follow up to Quarterly Meeting issues More timely responses Transparency in tribal shares issue Request money for OIT in 2020 request – include money for Tribes PRC consultation request -- SFC Tribal Consultation follow up Loan Repayment program placement follow up, include visit with HRSA on primary care physicians moving to inpatient Small Ambulatory Grant Program follow up	Melanie Fourkiller	October 25, 2017	

29.	Tribal Medicaid Benefit Package approaches	Doneg McDonough Rhonda Beaver, Melissa, Melanie, Jim, Caitrin, Elliot Millholin, Devin Delrow, Chief Malerba	October 25, 2017	

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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)

- Discussion of IHS Strategic Plan Workgroup:
  - Discussed Timelines of Responses to TSGAC Issues
  - Workgroup Input
  - Volunteers from DSTAC
- Lost Collections from Private Insurance -- Pharmacy Benefit Managers and Medical Services
  - Trust Responsibility
  - Tribal Consultation
  - Tribes not referenced in same was as failh based organizations and states
  - Not mentioned item is determinates of health
  - Broadband/Technology
  - Availability of primary care in indian country
  - IHS not a big contributor to the plan
  - 535 (portion of the plan)—should include all genders, whole lifespan
- Tribal Consultation on Sanitation Deficiency System Guidance Document
- Interviews for Director, Office of Tribal Self-Governance, IHS
  - SES hiring moratorium
  - Formal process for selecting position-also consider the Acting OTSG Director
- Level of Need Funded Workgroup and Process
  - Unmet obligations/requirements-rather than need
  - Need the Workgroup established asap-concerned that Cliff will do the work without us
  - Need to understand what they are going

    - Perhaps send a follow up letter identifying TSGAC reps to participate on Workgroup
    - Add Dee Sabatus to LNF working group
- Metrics and analysis of impact of Medicare-Like Rates Implementation
    - Should we pursue a study
    - PRC Workgroup- ask them to pursue this report-how well
    - Huge benefit for those that were not in a position to work with the providers to get the rates down
- Other
    - Medicaid Waivers
        - Maine has requested waiver without consulting Tribes
    - Biogenetics-NIH Advisory Committee
        - NIH Biogenetics want to encourage AI/AN to participate in all of us project and send in bio sample and medical records and then researchers could use it for anything
        - Some tribes have moratorium on genetic testing, Tribes need to remain in control of their own data/research
        - Blood Quantum was used as termination in New England
        - NIH requested comments-request extension to comment period-expired in early October 2017
    - CHEF
        - Tribal Self-Insured plans as alternate resource
        - IHCIA precludes IHS from billing Tribal SI plans unless they are granted permission
        - October 6th letter
    - VA
        - We are not a vendor, we are another federal health program and expect our OMB rate to be honored
        - PRC reimbursement
    - Grants
        - Not making much ground
        - Need to look at legislative language
        - IHS Looking for recommendations- looking at National Behavioral Health Advisory Committee
        - Need interagency agreements to send money from HHS op divisions to IHS
        - Also need to identify the true number of funds needed to fund Tribes/ IHS appropriately
    - PRC
        - Population growth-funding has not kept pace with the growth, and some programs have had to rely on the State for filling the gap
        - Discussion of mandatory funding
    - Distribution of Funds-Transparency
        - IHS Doesn't have full disclosure about distribution of funds (Ak-Chin)
        - IHS Calling them subcontractor, under another Tribe(Ak-Chin)
            - How are they distributing funds between the two tribes?

9:00 am **Meeting Called to Order**

Welcome

Invocation: Delia Carlyle, Council Member, AK-Chin Indian Community

Roll Call:

Alaska
Albuquerque
Bemidji
Billings
California
Navajo
Oklahoma 1
Oklahoma 2
Portland
Tucson

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 and Principal Deputy Director, IHS (Invited)

- RADM Chris Buchanan, Acting Secretary thanked the attendees and participants for their continued support. Stating that TSGAC is an important partner with IHS. Apologized that RADM Weahkee is at DSTAC this morning but will be attending the Executive Session today.
- Acting Secretary spoke to the nomination and appointment process for Director of IHS stating that Robert Weaver has been nominated.
- Stated a focus on IHS four priorities-people, partnership, and quality
    - People- New appointment of individuals to IHS positions RADM Kevin Meeks has taken the position as Deputy Director of Field Operations, Erick Hargen, Acting Secretary HHS, Travis Watts, Acting OCAO Director and Emily Newman, Senior Advisor to the Director, IHS.
    - Partnership-Focus on our relationship with tribes and working on Strategic Plan
    - Quality- Promote practices and policies that improve healthcare and services to patients. Development of Uniform Health Quality and Safety Standards.
- Joint DSTAC/TSGAC meeting; rethink the schedule next time to ensure IHS can attend
    - Commissioned Corps: 45 IHS Officers over the last two weeks deployed to Puerto Rico
    - Partnerships: RADM WEahkee took part in 40th anniversary of Menominnee Health Clinic – 1977 first Indian owned and operated health care facility
    - IHS Strategic Plan – HHS Re-Imagine Initiative
        - Requesting input on forming the Tribal/Federal Workgroup
    - 16.5$ million in grants awarded recently

  - New higher thresholds for HHS approval of renovation/construction – HHS commitment to remove barriers for IHS operations.
  - Last week was national health quality week;
    - New national credentialing and privileging system
    - Alb, OCAO using new system, other Areas coming on line by end of year
    - Identifying single accrediting system
    - New dashboard for monitoring performance indicators
  - Resources, CR for 2018 through December 8th, 2017
    - Slight rescission from FY 2017
    - House mark has increases for IHS
  - Three month extension for SDPI; continue to provide TA to Congress for longer renewal of SDPI authorization.
- Tribal Comment: funding for detox – New Mexico is seeing a trend moving from social detox to medical detox. Many facilities for social detox have been closing due to liability reasons. Will there be resources or support for more medical detox to address this need?
  - Response: Do not have an answer today, but both are appropriate approaches and we seek to include culture in our approaches to detox. There will not be one approach as Social detox and Medical detox are separate issues.
- Tribal Comment: Request that utilize the opportunity in areas where there are hospitals that are not always at capacity, to train up the staff for medical detox. If these hospitals have empty beds, use them.
  - Response: Great point, perhaps for next meeting, we can report on our progress.
- Tribal Comment: There is announcement expected from WH on state of emergency on the opioid crisis. Is the Federal government gathering data on Tribal communities/Tribal members? Sometimes, it is 2-5 years down the road before it becomes an epidemic in Tribal communities. Now would be the time to gather data and implement interventions/prevention to avoid an epidemic if one does not currently exist. Need more resources in Tribal Epi Centers to develop these data and trends, funds that are not passed through the States.
  - Response: Activities at the HHS and IHS level to identify resources. Internally for IHS, not aware of specific data gathering activity. Some investigations with OIG currently, visiting our facilities. They are looking at the measures to protect patients, controls, amounts prescribed, training, checking drug databases, etc. Agree that getting data to work on prevention efforts would be a good first step. Totally agree that funds should not be passing to Tribes through States. The HOPE committee was created
  - Tribal Comment: Funding should be provided directly to tribes to gather their own data. Epi Centers are critical to tribes and there need to be more money to address needs. The IHS Budget should be moved from discretionary to mandatory.
- Tribal Comment: Re: deployment of Corps. Could a Tribe declare a state of emergency in health and get assistance in a similar way?

- Response: pulling officers out of the current programs for deployment also causes a problem.
- Tribal Comment: There should be a mechanism in place to declare health disasters so we can get boots on the ground to help tribes. There is a cluster of suicide occurring when you take tribal officers away from tribal sites to assist with other things (ie, hurricanes, disasters) this needs to be looked into because it leaves a need for services back home.
- Response: When the hurricanes were happening and the call went out for assistance it was clear that we were not going to ask for any more than was needed but we were in the red level stage. Federal still needs the approval from areas. Tribes are able to make their own disaster declarations- they should make a request for emergency management and deploy staff out to the tribes.

9:40 am **TSGAC Committee Business**

- Approval of Meeting Summary (July 2017)
  - Motion
  - Second
  - Passed without objection
- Update: 2017 Tribal Strategy Session, September 5-6, 2017
  Jennifer McLaughlin, Self-Governance Associate, Jamestown S'Klallam Tribe
  - Recap
  - Approach was to develop actions related to Strategic Plan

10:00 am **Office of Tribal Self-Governance Update**
Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, IHS

- **People:** Staff is important- Office currently has 2 vacancies for Financial Analysts and the hiring freeze has now been lifted. ALN's serve an invaluable role and need a stronger pool of Self-Governance ALN's.
- **Partnerships:** FY2017 five new SG tribes; 95 Title V compacts and 121 funding agreements; $2 billion dollars to tribes transferred to tribes. Helped to facilitate 29 Tribal delegation meetings from 10 IHS areas. Received 10 final Officers, rejected 2, withdrew 7 and 1 pending.
- **Quality:** Implementing ISDEAA Title V Authorities.
  - Digital Accountability and transparency act (Data Act) of 2014- compliance- goal is to have funds that have been transferred to have more transparency with our data.
  - Updating 2002 Headquarters PFSA Manual- discussed it in the March meeting and haven't had much action until recently. IHS started to develop a work plan and setting up the systems to make the review happen. There will be Tribal consultation.
  - FY2015 & FY 2016 SG Report to Congrress- producing it for final agency review. Report will be submitted for consultation in the next few months.
  - ISDEAA Title V Team Process Improvement- How to process the funding agreements, amendments, compacts and payments. IHS is doing a process improvement meeting.

- **Resources-** FY2017 Cooperative Agreements- 3 Successful grantees this year
    - Planning $120,000 (Paskenta Band of Nomlaki Indians/Rolling Hills Clinic) (California Area)
    - Negotiation $48,000 (Salt River Pima-Maricoma Indian Community) (Phoenix Are) & Pascua Yaqu1 Tribe (Tucson Area)
    - End of year transfers – continue to support MOU with SGCE to support SGCE and support TSGAC and Self-Governance Activities
    - Jamestown S'Klallam Tribe – ACA – Self- Governance National Indian Health Outreach and Education
    - Government Performance and Results Act Pilot Projects (5)
    - Resources FY2018 Continuing Resolution is being processed for some and some have been completed - Period (10/1/2017 – 12/8/2017 (18.9% of the year) Reduction of .6791%. Each CR plays into how long it takes to process payments for Tribes that are Self-Governance.
- Tribal Comments: You talk about an internal process to look at the law. Title V is the law and the agency would be better served to follow the law. The Agency at times develops a policy outside the scope of the law. Are you able to give a 101 SG primer to staff so they understand?
    - Response: We provide briefings and participate in internal discussions so there is an opportunity to do it.
- Tribal Comments: It is also about how they interpret the law and it should be based on Tribal empowerment and not paternalistic notions. We always start at ground zero every time someone new and they need to be trained appropriately.
    - Response: Rear Admiral - On a weekly basis we get updates on the activities going on.
- Tribal Comments: Appreciate it because GAO has been out visiting us. They are talking about impediments to the Tribes being successful in Self-Governance. They are trying to figure out since it is the law why it is so difficult.Continuing Resolution issue – Tribes leave stuff in reserve in anticipation of these times but that makes us forgo services. When we act responsibly we get penalized for not using the money and then our funding gets cut. We struggle to do what we can with the limited dollars we have. For ten years, Tribes have been working off of CRs but we still have to maintain the programs and services. How are we expected to plan, implement and sustain without assurances that the money is coming down the pipe?
    - Response: Appreciate your comment and I hear it. For our staff, we are well aware of the concerns and the urgency of getting funds out to the Tribes.

- Tribal Comment: Thank you for listening to us on cooperative agreements deadline and moving it up.

10:30 am **Break**

10:45 am **Joint TSGAC and Direct Service Tribes Advisory Committee Meeting, October 23, 2017 – Update and Next Steps**
Marilynn "Lynn" Malerba, Chief, Mohegan Tribe, and Chairwoman, IHS TSGAC
Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, IHS
Melanie Fourkiller, Policy Analyst, Choctaw Nation of Oklahoma, and TSGAC Tribal Technical Workgroup Co-Chair

- Tribal Comment: Small group but really good discussion. Most of the topics on that agenda are on our agenda over the next two days. There was a lot of commonality between us (Direct Service and SG Tribes). We discussed re-imagine, strategic planning, VA, - a lot of common issues.
- Tribal Comment: Take away – time between meetings is lengthy – interest in keeping in contact more often and we have been doing it informally with joint letters of joint issues. Work and collaboration can continue and we can enhance it a bit.
- Response- It is exciting to have all the Tribal leaders speak on the same and similar issues that impact everyone across Indian country. It was the third annual meeting and a lot of great discussion. Recommendations on format or how often to have these meetings we are interested in hearing it.
- Common themes – Medicaid reform; Office of Information Technology (add planning dollars – look to see how VA is funding it)
- Next Steps – How often should we convene and should we do phone calls in between. Share action items from Direct Service and Self-governance meetings when we convene because it could spur more discussion around topics of mutual interests. Also review the charters between each of the committees. We have recently reviewed and amended the Charter for this group. (circulate it with this group)
- Recommendation on how to formulate the Federal Tribal Workgroup on the Strategic Plan – an item to think about.

11:15 am **Office of Resource Access and Partnerships Update**
Terri Schmidt, RN, Acting Director, Office of Resource Access & Partnerships (Invited)

- Workgroup to address lack of payment by private insurers for Pharmacy Benefit Manager (PBM) and certain medical claims
- Department initiated discussions with Caremark, and educated
- Caremark informed IHS that they want to make payments according to the law and discuss logistics
- Claims rejected for last 365 days will be able to be filed on paper?
- Caremark agreed to identify a point of contact for Tribes to contact in working directly with them.

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

1:30 pm **Renewing the National IHS-Veterans Administration Memorandum of Understanding**

Honorable Carolyn Clancy, M.D., MACP, Deputy Under Secretary for Health for Organizational Excellence, Department of Veterans Affairs
Benjamin Smith, Deputy Director for Intergovernmental Affairs, IHS (Invited)

- Veterans Health Administration's request to alter the payment methodology to IHS and Tribal Health Programs
- Coordination of Care
- Follow up to the Veterans Administration's Fall 2016 Consultation and July, 2017 Roundtable

Dr. Clancy: Deputy Undersecretary VHA

- Discussion of her background, familiarity with our agreements, and history of reimbursement agreement;
- Expanded agreements to include native and non-native patients, due to remoteness (AK)
- Extended these agreements through June of 2019
- Requested assistance with outreach to ensure Veterans are acces
- 2017, 5.6 million reimbursed;
- Agreements also encourage resource sharing;
- New agreement authorizing Tribes to utilize CMOP;
- 60 IHS pharmacies participating;
- PRC reimbursement and reimbursement for non-native veterans where the services are not available. Very interested in building upon our relationship, need new legislation to do that.
    - Trying to get legislation passed – CARE Act
- VA takes care coordination very seriously;
- Consolidating all pots of money for purchasing care in the community – consolidating community care;
- 100k non-native veterans, if they were able to access IHS/Tribal facilities, they would be able to access care closer to home with less wait times.
- Confident that the legislation will pass prior to the end of the FY – it will likely take a year to implement. They will be 'rolling out a "new contract"'
-

2:30 pm **Indian Health Service Budget Update**

Elizabeth Fowler, Deputy Director for Management Operations, IHS (Invited)

- Fiscal Year 2017 Funding Distribution
- Fiscal Year 2018 Appropriations
- Fiscal Year 2020 National Budget Formulation
- Liz Fowler, Budget Update:
    -

3:00 pm **Legislative Update**

Caitrin Shuy, Director of Congressional Relations, National Indian Health Board (Invited)

- Status of Health Reform Legislation
- Special Diabetes Program for Indians

- Restoring Accountability in the IHS of 2017 (S 1250 & HR 2662)
- Other Updates

3:30 pm **Office of Information Technology Update (OIT)**

CAPT Mark Rives, DSc, Director, Office of Information Technology, IHS (Invited)
Randall Hughes, Tribal Liaison, OIT, IHS (Invited)
Stuart Ferguson, PhD, Chief Technology Officer, Alaska Native Tribal Health Consortium, TSGAC Representative to ISAC (invited)

- Update from ISAC Meeting, September 19-20, 2017
- Veteran Affairs Migration to Cerner and Impact on the Resource and Patient Management System (RPMS) Updates
- Future plans for RPMS
- IT Service Catalog – Tribal Consultation results and next steps
  - CAPT Rives: We did not choose the timing of the VA decision; but we can choose what we do with this opportunity.
  - ISAC, Sept 19-20 – Updating the ISAC charter; updating OIT human capital management plan; revising the FY 2018-19 IT priorities
  - **TSGAC needs to develop feedback on charter – by November 6th – especially in the change in membership (NIHB and IHS, at large members). Change in how Chairs are elected (Tribal Chair would alternate every two years between DSTAC and TSGAC)**

4:00 pm **Implementation of the IHS Quality Framework and Associated Initiatives**

Capt. Michael Toedt, M.D., IHS Chief Medical Officer (Invited)
Jonathan Merrell, RN, BSN, MBA, IHS Acting Deputy Director for Quality Health Care (Invited)

- Update on IHS accreditation and credentialing processes
- Patient wait times/Improving Patient Care (IPC) initiative
- Workforce development and critical staff vacancies
  - Government and Accounting Office (GAO) Visits
- Dr. Toedt, CMO
  - Hep C projects successes and replication
  - Quality framework: concerns of Tribal Leaders, IHS and Congress
  - Accountability has been difficult, due in part to decentralization.
  - Accountability Dashboard – defines measures that HQ is looking for at IHS sites (each Area CMO)
    - Have or working towards accreditation and patient centered medical home; active quality improvement program; hospitals accredited as hospitals; influenza vaccinations; improvement processes for safety; active emerg. preparedness plan; opioid prescribing policies that conform to CDC/IHS; federal employee viewpoint survey use; hospital improvement and innovation network;
    - Adding defined improvement of patient experience survey and Wait time standards
    - Credentialing and privileging – rolling out a single software system – decision-making is still with local governing body.
    - Patient experience of care surveys

- Patient wait times announcement – minimum standard
-

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

5:00 pm **Recess until October 25, 2017**

Wednesday, October 25, 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 (Invited)

8:45 am **Contract Support Cost Policy Update**
Mickey Peercy, Executive Director of Self-Governance, Choctaw Nation of Oklahoma
Roselyn Tso, Acting Director, IHS Office of Direct Service and Contracting Tribes (Invited)

- Workgroup Update, August 16, 2017 Meeting
- Next Steps
- Mickey Peercy: Review of the history of CSC policy, funding and claims.
- Liz Fowler: Discussed CSC funding status; CSC policy implementation and finalizing the ACC templates.
  - Some Tribes had agreed to a 2014 final amount of CSC but were not paid yet. They have since been paid.
  - There were concerns about how long it takes DCA to negotiate rates with Tribal Orgs (HHS). Asked that IHS do some
  - Estimates for CSC – would like to come back to the Workgroup, and discuss the calculation in more detail. It seems there is a similar approach to what the Tribes have taken to make projections and estimates; the differences may be due to the timing of when the estimate is made.

9:15 am **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 Tool)
- Administration and Congressional ACA Related Actions in 2017 and 2018

9:45 am **"Re-Imagine HHS" Initiative, HHS Strategic Plan and IHS Strategic Plan Development**
Marilynn "Lynn" Malerba, Chief, Mohegan Tribe, and Chairwoman, IHS TSGAC
RADM Michael D. Weahkee, Acting Director and Principal Deputy Director, IHS (Invited)

- "Re-Imagine HHS" Report due to Office of Management and Budget by September 11, 2017
- HHS Strategic Plan Update and Tribal Consultation
- Process and timeline for IHS Strategic Plan Development

10:30 am **Joint TSGAC and Acting IHS Director Discussion**

11:15 am **Closing Remarks**
Marilynn "Lynn" Malerba, Chief, Mohegan Tribe, and Chairwoman, IHS TSGAC
RADM Michael D. Weahkee, Acting Director and Principal Deputy Director, IHS (Invited)

11:30 am **Lunch**

12:15 pm **TSGAC Technical Workgroup Working Session**

12:45 pm **Adjourn TSGAC Meeting**

SPIRIT LAKE TRIBE

Myra Pearson
Chairperson
Cell: 701-230-4975

November 30, 2017

Marilynn Malerba, Chairwoman
Tribal Self-Governance Advisory Committee
c/o Self-Governance Communication & Education
PO Box1734
McAlester, OK 74502

RE: Nomination to the Tribal Self-Governance Advisory Committee

Dear Chairwoman Malerba,

Spirit Lake Tribe would like to nominate Kenneth Baker, Jr. to represent the Great Plains as the PRIMARY representative and Arlis Krulish as the alternate on the Tribal Self-Governance Advisory Committee.

Below is the contact information for:

Kenneth Baker, Jr.
Spirit Lake Health Center
PO Box 309
Fort Totten, ND 58335
(701) 766-1672
Kenneth.baker@ihs.gov

Arliss Krulish
7473 35th St NE
Fort Totten, ND 58335
(701) 766-1600
Arliss.krulish@ihs.gov

Thank you for your consideration of our request. If you have any questions, please give me a call or email me at mpearson@spiritlakenation.com.

Sincerely,

Myra Pearson, Chairwoman

KENAITZE
INDIAN
TRIBE

www.kenaitze.org
Phone: (907) 335-7200 • FAX: (855) 335-8865
P.O. Box 988 • Kenai, AK 99611

January 10, 2018

Marilynn Malerba
Chairwoman
Tribal Self-Governance Advisory Committee
c/o Self-Governance Communication & Education
PO BOX 1734
McAlester, OK 74502

RE: Nomination to the IHS Tribal Self-Governance Advisory Committee

Dear Chairwoman Malerba,

Please find attached a letter from our Chair and Vice Chair for the Kenaitze Indian Tribe seeking to replace our current Primary Advisory Committee Representative for the Alaska Region with our new Executive Director. The seat is held by a Kenaitze Indian Tribe representative, but she left the tribe late last year. Our current Executive Director is Bart Garber, a former NARF attorney and Native business manager.

Below is the contact information for Bart Garber:

Mailing Address:	PO Box 688, Kenai, Alaska 99611
E-mail Address:	bgarber@kenaitze.org
Phone Number:	907 335-7210

Thank you for your consideration of our request. If you have any questions, please contact Wayne Wilson, Chair, Kenaitze Indian Tribe at 907 398-7839.

Sincerely,

Bart Garber
Executive Director

KENAITZE

INDIAN

TRIBE

WWW.KENAITZE.ORG

PHONE: (907) 335-7200 • FAX: (907) 335-7239

P.O. BOX 988 • KENAI, AK 99611

January 9, 2018

IHS Tribal Self-Governance Advisory Committee
303 South Fifth Street
McAlester, OK 74501

Re: Primary Alaska Representative – Executive Director, Kenaitze Indian Tribe

Advisory Committee Members,

Jaylene Peterson-Nyren Kenaitze Indian Tribe's former Executive Director was replaced by Bart Garber as Kenaitze Indian Tribe's Executive Director on September 27, 2018. Ms. Peterson-Nyren is the current Primary Alaska Representative on the IHS TSG Advisory Committee. The Kenaitze Indian Tribe requests that the IHS Tribal Self-Governance Advisory Committee seat Bart Garber as the Primary Alaska Representative at your January 24-25 meeting in Washington, D.C.

Your assistance in this matter is appreciated. Mr. Garber will be in attendance at your meeting.

With Respect,
KENAITZE INDIAN TRIBE

Wayne Wilson, Chair

Bernadine Atchison, Vice Chair

Summary of IHS Tribal Self-Governance Advisory Committee (TSGAC) Correspondence
Year: 2015-2018

Updated: January 8, 2018

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
1.	1/8/18	CMS Regulations.gov	Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program (CMS-4182-P)	Official TSGAC comments	
2.	11/22/17	RADM Weahkee, Acting Director, IHS	Level of Need Funded IHS/Tribal Workgroup	TSGAC list of representatives to serve on the Workgroup.	
3.	11/22/17	RADM Weahkee, Acting Director, IHS	Response to October 6, 2017 IHS CHEF Letter	TSGAC Formal comments following *Redding* decision.	
4.	11/6/17	Francis Collins, M.D., Ph.D., Director National Institute of Health	Proposal to Update Data Management of Genomic Summary Results	TSGAC Request for Extension to the Comment Period on the Proposal	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
5.	11/6/17	RADM Weahkee, Acting Director, IHS	Response to October 6, 2017 IHS CHEF Letter	TSGAC Formal comments.	
6.	11/3/17	RADM Weahkee, Acting Director, IHS	IHS Strategic Plan Draft Framework, 2018-2022	Transmittal of TSGAC formal comments.	
7.	11/1/17	Phoenix Area Tribes Bemidji Area Tribes Great Plains Area Tribes	IHS Tribal Self-Governance Advisory Committee Member Vacancy	Request for Tribal nominations to fill TSGAC vacancies	
8.	10/31/17	RADM Weahkee, Acting Director, IHS	Follow-up Items from Tribal Self-Governance Advisory Committee Meeting, October 24-25, 2017	TSGAC Summary of Discussion, Recommendations, Next Steps.	
9.	10/30/17	Jennifer Cooper, Acting Director, OTSG	Self-Governance National Indian Health Outreach And Education (2016-2017)	Transmittal of Final report for 2016-2017	
10.	10/30/17	Honorable Don Wright, M.D., M.P.H., Acting Secretary, HHS & Ms. Kathleen McGettigan, Acting Director, OPM	Senior Executive Service (SES) Hiring Moratorium	TSGAC Request to Exempt Indian Health Service (IHS) from Moratorium	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
11.	10/27/17	HHS Office of the Assistant Secretary for Planning and Evaluation Strategic Planning Team Washington, DC 20201	Department of Health and Human Services Strategic Plan	TSGAC Formal Comments	
12.	10/13/17	RADM Weahkee, Acting Director, IHS	Request for Service Unit Data on Health Insurance Status of Active Users	TSGAC request for updated information for FY2017	
13.	9/14/17	RADM Weahkee, Acting Director, IHS	Unpaid and Underpaid Third Party Benefits from Private Insurers	Joint TSGAC and DSTAC letter requesting IHS designate it a high priority to address the inappropriate and illegal action by insurance companies and benefit mangers erroneously under paying Indian health and Tribal facilities on behalf of all of Indian country.	IHS Acting Director responded to TSGAC and DSTAC in letter dated 10/20/17.
14.	8/31/17	RADM Weahkee, Acting Director, IHS	Sanitation Deficiency System Guide for Reporting Sanitation Deficiencies for Indian Homes and Communities	TSGAC Request for Tribal Consultation	IHS Acting Director responded to TSGAC in a multi-issue response letter dated 10/22/17.
15.	8/31/17	RADM Weahkee, Acting Director, IHS	OTSG Director	Participation in the Office of Tribal Self-Governance Director Interview and Selection Process	IHS Acting Director responded to TSGAC in a multi-issue response letter dated 10/22/17.
16.	8/1/17	National Indian Health Board	Jake White Crow Award	TSGAC Letter of Support for Myra Munson's Nomination – Jake White Crow Award	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
17.	7/31/17	RADM Weahkee	Recommendations for the IHS Scholarship and Loan Repayment Programs	TSGAC formal comments and recommendations.	
18.	7/31/17	Jennifer Cooper Acting Director, OTSG	Request for ACA/IHCIA National Outreach and Education Funding (FY2018)	Request for on-going funding of $300,000 for FY2018.	Funding received from OTSG for project year 2017-2018 through an amendment to the Jamestown S'Klallam Tribe Funding Agreement (September 2017.)
19.	6/22/17	The Honorable Thomas E. Price Secretary Department of Health and Human Services	Request for Tribal Consultation on HHS Reimagining Initiative and Invitation to the TSGAC Quarterly Meeting July 18-19, 2017	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.	
20.	6/8/17	Bradley Crutcher Chairman Fort McDermitt Paiute and Shoshone Tribe	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 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.	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
21.	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.	
22.	5/26/17	Rear Admiral Chris Buchanan Acting Director, IHS	CHEF Final Rule	TSGAC Request to Delay Catastrophic Health Emergency Fund Final Rule	
23.	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	Letter dated 7/18/17 received from RADM Weahkee which addresses and responses to several TSGAC letters and issues raised during the March 2017 TSGAC Quarterly meeting.
24.	5/24/17	Ms. Seema Verma Administrator Centers for Medicare & Medicaid Services	Medicaid Work Requirements for American Indians and Alaska Natives	TSGAC Comments	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
25.	5/18/17	Rear Admiral Chris Buchanan Acting Director, IHS RADM Kevin Meeks Acting Deputy Director of Field Operations	Tribal Participation in the Department of Health and Human Services plan to carry out Executive Order 13781	Request to Schedule a Joint TSGAC/DST Call	
26.	5/10/17	Rear Admiral Chris Buchanan Acting Director, IHS CAPT Mark T. Rives, USPHS Director and Chief Information Officer Office of Information Technology, IHS	TSGAC Delegate to the Information Systems Advisory Committee (ISAC)	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).	
27.	5/5/17	Nikki Bratcher Bowman, Acting Director Office of Intergovernmental and External Affairs U.S. Department of Health and Human Services	STAC National At-Large Primary Delegate Nomination	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).	
28.	5/1/17	Department of Health and Human Services	HHS 19th Annual Tribal Budget Consultation Session on the FY 2019 Budget Request	Written TSGAC Testimony Submitted	

Ref. #	Date Sent/ Received	Addressed To	Topic/Issue	Action(s) Needed	Response Received
29.	4/30/17	Jennifer Cooper Acting Director, OTSG	Self-Governance Health Reform National Outreach and Education Semi-Annual Report	Transmittal of 6-month Report	
30.	4/11/17	Rear Admiral Chris Buchanan Acting Director	Formation of the Community Health Aid Program (CHAP) Workgroup	TSGAC Recommendations	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.
31.	3/7/17	CMS via regulations.gov	Market Stabilization Proposed Rule (CMS-9929-P)	TSGAC Formal Comments	
32.	2/27/17	Rear Admiral Chris Buchanan Acting Director Indian Health Service	Self-Governance Negotiations and Create Agency Lead Negotiator Pilot Project	TSGAC Recommendations to Improve Self-Governance Negotiations and Create Agency Lead Negotiator Pilot Project	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.
33.	1/27/17	Norris Cochran Acting Secretary Department of Health and Human Services Rear Admiral Chris Buchanan Acting Director Indian Health Service	Support for Broad Exemption of Indian Health Service from Federal Hiring Freeze	TSGAC support and request for exemption from the hiring freeze for certain staff and contracted positions at the IHS	

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34.	12/16/16	IHS Principal Deputy Director	Identification of Staff for Developing Level of Need Funded Data	TSGAC provided recommendations regarding analysis of the Indian Health Care Improvement Fund (IHCIF) and the Level of Need Funded (LNF)	
35.	12/14/16	IHS Principal Deputy Director OTSG Acting Director	Final Report, "TSGAC Report Network on Adequacy in the Health Insurance Marketplace: Analysis of Two Tribal Sites"	Transmittal of Final Report, "TSGAC Report Network on Adequacy in the Health Insurance Marketplace: Analysis of Two Tribal Sites"	
36.	12/5/16	IHS Principal Deputy Director	Updated Contract Support Cost (CSC) Policy	Thank you letter and request that IHS develop a training and outreach plan for Tribal and Federal employees on the new CSC Policy.	
37.	11/8/16	Leonard M. Harjo Chief Seminole Nation of Oklahoma	Congratulations and Welcome to Self-Governance		
38.	11/8/16	John Berrey Chairperson Quapaw Tribe of Oklahoma	Congratulations and Welcome to Self-Governance		
39.	11/8/16	Daniel L.A. Preston, III Anthony J. Francisco, Jr. Representatives Tohono O'odham Nation	TSGAC Tucson Area Representatives Appointment and Participation		

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40.	11/4/16	IHS Director via consultation.gov	IHS Headquarter Re-alignment	TSGAC Formal Comments	
41.	11/2/16	Dr. Richard A. Stone Principal Deputy Under Secretary for Health Veterans Administration	Request for the Information about the Veterans Administration's Co-Payment Policy	TSGAC follow up letter from October meeting and discussion with Dr. Stone	
42.	11/2/16	David J. Shulkin Under Secretary for Health Department of Veterans Affairs	Veteran Affairs' Proposal to Consolidate Community Care Programs	TSGAC Formal Comments	
43.	10/31/16	IHS Director via consultation.gov	Catastrophic Health Emergency Fund Proposed Rule (RIN 0905-AC97)	TSGAC Formal Comments	
44.	10/31/16	OTSG Acting Director	Self-Governance National Indian Health Outreach and Education	Transition of Final Report for 2015-2016	
45.	10/28/16	Kitty Marx, CMS	Tribal Technical Advisory Group (TTAG) Appointments	TSGAC Re-appointment of TTAG Reps	

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46.	10/28/15	IHS Director via consultation.gov	Purchasing Health Care Coverage (IHS Circular 2016-08)	TSGAC Formal Comments	
47.	10/5/16	CMS via regulations.gov	HHS Notice of Benefit and Payment Parameters for 2018 (CMS-9934-P)	TSGAC Formal comments	
48.	9/27/16	IHS Principal Deputy Director	FY 2015 Report to Congress on Administration of the Tribal Self-Governance Program	TSGAC comments and request to work with IHS to implement the suggested Tribal changes.	
49.	9/16/16	IHS Principal Deputy Director	IHS Quality Framework Draft	TSGAC Comments on IHS Quality Framework Draft	
50.	8/23/16	Dr. Baligh Yehia, MD Assistant Deputy Undersecretary for Health for Community Care Veterans Health Administration U.S. Department of Veterans Affairs	Opportunities for Partnerships between Tribal Health Programs and the Veterans Administration	TSGAC comments on the existing Indian Health Services/Tribal Health Programs-Veterans Administration (IHS/THP-VA) Memorandum of Understanding (MOU) and Choice Act Agreements	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.
51.	8/16/16	HHS Regulations	RIN 0991-AC06: Comments on Proposed Rule; Health and Human Services Grant Regulation: Published on July 13, 2016 (81 Federal	TSGAC formal comments to proposed rule	

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			Register 45270, et seq.		
52.	7/21/16	Mr. Benjamin Smith, Director, Office of Tribal Self-Governance, IHS	Request for ACA/IHCIA National Outreach and Education Funding (FY2017)	TSGAC formal request for funding	
53.	7/14/16	Mr. Michael Fisher Lead Contract Specialist Indian Health Service	Solicitation Number 16-IHS-HQ-SS-0001	TSGAC Formal Comments	
54.	7/8/16	IHS Principal Deputy Director	Request to Make Self-Governance Resources Available Publicly	TSGAC request to make negotiation documents publicly availability on the OTSG website as resources for Self-Governance Tribes.	
55.	6/17/16	Centers for Medicare & Medicaid Services (CMS) Department of Health and Human Services P.O. Box 8011 Baltimore, MD 21244-1850	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)	TSGAC Formal Comments	

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56.	6/9/16	IHS Principal Deputy Director via consultation@ihs.gov	Proposed IHS Contract Support Costs Policy	TSGAC Formal Comments	
57.	5/20/16	Betty Gould, Regulations Officer Indian Health Service, Office of Management Services	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)	TSGAC Formal Comments	
58.	5/13/16	Treasury	TSGAC Formal Request for Targeted Partial Administrative Relief from Employer Shared Responsibility Provisions	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.	
59.	5/10/16	IHS Principal Deputy Director	Catastrophic Health Emergency Fund Proposed Rule (RIN 0905-AC97)	TSGAC formal comments on proposed rule	

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60.	5/10/16	IHS Principal Deputy Director	TSGAC Comments on SASP Program Funding Distribution	TSGAC input on the Substance Abuse and Suicide Prevention program in preparation for the funding opportunity announcement planned for early June 2016	
61.	5/6/16	Steve Petzinger, OMB Program Examiner	Follow up from March 2016 Tribal Self-Governance Advisory Committee Meeting	Summary of the main issues and actions discussed during TSGAC meeting	
62.	5/5/16	CMS	CMS-10458, "Consumer Research Supporting Outreach for Health Insurance Marketplace	TSGAC Formal Comments	
63.	4/24/16	IHS Principal Deputy Director OTSG Director ORAP Acting Director	SG National Outreach and Education on ACA/IHCIA	Transmittal of 6-month Report	
64.	4/18/16	The Honorable Sylvia Burwell, HHS Secretary The Honorable Robert A. McDonald, VA Secretary	Reimbursement Agreement between the Indian Health Service and Veterans Affairs	TSGAC request to include PRC services in reimbursement agreements between the IHS/Tribes and the VA, as soon as possible.	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.
65.	4/18/16	Mary Smith, IHS Principal Deputy Director	CHEF Proposed Rule 42 CFR Part 136 - RIN 0905AC97, Catastrophic Health Emergency Fund, File Code 0905AC97	Request to Withdraw Proposed Rule, conduct Tribal Consultation and then reissue the rule.	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.

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66.	4/18/16	Mary Smith, IHS Principal Deputy Director	Recommendations for Health Care Facilities	TSGAC Recommendations	7/23/2016 – Response letter received from IHS. The letter outlines IHS specific responses to each TSGAC recommendation.
67.	4/11/16	Thomas West Kathryn Johnson Treasury Department	Excise Tax on Certain Employer-Sponsored Health Benefits	TSGAC Follow up comments from March 2016 quarterly meeting.	
68.	4/5/16	Sylvia Matthews Burwell, Secretary, Andy Slavitt Acting Administrator, Centers for Medicare and Medicaid Services	Oklahoma Section 1115 Waiver Amendment Request	TSGAC Formal Comments	
69.	3/29/16	Mary Smith, IHS Principal Deputy Director	Request for Service Unit Data on Health Insurance Status and 2016 Appropriation	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)	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.
70.	2/29/16	Office of Management and Budget Office of Information and Regulatory Affairs Attn: CMS Desk Officer	CMS–10519, Agency Information Collection Activities: Submission for OMB Review	TSGAC Formal Comments	

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71.	2/19/16	Centers for Medicare & Medicaid Services	Comments on CMS-9936-N; Waivers for State Innovation	TSGAC Formal Comments	
72.	2/2/16	Dr. Debra Houry, MD, MPH Director, National Center for Injury Prevention and Control Centers for Disease Control and Prevention	CDC Proposed 2016 Guideline for Prescribing Opioids for Chronic Pain; Docket CDC-2015-0112	Support for USET Comments on the Proposed Guidelines	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 overdoes from opioids.
73.	1/15/16	Center for Consumer Information and Insurance Oversight, CMS, HHS	Comments on Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces	TSGAC Comments on Draft Letter	
74.	1/13/16	Mr. Thomas West Tax Legislative Counsel Office of Economic Policy Department of Treasury	Invited to Jan 27-28, 2016 TSGAC Meeting	Continue discussion on Permanent Administrative Relief from Affordable Care Act's Employer Mandate on Tribes for Tribal Member Employees	Response Received January 14, 2016. Mr. West and others are unavailable, but continue to work on this issue as it is related to Tribes.
75.	1/5/16	Jerry Menikoff, M.D., J.D. Office for Human Research Protections Department of Health and Human Services 1101 Wootton Parkway Suite 200 Rockville, MD 20852	HHS-OPHS-2015-0008 – Proposed Revisions to the Federal Policy for the Protection of Human Subjects	TSGAC Official Comments on Proposed Rule	

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76.	12/21/15	Centers for Medicare & Medicaid Services	CMS-9937-P, Notice of Benefit and Payment Parameters for 2017	TSGAC Official Comments on Proposed Regulation	
77.	11/17/15	Kitty Marx CMS	TSGAC comments	Support for 100 Percent FMAP Proposal	
78.	11/10/15	Mr. Robert McSwain Principal Deputy Director, IHS	Payment of Settlements to Civil Service Employees	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.	
79.	11/9/15	U.S. Department of Health and Human Services Office for Civil Rights	Nondiscrimination in Health Programs and Activities (RIN 0945-AA02). 80 Fed. Reg. 54172 (Sep. 8, 2015).	TSGAC comments in response to its proposed rule on Nondiscrimination in Health Programs and Activities (RIN 0945-AA02). 80 Fed. Reg. 54172 (Sep. 8, 2015).	
80.	11/3/15	Mr. Robert McSwain Ms. Mary Smith IHS	Interpretation of Duplication Provision in 25 U.S.C. § 450j-1(a)(3)	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.	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.

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81.	11/3/15	Honorable Sylvia M. Burwell, Secretary Department of Health and Human Services	Final Rule related to expand the Medicare-Like Rate	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.	
82.	10/27/15	Honorable Robert A. McDonald Secretary of Veterans Affairs	Comments on Veterans Access, Choice and Accountability Act of 2014 (Choice Act)	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).	
83.	10/26/15	Dr. Elaine Buckberg Deputy Assistant Secretary for Policy Office of Economic Policy Department of Treasury	Request for Permanent Administrative Relief from Affordable Care Act's Employer Mandate on Tribes for Tribal Member Employees	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.	
84.	10/23/15	Dr. Elaine Buckberg Deputy Assistant Secretary for Policy Office of Economic Policy Department of Treasury	Request for Extension of Transition Relief from the Employer Mandate	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.	

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85.	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).	
86.	10/16/15	Mr. Robert G. McSwain Mr. Ben Smith Mr. Carl Harper	Transmittal of FINAL Self-Governance National ACA Education and Outreach Report	No action needed. Transmittal of final report for the time period October 1, 2014 through September 30, 2015.	
87.	10/14/15	Internal Revenue Service P.O. Box 7604 Ben Franklin Station, Room 5203 Washington, DC 20044	Notice 2015-52 on Section 4980I — Excise Tax on High Cost Employer Sponsored Health Coverage	TSGAC comments and recommendations.	
88.	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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89.	9/30/15	Mr. Jeff Wu Deputy Director Center for Consumer Information and Insurance Oversight Centers for Medicare and Medicaid Services	Response to Request for Tribal Consultation on Referrals for Limited Cost-Sharing Variation Plans	TSGAC comments and recommendations.	
90.	8/28/15	Mr. Robert G. McSwain, Principal Deputy Director Indian Health Service	Fiscal Year 2014 Report to Congress on the Administration of the Tribal Self-Governance Program	TSGAC input on report in response to IHS request for comments.	
91.	8/4/15	Dr. Elaine Buckberg Deputy Assistant Secretary for Policy Office of Economic Policy Department of Treasury	Exemption of Tribes from the ACA Employer Mandate	Invitation to October 2015 TSGAC Quarterly meeting to discuss topic.	Confirmed attendance for Oct 7, 2015 at 10:30 am. Pre-briefing scheduled for Oct 2.
92.	8/4/15	Mr. Robert G. McSwain, Principal Deputy Director Indian Health Service	Quality Reporting Measures	Request that IHS conduct an analysis and comparison of the GPRA and Clinical Quality Management approaches.	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

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					TSGAC meeting.
93.	8/4/15	Centers for Medicare and Medicaid Services Department of Health and Human Services Attn: CMS-10561	Comments on CMS-10561, ECP Data Collection to Support Qualified Health Plan (QHP) Certification for PY 2017	TSGAC Official Comments	
94.	7/28/15	Geoffrey M. Standing Bear Principal Chief Osage Nation	Welcome to Self-Governance		
95.	7/27/15	Mr. Robert G. McSwain, Principal Deputy Director Indian Health Service	Multi-Purpose Agreement (MPA) and Joinder Agreement & ISAC Presentation	Address Tribal comments on MPA; and follow up with OIT to host Webinar regarding ISAC.	
96.	7/27/15	Centers for Medicare and Medicaid Services	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	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/NIHB.	

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97.	7/10/15	Carolina Manzano Chief Executive Officer Southern Indian Health Council, Inc.	Welcome to Self-Governance		
98.	7/10/15	Vincent Armenta Tribal Chairman Santa Ynez Band of Chumash Indians	Welcome to Self-Governance		
99.	7/10/15	Dan Courtney Chairman Cow Creek Band of Umpqua Tribe of Indians	Welcome to Self-Governance		
100.	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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101.	6/12/15	Mr. P. Benjamin Smith, Director, Office of Tribal Self-Governance, Indian Health Service	Tribal Leadership Priorities for "Self-Governance National Indian Health Outreach and Education"	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	
102.	6/9/15	Mr. Robert G. McSwain, Acting Director Indian Health Service	Payment of IHS Employee Settlements.	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.	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.

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103.	5/15/15	Internal Revenue Service	Notice 2015-16 on Section 4980I — Excise Tax on High Cost Employer-Sponsored Health Coverage	TSGAC Comments in Request to Notice from IRS.	
104.	4/27/15	Mr. Robert G. McSwain, Acting Director Indian Health Service	Healing our Spirits Worldwide Gathering	Request of IHS support in this effort and the participation of P. Ben Smith, Director, Office of Tribal Self-Governance (OTSG).	IHS Responded on August 29, 2015 to the TSGAC and stated that Mr. Smith is confirmed to attend and participate in the HOSW gathering.
105.	4/23/15	Mr. Robert G. McSwain, Acting Director Indian Health Service	Detail of OTSG Deputy Director	TSGAC request to Director to re-evaluate the detail and assign other staff to OUIHP as soon as practicable.	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.
106.	4/21/15	Mr. Robert G. McSwain, Acting Director Indian Health Service	Special Diabetes Program for Indians (SDPI)	TSGAC comments in response to the DTLL request for comments/consultation on the SDPI programs.	
107.	4/20/15	Mr. Robert G. McSwain Mr. Ben Smith Mr. Carl Harper	Transmittal of Self-Governance National ACA Education and Outreach Report	No action needed. Transmittal of 6-month report for the time period October 1, 2014 through March 31, 2015.	
108.	4/8/15	Mr. Robert G. McSwain, Acting Director Indian Health Service	Payment of Contract Support Costs for MSPI and DVPI funding	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	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

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				CSC funds within 30 days.	provide additional funds beyond what is included in the project budgets.
109.	4/8/15	Mr. Robert G. McSwain, Acting Director Indian Health Service	Thank you on Rates of CSC Settlement and Claim Resolutions	Continue timely resolution of outstanding claims and consistent full funding of CSC.	
110.	4/3/15	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	Thank you for participating in the Tribal Self-Governance Advisory Committee Quarterly Meeting, March 24, 2015	Further dialogue to occur during the Thursday, April 30th Breakout Session A7, *Pursuing and Reinvesting Third Party Revenue,* at the upcoming 2015 Annual Tribal Self-Governance Consultation Conference in Reno, NV	
111.	2/26/15	The Honorable Derek Kilmer	Self-Governance Tribes 2015 Appropriations Requests for the Bureau of Indian Affairs	Joint letter from TSGAC/SGAC	
112.	2/10/15	The Honorable Derek Kilmer	Self-Governance Tribes 2015 Appropriations Requests for Indian Health Service	Joint letter from TSGAC/SGAC	

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113.	2/9/15	Chief Marilynn Malerba, Chairwoman TSGAC	Agency response to information requested QHPs to IHCPs in specific regions	CMS staff are available to address specific QHP problems and provide further assistance in the process	Response from Marilyn Tavenner, CMMS 2/2/15 to letter dated 12/19/14
114.	1/31/15	Chief Marilynn Malerba, Chairwoman TSGAC	Agency response to the ongoing and unprecedented international Ebola crisis		Response from Dr. Y.Roubideaux, IHS Director, 1/31/15 to letter dated 10-17-14
115.	2/5/15	IHS Director,Dr. Y. Roubideaux	Mandatory Appropriations for Contract Support Coasts	Appreciated partnership and looking forward to working to advance long-term solutions for funding CSC	
116.	2/4/15	Betty Gould, Regulations Officer, IHS and Carl Harper, Director ORAP,IHS Submit via regulations.gov	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	Being able to engage in Tribal Consultation on the proposal	
117.	1/20/15	Chief Marilynn Malerba, Chairwoman TSGAC	Concerns regarding procedural consistency and information sharing during CSC negotiations on Disputed claims		Response from Dr. Y. Roubideaux, IHS Director, 1/20/15 to letter dated 12-2-14

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118.	1/14/15	Ms Tracy Parker Warren Office of Public and Intergovernmental Affairs OTGR(075F)-VA	Comments Submitted Response to Notice of TC: Sec 102 © of the Veterans Access, Choice and Accountability Act of 2014	Urge the Reports enter into agreements for reimbursement also current agreements be used and expanded where possible to speed up implementation to eligible veterans	
119.	1/12/15	CCIIO-CMS-DHHS	Comments on Draft 2016 Letter to Issuers in the Federally-Facilitated Marketplace	We are available to discuss any of the recommendations contained in the correspondence and attachment on CMS-9944-P	
120.	1/8/15	IHS Director, Dr. Y. Roubideaux	2015 TGSAC Quarterly Meetings and Tribal Self-Governance Annual Conference Information	Adjustment to your schedule due to changes for the January Qrtly meetings	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

IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

c/o Self-Governance Communication and Education
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Delivered Electronically to HHSPlan@hhs.gov

October 27, 2017

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Strategic Planning Team
200 Independence Avenue SW, Room 415F
Washington, DC 20201

RE: Strategic Plan Comments

The Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC) is pleased to provide initial input on the Department of Health and Human Services (HHS) Draft FY2018-2022 Strategic Plan. As an advisory committee to the IHS Director, TSGAC wishes to support and provide feedback so that the final Strategic Plan bolsters the agency, supports Tribes and Tribal organizations, and, most importantly, embodies the Federal trust responsibility and government-to-government relationship.

History of the Government-to-Government Relationship

The principles of governance of Tribal Nations have long had an influence on the governments and society of the Americas. The prominence of these principles had an historic influence on the formation of democracy and the United States of America.[1] The United States has recognized this historic relationship in more than 370 treaties, the first article of the US Constitution, hundreds of statutes, Federal case laws, regulations and executive orders. Each affirms the Federal government's trust obligation to provide benefits and services in perpetuity in exchange for millions of acres of land and significant resources ceded to the U.S. Collectively, they represent a relationship between sovereigns and established the "government-to-government" principle and the Federal Trust Responsibility. Therefore, the Strategic Plan goals and objectives should work to uphold this relationship; and HHS leadership should ask that operating divisions work to measure and report their progress toward strengthening this relationship.

Further, Congress has passed numerous Indian-specific laws to provide for Indian health care, including establishing the Indian health care system and passing the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1601 et seq. In the IHCIA, for instance, Congress found that "Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people." Id. § 1601(1). In the Indian Self-determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 450 et seq., Congress enabled Tribes to contract to run their own health care programs while also preserving Tribes' rights to choose that services continue to be provided directly by the IHS. Congress has also legislated to provide Indians with access to general health programs, such as Medicaid, while creating Indian-specific protections within those programs that reflect this unique political relationship. As a result, TSGAC asks that HHS commit to measure its success in promoting and improving the health and welfare of American Indians and Alaska Natives (AI/AN) across the United States.

[1] Tribal Nations and the United States, An Introduction, National Congress of American Indians

TSGAC Comments and Recommendations

With these principles in mind, TSGAC would like to provide the following comments and recommendations regarding the draft Strategic Plan:

The Strategic Plan should focus on the Indian health care system as a system that has responsibility to provide accessible and quality health care for AI/ANs. The Indian health care system is diverse and includes direct health care, preventive care, health care facilities construction, water and sanitation services, and all public health services. Yet, the Strategic Plan does not adequately reflect the broad responsibility HHS has to AI/ANs. For example, the Medicaid program has become a growing avenue for the Federal government to meet its trust responsibility to Tribes and Tribal members. An impediment to more fully meeting this obligation is the great disparities across states with regard to Medicaid eligibility and Medicaid covered services for AI/ANs. Though TSGAC recognizes that elements of this will require a legislative fix, we encourage HHS to leverage every opportunity to use the Federal government's discretion to provide uniform access for all AI/ANs to a comprehensive set of essential health care services no matter the state of residence of the AI/AN. Additionally, TSGAC would suggest that each objective and goal identify how and whether the agency is providing services to AI/ANs or supporting the IHS mission and vision.

Meaningfully include Tribes and Tribal Organizations. Tribes are not equitably treated throughout the plan which is problematic as they directly administer health care, social services, TANF, and WIC programs. As stated earlier, HHS has a Constitutional responsibility to Tribes and AI/ANs across the country. However, the Strategic Plan seems to only promote faith-based and community organizations. The next draft of the plan should meaningfully include Tribes and Tribal organizations. Specifically, in instances in the Strategic Plan where HHS indicates the need to coordinate efforts with entities outside of HHS, Tribal governments should be identified as an entity to be engaged.

Raise the level of IHS engagement across the Strategic Plan. The IHS agency "voice" is quieter than other HHS operating divisions within the draft. IHS services are linked to disparity areas such as economic, social well-being, and communicable diseases; yet, IHS is noticeably missing from agencies referenced on information technology and healthcare communication. IHS participation should be fully involved at all levels of HHS planning, organization, and operation. IHS must be listed as a contributing division in each of the goals and objectives, as all goals and objectives relate to providing quality health care to AI/ANs. For example, Objective 1.2 states "focusing on populations at high risk for poor health outcomes." This statement clearly applies to the AI/AN population. However, IHS is not listed under contributing divisions. There are numerous places within the Strategic Plan where this is an issue. HHS should reconsider how to include IHS in a way that embodies the Federal government's trust responsibility to Tribes and AI/ANs.

Include modernization of the Health Information System serving the Indian health care system as an objective under Goal 1. The Resource and Patient Management System (RPMS) serves as the IHS electronic health record (EHR), but has long struggled to support modern health information technology needs and mandates. Additionally, the Veterans Administration June 2017 announcement that they are moving to a commercial EHR will likely have negative impacts on the ongoing RPMS modernization effort. RPMS must be replaced so physicians can adequately manage their patient's health care needs. HHS has a responsibility to commit the financial and human capital to ensure that the Indian health system can operate in a 21st century environment.

Commit to research and explore funding mechanisms for construction of new Indian health care facilities. The IHS Joint Venture Construction Program (JVCP), authorized in Section 818 of the IHCIA, has been a very successful tool for Tribes and the Federal government to partner in replacing outdated health care facilities. As such, HHS should set a goal to open that program for solicitation every two years and leverage the opportunity as often as possible. TSGAC supports the continued use of this mechanism and asks that HHS support increases for the JVCP to address the increasing need for modern health care facilities in Indian Country.

Prioritize inter- and intra-agency agreements to develop basic infrastructure in Indian communities. In order to protect the health of AI/ANs where they live, learn, work and play, HHS needs to encourage collaboration between all operating divisions and, when possible, other Departments. HHS should encourage agencies to pool funding to support health initiatives, particularly those that are necessary to support infrastructure development, such as clean drinking water, safe wastewater management, and expansion of broadband access in Tribal communities.

It is difficult to believe that in the 21st century these basic community infrastructure elements are lacking in many Tribal communities. 13% of AI/AN homes in Indian Country lack access to safe drinking water and/or safe wastewater compared to the 0.6% of non-native homes.[2] IHS has successfully developed sanitation infrastructure in Tribal communities through partnership with the Environmental Protection Agency (EPA). This interagency agreement could be a way to streamline the funding for other national initiatives like public and behavioral health. TSGAC recommends identification and inclusion of this critical issue in the HHS Strategic Plan. TSGAC further recommends that HHS collaborate with other Federal Departments to establish and expand broadband communications infrastructure. Given the growing reliance on the internet as a critical community infrastructure, such as telehealth and public safety notifications, Tribal communities cannot be left behind.

Specifically include objectives to promote the health care workforce for IHS. The Indian health care workforce needs a lot of improvement with some enhanced funding streams for automatic qualification of Indian health care facilities as eligible health care facilities for all IHS loan repayment programs as well as HRSA scholarships and loan repayment programs. Across the draft HHS strategic plan, discussions about “access” include recruitment, training, loan forgiveness and retention. However, there are entire professions being ignored that could increase access in some states up to 71% for Medicare recipients. Providing behavioral health provider waivers for rural and provider-scarce areas will produce immediate relief. Legislators have been attempting to remedy this problem with statutory relief for the last 15 years.[3] The recruitment and retention pipeline mentioned could take decades to realize substantial changes. Meanwhile, the AI/AN Baby Boomer population is currently at a historical peak. Prioritization of the Indian health care workforce in the Strategic Plan will provide overdue support to a barren system.

Develop consistent, reliable and comprehensive support for public health infrastructure in Indian Country. IHS and Tribal governments have significant public health responsibilities, similar to those of State governments. However, IHS has had to prioritize its limited and insufficient appropriations to treatment of immediate medical conditions. Tribal governments work within complex jurisdictional constructs that vary from region-to-region, but are common in that there is not a sufficient Tribal tax base from which to fund necessary Public Health efforts.

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[2] *Meeting the Access Goal: Strategies for Increasing Access to Safe Drinking Water and Wastewater to American Indian and Alaska Native Homes*. Infrastructure Task Force Access Subgroup. March 2008.
[3] See current legislation in both congressional houses: HR3032; S1879.

Tribal governments, as discussed previously, have a government-to-government relationship with the Federal government, and therefore Indian lands are not the jurisdiction of States. The Centers for Disease Control (CDC) provides some competitive grants that fund relatively very few Tribes for specific initiatives. CDC does not fund Tribal governments in a non-competitive, consistent manner as they do States for Public Health Infrastructure. Development of a sustainable infrastructure will provide our governments with the foundation upon which to build public health interventions and reliably and consistently partner with other governments (State, county, municipal) to advance the public health.

Include all genders and stages of life under Goal 2. The objectives listed under Goal 2 should be expanded to include all genders and stages of life, including prenatal development, as the Indian health care system seeks to support all Tribal citizens.

Consider the Tribal impact in any change to centralized business processes. Several of the goals discuss streamlining business processes for the department. TSGAC agrees that there are numerous processes that have become very bureaucratic and unnecessary and look forward to the changes HHS has proposed. HHS should specifically identify any business processes that are subject to centralization and ensure that Tribal Consultation requirements are met prior to enactment and potential impact to Tribes.

Make the expansion of Self-Governance an objective to provide more effective and efficient services to AI/ANs. In 2000, Congress authorized Tribes to enter into Self-Governance compacts and funding agreement with the IHS as a permanent authority under ISDEAA.[4] In the same legislation[5] also included Title VI, Demonstration Feasibility Study, further amending the ISDEAA, by requiring HHS to conduct a study to determine the feasibility of a Tribal Self-Governance demonstration project for appropriate HHS programs, services, functions, and activities (or portions thereof) in agencies other than the IHS. HHS submitted the required report to Congress in March of 2003, concluding that the demonstration project was feasible. However, HHS has not prioritized the development and implementation of such a demonstration project. TSGAC believes that Self-Governance is a streamlined model that decreases bureaucracy and leverages Federal funding to meet local need. TSGAC asks that HHS include expansion of this model to operating divisions, other than IHS.

Continue to support the sovereign right of Tribes to provide oral health through the Dental Therapy model. Tribes in several states have exercised their rights to employ one of the most promising models to address oral health needs in rural and remote communities – dental therapy. These providers receive the exact same education as dentists do in the operations they are licensed to perform and operate under a dentist's general supervision. Currently, dental therapists operate in 54 countries, the state of Minnesota, and in Tribal communities in Alaska, Oregon, and Washington. Dental therapists will soon operate in Vermont and Maine, as those states have enacted authorizing legislation. Leveraging Dental therapists allow Tribes to provide more services for more patients, which increases revenue, which allows the Tribe to hire more providers, who see more people, and so on. In fact, a June 2014 PEW Report titled, *Expanding the Dental Team*, concluded that just two Dental therapists provided diagnostic, preventative, and restorative care to 1,352 patients and performed 7,356 procedures and that the revenue generated by the therapists exceeded costs of employment when compared with the reimbursement value of patient care they provided.[6] As such, TSGAC insists that HHS uphold the trust responsibility and promote the use of Dental Therapy in Tribal communities.

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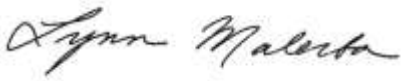
[4] Title V of the Indian Self-Determination and Education Assistance Act is codified at 25 U.S. C. § 458aaa et seq. The regulations are codified at 42 C.F.R. Part 137.
[5] Tribal Self-Governance Amendments Act of 2000
[6] *Expanding the Dental Team*. The Pew Charitable Trusts. June 2014.

In closing, we thank you for the opportunity to provide written and oral comments on the HHS Strategic Plan. We look forward to working with HHS to implement, evaluate, and report the outcomes of the final FY2018-2022 Strategic Plan. If you have any questions or would like to discuss these comments in further detail, please contact me at lmalerba@moheganmail.com.

Sincerely,



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

cc: RADM Michael Weahkee, Acting Director, IHS
Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, IHS
TSGAC Members and Technical Workgroup

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Delivered Electronically to: don.wright@hhs.gov
Delicia.harrell@opm.gov

October 30, 2017

Honorable Don Wright, M.D., M.P.H.,
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Ms. Kathleen McGettigan, Acting Director
Office of Personnel Management (OPM)
Office of the Director
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Washington, DC 20415

RE: Request to Exempt Indian Health Service (IHS) from Senior Executive Service (SES) Hiring Moratorium

Dear Secretary Wright and Director McGettigan:

I write on behalf of the Indian Health Service (IHS) Tribal Self-Governance Committee (TSGAC), which is representative of 360 federally-recognized Tribal governments participating in Self-Governance. The TSGAC advises the Director of IHS on health policy and other matters affecting Tribes. We are concerned about a recent situation that prevents the IHS from filling critical vacancies that enable the agency to fulfill its mission and support to Indian health care and Tribal governments. A hiring moratorium went into effect for HHS on September 29, 2017 with the resignation of Secretary Price and applies to all SES Qualifications Review Board cases being processed by OPM for the IHS, in accordance with 5 C.F.R. §317.502(d).

IHS operates direct health care facilities across the country that provide vital services to American Indians and Alaska Natives (AI/AN). Often, these facilities are rural, remote, and in locations where it is very difficult to recruit and retain executive leadership. Permanent leadership in the IHS organization is necessary to achieve and maintain high quality of health care services. Consequently, vacancy rates are high, and timely selection and appointment of SES personnel is critical to IHS' success and fulfillment of the trust responsibility to AI/AN. Although IHS is a relatively small Operating Division within HHS, it is of high impact to Tribal communities and primarily provides direct health services.

For these reasons, the TSGAC respectfully requests consideration of lifting the moratorium on filling SES appointments for the IHS. If you have any questions or would like to discuss these comments in further detail, please contact me at lmalerba@moheganmail.com. Thank you.

Sincerely,

Lynn Malerba

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

cc: RADM Michael Weahkee, Acting Director, IHS
Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, IHS
TSGAC Members and Technical Workgroup

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Sent electronically to Denise.Turk@ihs.gov

October 31, 2017

RADM Michael D. Weahkee, M.B.A., MHSA
Assistant Surgeon General, U.S. Public Health Service
Acting Director, Indian Health Service
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RE: Follow-up Items from Tribal Self-Governance Advisory Committee Meeting, October 24-25, 2017

Dear RADM Weahkee:

Thank you for attending the fourth Quarterly Meeting of the Tribal Self-Governance Advisory Committee (TSGAC) held in Washington, DC, on October 24-25, 2017. The TSGAC appreciates the open conversation and updates from Indian Health Service (IHS) on issues important to Self-Governance Tribes. There were several requests made during the meeting, most of which you committed to follow up on in a timely manner.

The following items capture some of the comments and summarize the discussion at the TSGAC meeting, to which we look forward to your response:

1. **Timeliness of responses to TSGAC.** As discussed, while we sincerely appreciate getting written responses to issues identified during the Quarterly Meetings, the TSGAC needs to receive these ahead of our scheduled meetings with enough time to allow Tribal leadership an opportunity to review and prepare comments. We suggest that midway between Quarterly Meetings would be a reasonable goal for responses from IHS.

2. **Transparency in Budgets, Tribal Allocations/Shares and Distribution Methodologies.** Some Tribes are not receiving full disclosure and transparency for their specific Tribal allocations of funds and how they are derived. All Tribes should have ready access to their specific allocations, shares and the distribution methodology and data that was used to allocate the funds. In addition, for those Area level tables that show Area-wide data, we request that these be posted on the OTSG webpage similarly to the Headquarters tables.

3. **Selection of a Permanent Office of Tribal Self-Governance (OTSG) Director.** The TSGAC transmitted a letter on August 31, 2017 identifying Tribal Leaders to participate in interviews and selection process for the OTSG Director. We understand that presently there is a moratorium on hiring Senior Executive Service (SES) positions, and we will request that IHS be exempted under separate communication. Once IHS has received authority to proceed with the selection process for this position, the TSGAC reiterates its request to participate in the applicant screening, interview and selection process and to make a recommendation for a candidate to fill this position.

4. **Request Funding for the Office of Information Technology (OIT) Planning in the FY 2020 Budget Request.** The TSGAC appreciates the frequent updates and opportunities for input on the future of the Resource Patient Management System (RPMS). During our meeting, the TSGAC expressed support for requesting funds to plan for the future of RPMS (or its successor)

in the IHS FY 2020 budget request. In doing so, we will also request that the amount include funding to accommodate those Tribes who have assumed their Tribal shares of RPMS and utilize other health information technology, who are eligible to, and may be interested in assuming their shares of any appropriation increases to OIT. Please ensure this request is completed and forwarded as soon as practicable, as IHS Areas have already begun their budget formulation meetings.

5. **Tribal Consultation on any revised Purchased and Referred Care (PRC) Manual or Policy.** The TSGAC takes note that a draft set of revisions to the PRC Manual have been shared with the PRC Workgroup for input. While consultation with the Workgroup is an important initial step, the TSGAC requests a broad and specific Tribal Consultation on any proposed PRC Manual changes, with timelines, to allow all Tribes the opportunity to participate in meaningful consultation prior to the adoption of changes to the Manual. TSGAC has an immediate concern with the recent policy described in your October 6, 2017 letter that would include Tribal self-insurance plans as alternative resources for purposes of the Catastrophic Health Emergency Fund (CHEF) program without authorization by the Tribe, which we will address in more detail under separate cover.

6. **Tribal Consultation on the Sanitation Deficiency System (SDS) Guidance Document.** IHS informed the TSGAC during the July 2017 Quarterly Meeting that the SDS Guidance was under revision and would be reissued shortly. The TSGAC sent a letter to IHS on August 31, 2017 requesting Tribal Consultation on the SDS Guidance, to which you provided a written response dated October 22, 2017. During the Quarterly Meeting, it was discussed that more information was expected to be received over the coming months specific to the Sanitation Facilities Construction program that may influence the policy, and that IHS would provide an update to the TSGAC within 30 days. The TSGAC appreciates the need to have a fully informed process, and looks forward to a Tribal Consultation process with a specific timeline for meaningful input prior to a revised SDS Guidance document being issued. However, we are concerned that Headquarters staff is currently applying an interpretation of the deficiency levels to projects that we do not share, which we have been informed cannot be changed after November 1, 2017.

7. **IHS Loan Repayment Program Placement and Health Resources and Services Administration (HRSA) Issues.** Tribal sites have always been considered eligible placement sites for the IHS Loan Repayment recipients to perform their required service. Tribal programs are increasingly being informed that their facilities are no longer eligible for placement, because they are maintaining lower vacancy rates than other programs, which seems to penalize high performing health operations. This has effectively rendered Tribes ineligible for placement of these health professionals, without regard for residence of, Tribal affiliation, or preference of the student. We look forward to your response after reviewing this matter. Additionally, HRSA removes eligibility for loan repayment for participants that are initially placed in primary care, but that may later move to inpatient care in the same health system. We request that IHS confer with HRSA on this matter in an attempt to find a solution so that IHS and Tribal facilities can retain these health professionals.

8. **Eligibility Issue for Small Ambulatory Program (SAP) Grants.** Certain Tribes have been notified that since they have previously received a SAP grant, they are not eligible for future competitive cycles. This is not reasonable, as a Tribe's previous project may have been over a decade ago and dire facility needs may still exist. The TSGAC looks forward to a very quick resolution to this matter, as the deadline for SAP applications is December 1, 2017.

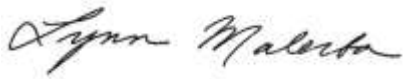
9. **Follow up to the Contract Support Cost (CSC) Workgroup Meeting, August 16, 2017.** The IHS CSC Workgroup met on this date in Tulsa, Oklahoma to finalize the calculation templates, among other tasks. We are requesting that the revised draft templates, including the agreed-upon edits, be distributed to the Workgroup. Additionally, we look forward to your follow up on the items that IHS committed to reconsider during the same meeting.

10. **Advocate for IHS input and Tribal Consultation on State Medicaid Waivers.** Despite the efforts of Centers for Medicare and Medicaid Services' (CMS) to reinforce the requirements for Tribal Consultation regarding Medicaid waivers, some States are not including meaningful consultation from Tribes prior to submitting waiver proposals to CMS. Most of these States are included within an IHS Area, and we request that IHS interact with State Medicaid agencies on these waivers to provide technical assistance and advice on Tribal Consultation.

11. **IHS Strategic Plan.** During discussion at the quarterly TSGAC meeting, the Committee provided feedback regarding formulation of a Tribal/Federal Workgroup to develop the IHS Strategic Plan. Specifically, the TSGAC recommended that the entire Direct Service Tribes Advisory Committee (DSTAC) and the TSGAC be included as Tribal representation on such a Workgroup. These Committees are comprised of Tribal Leadership, are responsible for advising the Director of IHS, and are geographically representative. This would prevent having to identify new Tribal representatives in a very short timeframe to work on the Strategic Plan. Additionally, the TSGAC recommended inclusion of the TSGAC Technical Workgroup members in the process, as well as any Tribal technical representatives of the DSTAC. Detailed, written input to the IHS Strategic Plan Framework will be provided under separate cover.

The health care landscape and future contains a great deal of uncertainty, and we appreciate your continued commitment to advancing our mutual goals of providing increased access to high quality health services to Tribal communities. We appreciate our positive partnership on these issues and all of the other challenges in Indian Country. If you have any questions or would like to discuss these comments in further detail, please contact me at lmalerba@moheganmail.com. Thank you.

Sincerely,



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

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Sent electronically to consultation@ihs.gov

November 3, 2017

RADM Michael D. Weahkee, M.B.A., MHSA
Assistant Surgeon General, U.S. Public Health Service
Acting Director, Indian Health Service
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Rockville, MD 20857

RE: Comments on IHS Strategic Plan Draft Framework, 2018-2022

Dear RADM Weahkee:

On behalf of the Tribal Self-Governance Advisory Committee (TSGAC), I submit the following in response to your September 22, 2017 letter requesting comments on the Indian Health Service (IHS) Strategic Plan, 2018-2022, including the draft Framework and Tribal Consultation process.

Recommendations Concerning Formulating a Tribal/Federal Workgroup on the IHS Strategic Plan. As discussed during the quarterly meeting of the TSGAC held October 24-25, 2017, the TSGAC recommends that the entire Direct Service Tribes Advisory Committee (DSTAC) and the TSGAC be included as the Tribal representation on such a Workgroup. These Committees are comprised of Tribal Leadership, are responsible for advising the Director of IHS and are geographically representative. This would prevent having to identify new Tribal representatives in a very short timeframe to work on the Strategic Plan. The TSGAC recommends inclusion of the TSGAC Technical Workgroup members in the process, as well as any Tribal technical representatives of the DSTAC. In addition, due to the short development timeline, we recommend the Workgroup primarily complete its tasks by way of conference call, email, webinar, etc. to the extent possible, with at least one face-to-face session.

Draft Framework for IHS Mission, Vision, Goals, and Objectives

Mission - To raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

> Comments: The IHS Mission statement should specifically incorporate the unique Trust responsibility of the Federal government to provide health care. In the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1601(1), Congress found that "Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people." The Mission should be reflective of this important foundational basis.

Vision - A health system that promotes Tribal ownership and pride.

> Comments: Though the drafted vision is one that the TSGAC supports, the vision statement should describe a system in which Tribes would take ownership and express pride. It is the responsibility of every health system, no matter how care is delivered to actively work toward systemic improvements. As such, TSGAC suggests a vision which more specifically defines a continuously improving organization that results in the outcome articulated, such as, "A

comprehensive and connected system that emphasizes quality health care and Tribal collaboration."

Goal 1: To ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

Objectives:
1. Recruit, develop, and retain a dedicated, competent, caring workforce.
2. Build, strengthen, and sustain collaborative relationships.
3. Increase access to quality health care services.

Comments: Regarding Goal 1, the TSGAC recommends that the term "culturally acceptable" be revised, as this seems to be a low aspiration for the Agency. Rather, IHS should consider culturally relevant and culturally appropriate services and approaches as a foundational perspective and expectation for IHS. Objective 1 should be strengthened to promote and strengthen the health care workforce for IHS. IHS has been unable to meet the workforce needs with the current strategy. IHS must improve its ability to address workforce challenges creatively if the care needs of AI/ANs are going to be met. IHS should include a specific objective to build a strong and sustainable public health infrastructure for Tribes. An objective should be included to build capacity and identify resources needed to provide the full range of, and quantity of services authorized under the Indian Health Care Improvement Act. Another objective should be included to implement cultural competency standards in all training programs and policy development. In Objective 2, "collaborative relationships" should be expanded to "partnerships, both internally across the federal government and externally with Tribes and other health organizations and health business." Finally, an objective should be added to "Collaborate with other Operating Divisions within HHS and HHS leadership to facilitate access to funding elsewhere within HHS for IHS and Tribal programs, via inter-agency agreements or other means."

Goal 2: To promote excellence and quality through innovation of the Indian health system into an optimally performing organization.

Objectives:
1. Create quality improvement capability at all levels of the organization.
2. Provide care to better meet the health care needs of Indian communities.

Comments: We recommend that Goal 2 be slightly revised to read, "To promote excellence and quality through innovative strategies of the Indian health system into an optimally performing organization." TSGAC recommends that an Objective be added whereby the Agency encourages IHS employees to develop innovative solutions, work across silos to improve health care quality, strengthen and secure financial and capital resources, and build partnerships with stakeholders. Additionally, Objective 2, should be stated more explicitly and in measurable terms. Objectives should be able to be measured, so that the Agency and Tribes can determine whether there has been success or progress towards accomplishing them. TSGAC recommends that another Objective be written to address quality, such as, "Acquire and maintain accreditation at each applicable IHS-operated health facility." Another Objective should include "Implementing a quality and performance improvement plan for all health services, including direct health care, public health, behavioral health and wellness services, etc."

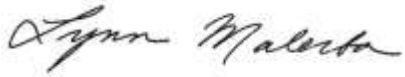
Goal 3: Strengthen IHS program management and operations

Objectives:
1. Improve communication within the organization, with Tribes and other stakeholders, and with the general public.
2. Secure and effectively manage assets and resources.
3. Modernize information technology and information systems to support data driven decision.

> Comments: The TSGAC recommends Goal 3 be revised to read, "Strengthen and streamline IHS program management, operations and processes." Regarding objectives, and while improving communication with Tribes is a laudable effort, another Objective should be written to facilitate and support Tribal choices under the ISDEAA, sharing information with Tribes timely as requested, and continuing to enhance partnerships with Tribes to effectuate meaningful Tribal Consultation and participation in matters and policies that affect Tribes. Another Objective should be included to, "Strengthen and streamline business processes in the organization, at each level of the IHS." TSGAC also recommends another Objective to "Research, develop and implement a performance/accountability component for all disciplines." Finally, we recommend an Objective to, "Develop and implement minimum, standard processes for improving accountability to Tribes."

Thank you for the opportunity to comment on the IHS Strategic Plan Draft Framework and Tribal Consultation process. As the project progresses over the coming months, we expect to continue to provide feedback as the Workgroup refines the Framework and develops the approaches, strategies and action steps to accomplish the plan. If you have any questions or would like to discuss these comments in further detail, please contact me at lmalerba@moheganmail.com. Thank you.

Sincerely,



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

cc: Francis Frazier, Director, Office of Public Health Support, IHS
Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, IHS
TSGAC Members and Technical Workgroup

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Submitted electronically to francis.collins@nih.gov

November 6, 2017

Francis Collins, M.D., Ph.D., Director
National Institute of Health
9000 Rockville Pike
Bethesda, MD 20892

RE: Request for Extension to the Comment Period on the Proposal to Update Data Management of Genomic Summary Results

Dear Dr. Collins:

On behalf of the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC), I write to request an extension to the comment period on the proposal to Update Data Management of Genomic Summary Results. The TSGAC represents 360 Tribal governments nationwide who have assumed and directly operate IHS health and related programs under the Self-Governance initiative. The request for comment was brought to the attention of the TSGAC at our quarterly meeting held on October 24, 2017, by a member of the NIH Tribal Advisory Committee. We realize that the comment period ended on October 20, 2017. However, neither the TSGAC nor many of the Tribes across the Nation were aware of the proposed updates and have not had an opportunity to review and comment on these updates.

This is a very important topic to Tribes and TSGAC believes that with appropriate notification the National Institute of Health (NIH) Office of Science Policy would receive many substantive comments regarding the new proposal for data management of genomic summary results. In fact, a member of the TSGAC has done a cursory review and strongly suggested that Tribes review the implications that the updates may have on the use of controlled and restricted data. Many Tribes have their own Institutional Review Boards that must consider and approve any applicable research conducted on their citizens. In particular, TSGAC is concerned for Tribal Nations that may already have data in the database and/or have plans to participate in future genomic research studies.

Your acknowledgement and favorable consideration to this request would be appreciated. We look forward to working with NIH in updating the data management of genomic summary results so that Tribal Nations and their customs are properly observed. If you have any questions regarding this request, please contact me at lmalerba@moheganmail.com. Thank you.

Sincerely,

Lynn Malerba

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

cc: RADM Michael Weahkee, Acting Director, IHS
Carrie D. Wolinetz, Ph.D., Associate Director for Science Policy, NIH
Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, IHS

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Sent electronically to consultation@ihs.gov

November 6, 2017

RADM Michael D. Weahkee, M.B.A., MHSA
Assistant Surgeon General, U.S. Public Health Service
Acting Director, Indian Health Service
U.S. Department of Health and Human Services
Mail Stop: 08E37A
5600 Fishers Lane
Rockville, MD 20857

RE: Response to October 6, 2017 IHS CHEF Letter

Dear RADM Buchanan:

On behalf of the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC), I am writing to follow up on concerns raised at the TSGAC Quarterly Meeting held on October 25, 2017 related to information in your October 6th letter explaining that IHS has temporarily suspended the final rulemaking of the Catastrophic Health Emergency Fund (CHEF) regulations pending an outcome in the *Redding* case.

The TSGAC thanks you for your decision to suspend CHEF regulations until the court has issued a decision on this matter. However, the TSGAC has serious concerns about assertions raised in the letter in which IHS explains that "Tribal self-insurance plans are already considered an alternate resource under the IHS Purchase/Referred Care (formerly Contract Health Service) Policy." The letter explains that the "IHS recently incorporated a limited policy based exception that applies only when a specific type of exclusionary clause is written into the self-funded insurance plan," referring to the IHS Manual. These statements that are made in the IHS letter are troubling for a number of reasons.

Initially, it is not correct that the IHS already treats Tribal self-insurance as an alternate resource under the IHS Manual. Section 2-3.8(I) of the Manual, titled "Exception to the IHS Payor of Last Resort: Tribal Self-Insurance Plans," states in part as follows:

> *The IHS is prohibited from seeking recovery when the health services provided to an eligible patient are covered by a self-insured health plan funded by a Tribe or Tribal organization under Section 206(f) of the IHCIA, P.L. 94-437, 25 U.S.C. §1621e(f). Consistent with congressional intent not to burden Tribal resources, the Agency has made a determination that Tribally-funded self-insured health plans are not to be considered alternate resources for purposes of the IHS' Payor of Last Resort Rule.*

The IHS Manual then explains that this is a narrow exception to the IHS's payor of last resort rule, but the Manual also requires that for the exception to apply, the self-insurance plan has to meet certain requirements and include an exclusionary clause in the plan language prohibiting payment to IHS (explaining that plans without the exclusionary clause are treated as an alternate resource). However, Section 206(f) of the IHCIA takes the opposite approach to the Manual: By statute, the IHS does not have a right of recovery against a Tribal self-insurance plan absent specific written authorization allowing IHS to bill the plan. 25 U.S.C. § 1621e(f).

Further, the exception for Tribal self-insurance in Section 2-3.8(I) of the IHS Manual has been in the Manual for many years, so the two comments included in the October 6th letter about the exception

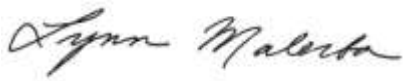
being "recent" and "policy-based" are not accurate. We have compared Section 2-3.8(I) in a version of the Manual from 2012, against the copy of the Manual on the IHS's current website at https://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p2c3#2-3.8I (last visited 10/24/17). The IHS has not made any changes to the Manual related to Tribal self-insurance and alternate resources in Section 2-3.8(I) (unless any such changes do not appear on the website to which the Acting Director cited in the October 6th letter). The exclusion for Tribal self-insurance in the Manual is not recent; rather, it is the IHS's policy of now defining Tribal self-insurance as an alternate resource to PRC and CHEF that is the recent change. Additionally, the exclusion for Tribal self-insurance is not a matter of IHS discretionary policy, as the Agency appears to argue, but is statutorily required by Section 206(f) of the IHCIA.

We also understand that the IHS Director's Workgroup on Improving Purchased/Referred Care (PRC Workgroup) is in process of reviewing and working with the Agency to finalize revisions to the "Indian Health Care Manual, Part 2, Chapter 3, Purchased/Referred Care." Based on feedback from several PRC Workgroup members and technical advisors, we understand that IHS is not proposing substantive changes to the definition of "alternate resources" at § 2-3.1E)(1). However, we understand that IHS has made substantive changes elsewhere in the policy that deal with alternate resources. For example, IHS proposes a rewrite at § 2-3.9(G) in which the language of the exclusionary clause has been eliminated, adds language that excludes charitable programs from alternate resources unless they have stop loss or reinsurance without explaining the limitation on Tribal programs, and is unclearly written to imply that all IHS or Tribal facilities are alternate resources to PRC.

Following our meeting with you, the Committee discussed these issues and felt that it is very important to bring these issues to your attention. The TSGAC felt that the IHS is trying to reframe IHS's long-standing/non-recent Manual language on Tribal self-insurance and find this to be unacceptable, particularly given the *Redding* litigation. It seems IHS is taking steps to implement policy and bolster its legal arguments related to the pending *Redding* case.

We appreciate and thank you for your commitment to suspend the CHEF regulations pending an outcome in the *Redding* case. We feel this is good policy practice to not issue regulations or guidance on matters that are under development and may change. On this basis, we also respectfully request that the IHS suspend finalizing the PRC Manual, which includes several issues that are at question in *Redding,* until the court has issued its opinion in that case. If you have any questions or wish to discuss these matters further, please do not hesitate to contact me at (860) 862-6192 or vial email at lmalerba@moheganmail.com.

Sincerely,



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

cc: Jennifer Cooper, Acting Director, IHS Office of Tribal Self-Governance
Elizabeth Fowler, Deputy Director, IHS Management Operations
TSGAC Members and Technical Workgroup

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Sent electronically to consultation@ihs.gov

November 22, 2017

RADM Michael D. Weahkee, M.B.A., MHSA
Assistant Surgeon General, U.S. Public Health Service
Acting Director, Indian Health Service
U.S. Department of Health and Human Services
Mail Stop: 08E37A
5600 Fishers Lane
Rockville, MD 20857

RE: Response to October 6, 2017 IHS CHEF Letter

Dear RADM Buchanan:

This is a follow-up to my recent letter, dated November 6, 2017, on behalf of the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC) regarding your October 6th letter and related discussion at the October 25 TSGAC Quarterly Meeting relating to the pending IHS Catastrophic Health Emergency Fund (CHEF) regulations. As noted in my November 6, 2017 letter, the TSGAC appreciates your decision to suspend issuance of final CHEF regulations until the court issues a decision in the *Redding* case, as that case involves questions over the legality of the IHS's treatment of Tribal self-insurance plans as alternate resources for purposes of the CHEF and Purchased/Referred Care (PRC) programs.

As you may be aware, the *Redding* court issued its decision on November 7, 2017, upholding the Tribes' position that Tribal self-insurance plans, like other health programs operated by Indian Tribes and Tribal organizations, have the same payer of last resort status as the IHS and that the IHS may not treat Tribal self-insurance plans as alternate resources for purposes of the CHEF or PRC programs absent the specific, written consent of that Tribe or Tribal organization. The decision, *Redding Rancheria v. Hargan*, No. 14-2035 (D.D.C. Nov. 7, 2017), is attached for your reference. In it the district court specifically rejects the IHS's argument that the payer of last resort rule, enacted by Section 2901(b) of the Affordable Care Act in 2010 and codified at 25 U.S.C. § 1623(b), invalidated any "policy based exception" that the IHS may have had regarding the treatment of Tribal self-insurance. Rather, the court held that Section 1623(b) is "unambiguous" in conferring payer of last resort status on any "health program operated by … Indian Tribes, Tribal organizations, and Urban Indian organizations," including Tribal self-insurance plans.

Further, the court held that in amending 25 U.S.C. § 1621e(f) simultaneously with enactment of Section 1623(b), Congress explicitly vested the decision of when to allow the IHS to recover from Tribal self-insurance plans with the Tribes—*not* the IHS. Section 1621e(f) provides that "[a]bsent specific written authorization by the governing body of an Indian Tribe … the United States shall not have a right of recovery under this section if the injury, illness, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian Tribe, Tribal organization, or urban Indian organization." The Redding court held that "A reading of the payor of last resort provision to exclude Tribal self-insurance programs, as urged by IHS, would directly contradict this clear intention to prevent the federal government from recovery for services covered by a self-insurance plan absent specific written authorization from the Tribe."

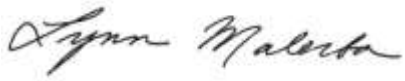
Clearly, the proposed CHEF regulations, which would have defined "alternate resources" to include any "Federal, State, *Tribal*, local, or private source of reimbursement for which the patient is eligible… [including] *Tribal* or local health care programs … *and private insurance*" (which private

insurance was to include Tribal self-insured plans, according to the preamble to the proposed rule) cannot be squared with the *Redding* decision. The *Redding* court affirmed that sections 1623(b) and 1621e(f) prohibit the IHS from treating Tribal self-insurance plans, or any other Tribal health program, as alternate resources unless a Tribe has specifically consented to such treatment. This ruling also invalidates the IHS's "policy" purporting to treat Tribal self-insurance plans as alternate resources unless they include a "specific type of exclusionary clause," as stated in your October 6th letter.

In light of the *Redding* decision, the proposed CHEF regulations are invalid and must be withdrawn. We therefore request that the IHS withdraw the proposed CHEF regulations and initiate consultation on revised proposed regulations that comply with the requirements of the IHCIA and with the court's ruling in the *Redding* case. Additionally, any treatment of Tribal self-insurance plans as alternate resources under the Indian Health Care Manual, Part 2, Chapter 3, Purchased/Referred Care would likewise be invalid. Therefore, we request that the IHS work with the IHS Director's Workgroup on Improving Purchased/Referred Care (PRC Workgroup) to ensure that revisions to that document likewise comply with the IHCIA and the *Redding* decision before they are adopted.

We wish to thank you again for suspending issuance of final CHEF regulations and for thereby avoiding the need to revise final, published regulations for non-compliance with statutory requirements. We look forward to working with you and to engaging in Tribal consultation on the CHEF regulations as well as the PRC Manual in order to finally lay these issues to rest. In the future, we hope that it will not require adversarial litigation for the IHS and Tribes to come to agreement on the statutory limitations and requirements of the IHCIA. If you have any questions or wish to discuss these matters further, please do not hesitate to contact me at (860) 862-6192 or vial email at lmalerba@moheganmail.com.

Sincerely,



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

cc: Jennifer Cooper, Acting Director, IHS Office of Tribal Self-Governance
Elizabeth Fowler, Deputy Director, IHS Management Operations
TSGAC Members and Technical Workgroup

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Sent electronically to Denise.Turk@ihs.gov

November 22, 2017

RADM Michael D. Weahkee, M.B.A., MHSA
Assistant Surgeon General, U.S. Public Health Service
Acting Director, Indian Health Service
U.S. Department of Health and Human Services
Mail Stop: 08E37A
5600 Fishers Lane
Rockville, MD 20857

RE: Level of Need Funded IHS/Tribal Workgroup

Dear RADM Weahkee:

Thank you for attending the fourth Quarterly Meeting of the Tribal Self-Governance Advisory Committee (TSGAC) held in Washington, DC, on October 24-25, 2017. The TSGAC appreciates the open conversation and updates from Indian Health Service (IHS) on issues important to Self-Governance Tribes. During the meeting, we discussed the Level of Need Funded (LNF) formula, which is the mechanism to distribute monies appropriated to the Indian Health Care Improvement Fund, and the fact the data worksheets have not been updated since 2012.

We appreciate your recent announcement that IHS will update the LNF data and establish an Indian Health Care Improvement Fund (IHCIF) workgroup. Below is a list of TSGAC and technical workgroup members who were identified to participate on the ICHIF workgroup during the October quarterly meeting. As noted in your November 13, 2017 "Dear Tribal Leader Letter" (DTLL), these representatives will acquire a delegation letter from Tribal leaders to ensure the Federal Advisory Committee Act (FACA) exception is maintained. An additional letter will be forthcoming and will include TSGAC's full comments on the workgroup's charge as requested in your November 13th DTLL.

TSGAC Recommendations for the IHCIF Workgroup
TSGAC would like to submit the following names of individuals to serve on the Level of Need Funded IHS/Tribal Workgroup who will work collectively with Mr. Cliff Wiggins, who you reported has been contracted to update the LNF data, and IHS staff in reviewing the data and updating the worksheets, etc:

Rhonda Butcher, Citizen Pottawatomi Nation, Rbutcher@potawatomi.org
Kasie Nichols, Citizen Pottawatomi Nation, kasie.nichols@potawatomi.org
Donna Swallows, donna.swallows@gtbindians.com
Caitrin Shuy, National Indian Health Board, cshuy@nihb.org
Tyson Johnston, TJohnston@quinault.org
Jim Roberts, Alaska Native Tribal Health Consortium, jcroberts@anthc.org
Melissa Gower, Chickasaw Nation, Melissa.gower@chickasaw.net
Melanie Fourkiller, Choctaw Nation, mfourkiller@choctawnation.com
Dee Sabattus, United Southern and Eastern Tribes, dsabattus@usetinc.org

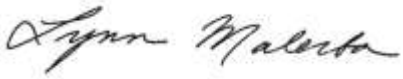
Short and Long-Term Planning
TSGAC strongly recommends that IHS identify at least three to four IHS staff members for Mr. Wiggins to mentor and cross train so that IHS Headquarters can continually update these worksheets in the future. Additionally, TSGAC recommends that the workgroup organize its work to prioritize objectives according to the phases below:

Phase 1, Short-Term – Update the LNF worksheets using the existing formula to ensure timely distribution of possible 2018 IHCIF appropriations.

Phase 2, Long-Term – IHCIF IHS/Tribal workgroup charge, process for updating and publishing data and timeline development for review of all the components of the LNF formula, etc.

The health care landscape and future contains a great deal of uncertainty, and we appreciate your continued commitment to advancing our mutual goals of providing increased access to high quality health services to Tribal communities. We appreciate our positive partnership on these issues and all of the other challenges in Indian Country. If you have any questions or would like to discuss these comments in further detail, please contact me at lmalerba@moheganmail.com. Thank you.

Sincerely,



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

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Submitted via: www.regulations.gov

January 8, 2018

Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Comments on Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program (CMS-4182-P)

Dear CMS Official:

I write on behalf of the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC) to comment on the Proposed Rule titled, "Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program".

The Proposed Rule would revise Medicare Part C and Part D regulations to implement certain provisions of the Comprehensive Addiction and Recovery Act (CARA) and the 21st Century Cures Act. In addition, the Proposed Rule seeks to improve program quality, accessibility, and affordability; improve the CMS customer experience; and address program integrity policies related to payments based on prescriber, provider, and supplier status. The Proposed Rule also would update the official Part D electronic prescribing standards, as well as clarify program requirements and certain technical changes regarding treatment of Part A and Part B appeal rights related to premium adjustments.

The TSGAC has concerns about the effect of the Proposed Rule on low-income American Indian and Alaska Native (AI/AN) Medicare beneficiaries. Under current Medicare Part D regulations, individuals dually eligible for Medicare and Medicaid or eligible for the Low-Income Subsidy (LIS) program qualify for a special enrollment period (SEP) that allows them to enroll in, switch, or disenroll from prescription drug plans (PDPs) at any time.[1] The Proposed Rule would limit the use of this Part D SEP for dual-eligible and LIS-eligible Medicare beneficiaries. For AI/AN Medicare beneficiaries, this could have the effect of blocking access to critically needed pharmaceuticals or, at a minimum, denying eligibility for reimbursement for these pharmaceuticals for a period of time.

[1] See 42 CFR 423.38(c)(4).

Discussion

Under the Proposed Rule, CMS would revise 42 CFR 423.38(c) to limit use of the Medicare Part D SEP for dual-eligible or LIS-eligible beneficiaries as follows:

- Add a new paragraph (c)(4)(i), under which most dual-eligible or LIS-eligible beneficiaries could use the Part D SEP only once per calendar year; and,

- Add a new paragraph (c)(4)(ii), under which dual-eligible or LIS-eligible beneficiaries assigned to a PDP by CMS or a state could only use the Part D SEP before that election becomes effective or within 2 months of their enrollment in the plan.[2]

Further, the Proposed Rule would make the Part D SEP unavailable for dual-eligible or LIS-eligible beneficiaries if their current PDP labels them as "at-risk" or "potentially at-risk" for substance abuse,[3] meaning that they could not switch plans or disenroll from the plan. This restriction on using the Part D SEP would remain in place until the plan removed the "at-risk" or "potentially at-risk" designation. If the plan identifies a dual-eligible or LIS-eligible beneficiary as "potentially at-risk," that designation would expire in 90 days if the plan does not subsequently designate the beneficiary as "at-risk." If the plan does subsequently designate the beneficiary as "at-risk," that designation would remain in place until: 1) the plan removes the designation based on a future determination; or, 2) after 12 months; whichever is sooner.

In contrast to the arguments made in putting forth the Proposed Rule, maintaining maximum flexibility regarding enrollment in Medicare Part D and the ability to change PDPs best serves the interests of low-income beneficiaries, especially AI/AN beneficiaries.

In the Proposed Rule, CMS noted that it supports the "underlying principle that LIS beneficiaries should have the ability to make an active choice" in electing PDPs. Yet, the proposed limits on the use of the Part D SEP would severely curtail this ability for dual-eligible or LIS-eligible Medicare beneficiaries who might have otherwise benefited from switching plans. In addition, as only a small subset of dual-eligible or LIS-eligible Medicare beneficiaries opt to use the Part D SEP each year (fewer than 10 percent in 2016, per CMS), the concerns cited in the Proposed Rule about allowing the current policy to continue seem unwarranted.

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[2] The proposed rule also would add a new paragraph (c)(9), under which all Medicare beneficiaries who have a change in their Medicaid or LIS-eligible status could use a new SEP to make an election within 2 months of the change, or of receiving notification of the change, whichever is later.

[3] The Proposed Rule would define an "at-risk beneficiary" as an individual who is eligible for Medicare Part D, identified by clinical guidelines, and determined "to be at-risk for misuse or abuse of such frequently abused drugs under a Part D plan sponsor's drug management program." The Proposed Rule would define a "potentially at-risk beneficiary" as an individual who is eligible for Part D, identified by clinical guidelines, and with respect to whom a "Part D plan sponsor receives a notice upon the beneficiary's enrollment in such sponsor's plan that the beneficiary was identified as a potential at-risk beneficiary (as defined in paragraph (1) of this definition) under the prescription drug plan in which the beneficiary was most recently enrolled, such identification had not been terminated upon disenrollment, and the new plan has adopted the identification." See proposed 42 CFR 423.100.

With regard to Indian Health Service (IHS) beneficiaries in particular, inserting the Medicare Part D drug plans into the relationship between Medicare/IHS beneficiaries and their IHS/Tribal providers is not helpful. IHS and Tribal health programs assist IHS beneficiaries in coordinating the delivery of needed health care services, including the provision of pharmaceutical services. Inserting the Part D drug plans into the decision-making process as to whether a low-income IHS beneficiary can switch plans—a decision often made in order to access a specific prescription drug or access the prescription drug at a more affordable cost—is unnecessary and would disrupt the patient-provider relationship.

To best meet the needs of low-income Medicare beneficiaries and the needs of IHS beneficiaries in particular, CMS should continue to allow these beneficiaries to have the ability to enroll in or switch plans based on their individual needs as provided under current law.

Recommendation

In response to the concerns outlined above, **the TSGAC requests that CMS, in finalizing the Proposed Rule, drop the proposals to limit the use of the Medicare Part D SEP for dual-eligible and LIS-eligible beneficiaries. Alternatively, if CMS intends to retain these provisions, the TSGAC requests that the agency specify an exemption for IHS-eligible persons.**[4]

Conclusion

Thank you for the opportunity to provide these comments on the Proposed Rule. In the future, we encourage CMS to engage with Tribes prior to the release of proposed rules, such as this one, which would have a significant impact on AI/ANs. 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.

Sincerely,

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

cc: Kitty Marx, Director, Division of Tribal Affairs/IEAG/CMCS
Jennifer Cooper, Acting Director, Office of Tribal Self-Governance, IHS
TSGAC Members and Technical Workgroup

[4] Under section 1311(c)(6)(D) of the Affordable Care Act, certain IHS-eligible persons enrolled in health insurance coverage through a Marketplace likewise are able to enroll in, switch, or disenroll from plans at any time throughout the year.

Indian Health Service Reimbursement Rates for 2018[1]

January 9, 2018

This brief provides information to Tribes on Indian Health Service (IHS) reimbursement rates—also known as "OMB rates" or "encounter rates"—for calendar year (CY) 2018.

On January 5, 2018, a notice was published in the Federal Register[2] announcing that the IHS Acting Director, under the authority of sections 321(a) and 322(b) of the Public Health Service Act, Public Law 83-568, and the Indian Health Care Improvement Act, has approved the following rates for inpatient and outpatient medical care provided by IHS facilities for CY 2018 for Medicare and Medicaid beneficiaries, beneficiaries of other federal programs, and for recoveries under the federal Medical Care Recovery Act. This notice does not include Medicare Part A inpatient rates, as they are paid based on the prospective payment system. Since the inpatient per diem rates set forth in this notice do not include all physician services and practitioner services, additional payment shall be available to the extent that those services are provided. The IHS reimbursement rates for CY 2018 appear below.

IHS Reimbursement Rates for CY 2018

Inpatient Hospital Per Diem Rate (Excludes Physician/Practitioner Services)

Lower 48 States $3,229
Alaska $3,277

Outpatient Per Visit Rate (Excluding Medicare)

Lower 48 States $427
Alaska $653

Outpatient Per Visit Rate (Medicare)

Lower 48 States $383
Alaska $595

Medicare Part B Inpatient Ancillary Per Diem Rate

Lower 48 States $740
Alaska ..... $ 1,061

[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] IHS, "Reimbursement Rates for Calendar Year 2018"; see 83 FR 682. https://www.gpo.gov/fdsys/pkg/FR-2018-01-05/pdf/2018-00047.pdf

Outpatient Surgery Rate (Medicare): Established Medicare rates for freestanding Ambulatory Surgery Centers.

Effective Date for CY 2018 Rates: Consistent with previous annual rate revisions, the CY 2018 rates will take effect for services provided on/or after January 1, 2018, to the extent consistent with payment authorities including the applicable Medicaid state plan.

Table 1 below provides a comparison of IHS reimbursement rates for CY 2018 and CY 2017.

Table 1: Comparison of IHS Reimbursement Rates, CY 2018 and CY 2017

Service		CY 2018 Rate	CY 2017 Rate	$ Change	% Change
Inpatient Hospital Per Diem Rate (Excludes Physician/ Practitioner Services)	Lower 48 States	**$3,229**	**$2,933**	**+$296**	**+10.1%**
	Alaska	**$3,277**	**$3,235**	**+$42**	**+1.3%**
Outpatient Per Visit Rate (Excluding Medicare)	Lower 48 States	**$427**	**$391**	**+$36**	**+9.2%**
	Alaska	**$653**	**$616**	**+$37**	**+6.0%**
Outpatient Per Visit Rate (Medicare)	Lower 48 States	**$383**	**$349**	**+$34**	**+9.7%**
	Alaska	**$595**	**$577**	**+$18**	**+3.1%**
Medicare Part B Inpatient Ancillary Per Diem Rate	Lower 48 States	**$740**	**$679**	**+$61**	**+9.0%**
	Alaska	**$1,061**	**$1,046**	**+$15**	**+1.4%**
Outpatient Surgery Rate (Medicare)	Lower 48 States and Alaska	Established Medicare rates for freestanding ambulatory surgery centers	Established Medicare rates for freestanding ambulatory surgery centers	N/A	N/A

Sources: IHS, 82 FR 5585 and 83 FR 682

Health Care Reform in Indian Country
Self-Governance Communication & Education
Self-Governance Tribes Striving Towards Excellence in Health Care

Steps to Update (or Add) Entry on the HHS Essential Community Provider List[1]

December 13, 2017

This brief seeks to provide guidance to Indian health care providers (IHCPs) on the steps they need to take to update information or obtain placement on the list of essential community providers (ECPs) maintained by the federal Department of Health and Human Services (HHS ECP List) for 2018 and 2019. The window to introduce an entry on the HHS ECP List for the 2018 plan year (PY 2018) closed on October 15, 2016. IHCPs (and other ECPs) currently appearing on the HHS ECP List for PY 2018 can update their entries through December 22, 2017, with any changes reflected in the HHS ECP List for PY 2019, scheduled for release in early 2018. ***To confirm that HHS has a record of an IHCP facility updating or adding an entry on the HHS ECP List for PY 2019, see the draft list at https://data.healthcare.gov/view/ecf3-gujb.***

IHCPs that do not appear on the HHS ECP List for PY 2018 also can approach a qualified health plan (QHP) issuer directly and request to contract with the issuer and appear as a contracting ECP. ***CMS allows issuers to identify ECPs that do not appear on the HHS ECP List for PY 2018 through a "write-in" process, provided that issuers arrange for these providers to submit an ECP petition to HHS by no later than the deadline for issuer submission of changes to their QHP application***.

IHCPs and other providers that seek to obtain placement on the HHS ECP List for PY 2019, or to update information in a current entry, must submit a petition, following the steps outlined in the table below.[2] ***CMS will close the submission window for new or updated entries to the HHS ECP List for PY 2019 on December 22, 2017, at 11:59 p.m***. A draft HHS ECP list for PY 2019 is available at https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy.

Steps for Submitting the Essential Community Provider Petition for PY 2019

1.	Access the electronic petition at https://data.healthcare.gov/cciio/ecp_petition.
2.	Begin answering the questions, filling in all required data fields and scrolling over the "i" buttons for additional instructions (when available).
3.	Answer questions about you (the submitter) in the "About You" section.
4.	Indicate under "Requested Action" whether your facility wishes to obtain placement on, change its data on, or remove itself from the HHS ECP List in the "Requested Action" section.

[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] For additional background information, see http://tribalselfgov.org/health-reform/webinars/new-process-to-retain-status-as-essential-community-provider-ecp/.

5.	Find your facility (if your facility currently appears on the HHS ECP List) by clicking on the "Check to see if you are on the list" button in the "Requested Action" section (a searchable database will open) and note your row number (you will need this later to complete the petition / question 7).
6.	Complete the "Eligibility," "Site Information," "Organization Information," and "Point of Contact" sections.
7.	After completing the petition, click the "Preview your Petition before Submitting" button.
8.	Fix validation errors (if any) found in the petition (indicated in red).
9.	Submit your finalized petition.

Contact for Assistance with Submitting Petition: EssentialCommunityProviders@cms.hhs.gov

Link to ECP Provider Petition Instructions: The instructions are embedded in the ECP Petition Web site (by clicking on Information icons).

Tribal Sponsorship of Medicare Part B and Part D Premiums[1]

November 30, 2017

Medicare plays an important role for elderly American Indians and Alaska Natives (AI/ANs) in obtaining necessary health care services.[2] But because of premiums and out-of-pocket costs, many Medicare-eligible AI/ANs are not able to access critical services covered under the various components of the Medicare program. Although Medicare beneficiaries generally pay no premiums for Part A, which covers inpatient hospital care, enrollment in Part B, which covers physician and outpatient services, and Part D, which covers prescription drugs, does require payment of premiums (see Tables 1, 3, and 5 below), prompting some elderly AI/ANs to opt not to enroll.

Premiums for Medicare Part B and D cover approximately 25% of program costs, with the federal government contributing the remaining funding.[3] As a result, the value of the services paid for under Medicare Part B and D typically far exceeds the amount of the premium payment, whether an enrollee has higher-than-average or average health care expenditures.

Table 1. Summary of Medicare Benefits

Medicare Part	Covered Services	Premium	Cost-Sharing
Part A	Inpatient hospital care	No	Inpatient deductible ($1,340 in 2018)
Part B	Physician services, outpatient care and certain other services	Yes ($134 in 2018, with higher premiums for higher-income beneficiaries)	Annual deductible ($183 in 2018) and coinsurance (20% for most services)
Part C	Medicare Parts A and B (and sometimes Part D) through private health plans	Yes, if any	Deductible, copayments, and/or coinsurance (might apply for certain services)
Part D	Outpatient prescription drugs	Yes (varies by plan)	Copayments and/or coinsurance

[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] For example, Medicare Part B makes payment for services such as outpatient specialty services. And, Medicare Part D covers, among other things, high-cost specialty medications that can contribute to tremendous improvements in the quality of life for certain patients, treatments that otherwise might not be available through the Indian Health Service (IHS) or through PRC referral.

[3] For more information on Medicare Part B costs, see https://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html. For more information on Part D costs, see https://www.medicare.gov/part-d/costs/part-d-costs.html.

To help maximize enrollment of AI/ANs in Medicare Part B and Part D (and increase the resources available to Indian health care programs), Tribes can initiate programs to pay premiums on behalf of Tribal members[4] ("Sponsorship").[5]

- Under federal regulations, employers, lodges, unions, and other organizations, including Tribes, can reimburse **Medicare Part B** premiums to one or more enrollees, and some Tribes have implemented Part B Sponsorship programs.[6]
- **Medicare Part D** law and regulations do not specifically address Tribal Sponsorship of premiums. However, Tribes are permitted to sponsor Part D enrollees, and some Tribes have implemented Part D Sponsorship programs by paying the Part D premiums on behalf of Tribal members.[7,8]

Medicare Part B Sponsorship

Medicare Part B covers a range of health care services for enrollees, including:

- Physician services;
- Outpatient care;
- Preventive services, such as screenings for diabetes, cancer, and cardiovascular disease;
- Some home health services;
- Some diabetes supplies;
- Clinical laboratory and diagnostic tests;
- Durable medical equipment; and
- Ambulance services.

Most individuals will get automatically enrolled in Medicare Part B at the time they reach age 65 and become eligible for Medicare, but others (*e.g.*, individuals who have not begun to receive Social Security benefits because they remain employed) will not get automatically enrolled. For individuals not automatically enrolled, enrollment in Part B can begin during the

[4] The term "Tribal member" is used in this brief to include any IHS beneficiary that a Tribe decides to sponsor, whether an enrolled member (or affiliated IHS beneficiary) of the sponsoring Tribe.
[5] In addition to paying the premiums for Medicare Part B and Part D, the option is available to Tribes to sponsor Medicare beneficiaries for "Medicare Supplemental" coverage which covers the out-of-pocket costs (e.g., deductibles and co-payments) charged beneficiaries under Medicare Parts A and B.
[6] See KFF, "The Role of Medicare and the Indian Health Service for American Indians and Alaska Natives: Health, Access and Coverage," page 9, at http://files.kff.org/attachment/report-the-role-of-medicare-and-the-indian-health-service-for-american-indians-and-alaska-natives-health-access-and-coverage.
[7] See TTAG, "Indian Sponsorship Under Exchanges," Attachment 1, page 1, at http://www.nihb.org/tribalhealthreform/wp-content/uploads/2013/06012011/TTAG%20-%20Enabling%20an%20Indian%20Sponsorship%20Option%20DIST%202011-04-13.pdf.
[8] IHS also has the authority to pay Medicare Part B (but not Part D) premiums on behalf of eligible AI/ANs. As of December 2014, however, IHS had not used this authority. See GAO, "Medicare and Medicaid: CMS and State Efforts to Interact with the Indian Health Service and Indian Tribes," page 10, at http://www.gao.gov/new.items/d08724.pdf.

7-month period that (1) starts 3 months before the month they turn 65, (2) includes the month they turn 65, and (3) ends 3 months after the month they turn 65. Outside of this initial enrollment period, the annual enrollment period for Part B runs from January 1 to March 31, with coverage beginning July 1.

Special Enrollment Periods (SEPs) Under Part B

Some individuals might qualify for an SEP that allows enrollment outside of the annual open enrollment period, but no SEP is available specifically for AI/ANs. The following individuals qualify for an SEP under Part B:

- Individuals enrolled in group health insurance based on current employment (excludes COBRA and retiree coverage), as long as they continue (or their spouse continues) working, can enroll in Part B at any time;
- Individuals whose current employment or enrollment in group health insurance based on current employment (excludes COBRA and retiree coverage) ends, can enroll over the 8 month period that begins with the month after the event;[9] and
- In some cases, individuals serving as volunteers abroad can enroll under an SEP.

Part B Premium

Part B enrollment requires payment of a premium, although lower-income enrollees might be eligible for premium assistance through a Medicare Savings Program (MSP). Eligibility for the

Table 2. Medicare Savings Program Income Eligibility and Asset Requirements for 2017

Medicare Savings Program	Helps Pay for:	Annual Income Limits		Asset Limits	
		Individual	Couple	Individual	Couple
Qualified Medicare Beneficiary (QMB)	Part A premiums Part B premiums Part A and B out-of-pocket costs	$12,300	$16,488	$7,390	$11,090
Specified Low-Income Medicare Beneficiary (SLMB)	Part B premiums only	$14,712	$19,728	$7,390	$11,090
Qualifying Individual (QI)	Part B premiums only	$16,524	$22,164	$7,390	$11,090
Qualified Disabled Working Individual (QDWI)[1]	Part A premiums only	$49,260	$65,988	$4,000	$6,000

[1] Figures include certain earned income disregards.

MSPs is determined by income level and an asset test (see Table 2 above for income eligibility and asset requirements).[10] Individuals pay their Medicare Part B premium via a direct

[9] The SEPs for individuals enrolled in or ending their enrollment in group health insurance based on current employment do not apply to those who qualify for Medicare based on having end-stage renal disease (ESRD).
[10] The Qualified Medicare Beneficiary (QMB) Program, Specified Low-Income Medicare Beneficiary (SLMB) Program, and Qualifying Individual (QI) Program provide assistance in paying Medicare Part B premiums. See

deduction from their monthly Social Security checks. As such, if a Tribe seeks to pay Medicare Part B premiums on behalf of eligible Tribal members, it would do so by reimbursing these individuals by the amount of their deductions. The Tribe, as part of such a Sponsorship program, could ask sponsored Tribal members to provide documentation that these deductions have occurred and then reimburse the Tribal member on a monthly basis or through a single annual payment.

Late Enrollment in Part B

In most cases, if individuals do not enroll in Medicare Part B when they first become eligible, they must pay a late enrollment penalty for as long as they participate in Part B.[11] An important exception to the policy is that Individuals who receive premium assistance through a Medicare Savings Program do not pay the late enrollment penalty. These programs include the QMB Program, SLMB Program, QI Program, and Qualified Disabled and Working Individuals (QDWI) Program. The Part B premium typically increases by 10% of the base Part B premium for each full 12-month period that individuals could have enrolled, but did not enroll, in Part B.[12] The Part B premiums and late enrollment penalties for 2018 are shown in Table 3.

Table 3. Medicare Part B Premiums and Late Enrollment Penalties, by Beneficiary Income and Tax Filing Status

Beneficiary Annual Income and Tax Filing Status (2016)			Monthly Premium (2018)[3]	Monthly Premium with Late Enrollment Penalty		
Filing Individually[1]	Married, Filing Joinly[2]	Married, Filing Separately		After 12 Months	After 24 Months	After 36 Months
$85,000 or less	$170,000 or less	$85,000 or less	$134.00	$147.40	$160.80	$174.20
$85,001-$107,000	$170,001-$214,000	--	$187.50	$206.25	$225.00	$243.75
$107,001-$133,500	$214,001-$267,000	--	$267.90	$294.69	$321.48	$348.27
$133,501-$160,000	$267,001-$320,000	--	$348.30	$383.13	$417.96	$452.79
$160,001 or more	$320,001 or more	$85,001 or more	$428.60	$471.46	$514.32	$557.18

[1] Individuals with annual income less than $16,524 might qualify for a Medicare Savings Program that helps pay Part B premiums (in 2017).

[2] Couples with annual income less than $22,164 might qualify for a Medicare Savings Program that helps pay Part B premiums (in 2017).

[3] For those not eligible for premium-free Part A (*e.g.*, an individual paid Medicare taxes for less than 30 quarters), the full Part A premium is $422 per month in 2018. If paid Medicare taxes for 30-39 quarters, the standard Part A premium is $232.

Apart from a Medicare Part B Sponsorship program for the base Part C premium, Tribes have the option of paying the late enrollment penalty on behalf of Tribal members directly to the

https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html.

[11] Generally, individuals who do not enroll in Medicare Part B during the 7-month period that (1) begins 3 months before the month they turn 65, (2) includes the month they turn 65, and (3) ends 3 months after the month they turn 65 are subject to this penalty (however, individuals who continue to work past age 65 for firms with more than 20 employees can delay enrolling in Part B until they leave their jobs, after which time they have an 8-month window for enrolling).

[12] There is not an Indian-specific provision exempting AI/ANs from late enrollment fees.

Centers for Medicare and Medicaid Services (CMS) by entering a "Surcharge Only Agreement" with the CMS. Under this agreement, the Tribe would submit to CMS an Excel spreadsheet (provided by the agency) with data on Sponsored Tribal members and establish a Pay.gov account to facilitate payment of the late enrollment penalty on their behalf. Once the Social Security Administration (SSA) has processed the data, Sponsored Tribal members will have only their base part B premium deducted from their monthly Social Security checks.

Medicare Part D

Medicare Part D covers outpatient prescription drugs through private prescription drug plans. In addition, prescription drug coverage is made available to Medicare beneficiaries through private Part C plans, referred to as Medicare Advantage,[13] which combines Part D prescription drug coverage with the comprehensive medical services under Medicare Parts A and B. Part D enrollment requires payment of a premium, although lower-income enrollees might qualify for the Low-Income Subsidy (LIS) program (also called "Extra Help"), which provides assistance with paying for Part D premiums, deductibles, and coinsurance.[14] Eligibility for the LIS program is determined by income level and an asset test (See Table 4 below for income eligibility and asset requirements). For eligible Medicare beneficiaries, the LIS program covers between 0% and 100% of their Part D premium, with those with the lowest income and asset levels receiving the most generous subsidies. Medicare beneficiaries can apply for the LIS program with SSA or their state Medicaid agency.

Table 4. LIS Program Income Eligibility and Asset Requirements for 2017: Part D Coverage

Annual Income Limits		Asset Limits	
Individual	**Couple**	**Individual**	**Couple**
$18,090	$24,360	$13,820	$27,600

In general, individuals can begin to enroll in Medicare Part D during the 7-month period that (1) begins 3 months before the month they turn 65, (2) includes the month they turn 65, and (3) ends 3 months after the month they turn 65. Outside of this initial enrollment period, most individuals can enroll in Part D only during the annual open enrollment period that runs from October 15 through December 7, with coverage beginning January 1.

[13] See discussion below on Part C plans.

[14] For more information on the LIS program, see https://www.medicare.gov/your-medicare-costs/help-paying-costs/save-on-drug-costs/save-on-drug-costs.html.

SEPs Under Part D

Some individuals might qualify for an SEP that allows enrollment in Medicare Part D outside of the annual open enrollment period, but no SEP is available specifically for AI/ANs. Individuals eligible for Medicare and Medicaid (dual eligibles) can enroll in, switch, or drop Part D plans at any time. Individuals who qualify for the LIS program also can enroll in, switch, or drop Part D plans at any time. The following individuals qualify for an SEP under Part D:

- Individuals who move to a new address, either outside of the service area of their plan or still within the service area but in a location with additional plan options, during the month before they move plus 2 additional months;[15]
- Individuals who move into, live in, or move out of an institution, such as a skilled nursing facility or long-term care hospital, for as long as they reside in the institution and for 2 months after the month they leave the institution;
- Individuals released from jail, for 2 months, beginning the month after their release;
- Individuals who lose Medicaid eligibility, leave health insurance through an employer or union (includes COBRA coverage), involuntarily lose creditable Part D coverage, leave a Medicare Cost Plan, or leave coverage through a Program of All-inclusive Care for the Elderly (PACE) plan, for 2 months, beginning the month after the loss of coverage; and
- Individuals whose plan changes its contract with Medicare (timeframe varies by case).[16]

Part D Premium

Individuals pay their Medicare Part D premium via direct payment to Part D plans. If a Tribe seeks to pay Medicare Part D premiums on behalf of Tribal members, it could do so by working directly with Part D plans to establish a process and minimize costs. Under such a Sponsorship program, the Tribe could provide information on the program to eligible Tribal members and have staff assist these individuals with the online enrollment process.[17] Tribal staff also typically work with account managers at Part D plans to reach agreements under which the Tribe provides the Part D plans with a list of sponsored Tribal members and the plans send consolidated bills to the Tribe on a monthly basis.

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[15] Individuals who wait to inform their plan about their change of address after they move qualify for the SEP during the month they inform their plan plus 2 additional months.

[16] A list of additional circumstances that can trigger special enrollment periods for Medicare Part D is available at https://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/special-circumstances/join-plan-special-circumstances.html.

[17] AI/ANs enrolling in Medicare Part D plans outside of the initial enrollment period might need to show the plan proof of creditable Part D coverage (IHS eligibility) to avoid the late enrollment penalty (*e.g.*, through a letter or telephone call from the Tribe or IHS).

Late Enrollment in Part D

Table 5 summarizes the premiums and late payment penalties for IHS-eligible persons and the general population. Individuals eligible for IHS do *not* have to pay a late enrollment penalty for Medicare Part D if enrolling after the initial enrollment period. For the general population, if individuals go without a Part D plan, a Part C plan that offers Part D coverage, or some other form of "creditable" Part D coverage for any continuous period of 63 days or more after their initial enrollment period ends, they might have a late enrollment penalty added to their Part D premium. But because eligibility for IHS qualifies as creditable Part D coverage,[18] IHS-eligible individuals do not have pay the late enrollment penalty.

Table 5. Medicare Part D Premiums and Late Enrollment Penalties, by Beneficiary Status, Income, and Tax Filing Status

Beneficiary Annual Income and Tax Filing Status (2016)[2]				Monthly Premium (2018)[1,2]	Late Enrollment Penalty[3,4]		
Beneficiary Status	Filing Individually[1]	Married, Filing Joinly	Married, Filing Separately		After 12 Months	After 24 Months	After 36 Months
IHS-eligible individuals	$85,000 or less	$170,000 or less	$85,000 or less	$35.02	No penalty	No penalty	No penalty
	$85,001-$107,000	$170,001-$214,000	--	$48.02	No penalty	No penalty	No penalty
	$107,001-$133,500	$214,001-$267,000	--	$68.62	No penalty	No penalty	No penalty
	$133,501-$160,000	$267,001-$320,000	--	$89.22	No penalty	No penalty	No penalty
	$160,001 or more	$320,001 or more	$85,001 or more	$109.82	No penalty	No penalty	No penalty
Individuals without Part D or creditable prescription drug coverage	$85,000 or less	$170,000 or less	$85,000 or less	$35.02	$4.22	$8.45	$12.58
	$85,001-$107,000	$170,001-$214,000	--	$48.02	$4.22	$8.45	$12.58
	$107,001-$133,500	$214,001-$267,000	--	$68.62	$4.22	$8.45	$12.58
	$133,501-$160,000	$267,001-$320,000	--	$89.22	$4.22	$8.45	$12.58
	$160,001 or more	$320,001 or more	$85,001 or more	$109.82	$4.22	$8.45	$12.58

[1] "National base beneficiary premium" ($35.02 in 2018) is used as the basis for the premium amounts listed in the table; actual Part D premiums vary by prescription drug plan.

[2] Individuals with annual income less than $18,090 and couples with annual income less than $24,360 might qualify for the LIS program, which helps pay Part D premiums (in 2017).

[3] Late enrollement penalty equals 1% of the national base beneficiary premium times the number of full months without Part D (or creditable) coverage.

[4] Table assumes no increase in the national base beneficiary premium from year to year; the national base beneficiary premium might increase from year to year, and as such, the actual penalty might increase from year to year.

Coverage/Cost-Sharing Under Part D Plans

Medicare Part D plans must offer either the defined standard benefit or an alternative equal in value ("actuarially equivalent") and also can provide enhanced benefits (see Table 6 below for

[18] Other examples of "creditable" coverage include coverage from a former employer or union, TRICARE, the Department of Veterans Affairs, or the Federal Employees Health Benefits Program; no similar exemption exists for the late enrollment penalty for Medicare Part B. See CRS, "Medicare: Part B Premiums," page 6, at https://www.fas.org/sgp/crs/misc/R40082.pdf.

information on the standard benefit).[19] However, Part D plans vary on their specific benefit design, cost-sharing amounts, utilization management tools (i.e., prior authorization, quantity limits, and step therapy), formularies (i.e., covered medications), and provider networks. For example, Part D plan formularies must include drug classes covering all disease states and a minimum of two chemically distinct medications in each class. In addition, Part D plans must cover all drugs in six "protected" classes: immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics. Nonetheless, specific name-brand medications might not be included in the formulary of a particular Part D plan.

Prior to selecting one or more Part D (or Part C) plans for use with Sponsored Tribal members, the Tribe should evaluate the available plans, including (1) assessing the ability of plan enrollees to access Indian health care providers (IHCPs) as in-network providers and (2) assessing the ability of IHCPs to receive payment, and the payment rates, from a Part D (or Part C) plan for services rendered.[20]

Table 6. Medicare Part D Standard Benefit for 2018

Initial coverage period	Deductible	$405
	Percentage of cost covered by enrollee	25%
	Initial coverage period coverage limit	$3,750
	Out-of-pocket (OOP) spending threshold before coverage gap begins	$1,343
Coverage gap	Percentage of cost covered by enrollee	35% for brand-name drugs; 44% for generic drugs
	Estimated total drug costs before catastophic coverage begins	$8,418
	Estimated OOP spending threshold before catastrophic coverage begins	$5,000
Catastrophic coverage	Percentage of cost covered by enrollee	5%
	Minimum cost covered by enrollee	$3.35 for generic/preferred drugs; $8.35 for other drugs

For 2018, the Part D standard benefit requires enrollees (or Indian health programs on their behalf) to pay a $405 deductible, and then 25% coinsurance until they reach a coverage limit of $3,750 in total drug costs (*i.e.*, combined plan and enrollee spending), followed by a coverage gap. In the coverage gap, as shown in Table 6, enrollees must pay for a larger share of their total drug costs than in the initial coverage period, until their total out-of-pocket spending

[19] For more information on Medicare Part D benefit parameters, see https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf.

[20] Under section 206 of the Indian Health Care Improvement Act (IHCIA), an IHCP is provided a right of recovery from an insurance company and other third-party entities, including Part D plans, for reasonable charges billed by an IHCP when providing services, or, if higher, the highest amount the third party would pay for services furnished by other providers. This right of recovery applies whether the IHCP is in a plan network or not.

reaches $5,000. After enrollees reach the catastrophic coverage threshold, they must pay either 5% of their total drug costs or $3.35/$8.35 for each generic and preferred/other drug, respectively. For purposes of coverage gap spending, direct spending by enrollees and drug costs incurred by Indian health programs on behalf of an enrollee count toward meeting the spending threshold.[21] Medicare indexes the standard benefit amounts annually based on the rate of Part D per capita spending growth.

Table 7 tracks the split between enrollee (and/or Indian health program) spending and Part D plan spending across the coverage periods.

Table 7. Medicare Part D Plan: Medicare and Enrollee Spending Shares for 2018

	Spending Range	Plan/Medicare Covers	Enrollee Pays	Total
Initial coverage period	$0-$400	$0	$405	$405
	$401-$3,750	$2,509	$836	$3,345
Coverage gap	$3,751-$8,418	$909	$3,759	$4,668
Catastrophic coverage	$8,419+	95% of costs	5% of costs[2]	--

[1] Kaiser Family Foundation, Figure 5. See https://www.kff.org/medicare/fact-sheet/the-medicare-prescription-drug-benefit-fact-sheet/.
[2] Or $3.35/$8.35 for generic and preferred/other drugs, respectively.

Alternative Prescription Drug Coverage Under Part C Plans

As another option, Medicare beneficiaries can obtain prescription drug coverage and potentially lower out-of-pocket costs by enrolling in a Part C (Medicare Advantage) plan. Under Part C, Medicare beneficiaries enroll in private plans that provide both Part A and Part B coverage and, in many cases, Part D coverage. Not all Medicare Advantage plans offer Part D coverage. Medicare beneficiaries who enroll in Part C plans must pay the Part B premium and, in many cases, an additional Part C plan premium. The average Part C premium in 2018 is $33.50 per month.[22]

In addition to premiums, Medicare Part C plan enrollees often must pay deductibles and coinsurance (or copayments) when accessing services, with these amounts determined annually by the plan effective January 1 of the coverage year. As compared to traditional Medicare Part A and Part B coverage, the Medicare Advantage plan might offer reduced out-of-

[21] CMS All-Tribes Call, November 2, 2012 (https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/11-2-2012-TranscriptAllTribesCall.pdf)
[22] The amount of premiums charged by (and level of access to) Medicare Part C plans varies substantially in different regions of the United States.

pocket costs. But as a trade-off to potentially lower out-of-pocket costs, patients are typically required to receive services from a more restricted list of health care providers than is available under fee-for-service Medicare. *If a Tribe seeks to pay Part C premiums on behalf of Tribal members, prior to enrolling members in the plan, the Tribe should (1) assess the ability of plan enrollees to access Indian health care providers (IHCPs) as in-network providers and (2) assess the ability of IHCPs to receive payment, and the payment rates, from a Part C plan for services rendered.*[23]

Out-of-pocket costs for Part C plan enrollees can vary widely, depending on the following factors:

- Whether the plan charges a monthly premium (in addition to the Part B premium);
- Whether the plan pays any of the monthly Part B premium;
- The amount of any annual (Part A or Part B) deductible or additional deductibles;
- The amount of any coinsurance or copayments the enrollee must pay for accessing services;
- The type and amount of services used;
- Whether the enrollee obtains services from in-network or out-of-network providers;
- Whether the enrollee requires extra benefits and whether the plan charges for those benefits;
- The amount of any out-of-pocket cost limits implemented by the plan; and
- Whether the enrollee qualifies for Medicaid or obtains financial assistance from their state.

Comparison of Part B and Part D Considerations

Table 8 below provides a comparison of considerations for Medicare Part B and Part D Sponsorship programs for Tribal members. In addition to the listed factors, for Part D plan Sponsorship, whether IHCPs are included in the provider network of a Part D plan and what the payment rates are under the Part D plan are two additional considerations. In addition, for Part D Sponsorship, a review of the plan formulary could be critical to determining the value of the coverage to particular Tribal members.

For additional reference, Table 9 below offers a comparison of Medicare Part B and Part D on a number of program elements regarding program operations and beneficiary (and/or Indian health program) costs.

[23] Under section 206 of the Indian Health Care Improvement Act (IHCIA), an IHCP is provided a right of recovery from an insurance company and other third-party entities, including Medicare Advantage plans, for reasonable charges billed by an IHCP when providing services, or, if higher, the highest amount the third party would pay for services furnished by other providers. This right of recovery applies whether the IHCP is in a plan network or not.

Table 8. Comparison of Medicare Part B and Part D Sponsorship Considerations for Tribal Members							
Sponsorship Program Type	**Covered Services**	**Enrollment Process**	**Late Enrollment Penalty**	**Late Enrollment Penalty Amount**	**Late Enrollment Penalty Exemption for Creditable Coverage** (*e.g.,* IHS Eligibility)	**Premium Payment Mechanism (w/o Sponsorship)**	**Premium Payment Mechanism (w/ Sponsorship)**
Part B	Physician services, outpatient care and certain other services	Automatic at age 65 (for SS check recipients; optional for others)	Yes	10% increase in premium ($134.00 for standard premium in 2018) for each full 12-month period eligible for, but not enrolled in, Part B	No	Deduction from enrollee SS check paid to federal government	Tribe pays enrollee for SS check deduction
Part D [1]	Outpatient prescription drugs	Optional at age 65	No (for IHS eligibles)	No late fee for IHS-eligible individuals[2]	Yes	Enrollee payment to private plan	Tribe pays private Part D plan (consolidated)

[1] Likewise, a Medicare beneficiary can enroll in a Part C (Medicare Advantage) plan that offers Part D prescription drug coverage.

[2] For the general population, the late enrollment penalty is 1% of the "national base beneficiary premium" ($35.02 in 2018) times the number of full months without Part D (or creditable) coverage.

Table 9. Comparison of Medicare Part B and Part D Program Operations and Beneficiary Costs		
	PROGRAM OPERATIONS	
	Part B	**Part D**
Covered Services	Physician services, outpatient care, and certain other services	Outpatient prescription drugs
Enrollment Process	Automatic at age 65 (for SS check recipients; optional for others)	Optional at age 65
Initial Enrollment Period	7-month period, beginning 3 months before the month individuals turn 65 and ending 3 months after the month they turn 65	7-month period, beginning 3 months before the month individuals turn 65 and ending 3 months after the month they turn 65
Annual Enrollment Period	January 1 to March 31, with coverage beginning July 1	October 15 to December 7, with coverage beginning January 1
Special Enrollment Periods	Yes, under limited circumstances (no SEP available specifically for AI/ANs)	Yes, under limited circumstances (*e.g.* individuals eligible for premium assistance and/or Medicaid can enroll in and switch plans any time; no SEP available specifically for AI/ANs)
	BENEFICIARY COSTS (2018)	
	Part B	**Part D**
Monthly Premium	$134 (with higher premiums for higher-income beneficiaries)	Varies by plan
Cost-Sharing	Annual deductible ($183) and coinsurance (20% for most services)	Annual deductible ($405) and copayments and/or coinsurance
Premium Assistance	Medicare Savings Programs for low-income individuals (< $16,524) and couples (< $22,164) (in 2017)[1]	Low-Income Subsidy Program for low-income individuals (< $18,090) and couples (< $24,360) (in 2017)[1]
Late Enrollment Penalty	10% increase in premium for each full 12-month period eligible for, but not enrolled in, Part B	1% of the "national base beneficiary premium"[2] times the number of full months without Part D (or creditable) coverage
Late Enrollment Penalty Exemption	No, unless individuals receive premium assistance	Yes, if individuals have creditable coverage (*e.g.* , IHS eligibility) or receive premium assistance

[1] Income-eligible individuals and couples also must meet asset limit requirements.

[2] The national base beneficiary premium is $35.02 in 2018.