IHS TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE

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Submitted Via Email: consultation@ihs.gov

July 6, 2018

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

Re: TSGAC Comments on Purchased and Referred Care (PRC) Chapter Update

Dear RADM Weahkee:

On behalf of the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC), I submit these written comments in response to the IHS May 18, 2018 Dear Tribal Leader Letter (DTLL) initiating Tribal consultation on changes to the Indian Health Manual (the "Manual"), Part 2, Chapter 3 "Services to Indians and Others" (also known as "Purchased/Referred Care" or "PRC") (the "PRC Chapter"). Included with these written comments is a redline of the Draft PRC Chapter. This redline document details most of our recommendations in the draft itself.

Background

IHS's legal authority for issuing the Manual is addressed in the eligibility regulation at 42 C.F.R. § 136.3, which provides that the IHS will periodically issue administrative instructions to its officers and employees that are primarily found in the Manual: "These instructions are operating instructions to assist IHS officers and employees in carrying out their responsibilities and are not regulations establishing program requirements which are binding upon members of the general public." Thus, the IHS cannot use the Manual to rewrite the PRC regulations at 42 C.F.R. Part 136, Subpart C and 42 C.F.R. § 136.61, which establishes the payor of last resort rule.

If the IHS wants to issue "substantive rules of general applicability adopted as authorized by law or statements of general policy or interpretations of general applicability," the IHS must publish them in the Federal Register in accordance with the Administrative Procedure Act (APA), 5 U.S.C. §§ 552(a) and 553 (notice and comment rulemaking). Thus, the IHS cannot use the Draft PRC Chapter to: (1) redline/edit and paraphrase the actual language of the regulations as a means to change the regulations without going through APA procedures; (2) establish formal agency interpretations of statutes and regulations again without complying with the APA; or, (3) declare, in certain instances, that the IHS will no longer adhere to specific requirements in the regulations.

Furthermore, as stated in 42 C.F.R. § 136.3 noted above, the Manual provides administrative instructions to IHS officers and employees carrying out PRC programs operated by the IHS. It is not binding on Indian Tribes and Tribal organizations carrying out contracted or compacted PRC programs under the Indian Self-Determination and Education Assistance Act (ISDEAA), unless a

Tribe or Tribal organization expressly agrees in its contract, compact, or funding agreement to be bound by the Manual.[1]

General Recommendations for the Draft PRC Chapter

While we appreciate that IHS is conducting Tribal consultation on the chapter, in the future, we encourage the IHS to meet with Tribal Workgroups and technical advisors to hear and incorporate their recommendations before issuing a DTLL, particularly on detailed matters such as this. In addition, we request that IHS utilize the PRC Workgroup to review the comments submitted during this consultation to develop a revised Draft PRC Chapter that will go out for Tribal consultation before being finalized.

In general, throughout the Draft PRC Chapter, there are numerous errors, including but not limited to: (1) terms are incorrectly phrased as plural or singular when it should be the opposite; (2) undefined or vague terms or phrases are used instead of those with specific meaning in the definitions section;[2] (3) specific terms are used inconsistently (*e.g.*, "Indian" versus "American Indian/Alaskan Natives"); (4) phrases and terms with acronyms are spelled out instead of identified by their acronyms; and (5) citations reference the wrong authority, and links do not work or reference incorrect materials. Some, but not all, of these errors are identified in the enclosed redline document.

Additionally, we suggest returning to the numbering of subsections to A, B, C, then (1), (2), (3), and a, b, c.[3] Similarly, the definitions in Section 2-3.1.5 should be ordered alphabetically. Furthermore, we cannot properly comment at this time on the proposed changes to numerous provisions referencing Manual Exhibits or the documents themselves because the IHS has not released or made public revised versions.[4]

The following is a summary of the major issues we have identified with IHS's proposed revisions to the PRC Chapter, and our recommendations.

Definitions

Since the PRC Chapter cannot re-define terms already defined by statute or regulation, Section 2-3.1.5 should contain definitions as already prescribed by law. For example, Section 2-3.1(5)(25) deletes "former reservations in Oklahoma" from the definition of "Reservation," even through the phrase is in the definition of the term in 25 U.S.C § 1603(16) and 42 C.F.R. § 136.21(i). If clarification is necessary for IHS officers and employees to understand terms, the PRC Chapter should set off the legal definition in quotes to contrast it with the Agency's own explanation.

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[1] 25 U.S.C. §§ 5329(c)(1) (model self-determination contract § 1(b)(11)), 5397(e).

[2] For example, "facility" compared to "IHS facility." Facility alone is an undefined term. Since the PRC Chapter does not regulate tribal health programs, we suggest identifying, where appropriate, the phrase as an IHS facility. Otherwise, this statement would infringe on tribal self-governance.

[3] These written comments reference the sections of the PRC Chapter using the numbering system in the Draft.

[4] The Manuel Exhibits that are unavailable for comment include: Manual Exhibit 2-3-B (Authorization for Use or Disclosure of Health Information); Manual Exhibit 2-3-J (Object Class Code Narratives and Service Class Code Narratives); Manual Exhibit 2-3-P (New; Discusses Time of Payment by IHS); Manual Exhibit 2-3-Q (New; Sample letter to patients notifying them that they are not liable for payment of services authorized and approved for payment under a PRC Program).Manual Exhibit 2-3-B; Manual Exhibit 2-3-J; Manual Exhibit 2-3-P; Manual Exhibit 2-3-Q.

Problematically, the definition of "Tribally-Operated Program," which is defined in Section 2-3.1(5)(31) as "a program operated by a Tribe or Tribal organization that has contracted under Pub. L. 93-638 to provide a PRC program," is inconsistent with the court's ruling in the *Redding Rancheria* case.

The court in *Redding Rancheria* interpreted the following provision, codified by the Patient Protection and Affordable Care Act (ACA) at 25 USC § 1623(b):

Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations (as those terms are defined in section 4 of the Indian Health Care Improvement Act [IHCIA] (25 U.S.C. § 1603) shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary.

During litigation, the IHS took the position that this language referred to the definition of the term "tribal health program" in Section 4(25) of the IHCIA, 25 U.S.C. § 1603(25), which is defined as a program compacted or contracted with the IHS under the ISDEAA. The effect of the IHS's interpretation was to exclude tribal self-insured health plans and make them alternate resources. The court rejected this argument, determining that the parenthetical language—"(as those terms are defined in section 4 of the IHCIA)"—referred to how all of the entities listed (the IHS, Tribes, Tribal organizations, and Urban Indian organizations) are defined in the IHCIA. The result of the court's holding was that "health programs operated by Indian tribes, tribal organizations" meant *any* health program operated by Tribes and Tribal organizations, including Tribal self-insurance plans.

Therefore, we recommend that the term "Tribally-Operated Program" be removed from the PRC Chapter and that the IHS instead use the term "Tribal Health Program," which is defined in Section 1603(25) of the IHCIA, for references to Tribally-compacted or contracted programs, as appropriate.

Payor of Last Resort Requirements

Alternate Resources

In numerous places throughout the Draft PRC Chapter, the IHS defines and provides criteria for determining what it would consider an "alternate resource." The definitions section includes programs under "the Social Security Act (*i.e.*, Medicaid, Medicare and Children's Health Insurance Program), other Federal healthcare programs, State and local healthcare programs, [the] Veterans Health Administration, and private insurance" (Section 2-3.1(5)(1)). The payor of last resort rule section also adds Vocational Rehabilitation, Children's Rehabilitative Services and the Crime Victims Act (Section 2-3.8(7)). Instead of multiple, inconsistent definitions, the Draft PRC Chapter should cite the current regulation at 42 C.F.R. § 136.21, referring to the definition of "alternate resources" at 42 C.F.R. § 136.61(c), for the definition. Then, in Section 2-3.8(7), the IHS may expand upon the definition with more information. Furthermore, the alternate resources section should state that "local" does not mean "Tribal," and "private health insurance" does not mean Tribal self-insured health plans.

In Section 2-3.8(7), the statement "All IHS or Tribal facilities that are available and accessible to an individual are considered alternate resources" appears to be intended to capture the requirement that an individual may not access PRC if services are available at the IHS/Tribal facility. However, that requirement is already in the regulations, and it is inappropriate to add here. As drafted, the language

suggests that both the IHS and/or a Tribe could be considered an alternate resource— i.e., alternate to themselves. This is inconsistent with the law, and inconsistent with the *Redding* decision. We recommend deleting the statement.

We recommend that IHS review their position of considering Veterans Administration (VA) resources as an alternate resource for care provided to AI/AN Veterans. IHS has stated that eligibility for VA healthcare services will be treated as an alternate resource, and if a patient is a veteran is eligible for healthcare provided by the VA and that person needs specialty care, the veteran patient will be referred back to the VA to receive the specialty care. This referral back to the VA leads to continuity of care issues that makes it difficult for the patient to navigate both systems. In addition, it subjects the AI/AN veteran to co-pays at VA healthcare facilities. As a result, we recommend that IHS pursue the full implementation of Section 405(c) of the Indian Health Care Improvement Act with the Veterans Administration by including PRC services in the Memorandum of Understanding in order to prevent further rationing of the amount of health care provided by Indian health care providers to AI/AN veterans and other eligible AI/AN in the system.

Sponsorship of Plans. In terms of other coverage provided by Tribes, from the language of Section 2-3.8(10) it appears the IHS would consider insurance purchased by a Tribe for its members (also known as "sponsorship" plans) as an alternate resource, unlike Tribal self-insurance but separate from reinsurance. Section 402 of the IHCIA, 25 U.S.C. § 1642, authorizes Indian Tribes, Tribal organizations, and urban Indian organizations to use federal funds available to them under the ISDEAA, Social Security Act programs (such as Medicare, Medicaid, and Children's Health Insurance Plan reimbursements), or under other Federal laws, to purchase "health care benefits coverage" for IHS eligible beneficiaries. It is unclear what the IHS means by "sponsorship through indemnity" in Section 2-3.8(10) of the Draft PRC Chapter. This should be clarified to simply state "sponsorship of insurance plans." Furthermore, for ease of reading, we suggest moving this provision up to be included within the provision about alternate resources in Section 2-3.8(7).

Charity or Indigent Care Programs. In Sections 2-3.8(1)(3) and 2-3.8(1)(7), the IHS states that a charity or indigent care program is not considered an "alternate resource" for purposes of the payor of last resort rule when the PRC provider absorbs the full cost of services provided. In other words, the IHS does not consider a non-Indian provider an available source of payment to himself or itself. One example of this could be when a hospital charity program writes-off the cost of care for services provided to persons eligible for the charity program. However, such programs may still be "health care resources" under the IHS payor of last resort rule at 42 C.F.R. § 136.61, and we think it is reasonable to conclude under the statutory language at 25 U.S.C. § 1623(b) that a charitable source of coverage—including write-offs by providers under established charity or indigent care programs—should be accessed before a PRC program would have to be the payer for care. We thus suggest that the language on charitable programs in Section 2-3.8(1)(3) be removed and the language in Section 2-3.8(1)(7) be revised to clarify that available charity or indigent care programs are considered alternate resources for purposes of PRC if an individual is eligible for the program or would be eligible but for having PRC.

Student Grant Funds. As drafted, the provision requiring students to purchase health insurance with grant funds places a requirement on students that may be incompatible with the terms of a grant(s). Additionally, it is unclear whether "individuals" in the next sentence means to require *any* person receiving funds for health insurance to purchase it, or only students. We recommend that the IHS

clarify and move the provision up to be included within the provisions for alternate resources in section 2-3.8(7).

Tribal Self-Insurance

Section 2-3.8(9) would expressly exempt "tribally funded self-insurance plans"[5] from consideration as an alternate resource but "[a]ny portion of the plan that is reinsured will not be considered Tribal Self-Insurance." While the proposed language as drafted may be intended to only include the reinsurance itself as an alternate resource, that is not how it reads. The language as drafted states that the IHS would consider the entire reinsurance plan an alternate resource if a Tribe has any reinsurance on it. While it may be appropriate for reinsurance to be considered an alternate resource when the reinsurance is paying, rather than the tribe, it is not appropriate for a Tribal Self-Insured plan to be considered an alternate resource simply because it is reinsured. Furthermore, the Draft PRC Chapter's exclusionary clause does not recognize that the IHS may bill Tribal self-insurance if the Tribe gives permission.[6] The PRC Chapter should not foreclose this option. The redline document revises provisions for the Tribal self-insurance to reflect these recommendations. Lastly, for ease of reading, we recommend moving this provision directly below the alternate resources provision and above the qualified health plan provision.

Failure to Follow Alternate Procedures

As Section 2-3.8(4)(1) is structured in the Draft PRC Chapter, it is not clear what action the 10-day timeframe applies to. Is it for contacting facility staff for help, to complete an application, or both? Or, does it reference the issuance of a denial letter? As currently drafted, it is unlikely that providers would be able to understand the requirements of this provision. Our redline document attempts to make this clearer. However, we recommend that the IHS revise this section to more accurately communicate the requirements. Furthermore, the current PRC Chapter provides for a 30-day timeframe, which the IHS changed to 10-days in the Draft PRC Chapter. The IHS should change it back to 30 days or provide a citation authorizing the change.

PRCDAs and the Process for Re-Designation

In Section 2-3.3(1), the IHS takes the position that it may only provide services in Purchased/Referred Care Delivery Areas (PRCDAs) under the current regulations, stating that it would have to amend the regulations by notice and comment rulemaking in order to recognize new PRCDAs. While the IHS does not directly state it, they appear to be taking the position that new PRCDAs established by Congress cannot be implemented until the IHS changes its regulations. This position is contrary to current law because acts of Congress supersede conflicting agency regulations.

Another confusing change seems to expand the consultation requirement. Currently, the regulations only require consultation with Tribes *within* a PRCDA;[7] but as we read the new provision in Section 2-3.4(3)(1) of the Draft PRC Chapter, an Area PRC Officer must consult with *any* Tribe affected by a designation or re-designation of a PRCDA. The intent behind the provision could be to simply

[5] We note that the phrase "tribally funded self-insurance plans" differs from the specifically defined term "Tribal Self-Insurance," and the defined term "Tribal Self-Insurance" should be used.
[6] *See* 25 U.S.C. § 1621e(f).
[7] *See* 42 C.F.R. § 136.22(b).

reiterate the consultation requirement instead of creating a new one, but this is not clear from how the IHS phrased it.

In Section 2-3.4(3)(3), the IHS includes an ad hoc PRCDA Designation/Re-Designation Committee—a Committee with which we are not familiar. It is unclear whether this Committee is new or if it is already existing practice that is just now being written down. As provided for in the Draft PRC Chapter, this Committee would review re-designation requests submitted to the Director of the Division of Contract Care (DCC) to determine if the information submitted meets the criteria set forth in Section 2-3.4(1). The Director of the DCC would then send the Committee's findings and recommendation to the Director of the IHS for a final determination. As drafted, the Committee's recommendation would replace that of the Director of the DCC. There is not much information about the Committee besides that its membership would include leadership from numerous offices within the IHS. We suggest including more information about the role and responsibilities of the Committee. We also request that there be Tribal representation on this Committee. Furthermore, stating that the PRCDA designation/re-designation cannot be appealed suggests that the IHS's decision cannot be appealed under the APA, which is incorrect.

Eligibility Requirements

The way in which both the current and Draft PRC Chapter outline the PRC eligibility requirements is different from how they are outlined in the PRC eligibility regulations, which creates significant confusion. In the enclosed redline document, we suggest that this be fixed in the Draft PRC Policy at Section 2-3.6(2), in order to mirror the outline in the regulations as follows:

To be eligible for PRC, an individual must be eligible for direct care as defined in 42 C.F.R. § 136.12; and either

1. reside within the U.S. on a Federally-recognized Indian reservation; or

2. reside within a PRCDA and;

    a. be a member of the Tribe or Tribes located on that reservation; or

    b. maintain close economic and social ties with that Tribe or Tribes.

We support several changes by the IHS in the eligibility section including: (1) a change to Section 2-3.6(3), which recognizes the ability of Tribes to define who is eligible for PRC though close economic and social ties; and (2) the addition of "high school" students as full-time students eligible for care outside of their PRCDA (Section 2-3.6(4)).

However, we have several recommendations for the new provision about PRC for persons in custody. The Draft PRC Chapter does not define what the IHS would consider "Indian law enforcement." We recommend the IHS clarify that the phrase "Indian law enforcement" includes both the Bureau of Indian Affairs (BIA) and Tribal law enforcement, and explain how the IHS would identify law enforcement agencies operating under a contract or compact with a Tribe to provide law enforcement services. Similarly, the purpose of putting "non-Indian" in parentheses is unclear.

Tribal Appeals Process

We support the new provision at the end of Section 2-3.11(4), which is the Tribal appeals process for contractors, because it recognizes that Tribal contractors are not legally required to use the IHS appeals process for their PRC program. However, it appears to only discuss the Tribal Appeals Process in terms of retained authority but does not refer to the option to buy back the appeals process. Our redline document adds language to recognize that tribes have this option.

Additionally, Section 2-3.11(5)(1) states that the IHS will not use "Tribal criteria and interpretations" in the appeals process. This is not consistent with several other provisions: Section 2-3.6(3), which states that the IHS will recognize Tribally defined criteria for PRC eligibility; Section 2-3.11(7) (following this provision) that recognizes that Tribes may set different standards for PRC eligibility and medical priorities; and Section 2-3.20(6), recognizing Tribal criteria for high cost cases. This provision should allow for a process that includes review by the aforementioned Tribal standards, not those set by the IHS. As an aside, we support all of the provisions recognizing the authority of Tribes to set their own criteria and standards.

Notification of a Claim

The definition of "Notification of a Claim" in Section 2-3.1(5)(22) is duplicative of Section 2-3.21(2)(1) and (2). As this term requires significant explanation, more in the form of requirements than a definition, we recommend that Section 2-3.1(5)(22) be deleted.

Section 2-3.21(2)(1) is paraphrased from 42 C.F.R. § 136.24(b), and is not an accurate statement of the regulations. This provision should accurately reflect the law. Similarly, Section 2-3.21(2) prefaces all the requirements that follow with citations to statutes and the regulations. This could lead the reader to presume that those statutes and regulations legally oblige the provider to meet the requirements. However, the three requirements in Section 2-3.21(2)(2) are not mandated by any law and are only provided for in policy. The enclosed redline document provides solutions to these problems.

Additionally, Section 2-3.21(2)(2)(1) appears to require information from a provider (whether a patient is eligible for care) that a provider would not have. It is the IHS's responsibility to determine whether a patient is eligible. If the IHS's intent is that this provision require sufficient information about the patient from the provider so that *the IHS* can identify a patient as eligible on its end, that is unclear and should not be a requirement. Similarly, the use of "IHS services" in this provision is unclear because it is an undefined term. We recommend removing this provision.

Recommendations for Clarifying Definition of "Referrals" and "Authorizations"

As part of the current review of and revisions to the IHS Manual, Part 2, Chapter 3, an opportunity exists to include and/or revise definitions of key terms in order to clarify what a "referral under [PRC]" means for purposes of securing the comprehensive cost-sharing protections under the ACA.

The following definitions are proposed by the IHS for the revised Part 2, Chapter 3, Section 5 of the IHS Manual:

"10. Medical Referral. A referral for health care services that is not authorized for payment by PRC."

"24. PRC Referral. An authorization for medical care by the appropriate ordering official in accordance with 42 CFR part 136 subpart C."

Further revisions of the proposed definitions would be useful and include the following (with additions appearing in bold and deletions appearing in strikethrough):

"10. ~~Medical~~ Referral. A referral for health care services **by an Indian health care provider that authorizes care** but that **does not represent that a patient is eligible for PRC** and does not authorize payment by PRC**, in accordance with 42 CFR part 136 subpart C**."

"24. PRC **Authorization** ~~Referral~~. An authorization **for payment** for medical care by the appropriate ordering official in accordance with 42 CFR part 136 subpart C."[8]

The modified definitions recommended above aim to achieve several goals:

1. Make a distinction between: (a) issuance of a referral for a health care item or service for a patient of an Indian health care program; and, (b) authorizing payment for the item or service.
    - A referral does not authorize payment.

2. Removes the term "medical" from the definition, as some health plan issuers interpret a "medical" referral to not include pharmaceutical services.

3. Indicates that a "referral" issued by an Indian health care provider is considered a referral under (and pursuant to the regulations of) the PRC program; this clarification is important as it:
    - Describes the referral in a manner consistent with the requirements of section 1402(d)(2) of the ACA;
    - Eliminates the need for PRC program staff to take an additional step to review formally a referral *and decline a PRC authorization* in order to—
        i. "Become" a PRC referral; and
        ii. Provide the Medicare-like rates protections of a PRC referral.[9]

Additional ACA-Related Modifications

The TSGAC also recommends changes to the language proposed by the IHS for the revised Part 2, Chapter 3, Section 8 of the Indian Health Manual, as follows:

- The subsection titled "Qualified Health Plan from a Federal or State Marketplace" should include the following revisions (with additions appearing in bold and deletions appearing in strikethrough):

[8] These changes might require changes in other parts of the IHS Manual to ensure consistency.

[9] The proposed changes would not prohibit an IHS or Tribal health care program from establishing a procedure under which a PRC program could formally consider these referrals, but it would eliminate the requirement that all programs impose this review process in order to secure the cost-sharing protections under the ACA.

"1. Qualified Health Plans (QHP) are available through the Marketplace where consumers can compare health insurance options. Pub. L. 111-148, Patient Protection and Affordable Care Act (March 23, 2010) provides special protection for members of Federally-recognized Tribes from cost-sharing (deductibles, coinsurance and copayments) for the provision of essential health benefits in a QHP.

2. Zero Cost-Sharing plans are only available to members of Federally-recognized Tribes and Alaska Natives with incomes at or between 100% and 300% of the federal poverty level.

1. In-Network Providers — **For purposes of the ACA cost-sharing protections,** a referral is not needed for the patient to receive an EHB from an "in-network" non-Indian health care provider.

2. Out-of-Network Providers — **For purposes of the ACA cost-sharing protections,** ~~authorized PRC referral~~ **a PRC authorization for payment** is required to cover ~~out of network~~ **balance billing** charges. **Balance billing charges are the difference between the amount that the provider charges and the maximum amount that the health plan pays for a covered service.** ~~Out of network~~ **Balance billing** charges are not a co-pay, co-insurance or deductible.

3. Limited Cost-Sharing plans are available to members of Federally-recognized Tribes and Alaska Natives with any level of income. There is no cost sharing as long as the service is **furnished by an Indian health care provider or** referred through a PRC program.

1. In-Network Providers — A PRC referral is required to avoid cost sharing for essential health benefits (EHB) furnished by **an "in-network" non-Indian health care provider**. The PRC referral must state it is for all EHB for the episode of care.

2. ~~In-Network Providers~~ **Prior Authorization** — **For a QHP (or other insurer) to make payment for an item or service, the QHP might impose various prior authorization requirements.** PRC staff need to confirm with the QHP and assist the beneficiary in acquiring **any prior authorizations, such as a** referral **from a primary care provider**.

3. Out-of-Network Providers — A PRC **authorization** is required to cover any out-of-network charges and to cover authorized charges up to the PRC rate. ..."

Other Issues

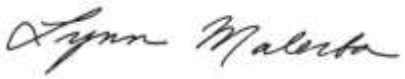
In Section 2-3.9(3), Authorization for PRC, the IHS appears to place a mandate on the Centers for Medicare and Medicaid Services (CMS). The IHS cannot govern the activities of the CMS. If there is an agreement between the IHS and the CMS recognizing that the CMS will take these actions, the IHS should reference it in this section.

We thank the IHS for providing Tribes with the flexibility to adjust funding based on local needs in Section 2-3.12(1), Allocation of PRC Funds. However, we note that the ability of individual PRC programs to make a determination about using PRC funds for staff administering the PRC program is problematically conditioned on the Area Director making annual reports (Section 2-3.12(3)(1)). As reflected in the enclosed redline document, the provision can be kept but should be made into a separate criteria instead of a condition for using PRC funds for staff administering the PRC program.

Conclusion

We appreciate the opportunity to provide our input into the IHS's revisions to the PRC Chapter, and your continuing commitment and partnership with Indian Country. Thank you for considering our written comments. At the close of the Tribal consultation period, the TSGAC requests that the PRC Workgroup be reconvened to review the detailed comments and develop a revised draft that incorporates the results from Tribal consultation. Should you have questions or require additional information, please do not hesitate to contact me at (860) 862-6192 or via email at lmalerba@moheganmail.com. Thank you.

Sincerely,



Marilynn "Lynn" Malerba
Chief, Mohegan Tribe
Chairwoman, TSGAC

cc: Jennifer Cooper, Director, Office of Tribal Self-Governance
TSGAC and Technical Workgroup Members

Attachment: Tribal Comment Letter Redline of Draft PRC Chapter